**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: |
|---|---|---|
| **What is the overall deductible?** | **$0** participating providers; **$700** person/**$1,750** family non-participating providers. Doesn't apply to preventive care and, in many cases, when participating providers are used. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**. |
| **Are there other deductibles for specific services?** | Yes. For retail pharmacy prescriptions, **$50** per person using non-participating pharmacy. 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. |
| **Is there an out-of-pocket limit on my expenses?** | Yes. For participating providers: **$1,000/** person and **$2,500/**family combined in-network and out-of-network; non-participating providers: **$1,800/** person and **$4,500/**family | The **out-of-pocket limit** 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. |
| **What is not included in the out-of-pocket limit?** | Premiums, deductibles, 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. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See **www.anthem.com/verizon** or call **1-855-869-8139** for a list of participating providers. | If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |

**Questions:** Call **1-855-869-8139** 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 **1-855-869-8139** 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**. |

- **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 is limited to $750 per calendar year. Limitations and copayments may vary by service; refer to SPD for details. |
| | Preventive care/ screening/immunization | No charge | 20% coinsurance | Coverage based on Affordable Care Act; limitations vary by service, age and frequency; refer to SPD for details. |
| **If you have a test** | Diagnostic test (X-ray, blood work) | $20 copay/visit | 30% coinsurance | Precertification required for certain procedures; refer to SPD for details. |
| | Imaging (CT/PET scans, MRIs) | $20 copay/visit | 30% coinsurance | |

| 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 drugs to treat your illness or condition** More information about **prescription drug coverage** is available from Express Scripts at **www.medco.com/verizon** or call **1-877-877-1878**. For specialty drugs, call Accredo at **1-877-877-1878**. | Generic drugs | Retail pharmacy (No deductible – see page 1) | | 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.<br>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.<br>If you choose a brand-name when a generic equivalent is available, you pay the generic copay plus the cost difference between the brand-name and the generic; the dollar maximum on your share of the fill will not apply. You pay this additional cost even if your doctor has indicated "DAW" ("dispense as written") on the prescription.<br>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. |
| | | Lower of $8 copay or discounted network price (DNP)/Rx | 30% of DNP, plus cost difference between DNP and retail price/Rx | |
| | | Mail order: Lower of $16 copay or DNP/Rx | | |
| | Brand name drugs | Retail pharmacy (No deductible – see page 1) | | |
| | | 30% of DNP ($25 maximum copay)/Rx | 40% of DNP, plus cost difference beween DNP and retail price/Rx | |
| | | Mail order: 30% of DNP ($50 maximum copay)/Rx | | |
| | Brand name drugs | Retail pharmacy (No deductible – see page 1) | | |
| | | 30% of DNP ($25 maximum copay)/Rx | 40% of DNP, plus cost difference between DNP and retail price/Rx | |
| | | Mail order: 30% coinsurance ($50 maximum copay)/Rx | | |
| | Specialty drugs | Covered as described above | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | Precertification required for certain procedures and for non-participating provider facility. Anesthesia is not covered when administered by a surgeon or assistant surgeon. 10% coinsurance for anesthesia administered at participating provider facility; 30% coinsurance for anesthesia administered at non-participating provider facility. Refer to SPD for details. |
| | Physician/surgeon fees | $20 copay (PCP); $25 copay (Specialist) | 30% coinsurance | Copays apply if surgery performed in a physician's office. Precertification required for outpatient surgery performed by a non-participating provider. 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 immediate medical attention** | Emergency room services | $75 copay/visit | $75 copay/visit | Copay waived if admitted; certification required within 2 days; you must contact your PCP within 48 hours of visit; 30% coinsurance for non-emergencies; refer to SPD for details. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | 20% coinsurance for non-emergencies. |
| | Urgent care | $20 copay/visit | $20 copay/visit | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | Semi-private room. Precertification required. Refer to SPD for details. |
| | Physician/surgeon fee | 10% coinsurance | 30% coinsurance | Refer to SPD for details. |
| **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 | Precertification required. |
| | Substance use disorder outpatient services | $20 copay/visit | 30% coinsurance | ——————none—————— |
| | Substance use disorder inpatient services | 10% coinsurance | 30% coinsurance | Precertification required. |
| **If you are pregnant** | Prenatal and postnatal care | $20 copay initial visit only | 30% coinsurance | Precertification required. |
| | Delivery and all inpatient services | 10% coinsurance | 30% coinsurance | Precertification 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 | Precertification required. Limited to 120 days per plan year for participating and non-participating providers. Every 5 home health care visits count as 1 day toward the plan year maximum. |
| | Rehabilitation services | Provider: $20 copay/ visit for evaluations Therapy visits and services: 10% coinsurance | 30% coinsurance | Rehabilitation and habilitation services means physical, occupational and speech therapy services. Medical necessity required; refer to SPD for details. |
| | Habilitation services | Provider: $20 copay/ visit for evaluations Therapy visits and services: 10% coinsurance | 30% coinsurance | |
| | Skilled nursing care | No charge | 30% coinsurance | Limited to 120 days per plan year for participating and non-participating providers. Every day of confinement in a skilled nursing facility counts as one half day toward the 20-day plan year maximum. Precertification required. |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | Precertification (approval) required if cost of purchase or rental of durable medical equipment is more than $5,000. |
| | Hospice service | No charge | 30% coinsurance | No bereavement counseling visits covered as hospice care. Lifetime limit of 180 days, of which no more than 60 days may be for inpatient hospice care. Additional 45 days may be authorized in certain circumstances. Precertification required. |
| **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.)**

- Acupuncture if it is prescribed by a physician for rehabilitation purposes
- Bariatric surgery
- Care that is not medically necessary
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot 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.)**

- Chiropractic care
- Hearing aids
- Infertility treatment
- Private duty nursing
- Routine eye care (Adult): Vision may be provided as a separate insured benefit when you elect medical coverage. Please see your SPD for details.
- Weight loss programs (participating providers only) for the medically necessary treatment for clinical obesity.

## 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:** $6,890
- **Patient pays:** $650

### 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 | $400 |
| Limits or exclusions | $200 |
| **Total** | **$650** |

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 **1-855-869-8139**.

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,860
- **Patient pays:** $1,540

### 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 | $100 |
| Coinsurance | $1,400 |
| Limits or exclusions | $40 |
| **Total** | **$1,540** |

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 **1-855-869-8139**.

# 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.

**Questions:** Call **1-855-869-8139** 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 **1-855-869-8139** to request a copy.