Verizon MEP PPO (MidAtl) 724: Anthem BCBS

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** You/You + Dependent(s)|**Plan Type:** INDEM

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?	**$400** person/**$1,000** family combined in-network and out-of-network; an additional **$250** person/**$625** family out-of-network. If you retire prior to January 1, 2013, deductible based on retirement date; ranges from $25-$250 (2.5 times family). In- and out-of-network combined. Doesn't apply to preventive care and, in many cases, when PPO 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?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. $**1,050** person/**$2,625** family in-network; non-participating providers: **$2,000**/person; **$5,000**/family. In-and out-of-network combined.	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, 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 **1-866-832-1229** 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**.
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 5. 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	$10 copay/visit	30% coinsurance	——————none——————
	Specialist visit	$10 copay/visit	30% coinsurance	——————none——————
	Other practitioner office visit	20% coinsurance	30% coinsurance	Limitations may vary by service; refer to SPD for details.
	Preventive care/screening/ immunization	No charge	No charge	Limitations vary by service, age and frequency; refer to SPD for details.
If you have a test	Diagnostic test (X-ray, blood work)	$10 copay/visit	30% coinsurance	Precertification required for certain procedures; refer to SPD for details.
	Imaging (CT/PET scans, MRIs)	$10 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 Medco at **www.medco.com** or call **1-877-877-1878**. For specialty drugs, call Accredo at **1-877-877-1878**.	Generic drugs	Retail pharmacy		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. For out-of-network pharmacy, pay full cost, then file claim. Your coinsurance is 47.5% 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. If you are age 65 or older and receive prescription drug benefits through Express Scripts Medicare™ (PDP) for Verizon, a Medicare-approved Part D plan which will provide coverage above the standard Medicare Part D plan, a few additional features apply to your prescription drug design. For example, you may receive a 90-day supply at retail and lower cost-sharing for medications filled during the catastrophic stage of the benefit. For additional details regarding this benefit, please contact Express Scripts at **1-877-877-1878** or **www.express-scripts.com/verizon** or review the guide that you received at enrollment.
		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		
	Single-Source	Retail pharmacy		
		30% of DNP ($25 maximum copay)/Rx	40% of DNP, plus cost difference between DNP and retail price/Rx	
		Mail order: 30% of DNP ($50 maximum copay)/Rx		
	Multi-Source	Retail pharmacy		
		40% of DNP ($30 maximum copay)/Rx	50% of DNP, plus cost difference between DNP and retail price/Rx	
		Mail order: 40% of DNP ($60 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; anesthesia is not covered when administered by a surgeon or assistant surgeon; refer to SPD for details.
	Physician/surgeon fees	10% coinsurance; $10 copay if performed in a physician's office	30% coinsurance	———————none———————

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	$25 copay/visit	$25 copay/visit	Copay 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.
	Emergency medical transportation	10% coinsurance	10% coinsurance	30% coinsurance if not an emergency.
	Urgent care	$10 copay/visit	$10 copay/visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification required; coverage limits may apply based on frequency; refer to SPD for details.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$10 copay/visit	30% coinsurance	——————none——————
	Mental/behavioral health inpatient services	10% coinsurance	30% coinsurance	Out-of-network: Precertification required.
	Substance use disorder outpatient services	$10 copay/visit	30% coinsurance	——————none——————
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	Out-of-network: Precertification required.
If you are pregnant	Prenatal and postnatal care	$10 copay initial visit only	30% coinsurance	——————none——————
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	Precertification required for newborn stay beyond mother's stay and for mother's and newborn's stay beyond 48 hours for normal delivery or 96 hours after a cesarean section.

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; limitations may apply to certain services; refer to SPD for details.
	Rehabilitation services	20% coinsurance	30% coinsurance	Precertification required; coverage limits may apply based on frequency; refer to SPD for details.
	Habilitation services	20% coinsurance	30% coinsurance	
	Skilled nursing care	No charge	30% coinsurance	Precertification required; limitations may apply to certain services; refer to SPD for details.
	Durable medical equipment	20% coinsurance	30% coinsurance	Precertification required for items over $5,000; certain limitations may apply; refer to SPD for details.
	Hospice service	No charge	30% coinsurance	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 (only under home health care)
- 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**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **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:** $6,900
- **Patient pays:** $640

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	$10
Coinsurance	$480
Limits or exclusions	$150
Total	**$640**

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:** $3,740
- **Patient pays:** $1,660

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	$120
Coinsurance	$1,500
Limits or exclusions	$40
Total	**$1,660**

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.

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.