

**Your healthcare benefits
(Post-1989 associate retirees)**

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Your healthcare benefits

Verizon's medical coverage for retired associates is designed to continue providing you and your family with financial protection from large medical bills once you've left the company, while also offering you the flexibility to choose an option that still meets your need to manage your share of expenses. Retiree coverage includes:

- Medical coverage options from which to choose, depending on your home zip code and/or Union membership.
- Coverage for your eligible dependents, if you enroll them.
- Preventive care services.
- Comprehensive coverage of medically necessary services and supplies, such as doctors' office visits, surgery, hospitalization, emergency care, and outpatient services.
- Prescription drug coverage.
- Coverage for mental health and substance abuse treatment.

Please keep this document handy and refer to it first whenever you have questions about your retiree medical benefits.

Medical plan for associate retirees

The Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Post-1989 Associate Retirees is one of several plans that together comprise Verizon Plan 550. General terms of Verizon Plan 550 are described in a separate plan document; those terms apply to the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Post-1989 Associate Retirees.

About this SPD

This document is the summary plan description (SPD) for the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Post-1989 Associate Retirees.

The Plan is subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. This document meets ERISA's requirements for an SPD and is based on Plan provisions effective January 1, 2009. It updates and replaces all previous SPDs and other descriptions of the benefits provided by the Plan. This SPD is part of this Plan.

Every effort has been made to ensure the accuracy of the information included in this SPD. Copies of Plan documents are available by contacting the Plan administrator in writing at the address provided in the "Additional information" section.

This SPD is divided into the following major sections:

- **Participating in the Plan.** This section explains your eligibility, eligibility for your dependents, and when eligibility ends.
- **Overview of your options.** This section describes the medical options available to you. Refer to it when deciding which option to choose and when you need information about your coverage and benefits.
- **Managed care network (MCN) option.** This section provides details of how the MCN option works.
- **Medical Expense Plan (MEP) preferred provider organization (PPO) option.** This section provides details of how the MEP-PPO option works.
- **No coverage option.** If you do not want coverage under this Plan, you can choose this option only if you have other Verizon-sponsored medical coverage (i.e., coverage under a spouse's plan).
- **More information about the MCN and MEP-PPO options.** This section provides more details for these options.
- **Coordination of benefits when you are not eligible for Medicare.** If you're covered by more than one medical plan, special rules apply for coordinating between plans.
- **Coordination of benefits with Medicare.** This section provides details on Medicare, including its coordination with your Plan coverage.
- **Health maintenance organizations (HMOs) and Medicare HMOs.** This section provides some details on HMOs and Medicare-sponsored HMOs.
- **Other benefits.** Regardless of the medical coverage option you choose, certain benefits are available to you.
- **Continuing coverage if eligibility ends.** In some cases, you and/or your dependents can continue coverage even after eligibility for the Plan ends.
- **Additional information.** This section provides additional details about the administrative provisions of the Plan and your legal rights.
- **Glossary.** Certain terms used in this SPD are defined in the glossary.

Important note

Verizon and its claims and appeals administrators have the discretionary authority to interpret the terms of the Plan and this SPD and determine your eligibility for benefits under their terms.

Verizon Benefits Center

The Verizon Benefits Center offers a Web site called Your Benefits Resources™ where you'll find tools to help you manage your benefits. You can access Your Benefits Resources on the Internet at www.verizon.com/benefits.

The Web site makes finding information fast and easy as it guides you through your benefits transactions, including enrollment. In addition to enrolling on the site, you can:

- Hotlink to other provider sites.
- Create and print personalized provider listings and maps to providers' offices for most plans.
- Review details about your healthcare and insurance plans. For overview information, use the comparison charts.
- Select and update your beneficiary designations.
- Verify your Verizon elections that are on file at the Verizon Benefits Center.
- Change Your Benefits Resources password.
- Give yourself a helpful "hint" in case you forget your password.

Verizon Benefits Center representatives are available should you have questions about your benefits (if you are eligible for Medicare, you will need to make enrollment elections with a Benefits Center representative or on Your Benefits Resources Web site). To reach the Verizon Benefits Center via telephone, call 1-877-4VzBens. Via this toll-free telephone number, you also can connect with other Verizon benefit providers.

Changes to the Plan

While Verizon expects to continue the Plan indefinitely, Verizon also reserves the right to amend, modify, suspend or terminate the Plan at any time, at its discretion, with or without advance notice to participants, subject to any duty to bargain collectively. The Plan may be amended by publication of any SPD, summary of material modification, enrollment materials or the communication relating to the Plan, as approved by Verizon.

Decisions regarding changes to, or termination of, benefits are made at the highest levels of management. Verizon employees below those levels do not know whether the company will adopt any particular change and are not in a position to speculate about such changes. Unless and until changes are formally adopted and are officially announced, no one is authorized to assure that any particular change will or will not occur.

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Participating in the Plan

Eligibility

The following chart briefly describes when retirees and their families are eligible for medical benefits and who is responsible for the cost. Please note that this is an overview only. For more information on cost, see “Cost of coverage” later in this section.

If a former CWA-represented associate:	Then:
Retired from Verizon or its predecessor after December 31, 1989 with a service pension from the Verizon Pension Plan for Mid-Atlantic Associates (formerly known as the Bell Atlantic Pension Plan).	Through December 31, 2011, the company pays the full cost and provides partial reimbursement for Medicare Part B premiums. For more information, see “Reimbursement of Medicare premiums” in the “Other benefits” section.
Terminated employment from Verizon or its predecessor after December 31, 1989 and received a disability pension from the Verizon Pension Plan for Mid-Atlantic Associates (formerly known as the Bell Atlantic Pension Plan).	Through December 31, 2011, the company pays the full cost and provides partial reimbursement for Medicare Part B premiums. For more information, see “Reimbursement of Medicare premiums” in the “Other benefits” section.
If a former IBEW-represented associate:	Then:
Retired from Verizon or its predecessor prior to January 1, 1997 with a service pension under the Verizon Pension Plan for Mid-Atlantic Associates (formerly known as the Bell Atlantic Pension Plan).	Through December 31, 2011, the company pays the full cost and provides partial reimbursement for Medicare Part B premiums. For more information, see “Reimbursement of Medicare premiums” in the “Other benefits” section.
Terminated employment from Verizon or its predecessor prior to January 1, 1997 and received a disability pension under the Verizon Pension Plan for Mid-Atlantic Associates (formerly known as the Bell Atlantic Pension Plan).	Through December 31, 2011, the company pays the full cost and provides partial reimbursement for Medicare Part B premiums. For more information, see “Reimbursement of Medicare premiums” in the “Other benefits” section.

Note: You also are eligible to participate in the Plan if you are an LTD benefit recipient, an eligible surviving dependent of a deceased employee or retiree, or a working retiree or if you are a former GTE retiree covered by a collective bargaining agreement between the company and the Union that provides for participation in this Plan.

Eligible dependents

Dependents must be enrolled through Your Benefits Resources Web site or the Verizon Benefits Center to have coverage. You can enroll your dependents who meet the Plan's definition of eligibility:

- Class I dependents.
- Grandfathered class II dependents: Grandfathered class II dependents are eligible for coverage only if currently covered; new class II dependents cannot be added.
- Sponsored parents.
- Sponsored children.

Important: LTD benefit recipients

LTD benefit recipients cannot enroll dependents acquired after becoming covered by the Plan. The only exception is if you were pregnant at the time you first enrolled in the Plan; in this case, you may enroll your newborn child. See "LTD benefit recipients" later in this section for more information.

