



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



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	Marathon Health & Wellness Centers: No charge, <u>deductible</u> does not apply. All other: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Chiropractic services limited to \$1,250 per individual per calendar year. <u>Coinsurance</u> for chiropractic services does not count toward the <u>out-of-pocket limit</u> .
	<u>Preventive care/screening/immunization</u>	Marathon Health & Wellness Center, routine immunizations: no charge and the <u>deductible</u> does not apply All other: 20% <u>coinsurance</u>	30% <u>coinsurance</u> ; for routine immunizations, no charge and the <u>deductible</u> does not apply	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Coinsurance</u> for <u>diagnostic tests</u> for chiropractic services does not count toward the <u>out-of-pocket limit</u> .
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Coinsurance</u> for imaging for chiropractic services does not count toward the <u>out-of-pocket limit</u> .

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 <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs (Tier 1)	\$10 <u>copay</u> /fill (30 days retail); \$20 <u>copay</u> /fill (90 days retail or mail order)	50% <u>coinsurance</u>	30-day supply at any retail pharmacy; 90-day supply CVS retail pharmacy or CVS mail order. Maximum of 3 retail fills at any retail pharmacy for maintenance medications, which then must be filled through CVS retail pharmacy or CVS mail order.
	Single-source brand drugs (Tier 2)	\$20 <u>copay</u> /fill (30 days retail) after \$100 <u>deductible</u> ; \$50 <u>copay</u> /fill (90 days retail or mail order) after \$100 <u>deductible</u>	50% <u>coinsurance</u> after \$100 <u>deductible</u>	Medical <u>Plan deductible</u> does not apply, however, brand <u>deductible</u> applies for retail, mail order and maintenance fills of brand drugs.
	Multi-source brand drugs (Tier 3)	\$20 <u>copay</u> /fill (30 days retail) after \$100 <u>deductible</u> plus difference in cost between generic and multi-source brand name drug with minimum <u>copay</u> of \$40; \$50 <u>copay</u> /fill (90 days retail or mail order) after \$100 <u>deductible</u> plus difference in cost between generic and multi-source brand name drug with minimum <u>copay</u> of \$100	50% <u>coinsurance</u> after \$100 <u>deductible</u>	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 <u>claim</u> for reimbursement. When you have your medication filled with a multi-source brand name medication, you are responsible for the brand name <u>copayment</u> , plus the difference in cost between the generic and multi-source brand name medication. Certain drugs may require prior approval. <u>Cost sharing</u> for <u>prescription drugs</u> does not count toward the <u>out-of-pocket limit</u> . Non-sedating prescription allergy medications, proton pump inhibitors, and compound prescriptions are covered at 50% <u>coinsurance</u> .
	<u>Specialty drugs</u>	Same <u>cost sharing</u> as Tier 1, Tier 2, and Tier 3 drugs, depending on the type of <u>specialty drug</u>	Not covered.	Must be filled through CVS Specialty Pharmacy. <u>Cost sharing</u> for <u>prescription drugs</u> does not count toward the <u>out-of-pocket limit</u> . Medical <u>Plan deductible</u> does not apply, however, brand <u>deductible</u> applies for retail, mail order and maintenance fills of brand drugs.

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% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u> ; except 20% <u>coinsurance</u> for air ambulance services	In limited and special circumstances, the plan covers transportation to the nearest hospital equipped to furnish the treatment not available in a local hospital.
	<u>Urgent care</u>	Marathon Health & Wellness Center: No charge, <u>deductible</u> does not apply. All other: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Charges based on semi-private room rates.
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Marathon Health & Wellness Center: No charge, <u>deductible</u> does not apply. All other: 20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Includes residential treatment facilities.

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 are pregnant	Office visits	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Maternity care as well as prenatal and childbirth expenses are not covered for dependent children. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Outpatient physical/occupational therapy limited to 40 visits per year combined. Speech therapy is covered as a result of both an illness or injury and/or a mental health or substance use disorder condition as provided by the plan. <u>Coinurance</u> for physical therapy does not count toward the <u>out-of-pocket limit</u> . Physical therapy includes <u>medically necessary</u> aquatic therapy if certain criteria are met.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of this service, even from a <u>network provider</u> .
	<u>Skilled nursing care</u>	Not covered	Not covered	You must pay 100% of this service, even from a <u>network provider</u> .
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Lifetime maximum of one wheelchair per individual.
	<u>Hospice services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	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 <u>network provider</u> .
	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even from a <u>network provider</u> .
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even from a <u>network provider</u> .

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• Acupuncture • Cosmetic surgery (except as provided by the <u>plan</u>.) • Dental care (Adult & Child) • <u>Habilitation services</u> • Hearing aids	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult & Child) • Routine foot care • <u>Skilled nursing care</u> • Weight loss programs (except for treatment for morbid obesity or <u>medically necessary</u> treatment of a mental health condition or substance use disorder)
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Bariatric Surgery (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 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? 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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$510*
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,070

Managing Joe's Type 2 Diabetes

(a year of routine network provider care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$600*
<u>Copayments</u>	\$510
<u>Coinsurance</u>	\$250
What isn't covered	
Limits or exclusions	\$100
The total Joe would pay is	\$1,460

Mia's Simple Fracture

(network provider emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$510*
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$460
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$970

***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.