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) 238-2551. 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) 238-2551 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network*: $300/individual or $600/family Out-of-Network: $600/individual *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. In-Network Preventive Health, Prescription and Dental 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?	Yes. Emergency Room -$70/visit, Dental Care - $25/individual or $75/family. 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?	In-Network*: $3,000/individual or $6,000/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?	Copayments for prescription drugs, deductible, Teladoc Online Doctor Visit, Wig Benefit, 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.whyuhc.com/uhss or call the Fund Office at (812) 238-2551 for a list of network providers. **Out-of-network providers may be treated as 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	25% coinsurance	50% coinsurance	Online Doctor Visit at www.teladochealth.com - no copayment, deductible or coinsurance, In-network only. 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 for specific covered services except for Routine Physical Exam which is paid up to $300 per year, then 25% coinsurance; all non-specified preventive services covered at 25% coinsurance	50% coinsurance	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 Plan Document
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	Benefits for COVID related testing will be paid in accordance with the CARES Act. Chiropractic services are covered under Chiropractic Benefit.
	Imaging (CT/PET scans, MRIs)			Chiropractic services are covered under Chiropractic Benefit.

*For more information about limitations and exceptions, see summary plan description (SPD).

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 at www.savrx.com or by calling (800) 228-3108.	Generic drugs	Retail – 20% ($10 min/ $20 max) Mail Order & Approved 90 day Retail – 15% ($25 min/ $50 max)	Not covered	No deductible on Prescription Benefits. Copayment does not apply to deductible or out-of-pocket limit. Present Prescription Drug Card at time of retail purchase. If Card is not presented, may submit receipt for reimbursement. Retail is 30-day supply. Mail Order & Approved Retail is 90-day supply. If generic equivalent is available; you will pay the applicable copayment plus the difference between the generic drug and the brand name drug. Cost Savings Programs are mandatory for certain drugs. If a biosimilar is available, you will be required to have a letter of medical necessity from your doctor subject to review by Sav-Rx to have the brand name drug. Precertification is required for drugs over $2,000. Call (800) 228-3108. See the Prescription Section of the Plan for Exclusions*
	Formulary brand drugs	Retail – 30% ($20 min/ $40 max) Mail Order & Approved 90 day Retail – 25% ($50 min/ $100 max)		
	Non-formulary brand drugs	Retail–40% ($40 min/ $80 max) Mail Order & Approved 90 day Retail–35% ($100 min/$200 max)		
	Specialty drugs	Mail Order – Generic: 15% ($8 min/ $16 max) Formulary brand: 25% ($16 min/ $33 max) Non-formulary brand: 35% ($40 min/ $80 max)	Not covered	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. If a biosimilar is available, you will be required to have a letter of medical necessity from your doctor subject to review by Sav-Rx to have the brand name drug. Cost Savings Programs are mandatory for certain specialty drugs and some drugs may be limited to a 30- or 90-day supply. See the Prescription Section of the Plan for Exclusions*

*For more information about limitations and exceptions, see summary plan description (SPD).

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)	25% coinsurance	50% coinsurance unless otherwise required by No Surprises Act	Precertification is required for some outpatient surgeries. Contact the Fund Office for more information.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	25% coinsurance	50% coinsurance unless otherwise required by No Surprises Act	$70 deductible per person per visit, including observation, unless life threatening sickness, accident, or inpatient admission.
	Emergency medical transportation			----------none----------
	Urgent care			Online Doctor Visit at www.teladochealth.com - no copayment, deductible or coinsurance, In-network only. Virtual visits provided by a physician's office in lieu of face to face will be covered under standard rates, including the deductible and applicable coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance unless otherwise required by No Surprises Act	No Friday or Saturday admission unless emergency, surgery within 24 hrs or Medically Necessary per doctor. Precertification is required.
	Physician/surgeon fees			Precertification is required.

*For more information about limitations and exceptions, see summary plan description (SPD).

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	25% coinsurance	50% coinsurance unless otherwise required by No Surprises Act	Online Doctor Visit at www.teladochealth.com- no copayment, deductible or coinsurance, In-network only. Virtual visits provided by a physician's office in lieu of face to face will be covered under standard rates, including the deductible and applicable coinsurance. Precertification is required for outpatient therapy and intensive outpatient programs.
	Inpatient services		Not covered unless otherwise required by No Surprises Act	In-patient treatment must be received at an In-Network facility. In-patient treatment is not covered at an Out-of-Network facility unless approved by Medicare. Must be supervised/ performed by MD. Precertification is required.
If you are pregnant	Office visits	25% coinsurance	50% coinsurance unless otherwise required by No Surprises Act	Cost sharing does not apply to preventive services. Depending on the type of services, coinsurance or 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			Class A coverage only. In-patient stay of at least 48 hours for the mother & newborn child following a vaginal delivery or at least 96 hours for the mother & newborn child following a cesarean section delivery. Benefits limited to female Employee or dependent spouse only. Precertification is required.
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Precertification is required.
	Rehabilitation services			
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	25% coinsurance	Not Covered	Precertification is required.
	Durable medical equipment		50% coinsurance	Precertification is required for electric/motorized scooter or wheelchairs, pneumatic compression devices and other devices. Contact the Fund Office for more information.
	Hospice services	25% coinsurance	50% coinsurance	Precertification is required.

*For more information about limitations and exceptions, see summary plan description (SPD).

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 your child needs dental or eye care	Children's eye exam	No charge	No charge up to $40	Limited to 1 exam every 12 months.
	Children's glasses	Frames: No charge up to the following allowances $250 for most frames $300 for featured frames or frames at Visionworks $135 for frames at Costco Eyeglass Lenses: Single vision, lined bifocal or lined trifocal – included with frames Contact Lenses (instead of frames and lenses): up to $250. Contact Lens Fitting and Evaluation Exam: available for up to $60 copayment.	Frames: Reimbursement up to $80 retail price Lenses: Single – Reimbursement up to $55 Bifocal – Reimbursement up to $80 Trifocal – Reimbursement up to $105	Lenses & Frames **or** Contact Lenses once every 12 months. 20% savings on cost over frames allowances. Standard Progressive lenses allowed with no copayment. Premium and Custom progressive lenses available for applicable copayment. Diabetic Eyecare Plus Program and other discounts available. Contact VSP at 800-877-7195 for more information.
	Children's dental check-up	0% coinsurance		Not subject to Dental deductible. Limit two dental check-ups and two bitewing x-rays per person per Calendar Year.

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 (unless used as an anesthetic for covered surgery)
- Bariatric surgery
- Cosmetic surgery (unless medically necessary)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Chiropractic care (up to $1,500 per Plan Year)
- Dental care (adult)
- Hearing aids (once every rolling 36 months)
- Routine eye care (adult)

*For more information about limitations and exceptions, see summary plan description (SPD).

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 (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) 238-2551 or the Department of Labor's Employee Benefits Security Administration at (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) 238-2551.
Fer Hilf griege in Deitsch, ruf (812) 238-2551 uff.

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

*For more information about limitations and exceptions, see summary plan description (SPD).

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	$300
■ Specialist coinsurance	25%
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	$300
Copayments	$10
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	$300
■ Specialist coinsurance	25%
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	$300
Copayments	$800
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$300
■ Specialist coinsurance	25%
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	$300
Copayments	$10
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$970**

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