Dependent class	Who they are	Relationship
Class I dependents (continued)	<ul style="list-style-type: none"> • Your unmarried children (as defined above) of any age who are dependent on you for support due to physical or mental disability if the disability began while they were covered as a child or full-time student and they were covered continuously. • Your same-sex domestic partner and his or her children who meet the Plan requirements for a same-sex domestic partner (and children of a same-sex domestic partner) may be eligible for coverage. For more information on eligibility requirements and tax implications, access Your Benefits Resources Web site or call the Verizon Benefits Center and speak with a representative. • Your unmarried children (as defined above and including any age requirements) who are alternate recipients under an approved qualified medical child support order (QMCSO). 	<ul style="list-style-type: none"> • Disabled child • Domestic partner/ domestic partner's child • Child
Sponsored children^{1,2}	<ul style="list-style-type: none"> • Your unmarried children from age 19 through the end of the calendar year in which they reach age 25 who are not full-time students or incapacitated and otherwise meet the definition of child, as described above. 	<ul style="list-style-type: none"> • Sponsored child
Sponsored parents^{1,2}	<ul style="list-style-type: none"> • A parent who was added to the Plan after December 31, 1989 and who meets all of the following eligibility requirements: <ul style="list-style-type: none"> — Is your parent or your eligible spouse's parent. — Lives in your home or in one you provide within 50 miles of you for at least 6 months before he or she is eligible and throughout the period he or she is covered under the Plan. — 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. 	<ul style="list-style-type: none"> • Sponsored parent
Grandfathered class II dependents^{1,2} <i>Note: You cannot add new class II dependents. Once dropped from coverage, grandfathered class II dependents cannot be reinstated.</i>	<ul style="list-style-type: none"> • Your grandfathered class II dependents are dependents who were continuously enrolled on or before December 31, 2000 and must be one of the following: <ul style="list-style-type: none"> — Your or your spouse's parent who was enrolled as a class II dependent on or before December 31, 1989 and for whom you provide at least 50% of his or her support. — A dependent, other than a parent, who was enrolled as a class II dependent on or before December 31, 1986 and for whom you provide at least 50% of his or her support. 	<ul style="list-style-type: none"> • Class II parent • Class II child • Class II grandparent • Class II sibling

² The plan does not cover services for substance abuse treatment and outpatient mental health treatment for sponsored children, sponsored parents or grandfathered class II dependents.

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. The order is served on Verizon or its agent for service of legal process and reviewed by the Verizon Benefits Center. You may obtain a copy of the QMCSO administrative procedures, free of charge, from the Plan administrator (via 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 automatically will change to the MEP-PPO or MCN option as applicable, depending on your home zip code and that of the child. Call the Verizon Benefits Center for information.

Important: If you enroll in an HMO

The eligibility requirements described in this section are the general eligibility requirements for the Plan. As an alternative, you may instead choose to enroll in an HMO. The eligibility requirements for HMOs available to you may differ from the general eligibility requirements for the Plan. **If so, the HMO's eligibility rules will override the rules described in this eligibility section.** Because of this, you should check with an HMO before enrolling to make sure its eligibility requirements suit your needs. Information on an HMO's eligibility rules can be obtained by contacting the HMO directly via the telephone number shown on the Health Plan Comparison Charts available on Your Benefits Resources Web site.

If your spouse or same-sex domestic partner is a Verizon employee or retiree

For medical coverage, if your spouse or same-sex domestic partner is employed by or retired from Verizon or an affiliate, the following rules apply:

- Children can be covered by one Verizon parent or the other, but not by both.
- You can be covered as a retiree under this Plan or as a dependent under another Verizon associate medical plan, but you cannot be covered as both. To be covered as a dependent under another associate plan, you must choose the no coverage option under this Plan. However, an exception occurs if your spouse or same-sex domestic partner is a management employee or retiree; you may be covered as both a retiree under this Plan and as a dependent under a Verizon management plan and do not need to waive coverage.
- Your spouse or same-sex domestic partner can be covered as an employee or a retiree under another Verizon associate medical plan or as a dependent under this Plan, but not as both. To be covered as your dependent under this Plan, your spouse or same-sex domestic partner must be eligible for and must choose the no coverage option under his or her plan. If he or she is not eligible to choose the no coverage option under his or her plan, your spouse or same-sex domestic partner cannot be covered under this Plan. If your spouse or same-sex domestic partner is a Verizon management employee or retiree who elects no coverage under the management plan and you elect to cover him or her under this Plan, he or she may receive a waiver credit (if eligible) under the management plan.

Enrolling in the Plan

When you retire, coverage for you and your enrolled class I, grandfathered class II, and sponsored dependents will continue under your active medical option until the end of the month in which you retire.

If you become disabled, coverage for you and your enrolled class I, grandfathered class II, and sponsored dependents will continue under your active medical option until the end of the month prior to that in which your LTD payments begin.

Near the time you retire or begin receiving LTD payments, you will receive information about enrolling in the Plan. This information will explain your options, the enrollment process and enrollment deadlines. You will have a 90-day initial enrollment period to make two choices about your coverage:

- **Medical option.** You will have to choose whether to be covered under the Plan and, if you want coverage, under which option. In most instances, these are your options:
 - Managed care network (MCN), if your home zip code is in the MCN service area, or you may choose to “opt-in” – even if you live outside the service area.
 - Medical Expense Plan (MEP) preferred provider organization (PPO), if your home zip code is outside the MCN service area.
 - HMO, if your home zip code is in one of the company-sponsored HMO service areas, or you may be able to “opt-in” – even if you live outside the HMO’s service area. You may be able to join a Medicare HMO if you are eligible for Medicare.
 - No coverage, only if you have other Verizon medical coverage (i.e., coverage under a spouse’s plan).
- **Coverage level.** You also will need to choose a coverage level. You have six options:
 - Pre-Medicare retiree only.
 - Pre-Medicare retiree plus one dependent.
 - Pre-Medicare retiree plus family (two or more dependents).
 - Medicare-eligible retiree only.
 - Medicare-eligible retiree plus one dependent.
 - Medicare-eligible retiree plus family (two or more dependents).

Sponsored parents and sponsored children must be covered under a separate category.

Provided you enroll within your 90-day initial enrollment period (your enrollment deadline is shown on the enrollment worksheet), your coverage will begin:

- On the first day of the month following your retirement if you are a retiree.
- On the first day of the month in which you are eligible to receive LTD payments if you are an LTD benefit recipient.

Notes for dependent enrollment

If you are not Medicare-eligible, you and any non-Medicare-eligible dependent you choose to enroll must be covered under the same option. For rules regarding Medicare-eligible dependents, see the “Health maintenance organizations (HMOs) and Medicare HMOs” section. If you choose no coverage, your family members also will have no coverage.

How do I enroll or make changes?

Log on to Your Benefits Resources Web site at www.verizon.com/benefits, or speak with a Verizon Benefits Center representative via the telephone number shown on your Important Benefits Contacts insert. Your Benefits Resources Web site 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).

If you do not enroll

Retirees

If you did not enroll during the 90-day initial enrollment period, you will have the following coverage effective the first day of the month after you retire:

- **If you are not Medicare-eligible**, you will continue to have coverage under the option you had as an active employee.
- **If you are Medicare-eligible and you were covered by an option other than an HMO as an active employee**, you will have coverage under the MCN or the MEP-PPO option, depending on your home zip code.
- **If you are Medicare-eligible and you were covered under an HMO as an active employee:**
 - You can continue to have coverage under your HMO if your HMO covers Medicare-eligible persons and you enroll as a Medicare-eligible person.
 - You will have coverage under the MCN or the MEP-PPO option (depending on your home zip code) if your HMO does not cover Medicare-eligible persons.

LTD benefit recipients

If you did not enroll within your 90-day initial enrollment period, your coverage will continue under the option you had as an active employee. Special rules may apply if you become Medicare-eligible; contact the Verizon Benefits Center for more information.

Enrollment as a surviving spouse or dependent

Surviving dependents of a retiree

Class I and grandfathered class II dependents who are enrolled in the Plan as of the retiree's date of death are eligible for 12 months of company-paid coverage under the Plan after the retiree's death.

