

Your Medical Coverage

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Introduction to your medical coverage

Verizon offers eligible retirees and dependents access to medical benefits to help protect against the high expenses that can result from a serious illness or injury.

Your options allow you to choose the medical coverage that best meets your needs and those of your dependents.

This summary plan description (SPD) describes the medical benefits available under:

- Verizon's Bell Atlantic Management Retiree Health Plan for Pre 4/1/1986 Management Retirees; and
- Verizon's Bell Atlantic Medical Expense Plan for Pre 1/1/1990 Associate Retirees

as of January 1, 2007.

This SPD can help you better understand and use your benefits. It replaces previous medical SPDs and is intended to comply with U.S. Department of Labor (DOL) requirements. For a complete summary of your medical benefits, review this SPD and keep it for future reference.

About this document

Your medical program is governed by The Plan for Group Insurance for former management employees and Verizon's Bell Atlantic Medical Expense Plan for former associate employees. The healthcare coverage described in those documents is commonly referred to as the medical plan. This summary plan description (SPD) is incorporated by reference into the official plan documents as the source of specific information relating to your medical benefits.

References to "Verizon" or "the company" refer to Verizon Communications Inc. and the participating companies. References to "you" or "your" refer to the covered retiree and covered eligible dependents. For enrollment elections, the references refer to the covered retiree only.

This document uses a variety of terms to describe your medical benefits. They are defined in the "Medical terms to know" section.

Medical plan contacts

<p>Your Benefits Resources Web site</p> <p>Verizon Benefits Center</p>	<p>Via the Internet at: www.verizon.com/benefits</p> <p>1-877-4VzBens Representatives are available from 8 a.m. to 6 p.m., Eastern time, Monday through Friday.</p>	<ul style="list-style-type: none"> • Enroll for coverage. • Verify overall eligibility and coverage. • Review personal benefits information. • Make changes to your coverage. • Update dependent information. • Hotlink to medical options provider sites. (Online only) • Create and print personalized provider listings and maps to a physician's office. (Online only) • Verify eligibility for COBRA coverage. • Enroll for COBRA coverage. • Notify Verizon of a COBRA qualifying event. • Update COBRA coverage due to a subsequent COBRA qualifying event.
<p>Social Security Administration</p>	<p>Via the Internet at: www.medicare.gov 1-800-772-1213</p> <p>Verizon Benefits Center 1-877-4VzBens Representatives are available from 8 a.m. to 6 p.m., Eastern time, Monday through Friday.</p>	<ul style="list-style-type: none"> • Request information about Medicare. • Request information about how Medicare eligibility affects your benefits

Who is eligible?

You are eligible for coverage if:

- You were a management employee who retired before April 1, 1986:
 - With a service pension under the Bell Atlantic Management Plan (currently known as Verizon’s Bell Atlantic Cash Balance Plan) or the Bell Atlantic Enterprises Retirement Plan (currently known as Verizon’s Bell Atlantic Enterprises Cash Balance Plan).
 - With a disability pension under the Bell Atlantic Management Plan and continue to receive a disability pension from that plan.
- You were an associate who retired before January 1, 1990:
 - With a service pension under the Bell Atlantic Pension Plan (currently known as the Verizon Pension Plan for Mid-Atlantic Associates).
 - With a disability pension under the Bell Atlantic Pension Plan and continue to receive a disability pension from that plan.

You are not eligible if...

You are not eligible to participate in the plan if you receive or are eligible to receive a deferred vested pension.

Eligible dependents

You can enroll your dependents who meet the plan’s definition for eligibility, subject to any exceptions for a particular health maintenance organization (HMO), including your:

Dependent class	Who they are
Class I dependents	<ul style="list-style-type: none"> • Your legal spouse (whether or not separated) • Your ex-spouse in Massachusetts (for fully insured options, which are not described in this SPD, only) • Your unmarried children until the end of the calendar year in which they reach age 19, provided they receive more than 50% of their support from you • Your unmarried children from age 19 through the end of the calendar year in which they reach age 25 and are full-time students at an accredited educational institution, provided they receive more than 50% of their support from you • Your unmarried children of any age who are dependent on you for support due to physical or mental disability if the disability began while covered as a child or full-time student and they were covered continuously • Your unmarried children (including any age requirements) who are alternate recipients under an approved qualified medical child support order (QMCSO)
Sponsored children	Your unmarried children from age 19 through the end of the calendar year in which they reach age 25 who are not eligible class I or grandfathered class II dependents and otherwise meet the definition of child

Dependent class	Who they are
Sponsored parents	<p>A parent who was added to the plans after December 31, 1989 and who meets all of the following eligibility requirements:</p> <ul style="list-style-type: none"> • Is your parent or your eligible spouse's parent • Lives in your home or in one you provide near you (within 50 miles) for at least 6 months before he or she is eligible and throughout the period he or she is covered under the plans • Is dependent on you for more than 50% of support • Has annual income from all sources (other than that received from you), including social security, of less than \$15,000
Grandfathered Class II dependents	<ul style="list-style-type: none"> • Your unmarried children who don't qualify as sponsored children or class I dependents • Your unmarried grandchildren • Your unmarried brothers and sisters • Your parents and grandparents and your spouse's parents and grandparents <p>Each grandfathered class II dependent must meet all of the following eligibility requirements:</p> <ul style="list-style-type: none"> • Was enrolled on or before December 31, 1989 • Is dependent on you for more than 50% of support <p>You cannot add new class II dependents. Once dropped from coverage, grandfathered class II dependents cannot be reinstated.</p>

Important: if you enroll in an HMO

If you enroll in a medical option other than the Medical Expense Plan (MEP), it may not provide coverage to all of your dependents, such as some Class II dependents. Contact the Verizon Benefits Center directly to confirm that your dependents are eligible for coverage.

When your spouse is a Verizon employee or retiree

If your spouse is a Verizon employee or retiree, you have several coverage choices, depending on the circumstances.

If your spouse is		
A management employee or retiree	Any other Verizon employee or retiree	You have these coverage choices:
X	X	Elect coverage for yourself and enroll your spouse and any dependent children as covered dependents
X	X	Elect coverage for yourself and your dependent children
X	X	Elect coverage for yourself
X		Elect coverage for yourself and participate in your spouse's plan as a covered dependent
X	X	Waive your coverage and participate in your spouse's plan as a covered dependent
X	X	Elect coverage for your dependent children under your plan or your spouse's plan – not both

Enrollment under a qualified medical child support order (QMCSO)

The medical plan provides coverage for a child under the terms of a QMCSO. This coverage applies when:

- You do not have legal custody of the child.
- The child is not dependent on you for support.

You do not have to wait for a benefits renewal period to enroll the child.

When the company receives a valid QMCSO, the custodial parent or state agency can enroll the affected child if you do not.

Changing your coverage

Changing your elections

You can change your elections at any time, as many times as necessary, for any reason. Your new coverage takes effect the first of the month following a 31-day waiting period. Here are some examples:

- If you make your new selection January 25, coverage is effective March 1.
- If you make your new selection June 1, coverage is effective August 1
- If you make your new selection September 15, coverage is effective November 1.

If you are changing from or electing a Medicare Advantage Plan HMO, you will need to complete and return an HMO form (this will be sent to you by the Verizon Benefits Center). Upon the health plan's approval of the form, you will be covered by the Medicare Advantage Plan HMO. Your coverage will be effective first of the following month if the approved form is returned by the 15th of the preceding month.

Benefits renewal

You are not required to change your elections during a formal benefits renewal period. However, an exception **may** occur if your medical option will not be available to you in the following plan year. If this happens, you will be notified prior to the benefits renewal period that your medical option will not be available, and that your coverage will default to another option if you do not change your election during benefits renewal. You also will receive a benefits renewal kit that includes information about all your medical plan options. At that time you can:

- Take no action. Your default medical coverage will take effect January 1 of the following year.
- Select a new medical option during the traditional benefits renewal period. Your new coverage will take effect January 1 of the following year.

You also can select a new option at any time, and your change will be effective the first of the month following a 31-day waiting period.

How do I make changes?

Log on to Your Benefits Resources Web site or speak with a benefits representative via the telephone number shown on your Important Benefits Contacts insert. Your Benefits Resources is available 24 hours a day, Monday through Saturday and from 1:00 p.m. to midnight, Eastern time on Sunday. Benefits Center representatives are available to help you from 8:00 a.m. to 6:00 p.m., Eastern time Monday through Friday (excluding holidays).

Cost of coverage

Verizon may make a contribution toward the cost of your coverage under the plans. If the cost of your coverage is more than the amount Verizon contributes, you pay the difference. You will receive notification of the cost of your coverage, if any, each year from Verizon.

Gaining/losing dependents

The following chart provides coverage and enrollment information should you gain or lose a dependent while you are covered under the Plan.

<p>You gain a new dependent</p>	<ul style="list-style-type: none"> • If you are a retiree who gains a new, eligible dependent through marriage, birth, adoption or placement for adoption, that person is covered on the date you gain the new dependent, as long as you call the Verizon Benefits Center within 60 days of the event (for former management employees) or 90 days of the event (for former associates). Otherwise, coverage begins the date you call the Verizon Benefits Center to enroll them. • If you are a retiree who gains a new, eligible dependent as the result of a QMCSO, you can enroll that dependent by calling the Verizon Benefits Center. Your election will take effect on the date the QMCSO is approved by the claims administrator. • If you are a retiree who gains a new, eligible dependent as the result of an event other than those listed above you can enroll that dependent by calling the Verizon Benefits Center. Your election will take effect the first of the month following your election. • If you are an LTD benefit recipient or a surviving dependent, you cannot enroll dependents acquired after you become covered by your plan.
<p>You lose a dependent through death, divorce or legal separation</p>	<ul style="list-style-type: none"> • If you lose a dependent through death or divorce, coverage for that dependent ends on the date of the event. However, you must call the Verizon Benefits Center to remove that dependent from your coverage; otherwise, you will continue to pay any required premiums. • If you lose a dependent through legal separation, coverage for your spouse continues, unless you call the Verizon Benefits Center to remove him or her from your coverage.
<p>A dependent loses eligibility</p>	<ul style="list-style-type: none"> • If a dependent loses eligibility in situations other than those described above, the dependent's coverage will continue until the end of the month in which the dependent loses eligibility. • If the dependent is a child who loses eligibility because he or she reaches the age 19 limit (age 25 if a full-time student), the child's coverage will continue until December 31 of the year in which) is reached. • If a child is a full-time student who graduates prior to December 31 of his or her 25th year or no longer maintains his or her full-time student status, his or her coverage will terminate at the end of the month in which he or she loses full-time student status. <p>When a dependent loses eligibility, you must call the Verizon Benefits Center before the dependent's coverage ends. You may have the option to decrease your coverage level. If you do so, your election will be effective on the date of the event, as long as you make your election within 60 days of the dependent's loss of eligibility (for former management employees) or 90 days of the dependent's loss of eligibility (for former associates). Otherwise, the election will be effective on the first day of the month following the date on which you notify the Verizon Benefits Center of the event.</p> <p>If you do not notify Verizon, any claims incurred by your ineligible dependent will become your financial responsibility; furthermore, if you do not disenroll your dependent within 60 days of when they become ineligible, they will lose their right to purchase continued healthcare benefits under COBRA and its subsequent amendments.</p>

<p>A dependent changes eligibility class</p>	<ul style="list-style-type: none"> • If you are a retiree whose dependent loses eligibility as a class I dependent but would be eligible for coverage as a sponsored child, you must notify Verizon by calling the Verizon Benefits Center within 60 days of the change (for former management employees) or 90 days of the change (for former associates) in eligibility to ensure your dependent's coverage will continue without interruption. <p>If you do not notify the Verizon Benefits Center of the change within 60 days (for former management employees) or 90 days (for former associates), the dependent's coverage will cease until notification is received. When notification is received, coverage will be reinstated on the first day of the month following notification.</p> <p>If a child's eligibility class changes from a sponsored child to a class I dependent due to enrollment as a full-time student, you must call the Verizon Benefits Center and certify the child's full-time student status.</p> <ul style="list-style-type: none"> • If you are an LTD benefit recipient or a surviving dependent, you cannot reclassify ineligible class I dependents.
<p>You move</p>	<p>If you move to a location outside of your current option's service area, you will have the opportunity to choose a new option.</p> <ul style="list-style-type: none"> • If you notify Verizon within 60 days (for former management employees) or 90 days (for former associates) of your move, your election will be effective on the date of your move. • If you do not notify Verizon within 31 days of the creation of your move package, your election will be effective on the first day of the month following the date on which the election is made.
<p>You become eligible for Medicare</p>	<p>When you become Medicare-eligible, you may change your medical plan option. To do so, you must call the Verizon Benefits Center and make your election within 31 days after you become eligible for Medicare. Your election will be effective once your application is approved.</p> <p>Note: Your application may not be approved until after your 65th birthday. In this case, the coverage you had before you became eligible for Medicare would continue until your application is approved.</p> <p>Prior to your 65th birthday (the date you become eligible for Medicare, unless you become eligible for Medicare due to a disability), the Verizon Benefits Center will send an enrollment package to you that will describe the plan options available to you. If your current option is no longer available due to your being Medicare-eligible, or you wish to choose a new plan, you will have 31 days to call the Verizon Benefits Center and speak with a representative to enroll.</p>

Special enrollment rules

If you or your dependents waived medical coverage because of other health insurance coverage, you may be able to enroll yourself or your dependents in the plan if you later lose that other insurance due to:

- Loss of eligibility.
- Termination of employer contributions for such coverage.
- Exhaustion of COBRA coverage.

If you enroll yourself or your dependents in the plan:

- Within 60 days (for former management employees) or 90 days (for former associates) of losing the other coverage, your or your dependents' coverage will be effective retroactive to the date of the event.
- After 60 days (for former management employees) or 90 days (for former associates) of losing the other coverage, your or your dependents' coverage will be effective the first day of the month following your enrollment.

In addition, if you gain a new dependent as a result of marriage, birth, adoption or placement for adoption, you will be able to enroll yourself and your dependents. If you enroll:

- Within 60 days (for former management employees) or 90 days (for former associates) of the event, your coverage will be effective retroactive to the date of the event.
- After 60 days (for former management employees) or 90 days (for former associates) of the event, your coverage will be effective the first day of the month following your enrollment.

When coverage ends

This section explains when participation in the plans ends for you, your dependents and your survivors.

Re-employment of a retiree	Coverage under the plans will end on the last day of the month in which you are re-employed by the company or an affiliate in a position other than temporary or occasional. If you are rehired as a working retiree, you will continue to be classified as a retired participant and will continue to receive retiree benefits. This provision applies to former CWA-represented associates only, who do not reside in Delaware or Pennsylvania, and does not apply to LTD benefit recipients
LTD benefits end	If you are an LTD benefit recipient, your coverage ends on the last day of the month in which you are no longer eligible for LTD benefits under the applicable company-sponsored LTD plan, unless you are eligible for coverage as a retiree. Note: If you lose plan coverage because you are no longer eligible for LTD benefits, you are not eligible for COBRA continuation coverage.

Cancellation of coverage	If you cancel coverage, your coverage will end on the last day of the month in which you elect to cancel coverage.
Failure to submit payment (if required)	If you are required to make a payment and it is not received on time, coverage will end on the first day after the last "paid through" date.
Dependent coverage	A dependent's or surviving dependent's coverage will end on the earliest date described in the following section. Your dependent or surviving dependent may be able to continue coverage under COBRA. See page 52 for more information.
Retiree's or LTD benefit recipient's coverage ends	<ul style="list-style-type: none"> • If the retiree's coverage ends for any reason except for when the retiree dies, coverage for all dependents will also end at the same time. • If an LTD benefit recipient's coverage ends for any reason except for when the LTD benefit recipient dies, coverage for all dependents will end on the last day of the month in which LTD benefits end.
Retiree dies	<ul style="list-style-type: none"> • Coverage for any class I and grandfathered class II dependents who are enrolled on the date of the retiree's death will continue until the last day of the 6-month period following the month in which the retiree dies. • After 6 months, class I dependents may continue coverage under the Retiree plans at 100% of survivor contribution rates • Coverage for the retiree's sponsored children and sponsored parents will end on the last day of the month in which the retiree dies
LTD benefit recipient dies	Coverage for the dependents of an LTD benefit recipient will end on the last day of the month in which the LTD benefit recipient dies.
Dependent or surviving dependent ceases to meet the eligibility requirements	<p>Coverage for a dependent or a surviving dependent will end on the earlier of either the date the dependent is covered as an employee or retiree under any company-sponsored medical plan or the last day of the month in which the dependent or surviving dependent no longer qualifies as a dependent under the plan, subject to the following (note that HMOs may have different eligibility requirements):</p> <ul style="list-style-type: none"> • Coverage for your spouse ends on the day he or she becomes divorced from you. • Coverage for a legally separated spouse will end on the day you elect coverage to end. • Coverage for a child ends on the last day of the calendar year in which he or she reaches age 19 (if not a full-time student), or the last day of the month in which the child is married, if earlier. • Coverage for a stepchild ends on the last day of the month in which he or she no longer lives with you, or the date the stepchild otherwise becomes an ineligible dependent, if earlier. • Coverage for a full-time student ends on the earlier of the last day of the calendar year in which the student reaches age 25 or the last day of the month in which he or she no longer qualifies as a full-time student because he or she reduces his or her course load to a level below full-time as defined by the educational institution, graduates or otherwise leaves school for reasons other than his or her illness or injury. • Coverage for a disabled child ends on the last day of the month in which he or she no longer meets the definition of a disabled child. • Coverage for a child under a QMCSO ends on the date you no longer are required to provide coverage for this child or, if earlier, the date the child no longer would be eligible for coverage, as defined above. • Coverage for a grandfathered class II dependent ends on the last day of the month in which he or she fails to meet the support requirements of a grandfathered class II dependent (see page 4).

