




This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com/verizon or by calling the Verizon Benefits Center at 1-855-489-2367 or visit www.verizon.com/benefitsconnection.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>\$0 participating providers; \$700/person \$1,750/family non-participating providers. Doesn't apply to preventive care and, in many cases, when PPO providers are used.</p>	<p>You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u>.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes. \$50 per person using non-participating pharmacy. There are no other specific <u>deductibles</u>.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.</p>
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes. For participating providers: \$1,000/person; \$2,500/family; non-participating providers: \$1,800/person; \$4,500/family. In- and out-of-network combined.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Premiums, copayments, any expense for failure to obtain pre-authorization for services, charges exceeding a service limit or dollar maximum, balance-billed charges, Rx and vision expenses, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No.</p>	<p>The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>
<p>Does this plan use a <u>network of providers</u>?</p>	<p>Yes. See www.anthem.com/verizon or call 1-866-832-1229 for a list of participating providers.</p>	<p>If you use an in-network doctor or other health care <u>provider</u>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u>, or participating for <u>providers</u> in their <u>network</u>. See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u>.</p>

Questions: Call 1-866-832-1229 or visit us at www.anthem.com/verizon. To request a copy of your plan's summary plan description (SPD), call the Verizon Benefits Center at 1-855-489-2367 or visit www.verizon.com/benefitsconnection.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-832-1229 to request a copy.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services .

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Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay/visit	30% coinsurance	_____none_____
	Specialist visit	\$25 copay/visit	30% coinsurance	_____none_____
	Other practitioner office visit	\$20 copay/visit	30% coinsurance	Calendar year limits; chiropractic care \$750 per calendar year maximum combined in- and out-of-network; refer to SPD for details.
If you have a test	Preventive care/screening/immunization	No charge	20% coinsurance	Limitations vary by service, age and frequency; refer to SPD for details.
	Diagnostic test (X-ray, blood work) Imaging (CT/PET scans, MRIs)	\$20 copay/visit \$20 copay/visit	30% coinsurance 30% coinsurance	Recertification required for certain procedures; refer to SPD for details.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available from Express Scripts at www.medco.com/Verizon or call 1-877-877-1878. For specialty drugs, call Accredro at 1-877-877-1878.</p>	<p>Generic drugs</p> <p>Brand-name drugs (Single Source and Multi-Source)</p> <p>Brand-name drugs (Single Source and Multi-Source)</p> <p>Specialty drugs</p>	<p>Retail pharmacy (after deductible – see page 1)</p> <p>Discounted Network Price (“DNP”), with a maximum copay of \$8/Rx</p> <p>Mail order: Lower of \$16 copay or DNP/Rx</p> <p>Retail pharmacy (after deductible – see page 1)</p> <p>30% of DNP (\$25 maximum copay)/Rx</p> <p>Mail order: 30% of DNP (\$50 maximum copay)/Rx</p> <p>Retail pharmacy (after deductible – see page 1)</p> <p>30% of DNP (\$25 maximum copay)/Rx</p> <p>Mail order: 30% of DNP (\$50 maximum copay)/Rx</p> <p>Retail pharmacy (after deductible – see page 1)</p> <p>30% of DNP (\$25 maximum copay)/Rx</p> <p>Mail order: 30% of DNP (\$50 maximum copay)/Rx</p> <p>Covered as described above</p>	<p>30% of DNP, plus cost difference between DNP and retail price/Rx</p> <p>40% of DNP, plus cost difference between DNP and retail price/Rx</p> <p>40% of DNP, plus cost difference between DNP and retail price/Rx</p> <p>40% of DNP, plus cost difference between DNP and retail price/Rx</p> <p>30% coinsurance</p> <p>30% coinsurance</p>	<p>For retail pharmacy, you can receive up to a 30-day supply with each order; for mail order, you can receive up to a 90-day supply.</p> <p>Your coinsurance is 50% if you fill the same long-term prescription at retail pharmacies more than 3 times and the dollar maximum on your share of the fill will not apply.</p> <p>If you choose a brand-name when a generic equivalent is available, you pay the generic coinsurance plus the cost difference between the brand-name and the generic; the dollar maximum on your share of the fill will not apply.</p> <p>If you choose a non-participating pharmacy you are responsible to pay the difference between the participating pharmacy and non-participating pharmacy retail price. You will pay the full cost of prescriptions and file a claim.</p>
<p>If you have outpatient surgery</p>	<p>Specialty drugs</p> <p>Facility fee (e.g., ambulatory surgery center)</p> <p>Physician/surgeon fees</p>	<p>10% coinsurance</p> <p>\$20 copay (PCP)/\$25 (Specialist) in office; 10% other settings</p>	<p>30% coinsurance</p> <p>30% coinsurance</p>	<p>Precertification required; coverage limits may apply; refer to SPD for details.</p> <p>Copays apply if performed in a physician’s office; see SPD for details.</p>