Note: Same-sex domestic partners and children of same-sex domestic partners are treated the same as your spouse and children for the purposes of survivor benefits.

After the end of the 12-month period, class I dependents can elect to pay the full cost to continue coverage as a surviving dependent. Grandfathered class II dependents' coverage ends at the end of the 12-month period of company-paid coverage; eligible class II dependent children can then continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments (see the "Continuing coverage if eligibility ends" section).

Coverage for sponsored parents and sponsored children ends on the last day of the month in which the retiree dies. Sponsored children can then continue coverage under COBRA (see the "Continuing coverage if eligibility ends" section).

If you are eligible for surviving dependent coverage, you will have a one-time opportunity to enroll prior to the end of your initial 12-month period of coverage. Generally, the surviving spouse enrolls all eligible surviving dependents. However, if there is no surviving spouse or if the surviving spouse declines to enroll, then the other eligible dependents may enroll individually.

At the end of the initial 12-month period of coverage, class I dependents may choose to become surviving dependents or they may elect COBRA continuation coverage (see the "Continuing coverage if eligibility ends" section). (**Note:** COBRA coverage runs concurrent with, and not in addition to, the 12 months of continued coverage provided under the Plan.) If the former associate's dependents elect COBRA continuation coverage, they will generally not have another opportunity to elect coverage as surviving dependents.

Surviving dependents of an LTD benefit recipient

Coverage for dependents of an LTD benefit recipient will end on the last day of the month in which the LTD benefit recipient dies.

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 30-day waiting period. Here are some examples:

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

If you are changing from or electing a Medicare Advantage (formerly Medicare+Choice) 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 HMO. Your coverage will be effective the first of the following month if the approved form is returned by the 15th of the preceding month.

Benefits renewal

You will not be 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 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.

Status changes

You gain a new dependent

If you are a retiree and you gain a new, eligible dependent through marriage, birth, adoption or placement for adoption, that person is automatically covered under your medical coverage option for 31 days after the event. **If you want medical coverage to continue for the new dependent, you must call the Verizon Benefits Center to enroll that dependent in the Plan (otherwise, coverage will end for that dependent after 31 days):**

- Your election will take effect on the date that you gained the new dependent, if you make your election within 90 days of gaining the new dependent.
- Coverage will begin again for new dependents on the first day of the month following your election, if you make your election more than 90 days after the event.

Note: You cannot add coverage for a new same-sex domestic partner or the child of a same-sex domestic partner.

If you are a retiree who gains a new, eligible dependent as the result of a QMCSO, you can enroll that dependent in the Plan 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 in the Plan 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 surviving dependent, you cannot enroll dependents acquired after you become covered by the Plan. The only exception is if you were pregnant at the time you were first enrolled in the Plan; in this case, you may enroll your newborn child as a dependent in the Plan in accordance with the provisions listed above.

You lose a dependent through death, divorce, legal separation or termination of a same-sex domestic partnership

If you lose a dependent through death, divorce, legal separation or termination of a same-sex domestic partnership, coverage for that dependent ends at the end of the month in which the event occurs. However, you must notify the company by calling the Verizon Benefits Center to remove that dependent from your coverage; otherwise, you will continue to pay any required premiums.

A dependent loses eligibility

If a dependent loses eligibility or ceases to be a dependent under the Plan in situations other than those described above, the dependent's coverage will continue until the end of the month in which the event occurs that causes the dependent to lose eligibility. An exception occurs if the dependent is a child who loses eligibility because he or she reaches an age limit for coverage. In this case, the child's coverage will continue until December 31 of the year in which the age limit is reached. However, if a child reaches the age 25 limit and 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.

If you are enrolled in an HMO, check with your HMO regarding eligibility rules since HMO rules may be different.

When a dependent loses eligibility, you must notify the company by calling 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 90 days of the dependent's loss of eligibility. Otherwise, the election will be effective on the first day of the month following the date on which the election is made.

If you do not notify Verizon, any claims incurred by your ineligible dependent will become your financial responsibility. **Note:** Be sure to disenroll your dependent within 60 days of when he or she becomes ineligible, to ensure he or she will not lose his or her right to purchase continued coverage under COBRA. For more information on COBRA, see the "Continuing coverage if eligibility ends" section.

A dependent changes eligibility class

If you are a retiree whose dependent loses eligibility as a class I dependent but would be eligible for coverage as a grandfathered class II dependent or sponsored parent or sponsored child, you must notify Verizon by calling the Verizon Benefits Center within 90 days of the change in eligibility to ensure your dependent's coverage will continue without interruption. Likewise, 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. If you do not notify the Verizon Benefits Center of the change within 90 days, 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.

If you are an LTD benefit recipient or a surviving dependent, you cannot reclassify ineligible class I dependents.

Continuing coverage when a dependent is ineligible

It is your responsibility to notify the Verizon Benefits Center within 60 days if your dependents no longer meet eligibility requirements. Otherwise, any claims incurred by an ineligible dependent become your financial responsibility and your dependent will lose the right to purchase continued healthcare benefits under COBRA.

Periodically, you may be asked to provide proof of your dependents' eligibility. If such proof is not provided, those dependents or surviving dependents will lose their eligibility for the Plan, effective as of the date determined by the Plan administrator.

You move

If you move to a location outside of your current option's service area, you will have the opportunity to choose a new option. If you notify Verizon by calling the Verizon Benefits Center and requesting a move package and make your election within 90 days of the creation of your move package, your election will be effective on the date of your move. If you do not call within 90 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.

You become eligible for Medicare

If you are receiving social security benefits when you turn age 65, you are automatically enrolled in Medicare Part A. If you are age 65 or close to age 65 and have not begun receiving social security benefits, you must apply for Part A. In either case, you must enroll in Part B coverage because your Verizon Plan will determine benefits assuming that you do have Medicare Part B coverage and you have received your Part B benefits. **If you are not enrolled in Medicare Parts A and B, you may not receive all the maximum amount of benefits you may be entitled to receive.** See the "When you become eligible for Medicare" section for more information on Medicare.

When you become Medicare-eligible, you may change your medical option. To do so, you must call the Verizon Benefits Center and make your election within 90 days after you become eligible for Medicare. Your election will be effective once your application is approved. **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.

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 medical 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 option, you will have 90 days to call the Verizon Benefits Center and speak with a representative to enroll.

Special enrollment rules

If you or your dependents (including your spouse or same-sex domestic partner) 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 (however, special enrollment is not available if loss of coverage was due to your or your dependents' failure to pay for such coverage).
- Exhaustion of COBRA coverage.

If you enroll yourself or your dependents in the Plan:

- Within 90 days of losing the other coverage, your or your dependents' coverage will be effective retroactive to the date of the event.
- After 90 days 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, placement for adoption, or acquisition of a same-sex domestic partner and his/her children you will be able to enroll yourself and your dependents. If you enroll:

- Within 90 days of the event, your coverage will be effective retroactive to the date of the event.
- After 90 days following the event, your coverage will be effective the first day of the month following your enrollment.

Cost of coverage

Each year, the company makes a contribution toward your company-sponsored benefits.

The company contribution covers the full cost of coverage for you and your enrolled class I and grandfathered class II dependents.

You pay the full cost of medical coverage for any sponsored children whom you choose to cover. You pay \$75 (indexed to medical CPI) per month for medical coverage for sponsored parents whom you choose to cover.

If your net credited service date under your pension plan is before August 3, 2008, the company's annual contribution toward coverage will be capped as shown in the chart below. On or after that date, if your benefits cost more than the company's annual contribution in any given year, you will pay the difference.