<p>Surviving dependents</p>	<p>In addition to the information under “Dependent coverage,” coverage for a surviving dependent will end on the earliest of the following dates:</p> <ul style="list-style-type: none"> • The last day of the month in which the surviving dependent requests that his or her coverage be cancelled. • The date the plan is terminated with respect to a participating company or with respect to surviving dependents. • The first day of the month for which a required contribution is not received in a timely manner. • The date coverage would otherwise end because the surviving dependent ceases to be an eligible dependent.
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Certificate of Creditable Coverage

When coverage ends, a Certificate of Creditable Coverage will be provided to you in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Present the certificate to your new employer or health insurer if you or your dependents have a pre-existing condition that would limit coverage under your new plan.

The certificate:

- Identifies the individuals who had coverage and the beginning and ending dates of coverage.
- Generally reduces the amount of time you are subject to a pre-existing condition exclusion under another plan.

Verizon provides a certificate, free of charge, if:

- You lose coverage under the medical plan.
- You become entitled to elect coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).
- Your COBRA coverage ends.
- You request a certificate before losing coverage.
- You request a certificate up to 24 months after losing coverage.

The new plan is not required to pay benefits for a pre-existing condition for 12 months (or 18 months for late enrollees) after your enrollment date into the new plan. However, the length of this pre-existing condition exclusion period must be reduced by the amount of your prior creditable coverage, as outlined on the certificate.

If you or your dependents go 63 days or more without coverage (called a break in coverage), you or your dependents may be subject to the pre-existing condition exclusion period. Check with your new employer or health insurer to verify the length of your pre-existing condition exclusion period.

Medical expense plan (MEP) option

The medical expense plan (MEP) is a traditional medical plan, where you can use any doctor or hospital you choose. The MEP pays benefits for medically necessary expenses as a percentage of reasonable and customary (R&C) charges after you meet the deductible.

How the MEP works

Here is a brief snapshot of how the MEP works:

Feature	Coverage
Deductible (per calendar year)	Minimum of \$25 and a maximum of \$150 (see below); Family deductible is three times the individual deductible
Out-of-pocket maximum (per calendar year)	\$1,000 per covered person; \$3,000 per family
Provider network	None; you can use any doctor or hospital you choose
Coverage for most expenses Coinsurance may be required, and exceptions and limitations may apply.	Usually 80%, after deductible
Coverage for hospitalization	Usually: <ul style="list-style-type: none"> • For the first 120 days of a single stay, 100% (no deductible) • After the first 120 days of the same stay, 80%, after deductible

Annual deductible

Each calendar year before the plan pays benefits for expenses that are subject to the deductible, a covered individual must meet the individual annual deductible, which is:

- 1% of your annual pension benefit or long-term disability (LTD) benefit in effect on December 31 of the previous calendar year, subject to a minimum of \$25 and a maximum of \$150.
- If you are a surviving dependent, your deductible is equal to the deductible that applied to the deceased retiree at the time of his or her death.
- If you are a long-term disability (LTD) benefit recipient, your deductible amount will be based on your annual LTD benefit amount as of December 31 of the preceding plan year.

However, if three or more covered family members (except for grandfathered class II and sponsored dependents) have expenses applied toward the individual deductibles that total the family deductible (three times the individual deductible), then for the remainder of the calendar year, no further individual deductibles apply.

Amounts paid for care for sponsored children, sponsored parents and grandfathered class II dependents do not count toward the family deductible. These dependents must meet their individual deductibles even if the family deductible has been met.

The following expenses may not be applied to the deductible:

- Charges that are not covered by the MEP.
- Amounts in excess of R&C.
- Amounts payable when pre-admission testing or any of the surgical procedures described under “Outpatient surgery” on page 21 is done on an inpatient basis and the inpatient admission is not considered medically necessary by the claims administrator.

Common accident provision

If two or more members of your family are injured in the same accident, the MEP requires only one individual deductible to be met (per calendar year) before it pays benefits for eligible accident-related expenses. This rule does not apply to grandfathered class II dependents or sponsored dependents.

Year-end carryover

Any covered expenses you have during October, November or December that apply to the current year’s deductible will also apply to the next year’s deductible. This feature helps you avoid paying the deductible twice within a short period of time.

Coinsurance

Typically, you pay a percentage of your covered expenses and the MEP pays the remainder. The percentage you pay is called coinsurance. The amount the MEP pays for your covered expenses will depend on the type of service you receive.

Basic benefits

The plan pays 100% of R&C for basic services. You pay any difference between R&C and the actual charge.

The following special rules apply:

- The plan will pay 100% of the covered charge for:
 - Inpatient hospital admissions in a semiprivate room up to 120 days per confinement (this limit is applied to the combination of hospitalization, skilled nursing facility stays and home health care).
 - Inpatient mental healthcare admissions in a semiprivate room up to 30 days per confinement.
 - Inpatient substance abuse treatment in a semiprivate room up to 60 days per lifetime, or 60 days of inpatient and outpatient combined. Each day of outpatient care is considered a half-day of inpatient care.
 - Facility charges for covered use of an ambulatory care facility or a birthing center.
 - Emergency care within 72 hours after onset of the accident or illness provided that services and supplies are covered under the plan.

- The plan will pay 80% of R&C plus 80% of the remaining 20% coinsurance for:
 - Covered surgery (and associated services) performed on an inpatient basis when hospitalization is determined by the claims administrator not to be medically necessary.
 - Physicians' services in connection with the use of an emergency room for nonemergency care.
- The plan will pay 90% of R&C plus 80% of the remaining 10% coinsurance for:
 - Anesthesia (except when administered in connection with certain outpatient surgical procedures that are subject to the outpatient surgery program).
 - Well-baby and newborn care.
 - In-hospital physician visits and consultations.
 - Pre-admission testing done on an inpatient basis and when confinement is determined by the claims administrator not to be medically necessary.
- The plan will pay 95% of R&C plus 80% of the remaining 5% coinsurance for:
 - Covered surgery except for second surgical opinions and certain outpatient surgery procedures (see page 22).
 - Maternity care.

Note: All outpatient surgery rules described above apply only to the covered surgical procedures described on page 22.

Other covered charges

For services covered as other covered charges, the plan generally pays 80% of R&C after the deductible, and your coinsurance is the remaining 20%. Other covered charges include services that aren't covered under basic benefits, such as doctor's office visits and chiropractic care.

For outpatient mental healthcare, however, the plan will pay 50% of R&C and your coinsurance will be the remaining 50%.

Annual out-of-pocket maximum

The annual out-of-pocket maximum for the MEP is \$1,000 per covered person, and \$3,000 per family, per calendar year. The following expenses do not count toward the out-of-pocket maximum, nor will they be paid at 100% after a covered person reaches the applicable out-of-pocket maximum:

- Amounts paid to satisfy the deductible,
- Charges that are not covered by the plan,
- Charges in excess of the R&C charge, or charges in excess of any applicable MEP maximums,

- Charges for use of a private hospital room to the extent not covered by the plan,
- Amounts you pay if you fail to obtain a required pre-admission review,
- Amounts you pay for pre-admission testing when the testing is done on an inpatient basis and hospitalization is not medically necessary,
- Amounts you pay for covered surgery when the surgery is performed on an inpatient basis and hospitalization is determined by the claims administrator not to be medically necessary,
- The cost difference between a brand-name drug and a generic drug when a physician has not prescribed the brand-name drug, and
- The difference between the discounted network price and the retail price when you purchase a prescription drug without your prescription drug card, or at an out-of-network pharmacy.

Lifetime maximum benefit

There is a lifetime maximum benefit of \$50,000 per covered person for covered services that are considered "Other Covered Charges." Examples of other covered charges include ambulance service, X-rays and lab tests, durable medical equipment and physical, occupational and speech therapy.

If you elected to enroll for an additional lifetime maximum of \$50,000, each covered person's lifetime maximum will be \$100,000.

The lifetime maximum will begin on January 1 of the year following the year in which you first become covered under the plan. For surviving dependents, the lifetime maximum will begin on January 1 of the year following the plan year in which the surviving dependent first becomes covered under the plan, whether as a dependent or a surviving dependent.

The first \$3,500 of benefits payable for other covered charges in any calendar year do not apply to the lifetime maximum.

Health management resources

Pre-admission review

Note: The pre-admission review requirements described below apply only if you and/or your dependents meet one of the following requirements:

- You and/or your dependents are Medicare-eligible and the Verizon-sponsored plan is your primary plan due to exhaustion of Medicare benefits or due to circumstances described on page X, or
- You and/or your dependents are not Medicare-eligible and the Verizon-sponsored plan is your primary plan.

See page 56 for more information on coordination of benefits (COB).

All inpatient admissions to hospitals or healthcare facilities (including inpatient mental healthcare and substance abuse treatment, hospice care and stays in a skilled nursing facility) must be certified as medically necessary through the pre-admission review program. The claims administrator will review the case and determine whether the proposed service or supply will be covered as medically necessary under the plan.

The claims administrator will then notify the physician and the covered person of its decision. If you or your physician disagree with the claims administrator's decision, you can appeal the decision.

The following special pre-admission review rules apply:

- Emergency admissions (including admissions for mental healthcare or substance abuse treatment) should be certified by the claims administrator no later than 48 hours after admission or the next business day, whichever is later; and
- Maternity admissions should be pre-certified before the anticipated delivery date, and the claims administrator should be notified of a pregnancy no later than 90 days before the anticipated delivery date, as estimated by a professional healthcare provider, and should be notified of the actual admission no later than 48 hours after the delivery date or the next business day, whichever is later. If these maternity notifications are given, there is no need to obtain further certification for hospital admission, to undergo concurrent review or risk any adjustment in benefits for any cases where the maternity admissions are up to 48 hours following a vaginal delivery or up to 96 hours following a cesarean section.

Pre-certification

If your physician recommends an inpatient admission, you should pre-certify your care by calling the claims administrator (see your Important Benefits Contacts insert for the telephone number). A family member or your physician may contact the claims administrator if you are unable to do so.

The claims administrator will notify the hospital or healthcare facility of its decision. If the claims administrator determines that the admission is medically necessary, the claims administrator will authorize coverage of an approved initial length of stay.

No benefits will be paid for services and supplies found not to be medically necessary.

Concurrent review

During an inpatient confinement, the claims administrator will periodically review the covered person's case and may modify the number of days of inpatient confinement initially authorized. If the covered person's physician believes additional days of inpatient confinement are required beyond the number of days initially authorized, the physician, the covered person or a family member must contact the claims administrator to determine how the plan will provide coverage for the extension.

If the covered person's physician disagrees with the claims administrator about whether additional days of inpatient hospitalization should be covered by the plan, the covered person or his or her physician may appeal the claims administrator's decision by providing additional information supporting the necessity of the additional days of hospitalization. See page 66 for information on claims and appeals.

Medical decisions regarding the length of stay beyond the number of days authorized and paid for under the terms of the plan as medically necessary are between the patient and his or her doctor.

Reimbursement

If pre-certification is obtained: If the hospitalization is determined to be medically necessary by the claims administrator, benefits will be paid as described starting on page 19. If the hospitalization is determined not to be medically necessary, no benefits will be payable.

If pre-certification is not obtained: If the hospitalization is determined to be medically necessary by the claims administrator, you will be required to pay the following:

- If you are a retiree or an enrolled dependent or surviving dependent of a retiree, the first \$250 of covered hospital room and board charges or 1% of your annual pension benefit as of the preceding December 31, whichever is less. This penalty will not apply to the deductible or out-of-pocket maximum, and will not be considered other covered charges under the plan.
- If you are an LTD benefit recipient or an enrolled dependent of an LTD benefit recipient, the first \$250 of covered hospital room and board charges or 1% of your annual LTD benefit amount as of the preceding December 31, whichever is less. This penalty will not apply to the deductible or out-of-pocket maximum, and will not be considered other covered charges under the plan.

If the hospitalization is determined not to be medically necessary by the claims administrator, no benefits will be payable and any amounts you pay for inpatient hospitalization will not apply to the out-of-pocket maximum. However, benefits for other covered services or supplies (such as surgeons' fees, diagnostic tests, etc.) may be payable.

Filing claims

If the patient is not eligible for Medicare

- You or your healthcare provider should submit your claim, along with a copy of the bill, to the claims administrator.
- After the claims administrator has received the bill for your care, it will determine how much of the bill to be paid, if any. It will also send you an explanation of benefits (EOB) statement. The EOB shows how much of the bill the plan paid and how much (if any) remains for you to pay.
- After you receive the EOB, you should receive a new bill from your medical provider for any remaining amount not covered by the plan.
- **Note:** You should submit your claims as soon as possible after receiving a healthcare service. The deadline for submitting claims is 15 months after the date the service was rendered.

If the patient is eligible for Medicare

If the patient is eligible for Medicare (and Medicare is the patient's primary plan):

- You or your healthcare provider should submit the bill for the care to Medicare.
- Medicare will then pay its portion of the bill. After Medicare pays its portion, you will receive a Medicare Summary Notice showing how much Medicare has paid.
- After you receive your Medicare Summary Notice, submit a copy of the notice, plus copies of any bills you have received from the provider, to the claims administrator.
- The claims administrator will then determine your eligible benefits and, if appropriate, send a payment to your healthcare provider. It will also send you an EOB statement. The EOB shows how much of the bill the plan paid and how much (if any) remains for you to pay. After you receive the EOB, you should receive a new bill from your medical provider for any remaining amount not covered by the MEP (indemnity plan) or Medicare.

What is covered

The tables in this section provide an overview of the benefits payable for covered services and supplies provided by the MEP.

Keep in mind, charges in excess of reasonable and customary (R&C) amounts will not be covered by the plan. If a charge for a covered service exceeds the R&C amount, the MEP option's reimbursement percentage will be applied to the R&C amount.

Inpatient hospital services

Room, board and ancillary services	<ul style="list-style-type: none"> • 100% of actual charges, if pre-certified for up to 120 days per confinement; • After 120 days, 80% of actual charges after deductible, if pre-certified <p>To calculate the 120-day limit, each day in a hospital counts as one full day. The 120-day limit is a cumulative number for all inpatient stays per plan year (and is a combination of all inpatient hospital stays, stays in a skilled nursing facility and home health care visits).</p>
In-hospital physicians' visits	90%; plan also pays 80% of your remaining 10% coinsurance, after deductible
Pre-admission testing (to determine if hospital care is necessary)	<ul style="list-style-type: none"> • Inpatient: 90% (hospital room and board charges are not covered) • Outpatient: 100% (if billed by a hospital, deductible applies)
<i>Continued next page</i>	

Hospital room and board

A private room will be covered when required by law, when medically necessary and ordered by your physician, or when approved by the claims administrator. If your situation does not meet one of these conditions and you choose to stay in a private room in a hospital that has semiprivate rooms, the plan will pay 100% of the charge for a semiprivate room. If the hospital only has private rooms, plan benefits will be 90% of the charge for the private room. Private room charges in excess of the most prevalent semiprivate room rate of that hospital or of hospitals in the same area are disregarded when determining plan benefits.

In-hospital visits

In-hospital visits will be covered for the treatment of conditions not related to routine maternity care. Coverage is limited to one visit by a physician per day, per specialty. In-hospital visits after the first visit each day will be covered at 90% of R&C after the deductible is met.

Customary pre and postoperative care visits are not covered.

In-hospital consultations

One consultation per specialty for each admission to a hospital will be covered, provided the covered person's attending physician requests the consultation. (However, the transfer of a patient from one physician to another for definitive treatment is not considered a consultation under the plan.)

In-hospital consultation coverage does not include travel expenses or loss of income. Staff consultations required by hospital rules or regulations are not covered.

Pre-admission testing

Testing performed in an outpatient department of a hospital, at an ambulatory surgical facility or other facility recognized by the hospital and a surgeon, will be covered provided the following conditions are met:

- The tests are necessary and consistent with the diagnosis and treatment of the condition.
- The covered person physically is present for the test.
- The admission is not canceled or postponed except:
 - As a result of a second surgical opinion.
 - As a result of the test findings themselves.
 - For other medical reasons.

