

**ANCON Construction Co. (8080) PPO Plan**

Coverage for: Individual, Family | Plan Type: PPO



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, a sample plan document is available at [tpaservices.vbagateway.com](https://tpaservices.vbagateway.com) or by calling 1-800-551-7334. 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](http://www.dol.gov/ebsa/healthreform) or call 1-800-551-7334 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">Network providers</a> \$600 Individual /\$1,500 Family; For <a href="#">Out-of-Network providers</a> \$1,200 Individual / \$3,000 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the calendar year <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes.</b> <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <a href="#">deductibles</a> for specific services?	<b>No</b>	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">Network Provider</a> : <b>\$2,500</b> person / <b>\$4,800</b> family; <a href="#">Non-Network Provider</a> : <b>\$5,000</b> person/ <b>\$9,600</b> family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a calendar year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Deductible</a> , <a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, <a href="#">copayments</a> , penalties for failure to obtain preauthorization, ineligible charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	<b>Yes.</b> based on where participant resides. See <a href="http://www.phpni.com/search/phpfrd">www.phpni.com/search/phpfrd</a> or call 1-833-278-2883 for PHP Freedom or <a href="https://providerlocator.firsthealth.com/cofinity">https://providerlocator.firsthealth.com/cofinity</a> or 800-831-1166 for Cofinity.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	<b>No</b>	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 copay	40% coinsurance	Virtual visits covered as any other office visit.
	<a href="#">Specialist</a> visit	\$20 copay	40% coinsurance	<a href="#">Preauthorization</a> is required for Pain Management Services.
	<a href="#">Preventive care/screening/Immunization</a>	\$20 copay	60% coinsurance	No calendar year maximum for wellness from birth to 24 months. Calendar year maximum applies to children ages 2 years to adult.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	<a href="#">Preauthorization</a> is required for MRI/CT/PET Scan. Excludes Bone Density studies.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at <a href="http://www.primetherapeutics.com">www.primetherapeutics.com</a> or 800-858-0723	Generic drugs	20%	Not covered	Covers up to a 30-day supply (retail), 90-day supply (mail order).
	Preferred drugs	40%	Not covered	
	Non-preferred drugs	40%	Not covered	
	Specialty drugs	See Prescription Drug Benefit Section	Not covered	Limited to 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	<a href="#">Preauthorization</a> is required for all outpatient services, and outpatient surgeries not done in a doctor's office.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 copay, then 20% coinsurance	\$200 copay, then 20% coinsurance	<a href="#">Preauthorization</a> is required if admitted. Copay waived if admitted.
	<a href="#">Emergency room care</a> Non-emergency	\$200 copay, then 20% coinsurance	\$200 copay, then 40% coinsurance	<a href="#">Preauthorization</a> is required if admitted. Copay waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% coinsurance	0% coinsurance	For facility-to-facility air ambulance transports, Precertification is required through Sentinel Air Medical Alliance: 1-877-542-8828.

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)	
	<a href="#">Urgent care</a>	\$35 copay	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	<a href="#">Preauthorization</a> is required. \$500 penalty per admission for non-use of pre-admission certification for inpatient hospital.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Office visit/Therapy	\$20 copayment	40% coinsurance	Virtual visits are covered as any other office visit.
	Outpatient services	20% coinsurance		
	Inpatient services	20% coinsurance	40% coinsurance	<a href="#">Preauthorization</a> is required.
If you are pregnant	Office visits	\$20 copayment	40% coinsurance	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Covered for dependent daughter. <a href="#">Preauthorization</a> is required for some maternity hospital stays
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% coinsurance	40% coinsurance	<a href="#">Preauthorization</a> is required. Limited to 100 days per calendar year.
	<a href="#">Rehabilitation services</a>	20% coinsurance	40% coinsurance	<a href="#">Preauthorization</a> is required for equipment over \$2,500.
	<a href="#">Habilitation services</a>	20% coinsurance	40% coinsurance	<a href="#">Preauthorization</a> is required for PT/OT/ST. Speech Therapy is limited to 30 visits per calendar year.
	<a href="#">Skilled nursing care</a>	20% coinsurance	40% coinsurance	<a href="#">Preauthorization</a> is required. Limited to 60 days per calendar year.
	<a href="#">Durable medical equipment</a>	20% coinsurance	40% coinsurance	<a href="#">Preauthorization</a> is required for equipment over \$2,500.
	<a href="#">Hospice services</a>	20% coinsurance	40% coinsurance	<a href="#">Preauthorization</a> is required for inpatient services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## 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](#).)

- Cosmetic Surgery
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Long Term Care
- Routine foot care, except for certain conditions
- Weight loss programs

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

- Bariatric Surgery
- Chiropractic care
- Infertility Treatment
- Private-duty nursing (Limited to 45 days per calendar year.)

**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: Indiana Department of Insurance at (800) 622-4461; (317) 232-2395 or [www.in.gov/idoi](http://www.in.gov/idoi); U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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 Plan Administrator of AALCO Distributing Company, Inc. at 1-260-422-9417 or PHP TPA Services at 1-800-551-7334 or [tpaservices.vbagateway.com](http://tpaservices.vbagateway.com). 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](http://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:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-798-2422

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-798-2422

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-798-2422

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*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](#) \$600
- [Specialist](#) [*cost sharing*] \$20
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$20
Coinsurance	\$1,880
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,500</b>

**Managing Joe's type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$600
- [Specialist](#) [*cost sharing*] \$20
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$20
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,620</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$600
- [Specialist](#) [*cost sharing*] \$20
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$200
Coinsurance	\$440
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,240</b>