Coverage category	Company contribution cap before you are eligible for Medicare:	Company contribution cap when you become eligible for Medicare:
Retiree only	\$12,580	\$6,330
Retiree plus one dependent	\$25,160	\$12,660
Retiree plus two or more dependents	\$31,450	\$18,990

If your net credited service date under your pension plan is on or after August 3, 2008, the company's annual contribution toward coverage will be as follows:

- If you **are not** eligible for Medicare, you will receive an amount equal to \$430 for each year of your net credited service, to a maximum of 30 years.
- If you **are** eligible for Medicare, you will receive an adjusted amount not less than 50% of the amount paid to pre-Medicare retirees with the same net credited service.

Special note for same-sex domestic partner coverage

Most dependents are considered Internal Revenue Service (IRS) tax dependents. You do not pay imputed income for IRS tax dependents.

If you cover a same-sex domestic partner, a domestic partner's child or another person who is not considered an IRS tax dependent, Verizon is required to report income for you that reflects the value of the coverage for tax-reporting purposes. This is known as imputed income. You will receive a W-2 annually for the value of coverage for any dependent who is not an IRS tax dependent.

Verizon assumes all dependents are IRS tax dependents, except same-sex domestic partners and their children. You must contact the Verizon Benefits Center if your same-sex domestic partner and his or her children are your IRS tax dependents or if you cover other dependents who are not IRS tax dependents.

Paying for coverage

If you are receiving a pension payment or LTD benefit from Verizon, your monthly cost (if any) will automatically be deducted from your check. In some cases, you may be able to arrange for direct billing rather than a deduction from your check, but your medical option choices might then be limited – call the Verizon Benefits Center for details. If you are not receiving a pension payment from Verizon, if you received a lump-sum pension payout, or if your pension payment is insufficient to cover the cost of your benefits, you will automatically be billed for your monthly cost (if any). You must make payment for any required contributions by the first day of each month.

If you are a disabled associate or a surviving dependent and you fail to make a payment, your coverage will end on the first of the month for which no payment was received. You will not be able to re-enroll in the Plan thereafter.

When participation ends

The following chart summarizes when coverage ends for you and your enrolled dependents. For information on continuing coverage and COBRA, see the “Continuing coverage if eligibility ends” section.

Retiree and LTD benefit recipient coverage	Coverage will end on the earliest date described below:
<p>Re-employment of a retiree</p>	<p>Coverage ends on the last day of the month in which you are re-employed by the company or an affiliate in a position that is other than temporary or occasional.</p> <p>When you subsequently retire:</p> <ul style="list-style-type: none"> • If you had been retired for 90 days or less before being rehired, you will be treated as a newly retired participant. • If you had been retired for more than 90 days before being rehired, you will be covered again under the Plan, subject to the terms and conditions that apply to individuals who retired on your initial retirement date. <p>Special note if you are a working retiree: A “working retiree” will continue to receive retiree benefits. This provision applies to Mid-Atlantic CWA retirees who are not working in Delaware or Pennsylvania.</p>
<p>LTD benefits end</p>	<p>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.</p>
<p>Cancellation of coverage</p>	<p>If you cancel coverage, your coverage will end on the last day of the month in which you elect to cancel coverage.</p>
<p>Failure to submit payment (if required)</p>	<p>If you are required to make a payment and it is not received on time, coverage will end on the first day of the month for which payment is not received.</p>
<p>Plan termination</p>	<p>Although the company does not intend to terminate the Plan, were the Plan to be terminated, all coverage would end on the date of termination.</p>

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 the "Continuing coverage if eligibility ends" section).
Retiree's or LTD benefit recipient's coverage ends	If the retiree's or LTD benefit recipient's coverage ends for any reason except when the retiree or LTD benefit recipient dies, coverage for all dependents also will end at the same time.
Retiree dies	<p>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 12-month period following the month in which the retiree dies. After the end of the 12-month period, class I dependents can elect to pay the full cost to continue coverage as a surviving dependent. Grandfathered class II dependents' coverage ends at the end of the 12-month period of company-paid coverage; eligible class II dependent children can then continue coverage under COBRA (see the "Continuing coverage if eligibility ends" section).</p> <p>Coverage for sponsored parents and sponsored children will end on the last day of the month in which the retiree dies. Sponsored children can then continue coverage under COBRA.</p>
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 last day of the month in which he or she becomes divorced or legally separated from you. • Coverage for a same-sex domestic partner ends on the last day of the month in which he or she fails to meet the definition of a same-sex domestic partner. • 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. <p style="text-align: right;"><i>(continued on next page)</i></p>

**Dependent or surviving dependent ceases to meet the eligibility requirements
(continued)**

- 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 illness, injury or school vacations.
- 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 in the “Dependent eligibility requirements” chart earlier in this section.
- 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 the “Dependent eligibility requirements” chart earlier in this section).
- Coverage for a sponsored parent ends on the earlier of the last day of the month in which he or she fails to meet the residential and income and support requirements applicable to sponsored parents under the Plan, or the first day of the month for which a required payment is not received.
- Coverage for a sponsored child ends on the earlier of the last day of the calendar year in which he or she reaches age 25, or the first day of the month for which a required payment is not received.
- Coverage for a child of a same-sex domestic partner ends on the last day of the calendar year in which the child reaches age 19 or age 25 (if a full-time student), as applicable, or the last day of the month in which he or she (or the same-sex domestic partner) otherwise fails to meet the definition of a child of a same-sex domestic partner (or same-sex domestic partner) as defined in the “Dependent eligibility requirements” chart earlier in this section.

Extended benefits

If you or your dependents are hospitalized

Coverage that otherwise would have ended for a covered person’s hospital room and board and related hospital facility services will continue (through the remainder of his or her hospital confinement) for a covered person confined in a hospital on the date his or her coverage otherwise would have ended, as long as the eligible or covered services are medically necessary. Other charges are the patient’s responsibility.

Continuation of coverage under COBRA

In some instances, a person whose eligibility for coverage under this Plan ends still may be able to continue coverage in accordance with a federal law called COBRA and its subsequent amendments. Continuation of coverage under COBRA is described under the “Continuing coverage if eligibility ends” section.

Certificate of Creditable Coverage

When any person's coverage under the Plan ends for any reason, including the end of COBRA continuation coverage, the company will send that person a Certificate of Creditable Coverage, free of charge, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This certificate may help the person receive coverage under another plan. Specifically, this certificate may help reduce or eliminate exclusionary periods of coverage for pre-existing conditions under the other plan. 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. You also will be provided with a certificate, free of charge, when you become entitled to elect COBRA continuation coverage, 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. To request a certificate, access Your Benefits Resources Web site or call the Verizon Benefits Center.

Surviving dependents

In addition to the information under the "When participation ends" chart, coverage for a surviving dependent will end on the earliest of the following dates:

- The last day of the month in which the surviving dependent requests that his or her coverage be canceled.
- 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.

Overview of your options

Plan options

The Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Post-1989 Associate Retirees gives you a choice of different types of medical options to meet your needs.

As a participant in the Plan, you have one or more of these options available depending on where you live:

- **Managed care network (MCN)**, if your home zip code is in the service area covered by the MCN. With the MCN, you can seek in-network care or out-of-network care. When you receive care through the network, you will receive the highest level of benefits available. If you receive medically necessary covered services outside the network, you will still receive benefits, but at a reduced level of coverage and higher out-of-pocket costs. If you are Medicare-eligible, this option coordinates with original Medicare (Medicare functions as your primary plan).
- **Medical Expense Plan (MEP) preferred provider organization (PPO)**, only if your home zip code is not in an MCN service area. This option allows you to use any licensed doctor or hospital you choose. Because PPO network providers have agreed to charge a network negotiated fee (NNF) for certain services, when you use PPO providers, you receive enhanced benefits. You receive a higher level of benefit coverage and because charges are based on the NNF, your out-of-pocket medical costs are lower. Your financial payment for medical care, if any, is based on the NNF rather than reasonable and customary (R&C) charges, and may consist of a fixed copayment rather than deductible and variable coinsurance, depending on the type of service provided. When you use non-PPO providers, benefits are based on R&C charges and not on the negotiated rates and benefit levels may be different. If you are Medicare-eligible, this option coordinates with original Medicare (Medicare functions as your primary plan). See the “Medical Expense Plan (MEP) preferred provider organization (PPO) option” section for additional information about the MEP-PPO option.
- **Health maintenance organization (HMO)**. In most parts of the country, you also will have the opportunity to join an HMO. If you join an HMO, you’ll usually need to choose one of the HMO’s doctors to be your primary care physician (PCP). Your PCP will then coordinate all your medical care. If you join an HMO, your care usually will be covered only if it is received through your PCP and other providers affiliated with the HMO. **You typically do not receive coverage for care not coordinated through your PCP, unless care is received for a true emergency.** If you are eligible for Medicare, you may be able to join a Medicare HMO, if offered in your area. See the “Health maintenance organizations (HMOs) and Medicare HMOs” section for more information.