Inpatient and outpatient surgery

Inpatient surgery	<p>95% (no deductible); plan also pays 80% of your 5% coinsurance, after you meet the deductible; (see below for exceptions)</p> <p>If surgery must be performed on an inpatient basis because of medical necessity, eligible services will be covered at 95% of the R&C amount</p>
Outpatient surgery	<ul style="list-style-type: none"> • 95% (no deductible); plan also pays 80% of your remaining 5% coinsurance, after deductible • See below for certain eligible surgical procedures paid at 100%
Anesthesia	<p>90% (no deductible); plan also pays 80% of your remaining 10% coinsurance, after deductible</p> <p>Anesthesia and its administration is not covered:</p> <ul style="list-style-type: none"> • When a separate charge is made for the administration of anesthesia by a surgeon or assistant surgeon in connection with the surgery performed, • When anesthesia is administered by the same physician who administers electroshock therapy. • When rendered in connection with a service that is not a covered service or supply under the plan.
<i>Continued next page</i>	

Outpatient surgery procedures paid at 100%

When certain eligible surgical procedures are performed on an outpatient basis, the plan will pay 100% of the R&C amount for that surgery. The plan will also pay 100% of R&C for diagnostic X-ray, laboratory and other associated expenses with no deductible applied. Eligible surgical procedures include, but are not limited to:

- Excision of lesions of the skin, subcutaneous and soft tissue (malignant and benign), including removal of cysts, tumors and lipomas,
- Musculoskeletal system (examination of the interior of a joint and certain surgical procedures),
- Varicose vein ligation,
- Digestive system (incision and drainage of intraoral abscess, cyst, perianal abscess),
- Male genital system procedures,
- Female genital system procedures,
- Maternity care and delivery,
- Eye and ocular adnexa procedures and
- Ear surgery.

The following special rules apply to only those procedures listed above and if performed on an inpatient basis when hospitalization is determined by the claims administrator not to be medically necessary:

- The plan will pay 80% of R&C for surgery and associated expenses with no deductible.
- The remaining 20% of R&C will not be covered and will not count toward the out-of-pocket expense maximum.
- Hospital room and board will not be covered.

Second surgical opinion

Because there are risks involved with any surgical procedure, you may wish to get a second opinion when surgery is recommended.

Under the MEP, up to three consultations may be covered by the plan, including associated X rays and laboratory tests. If the second surgical opinion is nonconcurring, the plan will cover a third surgical opinion and associated diagnostic tests on the same basis as a second surgical opinion.

Second surgical opinion consultations are covered at 100% of R&C. In addition, if a consultation is obtained, the following surgical procedures will be covered at 100% of R&C.

- Cholecystectomy (removal of the gallbladder),
- Coronary bypass,
- Hysterectomy,
- Knee surgery and
- Laminectomy (removal of the vertebral arch).

If a second opinion is obtained for one of the above procedures, the plan will pay 100% of R&C. If a second opinion is not obtained, the plan will pay 80% of R&C. The remaining 20% of R&C will not be covered and will not apply toward the out-of-pocket expense maximum,

Multiple procedures

In the event of multiple or bilateral surgical procedures or surgery performed in stages:

- For the major procedure, regular plan benefits will be paid. For each minor procedure, 50% of the regular plan benefit will be paid.
- Bilateral procedures (those that involve both of two symmetrical organs) will be paid up to the R&C amount for each procedure.
- An incidental procedure performed with the major surgery will not be covered, unless the incidental procedure is the only procedure performed in that operative field.
- Multiple surgical procedures involving more than one physician having different specialties shall be treated independently except that only one charge for use of the operating room and one for anesthesia will be covered.

Use of assistant surgeon

The services of a physician who actively assists an operating surgeon during surgery will be covered, as long as those services are required by the surgical procedure, as determined by the claims administrator.

Continued next page

Sterilization procedures

An initial voluntary sterilization procedure for a male or female covered person, including reversals, will be covered without restriction as to waiting periods, doctor's approval, etc.

Sex-change procedures

A transsexual operation will be covered as long as the covered person's provider submits satisfactory written evidence to the claims administrator that the operation is medically necessary. The claims administrator will then determine medical necessity.

Oral surgery

The following oral surgery is covered:

- Oral surgery for the treatment of diseases, injuries and defects of the mouth, jaws and associated structures
- Excision of bone or tissue from other than the oral cavity as a donor site for purposes of grafting, as long as the grafting is necessary due to accidental injury or illness
- Surgical treatments of temporomandibular joint (TMJ) dysfunction
- For Verizon Delaware Inc., Verizon New Jersey Inc. and Verizon Pennsylvania Inc. retirees and their dependents only: removal of impacted teeth in a hospital, the outpatient department of a hospital or ambulatory surgical facility, provided that the removal is determined to be medically necessary by the claims administrator.

Cosmetic surgery

Cosmetic surgery is covered only for the following reasons:

- To correct an accidental injury
- To correct congenital deformities or anomalies that result in functional impairments
- To provide reconstruction after or incidental to surgery resulting from trauma, infection or other illness of the involved part
- To provide reconstruction in connection with surgery performed for valid medical reasons (such as cysts, carcinoma, etc.) or as otherwise provided in the section called "Mastectomies and breast reconstruction"

All claims for cosmetic surgery are subject to medical necessity review by the claims administrator.

Mastectomies and breast reconstruction

Covered services include mastectomy, reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and services and supplies to treat physical complications during all stages of the mastectomy, including lymphedemas.

Special rules for transplants

Human organ and tissue transplants will be covered subject to the following:

- When the recipient and donor are both covered persons under the plan, benefits will be provided for both parties.
- When the recipient is a covered person under the plan, but the donor is not, benefits will be provided for both to the extent that benefits are not provided to the donor under any other plan.
- When the donor is a covered person under the plan, but the recipient is not covered under a plan that provides benefits for donor expenses, benefits will be provided to the donor for his or her expenses only. No benefits will be provided to the recipient.

Some procedures may be considered experimental or investigational but may be the last effort to correct a life-threatening condition. Each case will be reviewed individually by the claims administrator.

Maternity and newborn services

Maternity care (physicians' charges for pre/postnatal care and delivery)	95%; plan also pays 80% of your remaining 5% coinsurance, after deductible
Well-baby and newborn baby care (initial pediatric exam while mother is hospitalized) Limited to class I dependents only (i.e., newborn of unmarried dependents not covered)	90%; plan also pays 80% of your remaining 10% coinsurance
Birth centers (facility charge)	100% of actual cost after deductible, if pre-certified
<p>Benefits for maternity care will be provided for covered persons regardless of when the pregnancy began. Benefits will not be provided for services rendered after coverage has ended, even if the pregnancy began before coverage ended.</p> <p>Care given to the newborn child during the mother's stay and in the infant's nursery after birth will be covered if the child is a class I dependent. The newborn child of an unmarried dependent will not be covered.</p> <p>The plan will cover a hospital stay for a mother and her eligible newborn for 48 hours for a vaginal delivery and for 96 hours for a cesarean section. However, with the consent of the mother, a physician may discharge the mother and newborn sooner than this. Longer stays will be covered if considered medically necessary by the claims administrator.</p> <p>The following maternity care services are covered under the plan:</p> <ul style="list-style-type: none"> • Antepartum care, including prenatal services (such as initial and subsequent history, physical exams, routine urinalysis and maternity counseling) • Delivery, including vaginal delivery, cesarean section, ectopic pregnancy, miscarriage and abortion (voluntary or therapeutic) • Postpartum care, including hospital and normal office visits following the delivery • Services of a nurse midwife • Use of a birthing center and ancillary services provided by the birthing center (payable at 100% of the facility's fee after the deductible) • One pediatric examination of the eligible newborn child while the mother is hospitalized • Circumcision of the eligible newborn child when performed by a physician or surgeon 	

Outpatient treatments

Doctors' office visits	80%, after deductible
Doctors' home visits	80%, after deductible
X rays and lab tests, when the procedure is consistent with the diagnosis, symptom, injury or illness and is not part of a routine examination However, allergy tests and Pap tests are covered with or without a diagnosed condition	100%, no deductible
Radiation therapy, chemotherapy, electroshock therapy, hemodialysis	100% ,no deductible
Physical, occupational and speech therapy, only to the extent necessary to restore function lost due to illness or injury; duration must be prescribed by your doctor	80%, after deductible
Cardiac rehabilitation treatment	80%, after deductible Treatment under a cardiac rehabilitation program must be approved in advance by the claims administrator, and is covered for: <ul style="list-style-type: none"> • A cardiac patient who has been diagnosed as having angina pectoris. • A cardiac patient who has been hospitalized for a diagnosed myocardial infarction, coronary bypass surgery or coronary angioplasty. • Certain patients suffering from severe angina pectoris or symptomatic left ventricular disorders when these disorders have not responded to standard medical or surgical interventions, as determined by the claims administrator after review of relevant medical records.
Licensed chiropractor	80%, after deductible, up to \$500 per calendar year; maintenance chiropractic services not covered The \$500 limit does not apply to retirees and LTD benefit recipients from Verizon New Jersey, Inc. and their eligible dependents and surviving dependents.
Private duty nursing	80%, after deductible if medically necessary and pre-certified (see page 17)
Home health care	<ul style="list-style-type: none"> • 100% (no deductible), if pre-certified, for up to 120 days per confinement; • After the first 120-day limit is reached, 80% after deductible, if pre-certified <p>To calculate the 120-day limit, each home health care visit counts as one-fifth of a day. The 120-day limit is a cumulative number for all inpatient stays per plan year, and is a combination of all inpatient hospital stays, stays in a skilled nursing facility and home health care visits.</p>
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Home health care

To be eligible for benefits for home health care, a covered person's plan of treatment must be pre-approved by the claims administrator. No more than 30 days will be pre-authorized at one time. If home health care is needed beyond the pre-authorized number of days, the home health care agency or the attending physician must contact the claims administrator for an authorized extension.

A covered person's home health care must begin in accordance with the following:

- If the covered person is hospitalized and receiving inpatient benefits prior to home health care treatment, the covered person's home health care must have verbal authorization and commence within 72 hours of discharge.
- If the covered person is not hospitalized prior to home health care treatment, the covered person's home health care must commence within 72 hours of the claims administrator's verbal authorization.

The following home health care services and supplies are covered when they are determined to be medically necessary by the claims administrator and are billed for by the home health care agency:

- Ambulance service to transport the covered person to and from the local hospital as medically required (as determined by the claims administrator), but not if the service normally would be free of charge.
- Drugs prescribed by the physician and provided by the home health care agency.
- Hemodialysis services and equipment.
- Home health aide services, when supervised by an R.N. or a skilled team member, to provide non-skilled personal care to the covered person (e.g., assisting with self-administered medication, nutritional needs and exercises), and certain domestic care (e.g., changing the bed, doing laundry and cooking meals for the covered person only), but only to the extent the claims administrator determines that without such care hospitalization would be required.
- Therapeutic and diagnostic services, including diagnostic X rays, laboratory and pathology exams that would be covered if provided on an inpatient basis, but are provided on an outpatient basis by a home health care agency because the services require special equipment not readily available in the covered person's home.
- Services of a licensed or registered speech pathologist and/or audiologist.
- Maternity care.
- Medical social services provided by a licensed social worker.
- Medical/surgical supplies.
- Nursing care furnished by an R.N. or an L.P.N.
- Nutritional guidance provided by a qualified licensed dietitian, subject to approval of the claims administrator.
- Rental or purchase (if purchase price is less than rental cost) of durable medical equipment.
- Services of a certified inhalation therapist or licensed occupational therapist.
- Services of a licensed physical therapist or physical therapy rendered by a physical therapy assistant under the supervision of a licensed physical therapist and billed for by the licensed physical therapist.
- Visits by the attending physician will be covered even if billed for directly by the attending physician.

Preventive care services

Adult Annual Physical Exams	100% Covered (no deductible) <i>One exam every year.</i>
Well Woman Exam	100% Covered (no deductible) <i>One well-woman exam, every year, regardless of age and with or without a Pap test, including blood count and urinalysis.</i>
Prostate Specific Antigen Test	100% covered (no deductible) <i>One test every year.</i>

Prescription drugs

	In-network pharmacy	Out-of-network pharmacy	Mail Service pharmacy
Prescription drugs	Up to a 30-day supply	Up to a 30-day supply	Up to a 90-day supply
Generic and brand-name drugs	You pay 20% of the lesser of the discounted network price (DNP) or pharmacy's retail price (50% for mental healthcare drugs)	You pay 20% of the generic DNP, plus the difference between retail cost and generic DNP (50% for mental healthcare drugs)	You pay a \$12 copayment
You must use your prescription ID card at a network pharmacy to get in-network benefits. For more information about prescription drug coverage, see pages 38 through 45.			

Mental healthcare/substance abuse

Generally, all participants in the MEP, including your dependents, are eligible for mental healthcare and substance abuse benefits.

Inpatient mental healthcare	For the first 30 days of confinement, 100% of actual charges after deductible After the first 30 days, 80% after deductible
Outpatient mental healthcare	50% after deductible (out-of-pocket maximum does not apply).
Inpatient substance abuse treatment	100% of actual charges after deductible
Outpatient substance abuse treatment	100%
<ul style="list-style-type: none"> • Benefits for substance abuse treatment are limited to 60 days of inpatient care per lifetime or 60 days of inpatient and outpatient care combined. For partial hospitalization and intensive outpatient treatment for substance abuse, each day of care is considered one half-day of inpatient care. • Inpatient mental healthcare admissions separated by fewer than 180 days will be considered a single confinement. 	

Mental healthcare

Covered outpatient mental healthcare services include:

- Services rendered by a physician, social worker trained in psychiatry, or a licensed and certified clinical psychologist.
- Two consultations per plan year with a covered person's family members (spouse, parents, siblings, etc.) when required for treatment for the covered person.

Substance abuse treatment

The following treatment will be covered under the plan:

- Inpatient detoxification and rehabilitation at a state-licensed facility approved by the claims administrator. To be covered, detoxification must be followed by rehabilitation.
- Outpatient treatment, including drug therapy, psychotherapy, counseling, family therapy, and behavior therapy at a state-licensed facility or one that is approved by the claims administrator.

Note: Professional fees billed separately by private practitioners under an inpatient program are not eligible for reimbursement. Professional fees billed separately by private practitioners under an outpatient program will be covered if the provider is licensed and approved to provide outpatient substance abuse treatment and the treatment is part of an approved treatment program.

Pre-certification

As with any hospitalization, it is a good idea to pre-certify inpatient mental healthcare and substance abuse treatment. Before receiving inpatient mental healthcare or substance abuse treatment, you should call UnitedHealthcare (UHC) for pre-certification. (See your Important Benefits Contacts insert for the telephone number.)

Other services

Durable medical equipment	80%, after deductible <ul style="list-style-type: none">• The purchase of durable medical equipment will be covered if the purchase price is less than the cost of rental (or if the equipment cannot be rented) and long-term use of the equipment is planned.• Surgical stockings prescribed by a physician are covered; however, reimbursement is limited to two pairs per covered person, per plan year.• The following replacements are not covered under the plan:<ul style="list-style-type: none">— Items that are replaced due to loss or negligence— Items that are replaced due to the availability of a newer, more efficient model, except when a physician indicates that replacement is medically necessary
Prostheses	80%, after deductible <p>Replacement of a prosthesis will be covered only if required due to a change in the covered person's physical or medical condition, an accidental injury or the normal growth of a child. Replacement of an outdated prosthesis, if determined to still be functional or repairable, will not be covered.</p>

Ambulance services (in case of emergency only)	80%, after deductible Air transportation or other transportation in lieu of an ambulance may also be covered (for example, in a skiing accident or an automobile accident, if you are transported by helicopter from a remote area to the nearest facility adequate for treatment).
Prosthetic devices	80%, after deductible
Eyeglasses and hearing aids	80%, after deductible An initial pair of lenses after eye surgery or an initial hearing aid following ear surgery or injury will be covered if purchased within 90 days of the surgery or injury.
Blood and blood derivatives (to the extent not donated by the covered person, a family member or a donor in the covered person's name)	80%, after deductible
Chiropractic care	80%, after deductible <ul style="list-style-type: none"> • Benefits are limited to \$500 per plan year. • There is no benefit limit for retirees and LTD benefit recipients from Verizon New Jersey Inc. and their eligible dependents and surviving dependents.
Wigs (covered only for hair loss due to chemotherapy)	80%, after deductible Benefits are limited to \$300 per calendar year
Emergency room care (within 72 hours of injury or onset of illness and only in the case of an emergency)	100% (no deductible)
Skilled nursing facilities (limit of 120 days per plan year)	<ul style="list-style-type: none"> • 100% (no deductible), if pre-certified, for up to 120 days per confinement; • After the first 120-day limit is reached, 80% after deductible, if pre-certified <p>To calculate the 120-day limit, each day in a skilled nursing facility counts as one half-day. The 120-day limit is a cumulative number for all inpatient stays per plan year (and is a combination of all inpatient hospital stays, stays in a skilled nursing facility and home health care visits).</p>
Hospice care (lifetime limit of 180 days, of which no more than 60 days may be for inpatient hospice care)	100% (no deductible), if pre-certified After 180 days, up to an additional 45 days may be authorized, as determined by the claims administrator.

