

# Verizon PPO Plus Option 700B: UnitedHealthcare

Coverage Period: 01/01/2021 – 12/31/2021

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](http://www.myuhc.com) or by calling the HR Answers at 866.772.3182 or visit [yo/benefits](#). 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](http://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 <u>deductible</u> ?	<b>\$1,100</b> person / <b>\$3,300</b> family. Doesn't apply to preventive care and outpatient radiology services.	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> .
Are there services covered before you meet your <u>deductible</u> ?	<b>Yes. Preventive care.</b>	The <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	<b>Yes.</b> For retail pharmacy prescriptions, <b>\$25</b> per person using participating pharmacy; <b>\$75</b> 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 <u>deductible</u> amount before this plan begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<b>Medical:</b> For participating <u>providers</u> : <b>\$2,200</b> person / <b>\$6,600</b> family (participating and non-participating <u>provider</u> expenses combined).* <b>Prescription Drugs:</b> <b>\$3,300</b> person / <b>\$5,350</b> family for participating <u>providers</u> only.*	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.  *An additional layer of <u>out-of-pocket limit</u> protection applies so that your total <u>out-of-pocket</u> costs ( <u>deductible</u> , <u>coinsurance</u> and <u>copayments</u> ) for medical <u>and</u> prescription drug expenses will not exceed <b>\$7,150</b> per person and <b>\$14,300</b> for "family" (i.e. you + any eligible dependents).

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Important Questions	Answers	Why This Matters:
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>copayments</u> , 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. <u>Copayments</u> apply to the additional layer of out-of-pocket limit protection (\$7,150 person/\$14,300 family).
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-800-603-4305 for a list of participating <u>providers</u> .	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> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 copay	40% <u>coinsurance</u> after <u>deductible</u>	—————none—————
	<u>Specialist</u> visit	\$35 copay	40% <u>coinsurance</u> after <u>deductible</u>	Calendar year limits: chiropractor 20 visits; acupuncture 20 visits; physical/occupational therapy limited to 60 visits (combined); speech therapy limited to 45 visits.
	<u>Preventive care/screening/immunization</u>	No charge	No charge	—————none—————
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$20 copay for laboratory and pathology services; 20% <u>coinsurance</u> for radiology services	40% <u>coinsurance</u> after <u>deductible</u>	Precertification required for certain procedures.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u> after <u>deductible</u>	Precertification required for certain procedures.

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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)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at Express Scripts at <a href="http://www.express-scripts.com/verizon">www.express-scripts.com/verizon</a> or call <b>1.877.877.1878</b>. For specialty drugs, call Accredo at <b>1.877.877.1878</b></p>	Generic drugs	Retail pharmacy (after <b>deductible</b> – see page 1)		<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. Your <b>coinsurance</b> 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.</p> <p>If you choose a brand-name when a generic equivalent is available, you pay the generic <b>copayment/coinsurance</b> 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.</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>
		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 <b>deductible</b> – see page 1)		
		30% of DNP (\$60 maximum copay)/Rx	40% <b>coinsurance</b> (no maximum)/Rx	
		Mail order: 30% <b>coinsurance</b> (\$120 maximum)/Rx		
	Non-preferred brand drugs	Retail pharmacy (after <b>deductible</b> – see page 1)		
40% <b>coinsurance</b> (\$80 maximum)/Rx		50% <b>coinsurance</b> (no maximum)/Rx		
Mail order: 40% <b>coinsurance</b> (\$160 maximum)/Rx				
<a href="#">Specialty drugs</a>	Covered as described above			
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% <b>coinsurance</b> after <b>deductible</b>	40% <b>coinsurance</b> after <b>deductible</b>	<p>Precertification required for certain procedures. Anesthesia is not covered when administered by a surgeon or assistant surgeon.</p> <p>_____none_____</p>
	Physician/surgeon fees	20% <b>coinsurance</b> after <b>deductible</b> ; office visit copay applies if performed in physician’s office	40% <b>coinsurance</b> after <b>deductible</b>	

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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	<a href="#">Emergency room care</a>	\$200 copay	\$200 copay	Copay waived if admitted; certification required within two days; non-emergency use of emergency facility is not covered.
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	_____none_____
	<a href="#">Urgent care</a>	\$50 copay	\$50 copay	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Precertification required
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay	40% <u>coinsurance</u> after <u>deductible</u>	_____none_____
	Inpatient services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Precertification required.
If you are pregnant	Office visits	\$20 copay initial visit only	40% <u>coinsurance</u> after <u>deductible</u>	_____none_____
	Childbirth/delivery professional services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	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% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	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.

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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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	40% <b><u>coinsurance</u></b> after <b><u>deductible</u></b>	Precertification required. Up to 120 days per calendar year (in- and out-of-network days combined).
	<a href="#">Rehabilitation services</a>	<b>Provider:</b> \$35 copay <b>Facility:</b> 20% <b><u>coinsurance</u></b> after <b><u>deductible</u></b>	40% <b><u>coinsurance</u></b> after <b><u>deductible</u></b>	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).
	<a href="#">Habilitation services</a>	<b>Provider:</b> \$35 copay <b>Facility:</b> 20% <b><u>coinsurance</u></b> after <b><u>deductible</u></b>	40% <b><u>coinsurance</u></b> after <b><u>deductible</u></b>	
	<a href="#">Skilled nursing care</a>	No charge	40% <b><u>coinsurance</u></b> after <b><u>deductible</u></b>	Precertification required. Limited to 120 days per calendar year (in- and out-of-network days combined).
	<a href="#">Durable medical equipment</a>	20% <b><u>coinsurance</u></b> after <b><u>deductible</u></b>	40% <b><u>coinsurance</u></b> after <b><u>deductible</u></b>	Precertification required for purchase over \$5,000.
	<a href="#">Hospice services</a>	No charge	40% <b><u>coinsurance</u></b> after <b><u>deductible</u></b>	Precertification required.
<b>If your child needs dental or eye care</b>	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.

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## 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
- Routine dental care
- Routine foot care unless you have been diagnosed with diabetes
- Cosmetic surgery
- Long-term care

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

- Acupuncture if prescribed by a physician for rehabilitation purposes
- Hearing aids if required due to accidental injury
- Private duty nursing (when performed under home health care benefit)
- Bariatric surgery
- Most coverage provided outside the United States. See [www.myuhc.com](http://www.myuhc.com)
- Routine eye care
- Chiropractic 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](http://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](http://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](http://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 HR Answers at **1.866.772.3182** or visit [yo/benefits](#). 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](http://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, kwijigo holne' 1.855.489.2367.

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

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,100
■ <a href="#">Specialist copayments</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">copayments</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
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In this example, Peg would pay:

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

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,100
■ <a href="#">Specialist copayments</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">copayments</a>	\$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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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In this example, Joe would pay:

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

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,100
■ <a href="#">Specialist copayments</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">copayments</a>	\$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*)

<b>Total Example Cost</b>	<b>\$2,010</b>
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In this example, Mia would pay:

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

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.