If you are eligible for Medicare and want to join an HMO, your choice will be limited to those with Medicare HMO plans (referred to in this SPD as “Medicare HMOs”). There are two types of Medicare HMOs sponsored by Verizon: Medicare Advantage (formerly Medicare+Choice) HMOs and Medicare Supplemental HMOs. These Medicare HMOs generally provide all services covered by Medicare and typically offer additional benefits, such as coverage for preventive and routine care and prescription drugs. Your enrollment materials will explain which HMOs have Medicare plans and which do not. If you select a Medicare HMO, you will choose a PCP who coordinates your care within the Medicare HMO. To be covered, your care must be received through your PCP and other doctors and hospitals associated with the Medicare HMO. **You do not receive coverage for care not coordinated through your PCP, unless care is received for a true emergency.**

- **No coverage.** If you are a retiree or a long-term disability (LTD) benefit recipient, you may elect no coverage under this Plan only if you have other Verizon medical coverage (i.e., coverage under a spouse’s plan).

Opting-in

If you live outside the service area of the MCN, you can opt-in to the MCN. That is, you may decide that you are willing to travel farther to have access to a participating doctor in order to have MCN coverage.

If you live outside the service area of an HMO, you may be able to opt-in to an HMO. Call the Verizon Benefits Center for details since not all HMOs will allow members to opt-in.

Which option is best for you?

Only you can decide which option works best for you. Here are some things to consider when making your choice:

- If you want the flexibility to choose your own providers, think about selecting the bargained-for plan for which you’re eligible depending on where you live – the MCN or the MEP-PPO option. Both options use the Aetna Choice POS II provider network. You can confirm your desired provider participates in the network through Your Benefits Resources Web site or on Aetna’s Web site (see your Important Benefits Contact insert for contact information).
 - If you’re eligible for the MCN and seek medically necessary care in-network, you’ll pay only a small copayment for office visits, with most other medically necessary in-network care covered in full. However, you have the option to pay more to receive covered, medically necessary care from an out-of-network provider.
 - If you’re eligible for the MEP-PPO option and seek medically necessary care from PPO providers, you’ll pay only a small copayment for office visits. For other medically necessary care, the option generally provides a higher level of coverage, and charges are based on the network negotiated fee (NNF) when you use a PPO provider. If you prefer to choose a non-PPO provider, you may pay more, and coverage is based on reasonable and customary (R&C) charges.

- If you instead select an HMO, in most cases, you pay a copayment of \$15 for each visit to your doctor (and no more than \$50 for each emergency room visit). Most other medically necessary services are covered at 100% by the HMO.

If you're thinking about opting-in to the MCN or selecting an HMO, be sure to go to Your Benefits Resources Web site or call the Verizon Benefits Center to see which doctors and hospitals belong to the network and which will be available to you. If you visit doctors and hospitals outside the network, your medically necessary care will be covered at the lower rate (MCN) or not at all (HMOs) (unless you have a true emergency). Therefore, you'll want to be sure that the doctors and hospitals in the network are right for you.

- Also, when choosing an option, closely review the option's coverage provisions – including coverage for preventive care, prescription drugs, physical therapy, and mental health treatment. Certain options may offer better coverage for the types of care you are most likely to use.

Comparing your medical options

	MCN		MEP-PPO		HMO
Coverage feature	In-network	Out-of-network	Using a PPO provider	Using a non-PPO provider	
You have a PCP who directs your care	No	No	No	No	Yes; for most HMOs
You need referrals from your PCP before you receive care	No	No	No	No	Yes; for most services and in most HMOs
You can receive covered care anywhere in the United States	Yes (only within the MCN Mid-Atlantic service area)	Yes	Yes	Yes	No
You are covered for emergency care	Yes	Yes	Yes	Yes	Yes
You must pay a deductible before the Plan pays benefits for certain services	No	Yes	Yes or no, depending on the service	Yes	No
You pay a small per-visit copayment for most care	Yes	No	Yes or no, depending on the service	No	Yes
You pay a percentage of your covered care in coinsurance for certain services	No	Yes	Yes	Yes	No; most services are covered at 100% after the copayment

	MCN		MEP-PPO		HMO
Coverage feature	In-network	Out-of-network	Using a PPO provider	Using a non-PPO provider	
You may have to pay bills and submit claims for reimbursement	No	Yes	No	Yes	No
The Plan has an annual out-of-pocket maximum	Not applicable	Yes	Yes	Yes	Generally, not applicable

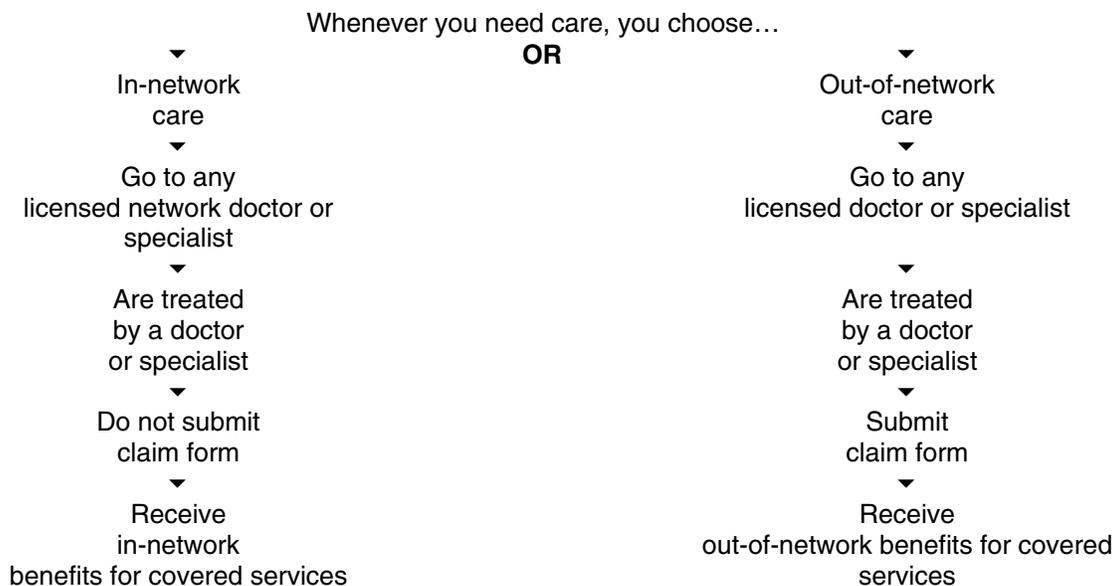
For additional information, please refer to the specific coverage summary charts in the “Managed care network (MCN) option” section and the “Medical Expense Plan (MEP) preferred provider organization (PPO) option” section.

