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?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan does not have a deductible.
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?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not applicable. Individuals who use a provider that does not accept Medicare are responsible for the difference between the Medicare allowance and the billed amount.	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider (You will pay the least)	Non-Medicare 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	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of flu and pneumococcal immunizations if the provider accepts Medicare assignment. The Plan pays 100% of your Medicare Part B deductible and your coinsurance. The Plan pays 20% of Medicare allowable for Hepatitis B shots, mammogram, bone mass measurements, pap test, pelvic exams, colorectal cancer screening, and prostate cancer screening. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit			
	Preventive care/screening/ immunization			
If you have a test	Diagnostic test (x-ray, blood work)	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of flu and pneumococcal immunizations if the provider accepts Medicare assignment.
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider (You will pay the least)	Non-Medicare 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. 3-fill maximum on maintenance drugs not filled through maintenance or mail order programs. 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. Non-sedating prescription allergy medications, proton pump inhibitors, and compound prescriptions are covered at 50% coinsurance.
	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	Not covered.	Must be filled through an OptumRx preferred retail pharmacy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider (You will pay the least)	Non-Medicare Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part B deductible and your coinsurance.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part B deductible and your coinsurance.
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge for days one to sixty; for days sixty-one to one hundred, the Plan will pay the per day coinsurance	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part A deductible and your coinsurance.
	Physician/surgeon fees	No charge if allowed by Medicare		The Plan pays 100% of your Medicare Part B deductible and your coinsurance.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Plan pays up to 50% of Medicare allowable	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part A deductible and coinsurance and your Medicare Part B deductible and coinsurance.
	Inpatient services	No charge for days one to sixty; for days sixty-one to one hundred, the Plan will pay the per day coinsurance		
If you are pregnant	Office visits	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part A deductible and coinsurance and your Medicare Part B deductible and coinsurance. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider (You will pay the least)	Non-Medicare Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Plan pays up to 20% of Medicare allowable	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part A deductible and coinsurance and your Medicare Part B deductible and coinsurance.
	Rehabilitation services	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part A deductible and coinsurance and your Medicare Part B deductible and coinsurance.
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even from a Medicare provider.
	Skilled nursing care	No charge for days one to twenty; for days twenty-one to one-hundred, the Plan will pay the per day coinsurance	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part A deductible and your coinsurance.
	Durable medical equipment	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part B deductible and your coinsurance.
	Hospice services			The Plan pays 100% of your Medicare Part A deductible and coinsurance and your Medicare Part B deductible and coinsurance.
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 Medicare provider.
	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even from a Medicare provider.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even from a Medicare 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.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs (except for treatment of morbid obesity)

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

- Bariatric Surgery (must meet all Medicare criteria)
- Chiropractic care (must meet all Medicare criteria)

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 on how 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**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Not applicable**

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 Medicare provider pre-natal care and a hospital delivery)

The plan's overall deductible	**N/A**
Specialist	**N/A**
Hospital (facility)	**N/A**
Other	**N/A**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$10*
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

The plan's overall deductible	**N/A**
Specialist	**N/A**
Hospital (facility)	**N/A**
Other	**N/A**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100*
Copayments	$510
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	**$710**

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

The plan's overall deductible	**N/A**
Specialist	**N/A**
Hospital (facility)	**N/A**
Other	**N/A**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$10*
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$10**

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

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