Aetna Inc. HMO 5580: Aetna Inc.

Coverage Period: 01/01/2018 – 12/31/2018

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual + Family | Plan Type: HMO

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.anthem.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 Aetna 1-877-525-2355 to request a paper copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating: Individual $0 / Family $0.	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.
Are there services covered before you meet your deductible?	Yes.	Medical and pharmacy services received from a participating provider or participating pharmacy.do not have a deductible.
Are there other deductibles for specific services?	Yes. For retail prescriptions, $50 per person using out-of-network pharmacy. 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.
What is the out-of-pocket limit for this plan?	Medical: For in-network providers: $3,850 person/ $8,950 family. Copays apply. Prescription Drugs: $3,300 person / $5,350 family for participating providers only. Member pays the difference cost shares and 50% coinsurance for long-term medications filled at retail are not included.	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, balance-billed charges, and health care this plan does not 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.aetna.com or call 1-877-525-2355 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?	Yes, for in-network specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.

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 / visit	Not covered	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	$30 copay/visit	Not covered	Coverage is limited to 20 visits per calendar year for Chiropractic care.
	Preventive care/screening/ immunization	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	————————none————————
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	————————none————————
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 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. 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)		
		20% coinsurance ($31.80 maximum)/Rx	40% coinsurance (no maximum)/Rx	
		Mail order: 20% coinsurance ($63.60 maximum)/Rx		
	Non-preferred brand drugs	Retail pharmacy (after deductible – see page 1)		
		30% coinsurance $42.40 maximum)/Rx	40% coinsurance (no maximum)/Rx	
		Mail order: 30% coinsurance $84.80 maximum)/Rx		
	Specialty drugs	Covered as described above		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$30 copay/visit	Not covered	————————none————————
	Physician/surgeon fees	No charge	Not covered	————————none————————
If you need immediate	Emergency room care	$120 copay / visit	$120 copay / visit	No coverage for non-emergency use.

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)	
medical attention	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$30 copay / visit	$30 copay/visit	No coverage for non-emergency use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 copay / stay	Not covered	Precertification required
	Physician/surgeon fees	No charge	Not covered	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / visit	Not covered	——————none——————
	Inpatient services	$150 copay / stay	Not covered	Precertification required.
If you are pregnant	Office visits	No charge	Not covered	——————none——————
	Childbirth/delivery professional services	$30 copay for physician maternity services	Not covered	Includes outpatient postnatal care.
	Childbirth/delivery facility services	$150 copay / stay for facility	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	$30 copay / visit	Not covered	Coverage is limited to 100 visits per calendar year.
	Rehabilitation services	$30 copay / visit	Not covered	Coverage is limited to 40 visits per calendar year for Physical, Occupational & Speech
	Habilitation services	No covered	Not covered	
	Skilled nursing care	No charge	Not covered	Coverage is limited to 100 days per calendar year.
	Durable medical equipment	No charge	Not covered	——————none——————
	Hospice services	No charge	Not covered	——————none——————
If your child needs dental or eye care	Children's eye exam	$30 copay/visit	Not covered	Coverage is limited to 1 routine eye exam per 12 months.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside U.S.
- Routine foot care
- Weight loss programs – Except for required preventive care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture if it is prescribed by a physician for rehabilitation purposes • Bariatric surgery • Chiropractic care – Coverage is limited to 20 visits per calendar year • Hearing Aids	• Infertility treatment – Coverage is limited to the diagnosis and treatment of underlying medical condition. Artificial insemination and ovulation induction limited to 3 separate attempts per lifetime • Private duty nursing	• Routine eye care (Adult) – Coverage is limited to 1 routine eye exam per 12 months

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	$0
Specialist copayment	$30
Hospital (facility) copayment	$150
Other copayment	$0

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	$300

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

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$150
Other copayment	$0

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	$6,200

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

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$150
Other copayment	$0

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$300

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