Managed care network (MCN) option

See “MCN coverage summary” later in this section for information on some covered services. In addition, see “Administrative information” under the “Additional information” section for a list of MCN administrators. For more information about covered services and your MCN benefits, access Your Benefits Resources Web site or contact the claims administrator via the telephone number shown on your Important Benefits Contacts insert or on your MCN ID card.

How the MCN works

When you need care, visit a licensed healthcare provider of your choice. Depending on whether you seek in-network or out-of-network care, the Plan works differently. The chart below describes how the MCN works.



In-network benefits

In-network copayments

A copayment is a flat dollar amount that you pay for covered expenses. When you seek in-network care under the MCN, your copayment is \$15 (\$5 if you are eligible for Medicare) for each office visit and \$15 for each urgent care facility visit. There is a \$25 copayment (\$5 if you are eligible for Medicare) for emergency care in a hospital’s emergency room (if you are admitted to the hospital, your copayment is waived).

If your dependent lives away from home

If you have a class I dependent who lives permanently away from home, you may request that the dependent’s care be covered – even though the dependent may live outside the MCN service area and may use only out-of-network providers. If your request is granted, benefits will not be based on the NNF, but instead will be based on R&C charges. Benefits are paid at 100%. For more complete information, contact Aetna, Inc. via the telephone number shown on your Important Benefits Contacts insert.

Out-of-network benefits

Out-of-network deductible

Each calendar year, you must meet a \$250 annual deductible per person before the MCN begins to pay benefits for covered services under the out-of-network portion of the option. This deductible applies to all covered services or supplies (see the chart under “MCN coverage summary” later in this section) provided under the MCN on an out-of-network basis in a year. The following expenses do not apply to the deductible:

- Amounts paid for in-network care, including emergency room and urgent care facility copayments.
- Amounts payable when pre-admission testing is done on an inpatient basis and the inpatient admission is not considered medically necessary by the claims administrator.
- Amounts payable for covered surgery (and associated X-ray, laboratory, anesthesia, and other expenses) when surgery is performed on an inpatient basis and inpatient admission is not considered medically necessary by the claims administrator.
- Expenses for prescription drugs.
- Amounts in excess of the R&C amount.
- Amounts paid for noncovered services and supplies.

Common accident provision

If two or more members of your family are injured in the same accident, the MCN 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 dependents classified as sponsored dependents and grandfathered class II dependents.

Year-end carryover (for former IBEW-represented associates only)

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

Out-of-network coinsurance

After you pay the \$250 deductible, the MCN typically pays 80% of the R&C charges and you pay 20% coinsurance and the difference between R&C and the actual charges for most other eligible expenses, including:

- Physician office visits.
- Laboratory/X-rays.
- Hospital charges.

The following special coinsurance rules apply when you receive out-of-network care:

- The Plan will pay 80% of the R&C amount, with no deductible, for preventive care services up to \$150 per office visit and subject to the schedule (see the “Preventive care services” section under the “MCN coverage summary” chart).
- The Plan will pay 60% of the R&C amount and you will pay 40% coinsurance for certain covered surgical procedures (as well as associated X-ray, laboratory, anesthesia, and other expenses) performed on an inpatient basis when hospitalization is determined by the claims administrator to be not medically necessary.
- The Plan will pay 100% of the R&C amount in excess of the deductible for pre-admission testing done on an outpatient basis in a hospital, ambulatory surgical facility or other facility recognized by the hospital and surgeon (provided that tests are necessary and consistent with the diagnosis and treatment of the condition).
- The Plan will pay 100% of actual charges for covered emergency care and urgent care, after you pay a \$25 (\$5 if you are eligible for Medicare) copayment for the emergency room or \$15 (\$5 if you are eligible for Medicare) copayment for urgent care. The \$25 copayment is waived if you are admitted to the hospital.
- You also are responsible for amounts above R&C.

When you use an out-of-network provider, it is a good idea to contact your claims administrator to pre-certify all inpatient hospital stays (including inpatient mental health and substance abuse treatment). In addition, you also should pre-certify selected outpatient procedures, home health care, hospice care, private duty nursing, and stays in a skilled nursing facility. (See “Pre-certification” in the “More information about the MCN and MEP-PPO options” section for more information on pre-certification.)

Annual out-of-network, out-of-pocket maximum

There is financial protection if you have large out-of-network expenses. If an individual’s share of covered out-of-network expenses reaches \$1,500 in a calendar year (not including the \$250 individual deductible), the MCN will pay 100% of the R&C amount for most additional covered out-of-network expenses for that individual for the rest of the calendar year. You are responsible for all amounts above the R&C.

Charges for out-of-network services or supplies will be applied to the out-of-network, out-of-pocket expense maximum only. The following expenses cannot be used to satisfy the out-of-pocket maximum (nor are they paid at 100% once the out-of-pocket maximum is reached):

- Copayments for in-network office visits or visits to an urgent care facility or emergency room.
- Charges for the noncovered use of a private hospital room.
- Amounts payable when pre-admission testing is done on an inpatient basis and the inpatient admission is not considered medically necessary by the claims administrator.

- Charges for surgery and associated X-ray, laboratory, and other expenses when surgery is performed on an inpatient basis and hospitalization is not medically necessary, as determined by the claims administrator.
- Expenses for prescription drugs.
- Charges that exceed R&C or other Plan limits.
- Charges that are not covered by the Plan.
- Amounts paid to satisfy the deductible.

Non-elective out-of-network care

If you (or a covered dependent) are in an out-of-network area when you need medical care, the following rules will apply:

- Covered urgent care or emergency care is covered at the in-network level, except as noted below:
 - For non-emergency care in an emergency room, benefits for medically necessary services and supplies will be paid at the out-of-network level.
 - When receiving care outside the country:
 - Covered urgent or emergency medical care is covered at the in-network level.
 - All other covered medical care will be covered at the out-of-network level.

If you did not submit claim forms, verify that they have been submitted (note that the forms must be in English).

Paying for out-of-network care and filing claims

If you are an MCN participant and you receive in-network care, your in-network provider files your claim for you. If you go outside the network for care, however, a claim must be filed before the Plan pays benefits.

When you receive a bill for out-of-network services, you or the healthcare provider should submit your bill to the claims administrator. (The name and telephone number of your claims administrator appears on your MCN ID card and your Important Benefits Contacts insert.)

Typically, if you show your MCN ID card to your doctor or other healthcare provider when you check in, the provider will submit the bill directly to the appropriate claims administrator. Occasionally, however, a provider may send you a bill without first submitting it to your claims administrator with a copy of the itemized bill.

After Aetna, Inc. has received the bill for your care, it will determine your eligible MCN benefits and, if appropriate, send a payment to your healthcare provider. It also will send you an explanation of benefits (EOB) statement. The EOB shows how much of the bill the Plan paid and how much remains for you to pay. (An EOB will not be sent to you if you do not owe any money.)

After you receive the EOB, you should receive a new bill from your medical provider for any remaining amount not covered by the MCN.

Requesting a claim form

If you need to file a claim for MCN benefits, you should contact your MCN claims administrator for a claim form. You can call your claims administrator via the Verizon Benefits Center or via the telephone number shown on your Important Benefits Contacts insert or on your MCN ID card.

Deadline for filing claims

If you need to file a claim, 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 received.

Lifetime maximum

The maximum benefit payable on behalf of a covered person using out-of-network providers (no lifetime maximum applies if you use MCN network providers) for other covered charges incurred during the covered person's lifetime is \$100,000. For calendar years 2009, 2010, and 2011, \$10,000 is automatically restored to the maximum for each covered person. Beginning in 2012, \$3,500 automatically will be restored to the maximum for each covered person. Examples of other covered charges include ambulance service, X-rays and lab tests, durable medical equipment and physical, occupational and speech therapy. See the chart under "MCN coverage summary" later in this section for a listing of other covered charges.

MCN coverage summary

This section provides an overview of the benefits payable for covered services and supplies provided by both the in-network and out-of-network portions of the MCN. (See "How the MCN works" for an explanation of in-network benefits and out-of-network coverage rules.)

