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 (812) 877-2581. 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 https://www.healthcare.gov/sbc-glossary/ or call (812) 877-2581 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$700 individual / $2,100 family *Certain Out-of-Network claims are treated as In-Network claims as required by No Surprises Act.*	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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. LiveHealth Online Health Doctor Visit, In-Network Prescription Drugs, COVID-19 vaccines, Sword Health Virtual Physical Therapy, and Wellness Benefits 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,000 individual / $8,000 family *Certain Out-of-Network claims are treated as In-Network claims as required by No Surprises Act.*	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Chiropractor visits, In-Network prescription drug copayments, premiums, balance billing charges and health care this plan doesn't 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 (800) 810-2583 for a list of network providers. **Out-of-Network providers* may be treated as In-Network providers *as required by No Surprises Act.*	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 an out-of-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 an out-of-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)	Out-of-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		LiveHealth Online Doctor Visit – No copayment, deductible or coinsurance. LiveHealth Online Doctor Visit is an In-network benefit. Virtual visits provided by a physician's office in lieu of a face to face visit will be covered under standard rates, including the deductible and applicable coinsurance.
	Specialist visit			----------none----------
	Preventive care/screening/ immunization	No Charge		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. For specific benefits and limitations, see Restated Plan Document and Summary Plan Description Sectionon Wellness Benefits and Preventive Services.*
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance		----------none----------
	Imaging (CT/PET scans, MRIs)			Prior authorization required.

*For more information about limitations and exceptions, see restated plan document and summary plan description.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-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 by calling the Fund Office at (812) 877-2581.	Generic drugs	Retail – up to 34 days - $15 copay/prescription up to 60 days - $30 copay/prescription up to 90 days - $45 copay/prescription Mail order – up to 90 days - $25 copay/prescription	Retail – up to 34 days – 50% coinsurance after medical deductible	No deductible on In-Network Prescription Benefits. In-Network copayment does not apply to deductible or out-of-pocket limit. No Out-of-Network coverage for Mail Order. Refills are limited to a maximum of five in a six month period and the number authorized by the prescribing Physician. If generic equivalent is available; you will be required to pay the applicable copayment, plus the price difference between the generic drug and the formulary brand name drug, unless the brand name is Medically Necessary. Some prescriptions are subject to step therapy requirements.
	Brand drugs	Retail – up to 34 days - $32 copay/prescription up to 60 days - $60 copay/prescription up to 90 days - $90 copay/prescription Mail order – up to 90 days - $64 copay/prescription		
	Specialty drugs			Specialty drugs require prior authorization. Call SavRx at (800) 228-3108. Must use SavRx Specialty Pharmacy. Limited to 30-day supply; 90-day supplies are available for certain specialty drugs, depending on manufacturer.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance unless otherwise required by No Surprises Act		----------none----------
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance unless otherwise required by No Surprises Act		----------none----------
	Emergency medical transportation			Emergency medical transportation to the nearest appropriate Covered Facility
	Urgent care			LiveHealth Online Doctor Visit – No copayment, deductible or coinsurance. LiveHealth Online Doctor Visit is an In-network benefit. Virtual visits provided by a physician's office in lieu of a face to face visit will be covered under standard rates, including the deductible and applicable coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance unless otherwise required by No Surprises Act		Weekend admissions and related charges are not covered except in a medical emergency or when a surgical procedure is scheduled for the following day. Based on average semi-private room rate per confinement.
	Physician/surgeon fees			----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance unless otherwise required by No Surprises Act		LiveHealth Online Doctor Visit – No copayment, deductible or coinsurance. LiveHealth Online Doctor Visit is an In-network benefit. Virtual visits provided by a physician's office in lieu of a face to face visit will be covered under standard rates, including the deductible and applicable coinsurance.
	Inpatient services	20% coinsurance unless otherwise required by No Surprises Act		Inpatient substance abuse services must be provided by an In-Network facility.
If you are pregnant	Office visits	20% coinsurance unless otherwise required by No Surprises Act		Limited to a Participant or Dependent Spouse. Cost sharing does not apply to preventive services. Depending on the type of services, coinsurance or a deductible may apply. Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			Limited to a Participant or Dependent Spouse. Inpatient stay of at least 48 hrs for the mother and newborn child following a vaginal delivery or at least 96 hours for the mother and newborn child following a cesarean section delivery.
If you need help recovering or have other special health needs	Home health care	20% coinsurance		Prior authorization required.
	Rehabilitation services			Sword Health Virtual Physical Therapy – No copayment, deductible or coinsurance. Prior authorization required for cardiac and pulmonary rehabilitation, occupational therapy, physical therapy, speech therapy, vision therapy
	Habilitation services	Not Covered		----------none----------
	Skilled nursing care			----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance		Prior authorization required.
	Hospice services	Not Covered		----------none----------
If your child needs dental or eye care	Children's eye exam	Not Covered		----------none----------
	Children's glasses			
	Children's dental check-up			

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.)

- Bariatric surgery
- Cosmetic surgery (see Plan for exceptions)
- Dental care (adult or child)
- Habilitation services
- Hearing aids
- Hospice care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult or child)
- Skilled nursing care
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Private-duty nursing
- Routine foot care

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: 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: the Fund Office at (812) 877-2581 or 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.

Language Access Services:
Para obtener asistencia en Español, llame al (812) 877-2581.

Fer Hilf griege in Deitsch, ruf (812) 877-258 uff.

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 in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$700**
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$700
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,170**

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

- **The plan's overall deductible** **$700**
- **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$700
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

- **The plan's overall deductible** **$700**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$10
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,110**

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