Emergency care

Emergency care is covered as long as the care is provided in a hospital's emergency room within 72 hours of an accidental injury or onset of a sudden, serious and life-threatening illness, as defined by the claims administrator. When an emergency room is used for nonemergency care, the facility charges will not be covered; physician's charges will be covered as other nonemergency care if medically necessary.

Skilled nursing facility care

Care in a skilled nursing facility is covered if approved in advance by the claims administrator, and if that care is not available on an outpatient basis, in a nursing home or in your home. The following services and supplies are covered, provided they are medically necessary and billed for by a skilled nursing facility:

- Room and board, including general nursing services, meals and special diets.
- Use of special treatment rooms.
- Prescription drugs prescribed by the physician, but only if billed for by the skilled nursing facility.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic services (the same as would be provided for a regular inpatient admission to a hospital).
- Therapy services (the same as would be provided for a regular inpatient admission to a hospital).
- Physicians' medical visits and consultations.

Admission to a skilled nursing facility must be pre-approved, must occur within 14 days of a prior hospital stay of at least three days, and must be for the continued treatment of the same illness or injury for which the covered person was in the same hospital.

Hospice care

To be eligible for hospice care, a physician must certify that the covered person meets the following criteria:

- The covered person has a confirmed diagnosis of terminal illness.
- The covered person has a life expectancy of six months or less.
- No further curative therapy is indicated for or desired by the covered person.

The following services and supplies will be covered if provided by an approved provider and billed for by a hospice care agency:

- Use of medical equipment.
- Dressings, medications and medical supplies.
- Use of a semiprivate room, board and general nursing care on an inpatient basis.

The following counseling services will also be covered if provided by an approved provider and billed for by a hospice care agency:

- Family counseling for the covered person and his or her immediate family members during the covered person's illness.
- Bereavement counseling of the covered person's immediate family members within 90 days after the covered person's death.

The hospice care program must be approved in advance by the claims administrator. No benefits are available for physicians' services for hospice care if billed for separately. Benefits may be provided for physicians' services for hospice care if billed for by the hospice care agency as part of the hospice care program.

Medical expenses not covered by the MEP

The following are some of the expenses that the plan does not cover. Obviously, only expenses incurred while you are eligible for and enrolled in the plan are covered. Additional expenses may not be covered. If you have any questions about whether an expense is covered, call the claims administrator.

Services or supplies covered elsewhere

- Services or supplies covered under any federal or state “no-fault” motor vehicle insurance provision that relates to medical treatment or other mandated insurance, regardless of whether the covered person properly asserts his or her rights under the motor vehicle insurance contract;
- Services or supplies for which the covered person recovers cost by legal action, insurance proceeds or settlement from a third party whose negligent or wrongful actions have caused or are alleged to have caused the covered person’s illness or injury or from the insurer of the third party;
- Services or supplies provided by a local, state or federal governmental agency, except as otherwise required by federal law;
- Services or supplies that are furnished, paid for or otherwise provided for treatment of a military service-connected disability or by reason of the present service of any person in the armed forces of a government; and
- Services or supplies provided for any condition covered by Workers’ Compensation laws or for any other occupational condition, ailment, injury or illness occurring on the job if one of the following is true:
 - The covered person’s employer provides reimbursement for such charges.
 - The covered person’s employer makes a settlement for such charges.
 - The covered person fails to assert his or her rights in attaining reimbursement from the employer.

This exclusion applies to all covered persons under the plan. The plan has the right to recover or place a lien on any benefits paid or payable if Workers’ Compensation provides benefits for the same condition.

Excluded hospital services and supplies

- Hospital inpatient care if the confinement is for dental treatment or services, except in the cases of:
 - Dental treatment or service when a physician other than a dentist certifies that hospitalization is medically necessary,
 - Dental treatment or services for accidental injury to the natural, healthy teeth occurring while covered under the plan (excluding any claim for accidental injury for \$250 or less),

- Temporomandibular joint (TMJ) dysfunction surgery, and
 - Removal of impacted teeth (for retirees and their dependents of Verizon Delaware Inc., Verizon New Jersey Inc. and Verizon Pennsylvania Inc. only), if hospitalization is medically necessary.
- Except in the case of oral surgery (see page 23), use of a hospital outpatient department for the removal of impacted teeth or dental procedures.
 - Hospitalization that is primarily for physical therapy or speech therapy that could have been provided on an outpatient basis.
 - Hospitalization that primarily is for X-ray, laboratory and other diagnostic studies, electrocardiograms or electroencephalograms, including pre-admission testing when confinement during such tests is not medically necessary.
 - Saturday and Sunday room and board charges for admissions on Friday or Saturday that are not emergency admissions.
 - Tests performed on an inpatient basis when the same tests had been performed on a pre-admission basis, unless retesting is determined by the claims administrator to be medically necessary.
 - Services rendered on an inpatient basis by physicians or surgeons who do not have admitting privileges, or by technicians not employed by or under contract to the hospital.
 - Hospitalization for surgery when that surgery is not medically necessary.
 - Facility charges for use of an emergency room for nonemergency care.

Services or supplies not medically necessary

- Care, treatment, services or supplies that are not medically necessary as determined by the claims administrator.
- Cosmetic surgery or drugs used for cosmetic purposes, unless performed to correct an injury caused by an accident, or unless necessary to correct functional medical problems caused by congenital deformities or anomalies or to provide reconstruction after disease.
- Care in an institution that is primarily for convalescent or domiciliary care, or custodial care, such as a place of rest, home for the aged, a nursing home, a half-way house or hotel.
- Acupuncture when used for therapeutic purposes.
- Diagnostic X rays and laboratory and machine tests that are not consistent with the diagnosis, symptoms or illness of the covered person.
- Athletic club dues or exercise equipment for the home.
- Preconception services or supplies for the purpose of inducing pregnancy, such as in vitro fertilization, artificial insemination, GIFT, ZIFT, or experimental or investigational services.

- Services or supplies related to weight control and obesity (even if prescribed by a physician).
- Services or supplies that are determined by the claims administrator not to be necessary for the diagnosis, care or treatment of the physical or mental condition involved, even when prescribed, recommended or approved by the attending physician or dentist.
- Charges determined by the claims administrators to be for educational services or supplies, such as training in the activities of daily living, instructions on scholastic skills, preparing for an occupation, treatment of learning disabilities or to promote development beyond any level of function previously demonstrated.
- Except if medically necessary, as determined by the claims administrator, inpatient private duty nursing services provided by an R.N. or an L.P.N.
- Services recommended by a nonprofessional, or services performed solely at the request of the covered person.
- Chiropractic care, developmental therapy, physical therapy, speech therapy and other therapy services for maintenance after the optimum level of improvement has been reached, as determined by the claims administrator.

Experimental or investigational services and supplies

Any service or supply determined by the claims administrator to be for experimental or investigational purposes, including drugs or other care, will not be considered a covered service or supply under the plan.

Charges by certain providers

- Charges of a physician or other professional provider on “stand-by” in the event complications might occur;
- Surgical or routine maternity care visits while hospitalized, to the extent those visits are considered part of the surgeon’s or obstetrician’s fee, as determined by the claims administrator;
- The administration of anesthesia by the surgeon, assistant surgeon or physician who also renders diagnostic tests, performs surgery or provides any other service for the same procedure; and
- Professional services provided to a covered person by the covered person’s family member or by a person residing in the covered person’s home.

Routine or convenience items

- Routine physical examinations;
- Routine foot care (such as removal of corns and calluses [except in connection with diabetes], orthopedic shoes, insoles and arch supports);
- Routine eye examinations, eyeglasses, contact lenses and eye refractions for the fitting of glasses, except as specifically provided under the plan;
- Routine hearing examinations and hearing aids, except as specifically provided under the plan;

- Vitamins (except prenatal vitamins), food and food supplements used as dietary supplements, except as provided under the prescription drug program (see page 38) or except if prescribed while hospitalized and taken on an inpatient basis as medically necessary;
- Personal comfort or beautification items while hospitalized, such as television rentals, barber services and guest meals;
- Innoculations, vaccinations, immunization shots and preventive gammaglobin shots;
- Diversional or recreational therapy;
- Convenience items, even when prescribed by the physician or provided by a hospital, if not medically necessary for treatment of the covered person's medical condition; and
- Miscellaneous equipment, including items in the following list.
 - Air conditioners
 - Bed rails, tables, trays or boards (except if an integral part of the hospital bed)
 - Bicycles
 - Children's strollers
 - Dietetic or health foods
 - Electric fans
 - Enuresis units
 - Escalator or elevator for the covered person's home
 - Food liquidators
 - Hand rails
 - Heating pads
 - Heating units for swimming pools
 - Humidifiers
 - Hypoallergenic cosmetics or toiletries
 - Ice bags
 - Mattresses, except when purchased with a hospital bed

- Niagra vibrators
- Overbed tables
- Puritron air fresheners
- Ramps
- Scales (weight)
- Telephones
- Thermometers
- Vaporizers
- Walking canes with seat

Home health care

- Eyeglasses and contact lenses or examinations, except as otherwise covered under the plan.
- Food, housing or home delivery (e.g., meals on wheels).
- Hearing aids, except as otherwise covered under the plan.
- Mental health treatment.
- Care provided in a nursing home or skilled nursing facility.
- Care primarily for rest or custodial care.
- Visits by physicians for care that is normally considered as part of postsurgical care.
- Visits for care unrelated to the diagnosis or the plan of treatment.
- Private duty nursing.
- Prosthetic devices.
- Services provided to a covered person whose place of residence is an institution that provides treatment to injured or disabled persons.
- Services provided to covered persons who are essentially not homebound for medical reasons.
- Services that would have been covered had the covered person been hospitalized.

Skilled nursing facilities

- Treatment of covered persons who have reached the maximum level of recovery possible for their particular condition and who no longer require definitive treatment other than routine supportive care;
- Treatment that does not require confinement in a skilled nursing facility and is designed solely to assist the covered person with the simple activities of daily living or to provide the protection of an institutional environment as a convenience to the covered person.
- Custodial care, care that is primarily domiciliary in nature, or care that provides room and board (with or without routine supportive care, training and supervision in personal hygiene and other forms of self-care) to a covered person who does not require medical or nursing services.
- Treatment of primary mental illness, including drug addiction, chronic brain syndrome and alcoholism without other specific medical conditions of a severity to require care. However, this exclusion will not apply to covered persons with primary mental illness receiving short-term convalescent care for a secondary medical condition for whom prognosis for recovery or improvement is considered favorable for that medical condition.
- Treatment of covered persons suffering senile deterioration who do not have a treatable medical condition requiring attention.
- Maternity care and care for newborns or infants.
- Physicians' medical visits in a skilled nursing facility are limited to one per day.

Other exclusions

- Charges in excess of the R&C charge or the DNP or in excess of any applicable annual or lifetime maximum, as determined by the applicable claims administrator.
- Charges for services or supplies provided before coverage begins or after coverage ends, except as specifically provided under this plan. Any charges incurred by the patient at any time they are not covered by the plan are the financial responsibility of the patient.
- Services or supplies for which there is no legal obligation to pay.
- Services for which the physician or other provider does not customarily bill his or her patient.
- Services or supplies provided as a result of injury or illness due to an act of war, declared or undeclared, that occurs after the individual becomes covered under the plan.
- Hospital room, board and ancillary services or supplies when hospital confinement is or becomes primarily rehabilitative, except as specifically provided under inpatient substance abuse treatment, unless the diagnosis and condition of the covered person are such that rehabilitation cannot be provided on an outpatient basis. However, use of a facility that is part of a hospital or an approved skilled nursing facility is a covered service or supply when rehabilitation is medically necessary, as determined by the claims administrator, due to an accidental injury, spinal injury or an illness such as a stroke.

- Treatment on or to the teeth except for:
 - Treatment when incurred due to an accidental injury to the natural, healthy teeth occurring while the individual is a covered person under the plan (excluding any claim for accidental injury when such claim totals \$250 or less).
 - Surgical procedures for TMJ dysfunction.
 - Dental treatment in a hospital when a physician other than a dentist certifies that hospitalization is medically necessary.
 - Removal of impacted teeth (for retirees and their dependents of Verizon Delaware Inc., Verizon New Jersey Inc. and Verizon Pennsylvania Inc. only) when use of a hospital or ambulatory surgical facility (ASF) is medically necessary, as determined by the claims administrator.
- Items that are considered capital improvements to the home, such as electrical wiring and plumbing.

Prescription drug program

Under the prescription drug program, there are three ways to fill your prescriptions:

- By presenting your Medco ID card at a participating retail pharmacy.
- Using a retail pharmacy outside of the network.
- Using the Medco By Mail service, referred to as the “mail service pharmacy.”

Using a participating pharmacy

For short term drugs (up to a 30-day supply), take your Medco prescription ID card to an in-network retail pharmacy. You can locate participating retail pharmacies on the Medco Internet site at www.medco.com or by calling Medco at 1-877-877-1878 and using the automated voice-response system.

Using a Nonparticipating Pharmacy

When you use a non-participating pharmacy, you'll pay 20% of the retail price (50% for mental health medications). You will then need to file a paper claim for reimbursement with Medco.

Medco By Mail

For maintenance drugs (up to a 90-day supply), you can use Medco by Mail, Medco's mail service pharmacy, where you'll pay a \$12 copayment for generic and brand-name drugs.

Diabetic kits (consisting of, for example, insulin, apparatus and supplies) are available from Medco By Mail when the order is placed as a single prescription order on the same day with insulin or other oral agents. A single copayment applies.

You'll receive a Medco By Mail package when you enroll for the first time, including a welcome letter, mail service pharmacy form, envelope and a health questionnaire. You should complete the questionnaire and return it to Medco By Mail to record your health history. When you have a prescription to fill, complete an order form and mail it in the envelope provided along with your original prescription and a check for the \$12 copayment to Medco By Mail. Your prescription will be sent to your home in approximately 14 days.

Initial orders

To order a prescription by mail:

- Use the Internet. Visit www.medco.com, select the “Benefits” tab and choose “Request a new prescription.” Or,
- Send your original prescription and your copayment to the Medco By Mail Service using an order envelope. You can pay for the initial prescription by check or money order or authorize billing to MasterCard®, Visa®, American Express®, Diners Club® or Discover® Card. Or,
- Have your doctor call 1-888-EASYRX (1-888-327-9791) for instructions for faxing the prescription.

Refills

There are currently three ways to order refills:

- Call the Medco By Mail Service at 1-877-877-1878 (inside U.S.) or 1-972-915-6695 (outside U.S.)
- Mail your copayment to the Medco By Mail Service using an order envelope.
- Go online at www.medco.com and charge it to your credit card.

If you can't wait two weeks to receive your medication, ask your physician to write two prescriptions – one for a two-week supply that you can use at your local pharmacy and one for your on-going supply that you can use for the mail service pharmacy.

Order envelopes

Call the prescription program if you need an order envelope. A new order envelope will be included with your medication.

What is covered

The prescription drug program covers the following items. Medco is an independent organization with its own contract provisions, benefits, and network providers. If you have questions about covered charges, you should contact Medco. See your Important Benefits Contact insert for contact information.

- Medications that require a prescription and that are medically necessary.

Medically necessary medications must be appropriate with regard to general medical standards for the diagnosis or treatment of an illness or injury. In addition, they must be the least intensive and most cost-effective, and not solely for convenience.

- Insulin needles and syringes.
- Diabetic kits (insulin, apparatus and supplies), available through Medco By Mail. You pay a single payment when the order is placed as one prescription on the same day with insulin or other oral agents. If you request the medication and supplies be refilled, but part of the request becomes subject to a "refill too soon edit," then the prescriptions will not be dispensed together.
- Over-the-counter insulin and diabetic supplies ordered separately (not as a kit). If you are Medicare-eligible, diabetic supplies are covered by Medicare, not by the prescription program.
- Immunization agents, vaccines, biologicals.
- Glucagon – for emergency treatment for diabetes.
- All U.S. Food and Drug Administration (FDA)-approved prescription contraceptives, including birth control pills, injections, implants and devices, such as diaphragms and IUDs.
- Bee sting kits – for those highly allergic to bees.
- Flu medications to prevent the flu for certain high-risk patients and those allergic to serum.

- Wellness drugs such as smoking cessation and weight loss prescriptions (some limitations may apply). See the “What is not covered” section on page 44 for more information.
- Drug Efficacy Study Implementation (DESI) drugs.
- Prenatal vitamins and pediatric fluoride vitamins.
- Synagis, a doctor-administered biological to prevent infections in premature infants.
- Drugs to prevent nausea and vomiting due to chemotherapy, radiotherapy or surgery.