Keep in mind, if you utilize out-of-network providers, charges in excess of the R&C amount will not be covered by the Plan. If charges exceed the R&C amount, the Plan will apply its reimbursement percentage to the R&C amount, and you may be responsible in full for the difference between the billed charges and the R&C amount. Certain other restrictions may apply – see the "Additional information" section.

Plan feature	Benefits	
	In-network (benefits are based on the NNF):	Out-of-network (benefits are based on the R&C):
Deductible requirements	None	\$250 per person, per calendar year; no family maximum
Annual out-of-pocket maximum (Per person, per plan year) Excludes copayment for in-network office visits or visits to an urgent care facility or emergency room; charges for the noncovered use of a private hospital room; amounts payable when pre-admission testing is done on an inpatient basis and the inpatient admission is not considered medically necessary by the claims administrator; charges for surgery and associated expenses when surgery is performed on an inpatient basis and hospitalization is not medically necessary; prescription drug charges, as well as noncovered services and supplies; amounts in excess of the R&C, or applicable Plan maximums and amounts paid to satisfy the deductible	None	\$1,500 per person (does not include deductible); no family maximum
Lifetime maximum benefit	None	\$100,000 per covered individual for other covered charges
When benefits are paid	For care received from a network provider, the Plan pays as shown below:	For covered non-emergency care provided on an out-of-network basis, benefits are based on the R&C amount and the Plan pays as shown below:
Inpatient hospital services		
Room and board	100%	80%, after deductible, if pre-certified (not covered when covered specified surgery is performed on an inpatient basis without medical necessity)
Pre-admission testing (to determine if hospitalization is necessary)	100%	80%, after deductible (hospitalization during inpatient testing is not covered)

Plan feature	Benefits	
	In-network (benefits are based on the NNF):	Out-of-network (benefits are based on the R&C):
X-rays and lab tests	100%	80%, after deductible, if pre-certified
Special care units	100%	80%, after deductible, if pre-certified
Maternity care	100%	80%, after deductible
Newborn baby care (initial pediatric exam while mother is hospitalized)	100%	80%, after deductible, if pre-certified
Skilled nursing facilities (limit of 120 days per plan year) ¹	100%	80%, after deductible, if pre-certified
Birthing centers	100%	80%, after deductible, if pre-certified
Hospice care (lifetime limit of 180 days, of which no more than 60 days may be for inpatient hospice care) ²	100%	80%, after deductible, if pre-certified
Surgery and anesthesia		
Inpatient surgery	100%	80%, after deductible, if pre-certified
Outpatient surgery	100% (you pay \$15 copayment – \$5 if you are eligible for Medicare – if an office visit is billed)	80%, after deductible, if pre-certified (for certain surgical procedures and associated X-ray, lab, and other expenses, if the procedure is performed on an inpatient basis and the inpatient admission is not medically necessary, the Plan pays 60%, subject to the deductible, and the remaining 40% will not count toward the out-of-pocket expense maximum)

¹ Each day of confinement in a skilled nursing facility will count as one half-day.

² After 180 days, up to an additional 45 days may be authorized, as determined by the claims administrator.

Plan feature	Benefits	
	In-network (benefits are based on the NNF):	Out-of-network (benefits are based on the R&C):
Outpatient services		
Doctors' office visits	100% after you pay \$15 per visit (\$5 if you are eligible for Medicare)	80%, after deductible
Doctors' home visits	100% after you pay \$15 per visit (\$5 if you are eligible for Medicare)	80%, after deductible
X-rays and lab tests	100% (you pay \$15 copayment – \$5 if you are eligible for Medicare – if an office visit is billed)	80% after deductible
Radiation therapy, chemotherapy, electroshock therapy, hemodialysis	100%	80%, after deductible
Physical, occupational, and speech therapy (duration must be prescribed by your doctor)	100%	80%, after deductible
Licensed chiropractor (benefits limited to \$750 per calendar year) ³	100%, after you pay \$15 (\$5 if you are eligible for Medicare) per visit (medically necessary charges; maintenance services not covered)	80% of approved charges (maintenance chiropractic services not covered), after deductible
Private duty nursing (noncustodial)	100%	80%, after deductible, if pre-certified

³ The \$750 limit does not apply to former IBEW-represented associates represented by Local 827 in New Jersey or their dependents and survivors.

Plan feature	Benefits	
	In-network (benefits are based on the NNF):	Out-of-network (benefits are based on the R&C):
Preventive care services		
Well-baby/well-child exams <i>Age 0 – 2 years: as prescribed Age over 2 – 25: 1 exam every year; includes immunizations</i>	100%, after you pay \$15 per visit (\$5 if you are eligible for Medicare)	80% (no deductible) ⁴
Adult physical exams <i>Age over 25 – 49: 1 exam every 2 years Age 50 and over: 1 exam every year</i>	100%, after you pay \$15 per visit (\$5 if you are eligible for Medicare)	80% (no deductible) ⁴
Well-woman exam <i>One well-woman exam, every year, regardless of age and with or without a Pap test, including the blood count and urinalysis</i>	100%, after you pay \$15 per visit (\$5 if you are eligible for Medicare)	80% (no deductible) ⁴
Immunizations and flu shot <i>One complete regimen of immunizations and one flu vaccine annually for children and adults</i>	100%, after you pay \$15 per visit (\$5 if you are eligible for Medicare)	80% (no deductible) ⁴
Fecal occult test <i>Age 18 – 39: 1 every 2 years Age 40 and over: 1 every year</i>	100%	80% (no deductible) ⁴
Colonoscopy or sigmoidoscopy <i>Age 50 and over: 1 every 3 years</i>	100%	80% (no deductible) ⁴
Routine mammogram <i>One annual routine mammogram for women regardless of age</i>	100%	80% (no deductible) ⁴
Prostate-specific antigen test <i>Age 18 – 49: 1 every 2 years Age 50 and over: 1 every year</i>	100%	80% (no deductible) ⁴

⁴ All out-of-network routine care services are subject to a maximum of \$150 per office visit and according to the applicable age and frequency schedule.

Plan feature	Benefits	
	In-network (benefits are based on the NNF):	Out-of-network (benefits are based on the R&C):
Hearing aids	Up to \$1,000 for hearing aid (and related exam and fitting) every 24 calendar months ⁵	
Home health care (limit of 120 days per plan year) ⁶	100%	80%, after deductible, if pre-certified
Mental health/substance abuse services		
Inpatient mental health treatment	100%	80%, after deductible) ⁸
Outpatient mental health treatment ⁷	100%, after you pay \$15 per visit (\$5 if you are eligible for Medicare)	80%, after deductible
Inpatient substance abuse treatment ^{7,9}	100%	80%, after deductible) ¹⁰
Outpatient substance abuse treatment ^{7,9}	100%, after you pay \$15 per visit (\$5 if you are eligible for Medicare)	80%, after deductible
Other services		
Durable medical equipment	100%	80%, after deductible
Ambulance services	100%, if the claims administrator determines your condition to be an emergency; otherwise, Plan pays 80%, after deductible	
Prosthetic devices	100%	80%, after deductible
Emergency care (within 72 hours of injury or onset of illness)	You pay \$25 if a true emergency (this copayment is waived if you are admitted through the emergency room)	
Urgent care	100% after you pay \$15 per visit	

⁵ In addition to routine hearing aid coverage, hearing aids may be available after ear surgery (if medically necessary), if purchased within 90 days of the surgery. Contact the claims administrator for more information.

⁶ Every five home health care visits will count as one day.

⁷ There is no coverage for grandfathered class II and sponsored dependents.

⁸ For former IBEW-represented associates: Out-of-network inpatient mental health treatment is limited to 30 days per covered person, per plan year.

⁹ Substance abuse treatment (in-network and out-of-network combined) is 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.

