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 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 or call 1-800-551-7334 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Network providers $600 Individual /$1,500 Family; For Out-of-Network providers $1,200 Individual / $3,000 Family	Generally, you must pay all of the costs from providers up to the calendar year 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.** Preventive care and primary care services 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. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits.
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?	For Network Provider: **$2,500** person **/$4,800** family; Non-Network Provider: **$5,000** person/**$9,600** family.	The out-of-pocket limit is the most you could pay in a calendar 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?	Deductible, Premiums, balance-billed charges, copayments, 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 **out-of-pocket limit.**
Will you pay less if you use a network provider?	**Yes**. based on where participant resides. See www.phpni.com/search/phpfrd or call 1-833-278-2883 for PHP Freedom or https://providerlocator.firsthealth.com/cofinity or 800-831-1166 for Cofinity.	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 copay	40% coinsurance	Virtual visits covered as any other office visit.
	Specialist visit	$20 copay	40% coinsurance	Preauthorization is required for Pain Management Services.
	Preventive Care / Screening Immunization	$20 copay	60% coinsurance	No calendar year maximum for wellness from birth to 24 months. Calendar year maximum applies to children age 2 years to adults.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization 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 www.primetherapeutics.com or 800-858-0723	Generic drugs	20% coinsurance	Not covered	Covers up to a 30-day supply (retail), 90-day supply (mail order).
	Preferred drugs	40% coinsurance	Not covered	
	Non-preferred drugs	40% coinsurance	Not covered	
	Specialty drugs Generic Preferred drugs Non-preferred drugs	 20% coinsurance 40% coinsurance 40% coinsurance	Not covered	Limited to 30-day supply – **Mail order** not included, specialty drugs must be filled at specialty pharmacy only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization 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	Emergency room care	$200 copay, then 20% coinsurance	$200 copay, then 20% coinsurance	Preauthorization is required if admitted. Copay waived if admitted.
	Emergency room care Non-emergency	$200 copay, then 20% coinsurance	$200 copay, then 40% coinsurance	Preauthorization is required if admitted. Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	For facility-to-facility air ambulance transports, Precertification is required through Sentinel Air Medical Alliance: 1-877-542-8828.
	Urgent care	$35 copay	40% coinsurance	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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization 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	Preauthorization is required.
If you are pregnant	Office visits	$20 copayment	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Covered for Dependent daughter. Preauthorization 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	Home Health Care *Limited to 100 days per calendar year.*	20% coinsurance	40% coinsurance	Preauthorization is required.
	Rehabilitation Services	20% coinsurance	40% coinsurance	Preauthorization is required for equipment over $2,500.
	Habilitation Services *Speech Therapy is limited to 30 visits per calendar year.*	20% coinsurance	40% coinsurance	Preauthorization is required for PT/OT/ST.
	Skilled Nursing Care *Limited to 60 days per calendar year.*	20% coinsurance	40% coinsurance	Preauthorization is required.
	Durable Medical Equipment	20% coinsurance	40% coinsurance	Preauthorization is required for equipment over $2,500.
	Hospice Care	20% coinsurance	40% coinsurance	Preauthorization 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; U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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. 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 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. 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.

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, kwiijigo holne' 1-800-798-2422

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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

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

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$20
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,620**

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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$200
Coinsurance	$440
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,240**

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