Verizon PPO Plus Option 700B: UnitedHealthcare

Coverage Period: 01/01/2023 – 12/31/2023

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** You/You+Dependent(s)| **Plan Type:PS1**

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. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling the Verizon Benefits Center at **1.855.489.2367** or visit **www.verizon.com/benefitsconnection.** 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 UHC at **1-800-603-4305** to request a paper copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,100** person / **$3,300** family. Doesn't apply to preventive care and outpatient radiology services.	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 services covered before you meet your deductible?	**Yes. Preventive care.**	The **plan** covers some items and services even if you haven't met the **deductible** amount. But a **copayment** or **coinsurance** may apply.
Are there other deductibles for specific services?	**Yes.** For retail pharmacy prescriptions, **$25** per person using participating pharmacy; **$75** 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.
What is the out-of-pocket limit for this plan?	**Medical:** For participating **providers**: **$2,200** person / **$6,600** family (participating and non-participating **provider** expenses combined).* **Prescription Drugs: $3,300** person / **$5,350** family for participating **providers** only.*	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.

Important Questions	Answers	Why This Matters:
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, 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.
Will you pay less if you use a network provider?	Yes. See **www.myuhc.com** or call **1-800-603-4305** 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**.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

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** after **deductible**	——————none——————
	Specialist visit	$35 copay	40% **coinsurance** after **deductible**	Calendar year limits: chiropractor 20 visits; acupuncture 20 visits; physical/occupational therapy limited to 60 visits (combined); speech therapy limited to 45 visits.
	Preventive care/screening/ immunization	No charge	No charge	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay for laboratory and pathology services; 20% **coinsurance** for radiology services	40% **coinsurance** after **deductible**	Precertification required for certain procedures.
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	40% **coinsurance** after **deductible**	Precertification required for certain procedures.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at Express Scripts at **www.express-scripts.com/verizon** or call **1.877.877.1878.** For specialty drugs, call Accredo at **1.877.877.1878**	Generic drugs	Retail pharmacy (after **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. Your **coinsurance** is 50% if you fill the same long-term prescription at retail pharmacies more than three times and the dollar maximum on your share of the fill will not apply. If you choose a brand-name when a generic equivalent is available, you pay the generic **copayment/coinsurance** plus the cost difference between the brand-name and the generic. The dollar maximum on your share of the fill will not apply. This additional cost will apply unless your doctor certifies that you are medically unable to take the generic medication and the exception is approved by Express Scripts. 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 $10 copay or discounted network price ("DNP")/Rx	Lower of $10 copay or retail price/Rx	
		Mail order: Lower of $20 copay or DNP/Rx		
	Preferred brand drugs	Retail pharmacy (after **deductible** – see page 1)		
		30% of DNP ($60 maximum copay)/Rx	40% **coinsurance** (no maximum)/Rx	
		Mail order: 30% **coinsurance** ($120 maximum)/Rx		
	Non-preferred brand drugs	Retail pharmacy (after **deductible** – see page 1)		
		40% **coinsurance** ($80 maximum)/Rx	50% **coinsurance** (no maximum)/Rx	
		Mail order: 40% **coinsurance** ($160 maximum)/Rx		
	Specialty drugs	Covered as described above		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**	Precertification required for certain procedures. Anesthesia is not covered when administered by a surgeon or assistant surgeon.
	Physician/surgeon fees	20% **coinsurance** after **deductible**; office visit copay applies if performed in physician's office	40% **coinsurance** after **deductible**	——————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 need immediate medical attention	Emergency room care	$200 copay	$200 copay	Copay waived if admitted; certification required within two days; non-emergency use of emergency facility is not covered.
	Emergency medical transportation	20% **coinsurance** after **deductible**	20% **coinsurance** after **deductible**	——————none——————
	Urgent care	$50 copay	$50 copay	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**	Precertification required
	Physician/surgeon fees	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay	40% **coinsurance** after **deductible**	——————none——————
	Inpatient services	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**	Precertification required.
If you are pregnant	Office visits	$20 copay initial visit only	40% **coinsurance** after **deductible**	——————none——————
	Childbirth/delivery professional services	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**	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.
	Childbirth/delivery facility services	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**	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	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 need help recovering or have other special health needs	Home health care	No charge	40% **coinsurance** after **deductible**	Precertification required. Up to 120 days per calendar year (in- and out-of-network days combined).
	Rehabilitation services	**Provider**: $35 copay Facility: 20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**	Physical and occupational therapy visits are combined and limited to 60 visits (in- and out-of network visits also combined); Speech therapy limited to 45 visits (in- and out-of-network visits combined).
	Habilitation services	**Provider**: $35 copay Facility: 20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**	
	Skilled nursing care	No charge	40% **coinsurance** after **deductible**	Precertification required. Limited to 120 days per calendar year (in- and out-of-network days combined).
	Durable medical equipment	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**	Precertification required for purchase over $5,000.
	Hospice services	No charge	40% **coinsurance** after **deductible**	Precertification required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Vision coverage may be available as a separate benefit. See your SPD for details.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Dental coverage may be available as a separate benefit. See your SPD for details.

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.)

- Care that is not medically necessary
- Cosmetic surgery
- Routine dental care
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes

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

- Acupuncture if prescribed by a physician for rehabilitation purposes
- Bariatric surgery
- Chiropractic care
- Hearing aids if required due to accidental injury
- Most coverage provided outside the United States. See www.myuhc.com
- Private duty nursing (when performed under home health care benefit)
- Routine eye care

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: **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**. 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 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.**

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1.855.489.2367.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.855.489.2367.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码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 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	$1,100
Specialist copayments	$35
Hospital (facility) coinsurance	20%
Other copayments	$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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$40
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,300**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,100
Specialist copayments	$35
Hospital (facility) coinsurance	20%
Other copayments	$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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$530
Coinsurance	$1,606
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,291**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,100
Specialist copayments	$35
Hospital (facility) coinsurance	20%
Other copayments	$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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$810
Coinsurance	$86
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,996**

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