Special purchase requirements for certain medications

Special requirements apply for the purchase of certain medications. For example:

- Before dispensing medications with the potential of fatal drug interaction with other drugs, the prescription program will alert the pharmacist who will determine if the doctor should be contacted.
- After clinical reviews are performed, patients who potentially may be overusing highly addictive narcotics may be limited to purchasing their medications at one participating retail pharmacy of their choice and Medco By Mail.

Preferred medication list

The prescription program uses a listing of preferred medications developed by Medco and a team of independent physicians and clinical pharmacists from many specialty areas. It is a carefully selected list of high-quality, commonly prescribed and cost-effective prescription medications. Many drug choices are available.

Ask your doctor to prescribe the “preferred” medications so you can help control costs for yourself and for Verizon. For information about preferred medications, visit Medco’s Web site or call Medco.

Generic medications

Generic prescription drugs have the same chemical makeup, but cost much less than brand name drugs. In fact, using a generic can save you hundreds of dollars each year. If you take medication – or are being prescribed a drug for the first time – be sure to ask your doctor if the medication is available as a generic.

If your doctor prescribes a brand-name medication and there is a generic equivalent or comparable medication on the preferred list, a participating or mail-service pharmacist may contact your doctor to discuss whether the alternate medication would be appropriate for your situation. However, you and your doctor make the final decision about your medication.

For former management employees only: *If your doctor prescribes a brand-name medication and there is a generic equivalent or comparable medication on the preferred list, a participating or mail-service pharmacist may contact your doctor to discuss whether the alternate medication would be appropriate for your situation. However, you and your doctor make the final decision about your medication.*

Select generic medications

Normally, generics and their brand-name counterparts have the same effect on a patient. However, some patients may have a different reaction to certain generic drugs, as compared to the brand-name medication:

- Clozaril (generic name: Clozapine), used for schizophrenia and psychotic disorders.
- Neoral, Sandimmune (generic name: Cyclosporine), used for kidney, liver and heart transplants.

If you are using one of these generic drugs, there is no reason to change to the brand name. If you start taking one of these drugs, you and your doctor should consider the generic first. These generics are approved by the FDA and considered safe. Adverse reactions to these drugs are rare. The primary concern is a change in effectiveness if you move from one to the other.

Both the brand and generic for these medications are on the preferred list and the lower amount that you pay for preferred medications applies.

Compound medications

Compound medications are custom made by a pharmacy according to a doctor's prescription. Often, these medications are made up of several ingredients, each with its own, unique identification number, called a National Drug Code (NDC).

Special rules apply for submitting claims for compound medications. See the "Filing claims" section on page 65 for more information.

Medications that require Coverage Review

Sometimes more information is needed than is provided by the prescription or the claim to determine if the Verizon plan covers it. Certain medications must undergo a coverage review before they are eligible for reimbursement under the program. When you have a prescription that needs this review before the claim is paid, and you fill it at a participating pharmacy, you may be requested to have your physician contact Medco. (Through the Medco By Mail service, the pharmacist will coordinate with the prescribing doctor automatically.) Having your doctor initiate this process prior to presenting the prescription to the pharmacist is highly recommended because it generates the fastest results. Have your doctor contact the Medco coverage review unit via the telephone number shown on your Important Benefits Contacts insert to initiate the review. Generally, approval takes two business days.

Generally, medications are selected for coverage review before dispensing if:

- The medication is often associated with complications.
- The medication has a high potential for adverse reactions.
- More information is needed to determine whether the drug meets the plan's coverage criteria.
- The medication is needed to treat complex conditions.
- The medication is effective only for some individuals or with other therapies.
- The medication is costly and often misused.

If you have a prescription that needs this review, the pharmacist will coordinate with the prescribing doctor. If you have a question about whether a medication will require coverage review, call Medco. For faster approval, you or your doctor can initiate the review process by contacting the Medco coverage review unit. Generally, approval takes two business days.

Examples of categories that require coverage review include:

Categories	
Acne therapy	Miscellaneous dermatologicals
Alzheimer's therapy	Multiple sclerosis
Appetite suppressants and other weight loss medications	Myeloid stimulants (fight infection and treat low white blood cell counts)
Erythroid stimulants (correct anemia in patients with dialysis, HIV, etc.)	Pain management
Hepatitis C	Smoking cessation
Human growth hormones	Rheumatoid arthritis agents
Interferons (treat immune disorders and infections)	

The following list reflects the categories that require coverage review for former management employees only:

Categories	
Cholesterol lowering medications	Migraine medications
Anti-influenza medications	Erectile dysfunction medications

The following list reflects the categories that require coverage review for former associate employees only:

Categories	
Migraine medications	Cholesterol lowering agents
Erectile dysfunction agents	

Limited coverage for certain drugs

The amount of medication covered for a specific period may be limited for some drugs, used infrequently or seasonally, in low doses, or by individuals with specific health conditions.

A number of factors are considered in determining the amount of medication that your plan covers, including but not limited to:

- The available dosage strengths.
- How often most people take the medication.
- Uses and quantities generally considered reasonable and safe.
- FDA-approved product labeling.

If your medication is prescribed in doses or quantities outside of these guidelines, coverage may be limited. While you or your pharmacist may initiate a review, having your doctor initiate the process can result in a faster review process.

Examples of categories of prescription drugs that have limits include the following:

Categories	
Allergy and asthma	High blood pressure and other heart conditions
Antidepressants	Sleep medications
Antiemetics	Diabetic agents/insulins
Antifungal	Migraine medications
Cholesterol lowering agents	Narcolepsy
COX-2 inhibitor (anti inflammatory agents and pain management)	Osteoporosis
Diabetic peripheral neuropathy and epilepsy	Proton pump inhibitors
Estrogens	Pain Management (Stadol NS)
Fertility agents	Erectile Dysfunction agents
Anti-influenza agents	

The Medco Specialty Care Pharmacy—Accredo

Some conditions, such as anemia, hepatitis C, multiple sclerosis, asthma, cystic fibrosis, hemophilia, growth hormone deficiency and rheumatoid arthritis, are treated with specialty medications. Specialty medications are those that usually are injected, require refrigeration, special handling and timely delivery. Examples include *Avonex*[®], *Enbrel*[®], *Forteo*[®], *Humira*[®] and *Procrit*[®].

If you use specialty medications, Accredo:

- Delivers your medications to you.
- Provides answers from a pharmacist, 24 hours a day, seven days a week, to your questions about the medications.
- Coordinates home health care and other healthcare services.
- Provides access to nurses who are trained in specialty medications.

For a complete list of specialty medications, visit the Medco Web site or call Accredo.

Coverage for Specialty Medications

If you take specialty medications on a long-term basis (three months or more), you will pay 50% of the medication's total cost at a participating retail pharmacy after the third time you purchase it. You can avoid these higher costs by ordering specialty medications through Accredo.

What is not covered

The prescription program does **not** cover:

- Medications not approved by the U.S. Food and Drug Administration (FDA).
- Medications that states restrict for sale or distribution.
- Medications that are not medically necessary or that do not treat an accidental injury, illness, pregnancy except those identified under "What is covered" on page 19.
- Over-the-counter medications (except for insulin and diabetic supplies), including smoking-cessation products.
- Smoking deterrents that require a prescription but are not taken in conjunction with a patient support program and Nicotine replacement products, more than a three-month supply of prescription Nicotine[®] Transdermal, Nicotine Nasal Spray, Nicotine Inhalation System and Bupropion Sustained-release Tablet (Zyban[®]) in a 12-month period or more than a six-month supply of Chantix in a 24-month period.
- Appetite suppressants and other weight loss drugs, unless for treating morbid obesity and taken in conjunction with a patient support program.
- Therapeutic devices, bandages, heat lamps, braces or artificial appliances (except insulin needles and syringes, over-the-counter diabetic supplies, unless covered by Medicare and diaphragms and IUDs that require a prescription).

- Health and beauty aids and medications for cosmetic purposes, such as Renova, Retin-A or Solage for age spots or as a wrinkle cream, and Propecia or Rogaine for hair loss.
- Blood or blood plasma.¹
- Dietary supplements.
- Medications for experimental use.
- Medication covered by Workers' Compensation laws or similar government programs, or for which no charge is made.
- Charges covered by Medicare, including both Medicare Part A and Part B – regardless of whether or not you have enrolled in or received Medicare Part A and Part B benefits.

Health maintenance organizations (HMOs) and Medicare HMOs

The HMOs available to you will vary depending on where you live. Some HMOs offer programs for people eligible for Medicare; others do not. Your enrollment materials will explain which HMOs (if any) are open to you.

Be sure your dependents are eligible for HMO coverage

The eligibility rules for an HMO may differ from the general rules that apply to the plan. **If so, the HMO's eligibility rules will override the general rules.** Because of this, if you have dependents you want to cover, be sure to check with the HMO to make sure they will be eligible for coverage under the HMO's rules.

Sponsored dependents: If you are considering moving a sponsored dependent from one HMO to another, be sure to check with the new HMO regarding their rules for eligible dependents. If a sponsored dependent enrolled in an HMO changes to another Verizon-sponsored plan, you will not be able to enroll the sponsored dependent in an HMO at a later date.

How HMOs typically work

When you join an HMO, all your care must be provided through the HMO's network of doctors and hospitals in order to be covered.

In general, HMOs cover routine physicals, annual gynecological exams and immunizations. HMOs also cover your medical expenses when you're sick or injured.

Every HMO has its own coverage provisions. If you are thinking of joining an HMO (or already have joined), you should access Your Benefits Resources Web site or contact the HMO directly to get full information about the HMO's coverage provisions. Upon request, you will receive written materials describing the services provided by the HMO, the conditions for eligibility to receive those services, the circumstances under which services may be denied, the procedures to be followed in obtaining covered services and the procedures for review of claims for services that are denied in whole or in part.

The remainder of this section describes some typical features of most HMOs.

Choosing a primary care physician (PCP)

When you join an HMO, you'll typically need to choose a PCP from the HMO's network of doctors. Your PCP will be your primary doctor – the physician who coordinates all your care and guides you through the HMO's services and network.

Procedures for receiving care

In most HMOs, your care is covered only if it is provided by your PCP or with a referral from your PCP. Because of this, the first thing you should do when you need care is contact your PCP. Your PCP will then decide whether to treat you or to refer you to other doctors or medical facilities within the HMO's network.

Emergencies

Most HMOs do not require you to contact your PCP first when you need care in a serious medical emergency. (You may need to contact your PCP if you need urgent care, however.) You should check with your HMO for complete details on emergency coverage.

Your costs

Generally, all you pay for care in an HMO is a fixed copayment each time you receive care. Some other services are covered at 100% by the HMO. Typically, you will not receive any bills for care and all claims will be handled directly by the HMO.

Prescription drug coverage for HMOs

Prescription drug coverage for most Verizon-sponsored HMOs is provided through the HMOs. Each HMO has its own coverage provisions. Therefore, you should contact your specific HMO for prescription drug information. However, some non-Medicare HMOs may have a retail and mail order pharmacy “carved out” to the Verizon prescription drug program administered by Medco instead of through the HMOs.

If your retail and home delivery pharmacy is carved out to Medco, your prescription drug benefits will be the same as described on pages 38 through 45 (however, no prescription drug out-of-pocket maximum will apply). Regardless of the administrator, contact the HMO or Medco (whichever is your prescription drug provider) for more information on your prescription drug program.

Supplemental behavioral health benefits

The company has designated a special administrator, currently Managed Health Network (MHN), to provide additional benefits to those participants who have exhausted the applicable HMO benefit limits for mental health and substance abuse treatment. The participant or the health plan must inform MHN that the HMO’s mental health and substance abuse treatment benefits have been exhausted and that he or she would like care to continue, based on medical necessity. Additional benefits may be provided if MHN determines that they are medically necessary, as defined by the plan. If MHN determines that benefits will be payable, those benefits will be 50% of reasonable and customary (R&C) for covered medical expenses to treat mental health disorders or substance abuse for each covered person, up to a \$1 million lifetime maximum. You can call MHN via the telephone number listed on your Important Benefits Contacts insert.

Medicare HMOs

Medicare HMOs offer Medicare-eligible individuals cost-effective alternatives to original Medicare. To enroll in a Medicare HMO, you must be enrolled in both Medicare Part A (hospital coverage) and Part B (physician coverage). In general, you are automatically enrolled in Medicare Part A and Part B when you reach age 65 or become Medicare-eligible. You must continue to pay premiums for Medicare Part B if you enroll in a Medicare HMO.

If you enroll in a Medicare HMO, you generally must use your PCP in order to receive benefits. Medicare HMOs provide the same types of services as non-Medicare HMOs, but with a focus on the special needs of Medicare-eligible members. You pay only a small copayment or none.

Keep your Medicare card: Even if you select a Medicare HMO, keep your Medicare card. You will need your Medicare card if you later choose to enroll in a medical plan option that is not a Medicare HMO.

There are two types of Medicare HMOs sponsored by Verizon:

- **Medicare Advantage HMO.** This type of option will be offered to you only if you live in a Medicare Advantage service area. A Medicare Advantage HMO is approved by the Centers for Medicare & Medicaid Services and **replaces** your original Medicare coverage. The Medicare Advantage HMO is responsible for coordinating all your healthcare needs and providing all the services covered by original Medicare.
- **Medicare Supplemental HMO.** This type of option is offered to you only if you live outside the Medicare Advantage Plan service areas. A Medicare Supplemental HMO typically **coordinates** with original Medicare. If you are in a Medicare Supplemental HMO, Medicare functions as your primary plan when the HMO coordinates with Medicare. Call member services to find out if your HMO coordinates with Medicare. (If the HMO does not coordinate with Medicare, the Medicare Supplemental HMO functions as your primary plan.) Your claims are submitted (usually by your provider – in some cases, you may be responsible for submitting your claims) to Medicare first; then the Medicare Supplemental HMO pays the difference between the Medicare benefit and the amount the HMO would have paid had it been your primary plan. **Note:** You may be able to opt-in to a Medicare Supplemental HMO. Call the Verizon Benefits Center for information.

Enrolling in a Medicare HMO

To enroll in either type of Medicare HMO through Verizon, you or your dependent must be:

- Medicare-eligible per Medicare guidelines.
- Enrolled in both Medicare Parts A and B.
- A permanent resident of a Medicare HMO service area.

You can enroll in a Medicare HMO (or change Medicare HMOs) at any time. You also have the option to leave the Medicare HMO and re-enroll in the Verizon Medical Expense Plan for New York and New England Pre 8/10/1986 Associate Retirees and Pre 7/2/1985 Management Retirees and ordinary Medicare.

- If you are enrolling yourself or your dependent in a Medicare Advantage Plan HMO for the first time, an HMO enrollment form must be completed for yourself and each Medicare-eligible dependent.
- If you or a dependent is disenrolling from a Medicare Advantage Plan HMO, an HMO disenrollment form must be completed for yourself and each Medicare-eligible dependent.
- Your election will be effective as soon as administratively possible once your enrollment or disenrollment form is approved. Until your election form is effective, you will continue to be covered under your previously elected medical plan option.
- There are no special enrollment or disenrollment guidelines for a Medicare Supplemental HMO.

- Under federal rules, no one is eligible for Medicare HMO coverage if he or she doesn't meet the guidelines above, is undergoing renal dialysis treatment or has had a kidney transplant within the last 36 months.
- **If you travel for part of the year:** Some Medicare HMOs have made provisions for retirees who live away from their permanent residence for more than 90 consecutive days each year. These plans allow you to receive coverage at both your permanent and temporary residences. You should call member services to check if your HMO has these provisions.

Coverage for dependents

If you or a dependent are Medicare-eligible, the following rules apply:

- Your Medicare-eligible family members may all select the same option – or different options. If you want to select different options for different family members, you may do so as long as at least one family member who is Medicare-eligible is enrolled in a Medicare Advantage Plan HMO. Then, other family members may choose a Medicare Advantage Plan HMO (where available) while others may select the Medicare MEP option, and
- All family members who are not Medicare-eligible must select the same option.

Note: If you choose to waive coverage, your family members must also waive coverage.

No coverage option

You can elect no coverage under the plans at the time you are first eligible or at any subsequent time. However, you are required to have other Verizon medical coverage (i.e., coverage under a spouse's plan) in order to elect the no coverage option.

If a surviving dependent waives medical coverage under the plans, he or she will not be able to elect coverage at a later date.

Other benefits

Reimbursement of Medicare premiums

Medicare Part B reimbursement is available to retirees, eligible spouses and disabled Class I dependents with end-stage renal disease after the first 30 months of Medicare coverage. Contact the Verizon Benefits Center for more information.

Continuing coverage

Coverage continuation rights under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), offers you the opportunity to continue coverage.

For additional information about your rights and obligations under the medical plan and under federal law, contact the Verizon Benefits Center.

What is COBRA continuation coverage?

COBRA coverage is a temporary continuation of medical plan coverage when it otherwise would end because of a life event, known as a “COBRA qualifying event.” (Specific qualifying events are listed later in this section.)

