The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-812-232-4384. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-812-232-4384 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** individual/**$1,500** family (January 1 – December 31)	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Routine immunizations are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. **$100** individual/**$300** family for brand name prescription drugs (January 1 – December 31). There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$1,500** individual/**$4,500** family (January 1 – December 31)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, prescription drugs, the deductible, coinsurance for physical therapy and chiropractic services, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use a non-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use a non-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	None
	Specialist visit	20% coinsurance	30% coinsurance	Chiropractic services limited to $1,250 per individual per calendar year. Coinsurance for chiropractic services does not count toward the out-of-pocket limit.
	Preventive care/screening/ immunization	20% coinsurance; for routine immunizations, no charge and the deductible does not apply	30% coinsurance; for routine immunizations, no charge and the deductible does not apply	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	Coinsurance for diagnostic tests for chiropractic services does not count toward the out-of-pocket limit.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Coinsurance for imaging for chiropractic services does not count toward the out-of-pocket limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com.	Generic drugs (Tier 1)	$10 copay/fill (retail); $20 copay/fill (mail order)	50% coinsurance	30-day supply retail; 90-day supply mail order. Maximum of 3 retail fills for maintenance medications, which then must be filled through mail order. Brand deductible applies for retail, mail order and maintenance fills. When you fill a prescription at a non-participating pharmacy or you do not have your ID card, you must pay the full cost of the prescription when you have it filled and submit a claim for reimbursement. When you have your medication filled with a multi-source brand name medication, you are responsible for the brand name copayment, plus the difference in cost between the generic and multi-source brand name medication. If prescription exceeds federal or clinically recommended dosages or quantity limits, no fill without prior approval. Cost sharing for prescription drugs does not count toward the out-of-pocket limit.
	Single-source brand drugs (Tier 2)	$20 copay/fill (retail) after $100 deductible; $50 copay/fill (mail order) after $100 deductible	50% coinsurance after $100 deductible	
	Multi-source brand drugs (Tier 3)	$20 copay/fill (retail) after $100 deductible plus difference in cost between generic and multi-source brand name drug with minimum copay of $40; $50 copay/fill (mail order) after $100 deductible plus difference in cost between generic and multi-source brand name drug with minimum copay of $100	50% coinsurance after $100 deductible	
	Specialty drugs	Same cost sharing as Tier 1, Tier 2, and Tier 3 drugs, depending on the type of specialty drug	Same cost sharing as Tier 1, Tier 2, and Tier 3 drugs, depending on the type of specialty drug	Must be filled through BriovaRx or an OptumRx preferred retail pharmacy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	30% coinsurance	None
	Emergency medical transportation	20% coinsurance	30% coinsurance	In limited and special circumstances, the plan covers transportation to the nearest hospital equipped to furnish the treatment not available in a local hospital.
	Urgent care	20% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Charges based on semi-private room rates.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	None
	Inpatient services	20% coinsurance	20% coinsurance	Includes residential treatment facilities.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Prenatal and childbirth expenses are not covered for dependent children.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	None
	Rehabilitation services	20% coinsurance	30% coinsurance	40 visits per year. Includes physical/occupational therapy. Coinsurance for physical therapy does not count toward the out-of-pocket limit. Physical therapy includes medically necessary aquatic therapy if certain criteria are met.
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even from a network provider.
	Skilled nursing care	Not covered	Not covered	You must pay 100% of this service, even from a network provider.
	Durable medical equipment	20% coinsurance	30% coinsurance	Lifetime maximum of one wheelchair per individual.
	Hospice services	20% coinsurance	30% coinsurance	Must have a physician's diagnosis of life expectancy of six months or less.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even from a network provider.
	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even from a network provider.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even from a network provider.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery (except to repair damage caused by injury, congenital defect, disease, or reconstructive surgery following mastectomy)
- Dental care (Adult & Child)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Skilled nursing care
- Weight loss programs (except for treatment for morbid obesity)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery (lifetime maximum of one treatment per individual; must meet certain criteria)
- Chiropractic care (limited to $1,250 per individual per calendar year)
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Mid Central Operating Engineers Health and Welfare Fund, P.O. Box 9605, Terre Haute, Indiana, 47808, at 1-812-232-4384. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of network provider pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$540*
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,100**

Managing Joe's type 2 Diabetes
(a year of routine network provider care of a well-controlled condition)

The plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600*
Copayments	$680
Coinsurance	$370
What isn't covered	
Limits or exclusions	$220
The total Joe would pay is	**$1,870**

Mia's Simple Fracture
(network provider emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$290
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$790**

***NOTE:** This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

A Health Reimbursement Account (HRA) is also available under this plan. The HRA generally covers expenses that qualify as allowable "medical care" by the IRS and satisfy any requirements imposed by the plan. Please refer to the SPD for additional details.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.