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	\$75 copay/visit	\$75 copay/visit	Copayment waived if admitted; certification required within 2 days; non-emergency use of emergency facility is not covered. Emergency care is covered for treatment of injuries within 72 hours of an accident or treatment of a sudden, serious and life-threatening illness. 20% coinsurance if non-emergency. _____none_____
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	\$20 copay/visit	\$20 copay/visit	
If you have a hospital stay	Facility fee (e.g, hospital room)	10% coinsurance	30% coinsurance	Precertification required.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	\$20 copay/visit	30% coinsurance	_____none_____
	Mental/behavioral health inpatient services	10% coinsurance	30% coinsurance	Out-of-network: Precertification required.
	Substance use disorder outpatient services	\$20 copay/visit	30% coinsurance	_____none_____
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	Out-of-network: Precertification required.
	Prenatal and postnatal care	\$20 copay initial visit only	30% coinsurance	30% coinsurance
If you are pregnant	Delivery and all inpatient services	10% coinsurance	30% coinsurance	Pre-certification required; refer to SPD for details.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Pre-certification required; limited to 120 days per plan year combined in- and out-of-network; every 5 home health care visits equals 1 day towards the plan year maximum.
	Rehabilitation services	Provider: \$20 copay/visit Facility: 10% coinsurance	30% coinsurance	Rehabilitation and habilitation services means physical, occupational and speech therapy services. Benefits are limited to medical necessity, and such services will not be covered if merely educational or developmental in nature; refer to SPD for details.
	Habilitation services	Provider: \$20 copay/visit Facility: 10% coinsurance	30% coinsurance	
	Skilled nursing care	No charge	30% coinsurance	Pre-certification required; 120-day plan year maximum combined in- and out-of-network. Every day in a skilled nursing facility will count as a half day.
	Durable medical equipment	10% coinsurance	30% coinsurance	Pre-certification (approval) required for purchase or rental over \$5,000.
	Hospice service	No charge	30% coinsurance	Pre-certification required; Lifetime limit of 180 days, of which no more than 60 days may be for inpatient hospice care.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Vision coverage is available as a separate benefit; refer to SPD for details.
	Glasses	Not covered	Not covered	
	Dental checkup	Not covered	Not covered	Dental coverage is available as a separate benefit; refer to SPD for details.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Care that is not medically necessary
- Dental care (Adult)
- Routine foot care
- Cosmetic surgery
- Long-term care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (in lieu of anesthesia when performed in relation to covered surgery)
- Infertility treatment
- Routine eye care (Adult): Vision may be provided as a separate insured benefit when you elect medical coverage. Please see your SPD for details.
- Bariatric surgery (participating providers only)
- Emergency care when traveling outside the U.S.
- Private duty nursing (when performed under the home health care benefit)
- Chiropractic care
- Weight loss programs (participating providers only) for the medically necessary treatment for clinical obesity
- Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-855-489-2367**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Verizon Benefits Center at **1-855-489-2367** or visit www.verizon.com/benefitsconnection. 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-855-489-2367**.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays: \$6,840**
- **Patient pays: \$700**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$50
Coinsurance	\$500
Limits or exclusions	\$150
Total	\$700

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact Anthem at **1-866-832-1229**.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays: \$4,450**
- **Patient pays: \$950**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$300
Coinsurance	\$500
Limits or exclusions	\$150
Total	\$950

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact Anthem at **1-866-832-1229**.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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