After a qualifying event, COBRA continuation coverage is offered to each “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries if coverage under the medical plan is lost because of the qualifying event. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period.

Qualified beneficiaries who elect COBRA continuation coverage must pay for it.

COBRA qualified beneficiaries

- **Retirees.** If you, your covered spouse or dependent child lose coverage under the plan, or if there is a substantial reduction in coverage under the plan because of Verizon’s bankruptcy, special rules may allow coverage to be continued for a certain period.
- **Spouse of retiree.** Your spouse is eligible for COBRA continuation if he or she loses coverage under the medical plan because of one of the following qualifying events:
 - You die.
 - You become divorced.
- **Dependent children.** Dependent children are eligible for COBRA continuation if they lose coverage under the medical plan because of one of the following qualifying events:
 - The parent-retiree dies.
 - The parents become divorced.
 - The child loses eligibility for coverage as a “dependent child” under the medical plan.

When COBRA coverage is available

The medical plan offers COBRA continuation coverage to qualified beneficiaries only after the Verizon Benefits Center has been notified that a qualifying event has occurred. (See the “Additional plan information” section on page 63 for contact information.)

Notification of qualifying events

When the qualifying event is the death of the retiree, **Verizon will notify** the Verizon Benefits Center (the COBRA administrator) of the qualifying event.

For other qualifying events (divorce of the retiree and spouse or a dependent child losing eligibility for coverage as a dependent child), **you or the qualified beneficiary must notify** the Verizon Benefits Center within 60 days after the qualifying event. See “Medical plan contacts” on page 2 for contact information.

How COBRA coverage is offered

After the Verizon Benefits Center receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each qualified beneficiary.

The Verizon Benefits Center provides a COBRA enrollment notice by mail within 14 days after receiving notice of the qualifying event and each qualified beneficiary has an independent right to elect COBRA continuation coverage.

Covered retirees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. It is critical that you (or anyone who may become a qualified beneficiary) maintain a current address with the Verizon Benefits Center to ensure that you receive a COBRA enrollment notice following a qualifying event.

How long COBRA coverage lasts

COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- The death of the retiree.
- Your divorce.
- A dependent child losing eligibility as a dependent child.

COBRA qualifying events

	Maximum continuation period (months) for:		
Qualifying event	You	Spouse	Covered child
Your covered child no longer qualifies as a dependent	N/A	N/A	36
You die ¹	N/A	36	36
You and your spouse divorce	N/A	36	36

You and your eligible dependents have 60 days from the date coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect continued participation under COBRA.

What COBRA coverage costs

COBRA participants must pay monthly premiums for coverage.

Premiums are based on the full cost of the coverage set at the beginning of the year, plus 2% for administrative costs. Dependents making separate elections are charged the same rate as a single retiree.

Payment is due at enrollment, but there is a 45-day grace period from the date you mail your enrollment form to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s).

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act also is available at www.doleta.gov/tradeact.

If you or your dependent elects COBRA continuation coverage:

- You or your dependent can keep the same level of coverage you had under the retiree medical plan or choose a lower level of coverage.
- Your or your dependent's coverage is effective as of the date of the qualifying event. However, if you waive COBRA coverage and then revoke the waiver within the 60-day election period, your elected coverage begins on the date you revoke your waiver.
- You or your dependent may change your coverage:
 - During your benefits renewal period.
 - If you have a qualified change in status.
 - If you have a change in circumstance recognized by the Internal Revenue Service (IRS) and Verizon.
- You may enroll any newly eligible spouse or child under the plan rules.

When COBRA coverage ends

COBRA coverage ends before the maximum continuation period if one of the following occurs:

- You or any of your covered dependents become covered under another medical plan, provided the plan does not have a legally valid pre-existing condition exclusion or limitation affecting the qualified beneficiary. If it does, Verizon COBRA coverage for that pre-existing condition continues as long as you pay the premium.
- You or your covered dependent fails to make contributions by the due date as required.
- Verizon stops providing any medical benefits to any retiree.

Continuation coverage also may be terminated for any reason the medical plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If you have questions

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa.

Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's Web site.

Coordination of benefits

If you or your dependents are covered under more than one medical plan (for example, a Verizon medical option and your spouse's plan), it is important to know about the coordination of benefits provision. This feature is designed to prevent duplicate payments for the same expenses. In other words, you generally cannot be reimbursed twice for an expense that is covered by both plans.

To ensure you are not paying for unnecessary coverage, consider:

- **Who pays first?** The “primary” plan pays benefits first:
 - Generally, the Verizon plan is primary when you (the Verizon retiree) are the patient.
 - If your spouse is the patient and is covered by both a Verizon plan and other group coverage, your spouse's plan pays first.
 - If your child is the patient and is covered by both a Verizon plan and your spouse's plan, the decision about which plan pays first is determined by the “birthday rule”:
 - The Verizon plan pays first if your (the retiree's) birthday (month/day) comes before your spouse's in the calendar year (for example, if your birthday is March 1 and your spouse's birthday is August 1).
 - If you and your spouse have the same birthday, the plan covering you or your spouse longer pays first.
 - If your spouse's plan does not use the birthday rule, the rules of his or her plan determine which plan pays first.
 - In the case of divorce, the plan of the parent with custody of the child generally pays first:
 - If the parent with custody remarries, that parent's plan still pays benefits first.
 - If a court decree gives financial responsibility to the parent without custody, that parent's plan pays benefits first.
 - If your spouse's plan does not have any coordination of benefits guidelines, that plan pays benefits first.
- **When Verizon pays second:** It will pay the difference between what it normally would pay if there were no coordination (after any deductible or copayment) and what the primary plan pays.

The following example shows how two plans coordinate when the Verizon plan is secondary. This example assumes that the Verizon plan covers charges at 80% and that you already have met the annual deductible.

Plan coordination when the Verizon plan is secondary	
Medical expenses	\$100
What the primary plan pays (the primary plan pays 80%)	$\$100 \times 80\% = \80
What the Verizon medical plan normally would pay (the Verizon medical plan pays 80%)	$\$100 \times 80\% = \80
What the Verizon medical plan pays after coordination	$\$80 - \$80 = \$0$

Benefits payable under the plan will be secondary to benefits provided or required by any group or individual automobile, homeowner's or premises insurance, including medical payments, personal injury protection, or no-fault coverage regardless of any provision to the contrary in any other policy of insurance.

Coordination with Medicare

Throughout this section, you will learn why it is critical that you enroll in Medicare Part A and Part B when becoming Medicare-eligible. As you will read, your Verizon retiree medical plan pays benefits "as if" you are enrolled in Medicare Part A and Part B when eligible, regardless of whether or not you actually are enrolled. Because your Verizon retiree medical plan pays secondary to Medicare, if you are not enrolled in Medicare Part A and Part B, you likely will be responsible for the services Medicare does not pay. Unlike Medicare Part A and Part B, you generally should **not** enroll in Medicare Part D, Medicare's prescription drug benefit. The prescription drug coverage offered to you under these retiree medical plans are, on average, equal to or better than the standard Medicare Part D prescription drug benefit available to you. In the majority of cases, electing a Medicare Part D prescription drug plan (PDP) will **not** provide you with additional value.

This SPD provides you with important information about Medicare and how it impacts your coverage under your Verizon retiree medical plan, including prescription drug coverage. The Verizon Benefits Center also can assist with questions. You should call 1-877-4VzBens, follow the instructions to reach the Verizon Benefits Center and speak to a representative. If you would like more information about Medicare, including how to enroll, call the Social Security Administration at 1-800-772-1213 or go to the Web site at www.medicare.gov.

The Medicare program

Medicare is a government program, administered by the Centers for Medicare and Medicaid Services (CMS), which provides basic medical coverage. Original Medicare is a "fee-for-service" plan made up of two parts, Medicare Part A and Part B.

Medicare Part A helps pay for medically necessary inpatient hospital care, post-hospital skilled nursing facility stays, home health care and hospice care. Medicare Part B helps pay for medically necessary physicians' services, outpatient medical and surgical services, diagnostic X rays and laboratory tests, and other outpatient services. Under both Medicare Parts A and B, you have an annual deductible to meet and coinsurance amounts to pay. In addition, a premium to participate in the Medicare program may apply. These amounts may change each year.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) added prescription drug benefits to Medicare effective January 1, 2006, which is commonly known as Medicare Part D. Private insurers contract with CMS to offer Medicare PDPs in a variety of designs (that are, on average, at least equal to the standard Medicare Part D design). Medicare PDPs will cover generic and brand-name drugs. Most Medicare PDPs will have a formulary, which is a list of drugs covered by the plan. This list must always meet Medicare's requirements, but it can change when plans get new information.

Medicare Advantage plans (previously known as Medicare + Choice plans and sometimes referred to as Medicare Part C) are alternative systems of healthcare that combine delivery of care and payment to promote cost-effective healthcare. Medicare Advantage plans only accept individuals who are enrolled in Medicare Part A and Medicare Part B, and Verizon only offers these plans to employees who have terminated or retired from Verizon, and their dependents. The Medicare Advantage plans that Verizon typically sponsors are Medicare Advantage – Prescription Drug plans or (MA-PDs). If you enroll in a MA-PD, you will be automatically enrolled in Medicare Part D. Unlike enrolling in Original Medicare and maintaining enrollment in a Verizon retiree medical plan, it makes sense for you to receive Medicare Part D benefits through the MA-PD, since you will not have prescription drug benefits through one of the Verizon retiree medical plans described in this SPD.

Your cost to participate in Medicare

Medicare Part A coverage

A monthly contribution, or premium, generally is not required to participate in Medicare Part A. However, in some cases – for example, if your earnings have been too low or sporadic to provide you with Medicare Part A benefits – you will not automatically receive Medicare Part A benefits, but you may be able to obtain Medicare Part A coverage by paying a monthly premium.

Medicare Part B coverage

Most individuals entitled to Medicare Part A automatically are enrolled in Medicare Part B. You pay a monthly premium for Medicare Part B, which is deducted from your social security check.

If you are unsure as to whether or not you should pay the monthly premium to participate in Medicare Part A and Part B coverage, the sections below provide additional insight.

Medicare Part D coverage

Individuals enrolled in Medicare Part A and/or Part B and live in the service area of a Medicare PDP are eligible for Medicare Part D. Individuals generally must enroll in Medicare Part D during an enrollment period (November 15 through December 31). If you do enroll you will have to pay a Medicare prescription drug plan premium (generally, about \$32 per month in 2006), which is not reimbursable by Verizon.

The importance of being enrolled in both Medicare Part A and Part B

It is important that you understand how Medicare Part A and Part B coordinate with your Verizon retiree medical plan so that you do not become responsible for potentially costly services, such as hospitalization. The benefits that you receive from your Verizon retiree medical plan depend on how Medicare and your Verizon retiree medical plan “coordinate” with each other. The “coordination rules” described in this document, which comply with Medicare's secondary payer requirements, define when your Verizon retiree medical plan pays after Medicare (“secondary payer”). Under the Medicare secondary payer requirements, the Verizon retiree medical plan almost always pays secondary to Medicare. In contrast, the Verizon “active” medical plan(s) almost always pay primary (or before) Medicare.

When your Verizon medical plan is the “primary payer,” it reviews your bill and pays expenses according to its benefit provisions first, or before Medicare. When your Verizon medical plan is the “secondary payer,” it pays residual expenses that are not payable by Medicare, and only pays for those residual expenses that are covered by the provisions of your Verizon retiree medical plan.

When your Verizon retiree medical plan is the secondary payer, it pays benefits “as if” you (and any Medicare-eligible dependents) are enrolled in Medicare Part A and Part B, regardless of whether you actually are enrolled. **If you receive services, and those services are not covered by Medicare because you are not enrolled, you will remain responsible for the cost of those services.** Therefore, it is extremely important for you to enroll in Medicare Part A (even if you have to pay a premium for Part A coverage) and Medicare Part B when you become eligible.

Unlike Medicare Part A and Part B, generally, Verizon retirees should not enroll in Medicare Part D. The prescription drug benefit offered with any of the Verizon retiree medical plans described in this SPD are, on average, at least as good as the standard Medicare prescription drug coverage. Accordingly, if you maintain enrollment in this Verizon prescription drug coverage, you will not need to pay extra if you later decided to enroll in a Medicare PDP.

If you do decide to enroll in a Medicare PDP, you will continue to be eligible to receive prescription drug coverage under these Verizon retiree medical plans. However, you will have to pay a Medicare Part D premium, which Verizon will not reimburse, and in the majority of cases, coverage under a Medicare PDP will not provide additional value to you.

If you elect a Medicare PDP, the benefits will be coordinated with your Verizon prescription drug coverage. Generally, benefits will be coordinated in the same manner as coordination with Medicare Part A and Part B, explained above. In addition, Medicare PDPs are required to pay a high percentage of covered prescription drug costs once you reach a certain out of pocket maximum amount each year. If you have both Medicare and Verizon prescription drug coverage, the amounts covered by Verizon prescription drug coverage will delay, and may prevent, you from reaching this limit.

Once you enroll in a Medicare PDP, Medicare has strict rules regarding whether you can disenroll even if you realize that the coverage is not value added to you. So, you should strongly consider whether to enroll in a Medicare PDP, unless you are sure that the coverage will provide additional value to you (for example, low income retirees who are not required to pay a Medicare Part D premium may benefit from a Medicare PDP). In the majority of cases, it will not.

When do I become eligible for Medicare?

You generally become eligible for Medicare Part A and Part B in any of these situations:

- When you attain age 65.
- If you become disabled and have received social security disability benefits for 24 months.
- If you have End Stage Renal Disease (ESRD).

You generally become eligible for Medicare Part D, once you enroll in Medicare Part A and/or Part B.

Which plan is primary, your Verizon retiree medical plan or Medicare?

Whether your Verizon retiree medical plan is the primary payer or the secondary payer depends, in part, on your employment status. Since individuals eligible for and enrolled in these options are retirees or dependents of retirees, Medicare **generally** is the primary payer for Medicare eligible retirees. (Of course, if you are not yet eligible for Medicare, these coordination rules do not apply.)

Medicare enrollment – general

When an individual is eligible for Medicare, it does not mean that he or she is enrolled in the Medicare program. The following are some general guidelines with respect to Medicare enrollment once you are Medicare-eligible:

- ***When you attain age 65:*** You will have an initial Medicare enrollment period, which is the seven-month period that begins three months before and ends three months after the month in which you reach age 65. If you file an application during the initial enrollment period and establish entitlement to Social Security benefits, your Medicare Part A and Part B benefits automatically will take effect on the first day of the month that you turn age 65. This does not necessarily mean Medicare is primary, however. Generally, you should apply for Medicare at (or shortly before) age 65 even if you do not intend to collect monthly benefits from Social Security.
- ***If you are/become disabled:*** Your Medicare Part A and Part B coverage will take effect on the first day of the month following your 24th month of entitlement to social security disability benefits. Of course, it's your responsibility to apply for social security disability benefits. You should contact Social Security at 1-800-772-1213 or www.ssa.gov to obtain more information regarding applying for Social Security disability benefits.
- ***If you have ESRD:*** Medicare eligibility for dialysis patients normally begins with the third month after the month in which renal dialysis begins. Medicare eligibility can begin earlier if you receive a transplant or participate in a self-dialysis training program during the three-month waiting period. To enroll in Medicare Part A and Part B due to a diagnosis of ESRD, you must file an application. Your dialysis center usually can assist you with your application or you can contact Social Security at 1-800-772-1213.

An individual's Part D initial enrollment period generally is the same as his or her Part B initial enrollment period. In addition, Part D has an annual enrollment period which generally occurs from November 15 through December 31.

Medicare Part B enrollment is voluntary, but...

CMS considers Medicare Part B a voluntary benefit. Since Medicare Part B coverage is voluntary, CMS or the Social Security Administration will give you an opportunity to disenroll from Medicare Part B, and may even tell you that "you do not have to have Medicare Part B coverage." While this is true because Medicare Part B is voluntary or optional, disenrolling from Medicare Part B can have adverse consequences either immediately or at a later date under your Verizon medical plan.

If you choose to disenroll from Medicare Part B coverage, to avoid paying the Medicare Part B premium, for example, there could be an impact on your medical benefits. The following statements illustrate when/if your Verizon medical benefits and Medicare benefits are impacted if you are not enrolled in Medicare Part B:

- The Verizon benefits that you receive will not be impacted when your Verizon medical plan is the primary payer.
- The Verizon benefits that you receive will be impacted when your Verizon medical plan is the secondary payer.
- The amount of Medicare benefits that you receive will be impacted when Medicare is the primary payer.
- The amount of Medicare benefits that you receive may be impacted when Medicare is the secondary payer.

If you are not enrolled in Medicare Part B when your Verizon medical plan becomes the secondary payer, you may be responsible for potentially costly services, such as physician, outpatient and diagnostic services. Although Medicare Part B is optional from Medicare's perspective, having Medicare Part B (and Medicare Part A) coverage is very important.

If you need to enroll in Medicare Part B, the initial enrollment period is the seven-month period that begins three months before and ends three months after the month of your Medicare eligibility. Under certain circumstances, there may be other Medicare Part B enrollment opportunities, but they may include late enrollment fees from CMS. ***Even though there is an initial seven-month period to enroll in Medicare Part B coverage, your Verizon medical plan assumes you have Medicare Part B coverage as soon as you are eligible.***

Administrative information

This section contains important information about how your benefits are administered and funded. It also contains information about your rights and responsibilities as a participant and steps you can take if certain situations arise.

Plan names/identification

The Plan is an employer-sponsored benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA) and subject to the reporting and disclosure requirements of this law. The plan is commonly referred to as the medical plan, but benefits are governed by two official plan documents: The Plan for Group Insurance and...

The Plan for Group Insurance is a welfare plan providing the medical benefits highlighted in this summary plan description (SPD) and described in the applicable summary of coverage (SOC) or certificate of coverage. The Verizon Choices Plan is a cafeteria plan that allows you to pay for benefits on a before-tax basis. Both plans are listed with the U.S. Department of Labor under Verizon Communications Inc.'s employer identification number: 23-2259884.

The plan number for The Plan for Group Insurance is 580. The plan number for The Verizon Choices Plan is 579.

Plan documents

The plan documents consist of:

- The official plan documents.
- This SPD.
- Applicable summaries of material modifications (SMMs) and other general communications identified as being part of the plans.
- Certificates of coverage and summaries of coverage.
- Any trust agreements formally adopted under the plans.
- The pertinent contracts between Verizon and the claims administrators and other firms that provide services under the plans.

Additional plan information

Plan sponsor/employer	Verizon Communications Inc. One Verizon Way Basking Ridge, NJ 07920
Plan administrator	The Verizon Employee Benefits Committee (VEBC) and/or the Chairperson of the VEBC c/o Verizon Benefits Center P.O. Box 1457 100 Half Day Road Lincolnshire, IL 60069-1457 1-877-4VzBens
Claims administrators	<p>Medical Expense Plan UnitedHealthcare P.O. Box 740803 Atlanta, GA 30374-0803</p> <p>Prescription Drug Program Medco 8111 Royal Ridge Parkway Irving, TX 75063</p>
Participating company	All Verizon domestic companies, except Verizon Wireless, Verizon Avenue and any company, location or group specifically excluded from participation by plan amendment Contact the Verizon Benefits Center (at the address above) to determine whether a particular Verizon affiliate is a participating company in the plan and to request that affiliate's address.
Agent for service of legal process	The plan administrator
Plan year	January – December

The claims administrator and its authority to review claims

The Verizon Employee Benefits Committee (VEBC) has delegated its authority to finally determine claims to the Verizon Claims Review Committee (VCRC). In some cases, the VCRC will delegate the authority to finally determine claims to certain other organizations on behalf of Verizon. Benefits under the plan are paid only if the VEBC, or its delegate, decides in its discretion that the applicant is entitled to them.

The claims administrator has:

- The authority to make final determinations regarding eligibility and benefit claims under the plan.
- Discretionary authority to:
 - Interpret the plan based on provisions and applicable law and make factual determinations about claims arising under the plan.
 - Determine whether a claimant is eligible for benefits.

- Decide the amount, form and timing of benefits.
- Resolve any other matter under the plan that is raised by a participant or a beneficiary or that is identified by the claims administrator.

In case of an appeal, the claims administrators' decisions are final and binding on all parties to the full extent permitted under applicable law, unless the participant or beneficiary later proves that a claims administrator's decision was an abuse of administrator discretion.

Funding and source of contributions

The Plan is funded by employer and employee contributions, with benefits paid from company revenues.

Here is how the medical plan options under The Plan for Group Insurance are funded:

Option	Funding information and source of contributions
MEP	Self-insured Employer and employee contributions
Other options	Self-insured and insured Employer and employee contributions
Mental healthcare/substance abuse	Self-insured Employer and employee contributions
Prescription program	Self-insured Employer and employee contributions

Self-insured plan options

Verizon pays a fee to an outside organization to process claims for the self-insured options. The fees and all benefit payments are paid from company revenues. None of the self-insured options guarantee medical benefits under a contract or policy of insurance.

Insured plan options

Verizon pays an insurance company or other provider a premium – from company revenues – for providing coverage under the insured options. The insurance company or other provider processes claims and makes all benefit payments. The Health Plan Comparison Chart available on Your Benefits Resources Web site, or by calling the Verizon Benefits Center, contains contact information for the administrator of the other options. If you contact the specific administrator, they will be able to tell you if your benefits are guaranteed under a policy of insurance (i.e., fully insured).

Filing claims

Disagreements about benefit eligibility or benefit amounts can arise. If the Verizon Benefits Center is unable to resolve the disagreement, Verizon has formal appeal procedures in place for Employee Retirement Income Security Act of 1974 (ERISA)-covered plans. You must file a claim within two years of the request for eligibility or benefits or your claim will be denied.

This section explains the steps you or your authorized representative is required to take to file an ERISA claim or appeal. The procedure is slightly different, depending on whether you have an “**eligibility**” claim or a “**benefit**” claim.

An **eligibility** claim is a claim to participate in a plan or plan option or to change an election to participate during the year. A **benefit** claim is a claim for a particular benefit under a plan. It typically will include your initial request for benefits.

Benefit claims and appeals are divided into four categories:

- **Post-service**

A claim for reimbursement of services already received. This is the most common type of claim.

- **Pre-service**

A claim for a benefit for which prior authorization is required by the plan.

- **Concurrent care**

A claim for ongoing treatment over a period of time or a number of treatments. For example, if you have been authorized to receive seven treatments from a therapist and during the treatment your therapist suggests 10 treatments, your claim is a concurrent care claim. Some concurrent care claims also are urgent care claims.

- **Urgent care**

A claim for medical care or treatment that, if the longer time frames for non-urgent care were applied, the delay could: (1) seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or (2) in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that could not be managed without the care or treatment that is the subject of the claim.

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
Step 1:				
<p>How to file a claim To file an eligibility claim, request a Claim Initiation Form from the Verizon Benefits Center at 1-877-4VzBens. You (or your authorized representative) must return the form to the Verizon Claims Review Unit at the address on the form.</p> <p>To file a benefit claim, you (or your authorized representative) should write to your health plan. See the “Medical plan contacts” section on page 2 for contact information or refer to the telephone number and/or Web site shown on the back of your ID card or the Health Plan Comparison Chart available on Your Benefits Resources Web site.</p> <p>You must include:</p> <ul style="list-style-type: none"> • A description of the benefits for which you are applying. • The reason(s) for the request. • Relevant documentation. 				<p>To file an urgent care claim, you should call the Verizon Benefits Center or your health plan. In addition, you must state that you are filing an urgent care claim.</p>
<p>What happens if you do not follow procedure If you misdirect your claim, but provide sufficient information to an individual who is responsible for Verizon benefits administration, you will be notified of the proper procedure within (see columns to the right) of receipt of the claim.</p>	<p>Not applicable. Response time frame does not begin until claim is properly filed.</p>	<p>5 days</p>	<p>Not applicable. Response time frame does not begin until claim is properly filed. If claim involves urgent care, 24 hours.</p>	<p>24 hours</p>

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
<p>How you will be notified of the claim decision</p> <p>If your claim is approved, the Verizon Claims Review Unit or the health plan will notify you in writing. For benefit claims, this notification is commonly referred to as an explanation of benefits or EOB.</p> <p>If your claim is denied, in whole or in part, the Verizon Claims Review Unit or the health plan will notify you in writing, except for urgent care. Your denial notice will contain:</p> <ul style="list-style-type: none"> • The specific reason(s) for the denial. • The plan provisions on which the denial was based. • Any additional material or information you may need to submit to complete the claim. • Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request). • The plan's appeal procedures. 				<p>If your claim is denied, the Verizon Claims Review Unit or the health plan will notify you by telephone. Within 3 days of this oral denial, you will receive a written denial notice, as explained under the general procedure. The denial notice also will explain the expedited review process.</p>

Step 2:

About appeals and the claims fiduciary

Before you can bring any action at law or in equity to recover plan benefits, you must exhaust this process. Specifically, you must file an appeal or appeals, as explained in this Step 2, and the appeal(s) must be finally decided by the claims fiduciary.

The Verizon Claims Review Committee (VCRC) is the claims fiduciary for all eligibility claims.

The Claims Review Committee has delegated its authority to finally determine claims to the health plans for benefit claims. The vast majority of health plans have accepted the responsibility of being the claims fiduciary. If the health plan has not, you will be notified in your claim denial notice, which will indicate that you should appeal to the Claims Review Committee.

The claims fiduciary is authorized to finally determine appeals and interpret the terms of the plan in its sole discretion. All decisions by the claims fiduciary are final and binding on all parties.

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
<p>How to file an appeal If your claim is denied and you want to appeal it, you must file your appeal within (see columns to the right) from the date you receive notice of your denied claim. You may request access to all documents relating to your appeal. If you have an appeal for eligibility (i.e., you wrote to the Verizon Claims Review Unit at Step 1), write to the address specified on your claim denial notice.</p> <p>If you have an appeal for benefits (i.e., you wrote to your health plan at Step 1), write to the contact identified by your health plan in your claim denial notice.</p> <p>You should include:</p> <ul style="list-style-type: none"> • A copy of your claim denial notice. • The reason(s) for the appeal. • Relevant documentation. <p>The individual/committee (and any medical expert) reviewing your appeal will be independent from the individual/committee who reviewed your claim. In addition, if your appeal involves a medical judgment, the claims administrator will consult with a healthcare professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request.</p>	<p>180 days</p>	<p>180 days</p>	<p>Within a reasonable period of time, considering the time period scheduled for reduction or termination of benefits</p>	<p>180 days</p> <p>You may orally file your appeal with the claims administrator. At the time your claim is denied, the Verizon Claims Review Unit or the health plan will give you instructions about how to file your appeal, including who the claims administrator is. You must identify that you are appealing an urgent care claim.</p>

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
<p>When you will be notified of the appeal decision You will be notified of the decision within (see columns to the right) of the claims administrator's receipt of your appeal.</p>	<p>Eligibility appeals: 60 days</p> <p>Benefit appeals:¹ 60 days, if the claims administrator provides 1 level of mandatory appeal</p> <p>30 days, if the claims administrator provides 2 levels of mandatory appeal</p>	<p>Eligibility appeals: 30 days</p> <p>Benefit appeals:¹ 30 days, if the claims administrator provides 1 level of mandatory appeal</p> <p>15 days, if the claims administrator provides 2 levels of mandatory appeal</p>	<p>Eligibility and benefit appeals:</p> <p>Before a reduction or termination of benefits would occur</p> <p>If the concurrent claim involves urgent care, 72 hours²</p>	<p>Eligibility and benefit appeals:</p> <p>72 hours²</p>
<p>How you will be notified of the appeal decision If your appeal is approved or denied, the claims administrator will notify you in writing.</p> <p>If your appeal is denied, in whole or in part, your denial notice will contain:</p> <ul style="list-style-type: none"> • The specific reason(s) for the denial. • A statement regarding the documents to which you are entitled. • An explanation of the voluntary appeal procedures, if any. • Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request). • The plan provisions on which the denial was based. • The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency." 				

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
Step 3:				
<p>How to proceed if necessary</p> <p>When the Verizon Claims Review Committee is the claims administrator, i.e., the Verizon Claims Review Committee reviewed your appeal, only 1, mandatory appeal is available. Verizon will not review your matter again, unless new facts are presented. You have a right to bring a civil action. As a reminder, the Verizon Claims Review Committee is the claims administrator for all eligibility appeals and benefit appeals for a handful of self-insured health plans.</p> <p>When a health plan is the claims administrator, the health plan may offer:</p> <ul style="list-style-type: none"> • 1 mandatory appeal. • 2 mandatory appeals. • 1 mandatory appeal and 1 voluntary appeal. <p>If the claims administrator offers 1 level of mandatory appeal, the claims administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action.</p> <p>If the claims administrator offers 2 levels of mandatory appeal, you may appeal to the claims administrator a second time. You must submit your second appeal within 180 days from the date that you received the denial of your first appeal. In addition, the claims administrator will provide you with an independent medical review, upon request, in conjunction with this second and final appeal.</p> <p>If the claims administrator offers 1 level of mandatory appeal and 1 level of voluntary appeal, you may appeal to the claims administrator a second time. The claims administrator will provide you with information regarding its voluntary appeal, if it applies. As indicated in “footnote 1,” you are not required to file a voluntary appeal before filing a civil action; however, you may find it helpful.</p>				
If the claims administrator provides 2 levels of mandatory appeal				
<p>When you will be notified of the second and final appeal decision</p> <p>You will receive a response within (see columns to the right) of the claims administrator’s receipt of your second and final appeal. If this appeal is denied, the claims administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action.</p>	30 days	15 days	Time period remaining from your first appeal. Of course, the clock stops while you are preparing your second appeal.	Time period remaining from your first appeal. Of course, the clock stops while you are preparing your second appeal.

¹If the claims administrator provides more than one level of mandatory appeal, the response time frame is shorter, as noted above. The claims administrator also may offer a **voluntary** level of appeal. You are not required to file a voluntary appeal before filing a civil action; however, you may find it helpful. The claims administrator will provide you with information regarding its voluntary appeal, if it applies. A voluntary appeal is not subject to the same time frames as mandatory appeals.

²If the claims administrator provides two mandatory appeals, both appeals must occur within the 72-hour time frame.

Your rights under ERISA

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue healthcare coverage for yourself, your spouse/domestic partner and/or your other eligible dependents if there is a loss of coverage under the plan as a result of a COBRA qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage rights.

Exclusionary periods of coverage for pre-existing conditions may be reduced or eliminated under your group health plan if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your plan, you should contact the plan administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA privacy rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule applies to “Protected Health Information,” which is defined as any written, oral or electronic health information that meets the following three requirements:

- The information is created or received by a healthcare provider, a Verizon health plan or Verizon.
- The information includes specific identifiers that identify you or could be used to identify you.
- The information relates to one of the following:
 - Providing healthcare to you.
 - Your past, present or future physical or mental condition.
 - The past, present or future payment for your healthcare.

The Notice of Privacy Practices for the Verizon health plans contains a complete explanation of your rights under the HIPAA Privacy Rule. The Notice describes how Protected Health Information may be used and disclosed, and how you can get access to that information. The following is a summary of those uses and disclosures of Protected Health Information and your rights with respect to Protected Health Information:

- The Verizon health plans may use or disclose your Protected Health Information for purposes of conducting healthcare operations or paying your healthcare claims.
- The Verizon health plans may use or disclose your Protected Health Information to tell you about treatment alternatives, or to provide you with information about other health-related benefits or services that may be of interest to you.
- The Verizon health plans may disclose your Protected Health Information to Verizon, as sponsor of the Verizon health plans, to assist Verizon in the performance of plan administrative functions. The Verizon health plans also may provide summary health information to Verizon, as plan sponsor, so that Verizon may obtain premium bids or modify, amend or terminate the Verizon health plans. Summary health information does not directly identify you, but summarizes claims history, claims expenses or types of claims experienced. Finally, the Verizon health plans may disclose your enrollment and disenrollment information to Verizon as plan sponsor.
- The Verizon health plans may disclose your Protected Health Information when required to do so by any federal, state or local law, and when permitted to do so under the circumstances set out in the Verizon Notice of Privacy Practices.
- The Verizon health plans may disclose your Protected Health Information to a law enforcement official for certain law enforcement purposes. For example, the Verizon health plans may disclose your Protected Health Information pursuant to a law requiring the reporting of certain types of wounds or other physical injuries.

- The Verizon health plans may disclose your Protected Health Information to healthcare providers to assist them in connection with their treatment or payment activities. In addition, the Verizon health plans may disclose your Protected Health Information to other entities subject to the HIPAA Privacy Rule to assist them with their payment activities or certain of their healthcare operations. For example, the Verizon health plans might disclose your Protected Health Information to a healthcare provider when needed by the provider to render treatment to you.
- Other than as permitted or required by law, the Verizon health plans will not use or disclose your Protected Health Information without your written authorization. If you authorize a Verizon health plan to use or disclose your Protected Health Information, you may revoke that authorization in writing at any time. If you revoke the authorization, the Verizon health plan no longer will use or disclose your Protected Health Information for the reasons covered by your written authorization. Your revocation will not affect any uses or disclosures a Verizon health plan already has made prior to the date the Verizon health plan receives notice of the revocation.

In general, you have the following rights regarding the Protected Health Information retained by a Verizon health plan:

- You have the right to request that a Verizon health plan restrict uses and disclosures of your Protected Health Information to carry out payment or healthcare operations.
- You have the right to request that a Verizon health plan communicate with you in a certain way if you feel that the disclosure of your Protected Health Information could endanger you.
- You have the right to inspect and obtain a copy of your Protected Health Information.
- If you believe that Protected Health Information a Verizon health plan has about you is inaccurate or incomplete, you have the right to request a correction.
- You have a right to request a list of disclosures made by a Verizon health plan of your Protected Health Information, other than those disclosures for which an accounting is not required.
- You have a right to request and receive a paper copy of the Notice of Privacy Practices for the Verizon health plans, even if you have received this Notice previously or agreed to receive this Notice electronically.

For more information regarding these rights and the privacy policies of the Verizon health plans, please review the Notice of Privacy Practices for the Verizon health plans. The Notice of Privacy Practices for the Verizon health plans is available on Your Benefits Resources Web site at www.verizon.com/benefits. Select “View or Print HIPAA Privacy Notice” in the “Learn More” section on the Benefits Overview page of the Benefits Manual. You may view the Notice on the Web site and/or print a paper copy from the Web site.

You also may request a paper copy of the Notice by calling the Verizon Benefits Center at 1-877-4VzBens. Have your social security number and Benefits Center password available. Listen to the main menu to make your selection and then follow the prompts to reach a representative. Benefits Center representatives are available from 8:00 a.m. until 6:00 p.m., Eastern time, Monday through Friday.

Your maternity rights (Newborns' and Mothers' Health Protection Act)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If a state law applies, your health maintenance organization (HMO) administrator will provide you with this information.

Your rights following a mastectomy (Women's Health and Cancer Rights Act of 1998)

Any health plan option that you select under a Verizon medical plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications at all stages of mastectomy, including lymphedema.

Benefits will be subject to the same annual deductibles and coinsurance provisions as for all other medically necessary procedures under your medical plan option.

These benefits already complied with the Women's Health and Cancer Rights Act that was enacted in October 1998.

For more information on mastectomy coverage, call your medical option's Member Services Department.

Verizon's rights and responsibilities

Reimbursement

This section applies when you recover damages, by settlement, verdict or otherwise, for an injury, sickness or other condition.

If the covered person has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the plan will not cover either the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness. These benefits are specifically excluded.

For this section, "you" means the covered Verizon employee, another covered person, a legal representative or the estate or heirs of a covered person (sometimes collectively referred to as "you").

However, if the plan does advance moneys or provide care for such an injury, sickness or other condition, you must promptly convey to the plan moneys or other property that you receive from any settlement, arbitration award, verdict insurance proceeds or monetary recovery from any party for the reasonable value of the medical benefits advanced or provided to you by the plan, regardless of whether or not:

- You have been fully compensated or made whole for your loss.
- You or any other party admits to liability.
- The recovery is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the plan has first priority to receive reimbursement for any payments made on your behalf, before payment is made to you or any other party. This reimbursement is required from any recovery you make, including uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation settlement, compromises or awards, other group insurance (including student plans) and direct recoveries from liable parties.

In order to secure the plan's rights when it pays benefits in these situations, you must acknowledge and agree to the following when you accept benefits from the plan:

- Acknowledge that the plan has first priority against the proceeds of any such settlement, arbitration award, verdict or other amounts you receive.
- Acknowledge that any proceeds of settlement or judgment, including your claim to such proceeds held by you or any other person, are being held for the benefit of the plan.
- Assign to the plan any benefits you may have under any automobile policy or other coverage, to the extent of the plan's claim for reimbursement.
- Cooperate with the plan and its agents, provide relevant information and take actions that the plan or its agents reasonably request to assist the plan in making a full recovery of the value of benefits paid.

- Consent to the plan's right to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the plan's rights under this section.
- Consent to the plan's right to deduct from any future benefits otherwise payable under the plan the value of benefits advanced under this section to the extent not recovered by the plan.
- Agree to not take any action that prejudices the plan's rights of reimbursement.

The plan is responsible only for those legal fees and expenses to which it agrees in writing. You may not incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the plan's recovery without the express written consent of the plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

In cases of occupational illness or injury, the plan's recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any Workers' Compensation or other coverage. Any award or compromise settlement, including any lump-sum settlement, shall be deemed to include the plan's interest and the plan shall be reimbursed in first priority from any such award or settlement.

The plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary or covered person, whether under comparative negligence or otherwise.

Subrogation

This section applies when another party is, or may be considered, liable for your injury, sickness or other condition (including insurance carriers who are so financially liable) and the plan has advanced benefits.

If you are a covered person under a self-insured plan option, you can contact the subrogation vendor directly with questions. If you are a covered person under an insured plan option, you can contact the claims administrator with questions. See your Important Benefits Contacts insert for contact information.

In consideration for the advancement of benefits, the plan is subrogated to all of your rights against any party liable for your injury or illness, or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to you under the plan. The plan may assert this right independently of you. This right includes, but is not limited to, the covered person's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage or other insurance, as well as your rights under the plan to bring an action to clarify your rights under the plan. The plan is not obligated in any way to pursue this right independently or on your behalf, but may choose to pursue its rights to reimbursement under the plan, at its sole discretion.

You are obligated to cooperate with the plan and its agents in order to protect the plan's subrogation rights. Cooperation means providing the plan or its agents with any relevant information requested by them, signing and delivering such documents as the plan or its agents reasonably request to secure the plan's subrogation claim and obtaining the consent of the plan or its agents before releasing any party from liability for payment of medical expenses.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the plan under this section. In the event that you fail to cooperate with this provision, including executing any documents required herein, the plan may, in addition to remedies provided elsewhere in the plan and/or under the law, set off from any future benefits otherwise payable under the plan the value of benefits advanced under this section to the extent not recovered by the plan.

The plan's subrogation right is a first priority right and must be satisfied in full prior to any of your or your representative's other claims, regardless of whether you are fully compensated for your damages. The costs of legal representation of the plan in matters related to subrogation shall be borne solely by the plan. The costs of your legal representation are borne solely by you.

Verizon's right of recovery

If, for some reason, a benefit is paid that is larger than the amount allowed by the medical plan, the medical plan has a right to recover the excess amount from the person or agency that received or holds this benefit. This excess amount is subject to a constructive trust in favor of the medical plan. The person receiving or holding plan benefits must produce any instruments or papers necessary to ensure this right of recovery.

Verizon's right to use your social security number for administration of benefits

Verizon retains the right to use your social security number for benefit administration purposes, including tax reporting. If a state law restricts the use of social security numbers for benefit administration purposes, Verizon generally takes the position that the Employee Retirement Income Security Act (ERISA) preempts such state laws.

Disclaimer

Your eligibility for benefits is determined by The Plan for Group Insurance and... including this summary plan description (SPD). The company has full discretionary authority to interpret the terms of the plans summarized in this document and determine your eligibility for benefits under the plans' terms. In some cases, Verizon has delegated this authority.

If you are covered by an option not described in this SPD, material for that plan option is provided to you separately by the administrator. The material is hereby incorporated into this document by reference. That material, together with this document, comprise your SPD.

Although Verizon presently intends to continue the plan outlined in this SPD, it reserves the right to act through its Board of Directors, most senior human resources officer or a designee of either to amend, modify, suspend or terminate the plan, in whole or in part, at any time, at its discretion, with or without advance notice to participants, for any reason, subject to applicable law and any duty to bargain collectively.

Accordingly, Verizon has the discretion to offer or terminate any medical plan option and may change the benefits design, administrators and service areas of any option. Changes generally correspond with the benefits renewal period. Review the Health Plan Comparison Chart you receive during benefits renewal for any plan changes.

The company also reserves the right to change the amount of required participant contributions for coverage under the plan at any time, with or without advance notice to participants.

Verizon also may transfer the obligations to provide welfare benefit-related assets, if it desires, to another entity in connection with: (1) a transaction in which Verizon transfers all or a portion of a business unit; or (2) an outsourcing arrangement, joint venture or other business transaction.

All terms of the plan are legally enforceable. However, this statement of benefits does not constitute a contract of employment or guarantee of any particular benefit.

As a matter of prudent business planning, Verizon continually is reviewing and evaluating various proposals for changes in its benefit plans and programs. Because of the need for confidentiality, such proposals are not evaluated below high levels of management. Verizon employees below such levels do not know whether Verizon will or will not adopt any future changes and/or new benefit plans and programs. Unless and until Verizon formally announces such changes, no one is authorized to give assurances that such changes will or will not occur.

Medical terms to know

A

Accidental injury

An injury caused by a chance event or unknown causes.

Ambulatory surgical facility (ASF)

An institution, either freestanding or part of a hospital, equipped and operated for surgery, for patients who are usually admitted for fewer than 24 hours.

Attending physician

The physician who is directing the covered person's care.

B

Brand-name drug

Their manufacturers patent brand-name drugs, so only their makers can sell them – usually at a high retail price. But when the patent expires, other makers, who often sell them at a much lower price, can produce these same drugs as generics.

C

Chiropractor

A person who is licensed to perform manipulation and specific adjustment of body structures to heal the body.

Custodial care

Custodial care is made up of services and supplies that meet one of the following conditions:

- Care furnished mainly to train or assist in personal hygiene or other activities of daily living rather than to provide medical treatment.
- Care that can safely and adequately be provided by persons who do not have the technical skills of a covered healthcare professional.

Care that meets one of the above conditions is custodial care regardless of any of these:

- Who recommends, provides or directs the care.
- Where the care is provided.
- Whether or not the patient, or another caregiver, can be or is being trained to care for himself or herself.

D

Doctor or physician

The definition of doctor includes a doctor of chiropractic (D.P.M. or D.S.C.), doctor of chiropractic (D.C.), doctor of dental medicine (D.M.D.), doctor of dental surgery (D.D.S.), doctor of medicine (M.D.), doctor of osteopathy (D.O.) and doctor of podiatry (D.P.M.).

A physician is a licensed, practicing physician acting within the scope of his or her license.

E

Educational or developmental

Educational or developmental services or supplies provide training in daily living activities, instruction in scholastic skills such as reading and writing, preparation for an occupation, treatment for a learning disability or promotion of the development beyond any functional level previously demonstrated.

Emergency

An injury or illness requiring immediate medical care, hospitalization or surgery because of conditions such as hemorrhaging, acute infection, trauma, fracture or malignancy.

Experimental or investigational

Any service or supply determined by the option administrator to be for experimental or investigational purposes, including drugs or other care, will not be covered.

G

Generic drug

A prescribed medication that is chemically equivalent to a brand-name medication that is no longer under patent protection.

H

Hospital

An institution that is licensed as a hospital. It must maintain on its premises all facilities needed for medical and surgical treatment, provide such treatment on an inpatient basis for compensation under the supervision of physicians and provide 24-hour service by registered graduate nurses.

“Hospital” does not include an institution that primarily is a place for rest, a place for the aged or a nursing home.

I

Illness

An illness is a bodily disorder or disease, including a mental health disorder or substance abuse.

Injury

An injury is an accidental physical injury to the body caused by unexpected external means.

Insured or self-insured

To learn whether the option you are enrolled in is fully insured or self-insured, go to Your Benefits Resources Web site and:

- Click on “Health, Insurance...” from the main navigation bar on the top of the page.
- Click on “Medical Coverage Details” in the “Your Plan Facts” box on the right-hand side.
- Scroll down to “Insured Status.”

If this section states “fully insured,” you should call the medical option administrator to request a free certificate of coverage. If the section states “self-insured,” call the Verizon Benefits Center to request a free summary of coverage.

Inpatient treatment

Care that requires an overnight stay at a hospital or clinic.

IRS tax dependent

An Internal Revenue Service (IRS) tax dependent is a U.S. citizen or resident who is a “qualifying child” or a “qualifying relative.”

A “qualifying child” generally is a person who:

- Is under the age of 19 (or 24 in the case of a student) or is permanently and totally disabled.
- Is your child, grandchild, brother, sister, stepbrother, stepsister, niece or nephew.
- Does not provide over one-half of his or her own support for the calendar year.
- Lives with you for more than one-half of the calendar year.

If a person does not meet the definition of “qualifying child,” he or she might be an IRS tax dependent by satisfying the “qualifying relative” requirements.

A “qualifying relative” generally is a person who:

- Is not your qualifying child or any other taxpayer’s qualifying child during the calendar year.
- Receives over one-half of his or her support from you for the calendar year.
- Is “related to you” or “lives with you for the entire calendar year as a member of your household.”

Examples

Your 25-year-old child might be your IRS tax dependent if he or she is a U.S. citizen or resident and receives over one-half of his or her support from you. Even though your child does not meet the definition of “qualifying child,” he or she meets the definition of “qualifying relative.”

Your domestic partner might be your IRS tax dependent if he or she is a U.S. citizen or resident, receives over one-half of his or her support from you and lives with you for the entire calendar year as a member of your household. Even though a domestic partner is not a “relative” in the traditional sense, he or she may meet the definition of “qualifying relative.”

Your domestic partner’s child typically will not be your IRS tax dependent, unless the domestic partner also is your tax dependent.

L

Legally separated

A covered person and his or her spouse are legally separated if they do not live together and if they have a signed document or a legal proceeding, such as a separation agreement, that indicates that the associate or his or her spouse intends to live separately.

M

Medically necessary

Services or supplies that meet the following requirements are medically necessary:

- They are consistent with the signs and symptoms of diagnosis and treatment of the behavioral disorder, psychological injury or chemical dependency.
- They are consistent with standards of good clinical practice.
- The care provides the desired results at an adequate level of service that can be safely provided.

Services and supplies may not be considered medically necessary even if a provider prescribes them.

Morbid obesity

For surgical treatment of morbid obesity, you or a covered dependent must meet all of the following criteria:

- Have a minimum body mass index (BMI) of 40.
- Have documentation of a diagnosis of morbid obesity for a minimum of five years from a physician.
- Be over age 21.

N

Network negotiated fee (NNF)

A network negotiated fee is the fee a network provider has agreed to accept as payment in full for covered services or supplies provided on an in-network basis.

O

Outpatient treatment

Care that does not require an overnight stay at a hospital or clinic.

P

Participating company

Verizon or any corporation or partnership that is an affiliate of Verizon that has elected to participate in Verizon's Bell Atlantic Management Retiree Health Plan for Pre 4/1/1986 Management Retirees or Verizon's Bell Atlantic Medical Expense Plan for Pre 1/1/1990 Associate Retirees.

Participating providers

Participating providers include state-licensed or state-certified psychologists, psychiatrists, social workers, psychiatric nurses, counselors, therapists and facilities that have met strict credentialing standards and are committed to delivering quality, cost-effective mental health and substance abuse treatment.

Pre-existing condition

A condition for which you or a dependent received advice, diagnosis, care or treatment during the six months before you enrolled in a new medical plan.

Prosthetic appliance

An artificial device that replaces all or part of a missing body part. It may also replace all or part of the functions of a permanently disabled or poorly functioning body organ.

Q

Qualified medical child support order (QMCSO)

A QMCSO is a judgment from a state court or an order issued through an administrative process under state law that requires you to provide coverage for a dependent child under Verizon's healthcare plans.

You may obtain a copy of the QMCSO administrative procedures, free of charge, from the plan administrator in care of the Verizon Benefits Center. In any case, if subject to an order, you and each child will be notified about further procedures.

Note: If you are enrolled in an HMO and are required under a QMCSO to provide coverage for a child who does not live in the HMO service area, coverage for you and your covered dependents will automatically change to an option designated by the Verizon Employee Benefits Committee (VEBC). Call the Verizon Benefits Center for information.

R

Reasonable and customary charges

Reasonable and customary charges means the lesser of the actual charge or the maximum fee allowance for a covered service or supply. The maximum fee allowance is determined by taking the following into consideration:

- The usual fee that the physician or provider most frequently charges the majority of patients for that service, supply or medical procedure.
- The prevailing range of fees charged for that service, supply or medical procedure in the same region by physicians or providers of similar training and experience.
- Unusual circumstances or complications requiring additional time, skill and experience in connection with that service, supply or medical procedure.

S

Spouse

Your spouse is a person of the opposite sex who is a husband or wife, pursuant to a legal union, under the laws of the state in which you live.

The definition of spouse specified in this document is consistent with the definition under the federal Defense of Marriage Act. The Verizon plan uses this definition, even if state or local laws define spouse differently.

Substance abuse

The nonmedical or recreational use of substances that alter the state of consciousness.

Sudden, serious and life-threatening illness

Severe symptoms that occur unexpectedly and that require immediate and urgent medical attention. The claims administrator makes the determination as to what qualifies.

T

Treatment facility

A treatment facility must meet all of these conditions:

- Is legally licensed as a hospital.
- Provides a broad range of 24-hour-a-day medical and surgical services for sick and injured persons by, or under the supervision of, a staff of physicians.
- Provides 24-hour-a-day nursing care by, or under the direction of, a licensed registered nurse (R.N.).
- Has organized facilities for surgical and medical diagnosis and treatment.

In no event does the term “hospital” include a convalescent nursing home or an institution or part thereof that is any of these:

- Used primarily as a convalescent facility, rest facility, nursing facility or facility for the aged.
- Furnishes primarily domiciliary or custodial care, including training in the routines of daily living.
- Operated primarily as a school.