¹⁰ For former IBEW-represented associates: Benefits for out-of-network inpatient substance abuse treatment are limited to 30 days per covered person, per plan year.

Prescription drugs	Using a participating	Using a nonparticipating pharmacy
Retail pharmacy (supply appropriate for up to 30 days of therapy)		
Annual deductible	No deductible required	\$50 combined for generic and brand name
Coinsurance		
Generic	You pay 15% of the discounted network price (DNP) but no more than \$25 per prescription	You pay 15% of the retail cost but no more than \$25 per prescription
Brand-name drugs when generic is not available	You pay 20% of the DNP but no more than \$45 per prescription	You pay 20% of the retail cost but no more than \$45 per prescription
Brand-name drugs when generic is available	You pay 30% of the DNP but no more than \$55 per prescription	You pay 30% of the retail cost but no more than \$55 per prescription
Medco Mail Service Pharmacy (supply appropriate for up to 90 days of therapy)		
Generic	You pay \$8 copayment or the DNP, whichever is less	
Brand-name drugs when generic is not available	You pay \$17 copayment or the DNP, whichever is less	
Brand-name drugs when generic is available	You pay \$25 copayment or the DNP, whichever is less	

More information about the MCN

The following section provides more detailed information on the MCN option.

Emergency care

If you need emergency care, go to the nearest emergency facility. If you're admitted to a hospital through the emergency room, your \$25 copayment will be waived. The emergency room should be used only for medical emergencies.

Note that the emergency room copayment does not count toward your annual out-of-network out-of-pocket maximum and cannot be used to satisfy the deductible.

¹¹Must use your prescription program ID card at a network pharmacy to get in-network benefits. You can purchase a supply appropriate for up to 30 days of therapy through an in-network pharmacy.

- For use of an emergency room without admission to the hospital, benefits are paid in-network and all medically necessary care is covered:
 - If the claims administrator determines your condition to be a true emergency, the Plan will pay 100% of the NNF for an in-network hospital or the actual charge in an out-of-network hospital.
 - If you go to an emergency room of an in-network hospital and the claims administrator determines your condition not to be a true emergency, the MCN will pay 80% of NNF, after the deductible, subject to medical necessity (as determined by the claims administrator). You will be responsible for any balance due. If you go to an emergency room of an out-of-network hospital, benefits are payable at 80% of the R&C charges and you will be responsible for any balance due.
- For an emergency admission to the hospital, benefits (including for use of the emergency room before admission) are paid in-network if admission is medically necessary (as determined by the claims administrator). If not, no benefits are paid.

For the use of an ambulance associated with your care, the following rules apply:

- The Plan will pay 100% for emergency use of an ambulance (whether or not you use a network ambulance service).
- The Plan will pay 100% of NNF for the non-emergency, medically necessary use of an ambulance when you use a network ambulance service.
- The Plan will pay 80% of the R&C amount after the deductible for the non-emergency, medically necessary use of an ambulance when you use an out-of-network ambulance service.
- The Plan does not provide coverage for ambulance service when not medically necessary.

Hospital room and board

The Plan covers room and board in a hospital ward or semiprivate room. 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 (80% of the R&C amount if out-of-network) for a semiprivate room. If the hospital only has private rooms, Plan benefits will be 90% of the charge (80% of the R&C amount if out-of-network) 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.

Surgery

Outpatient surgery

When eligible surgical procedures are performed on an outpatient basis, the Plan will pay 80% of the R&C amount for that surgery (if performed on an out-of-network basis). The MCN also will pay 80% of the R&C amount for diagnostic X-ray, laboratory, and other associated expenses subject to the deductible. Surgery performed on an in-network basis will be paid at 100% of the NNF, regardless of whether the surgery is performed on an inpatient or outpatient basis. The Plan also will pay 100%, after deductible, for pre-admission testing performed on an outpatient basis.

Eligible surgical procedures (when determined by the claims administrator to be medically necessary) include:

- 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 some surgery).
- Varicose vein ligation.
- Digestive system.
- Male genital system procedures.
- Female genital system procedures.
- Maternity care and delivery.
- Eye and ocular adnexa procedures.
- Ear surgery.

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

- The Plan will pay 60% of the R&C amount for surgery and associated expenses, subject to the deductible.
- The remaining 40% of the R&C amount and any amounts above R&C (if out-of-network hospital) will not count toward the out-of-pocket expense maximum.
- Hospital room and board will not be considered a covered service or supply under the Plan.

Second surgical opinion

Because there are risks involved with any surgical procedure, it's important to get a second opinion when surgery is recommended. Under the MCN, a second surgical opinion, including surgeon's fees and associated X-rays and laboratory tests obtained from a board-certified specialist, will be considered a covered service or supply under the Plan if obtained in-network. When the second surgical opinion is nonconcurring, the Plan will cover a third surgical opinion and associated X-rays and laboratory tests.

Second and third opinions are not covered if obtained out-of-network.

Multiple procedures

In the event of multiple or bilateral surgical procedures or when performed in stages, the following rules will apply when performed out-of-network:

- For the major procedure, regular Plan benefits will be paid. For each minor procedure, 50% of the R&C amount 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 will be treated independently, except that only one charge for use of the operating room and one charge for anesthesia will be covered under the Plan.

Note: The Plan will pay 100% of the applicable NNF for covered surgery rendered on an in-network basis under the MCN.

Use of an assistant surgeon

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

Sterilization procedures

An initial voluntary sterilization procedure or a reversal of such a procedure for a male or female covered person will be covered under the Plan, without restriction as to waiting periods, doctor's approval, etc.

Sex-change procedures

A transsexual operation will be covered under the Plan 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 shall determine medical necessity for this case.

Oral surgery

The following oral surgery is covered under the Plan:

- Oral surgery performed for the treatment of diseases, injuries, and defects of the mouth, the jaws, and associated structures.
- The 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.
- Removal of impacted teeth in a dentist's or oral surgeon's office or 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 under the Plan only for the following reasons:

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

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 considered covered services or supplies under the Plan, when not considered experimental or investigational, 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.

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.

Mental health and substance abuse treatment

MCN coverage for you and your eligible class I dependents includes treatment for mental health and substance abuse. Grandfathered class II dependents and sponsored dependents are covered for inpatient mental health care only.

The following charts summarize your mental health and substance abuse treatment benefits. For more detailed information, see below.

Mental health treatment	MCN pays in-network	MCN pays out-of-
Inpatient treatment	100% of NNF	80% of the R&C amount (Former IBEW-represented associates have a 30-day annual maximum per covered individual)
Outpatient treatment	100% of NNF after \$15 copayment (\$5 if you are eligible for Medicare)	80% of the R&C amount
Substance abuse treatment		
Inpatient	100% of NNF	80% of the R&C amount (Former IBEW-represented associates have a 30-day annual maximum per covered individual)
Outpatient treatment ²	100% of NNF after \$15 copayment (\$5 if you are eligible for Medicare)	80% of the R&C amount

Covered inpatient mental health services

Your covered inpatient mental health treatment includes inpatient hospitalization for mental health care, including physician visits and medication.

Covered outpatient mental health services

Your covered outpatient mental health treatment includes:

- Visits to a physician, a 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.) as part of treatment for the covered person.

Covered substance abuse treatment

The following treatment will be covered under the Plan:

- Inpatient detoxification when followed by rehabilitation at a state-licensed facility approved by the claims administrator.
- Outpatient treatment, including drug therapy, psychotherapy, counseling, family therapy, and behavior therapy at a state-licensed facility or when approved by the claims administrator.

¹ A \$250 deductible must be met before benefits are paid.

² Substance abuse treatment (in-network and out-of-network combined) is 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.

Note: Professional fees billed separately by private practitioners under an inpatient program are not eligible for reimbursement under the Plan. 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.

In-network benefits

When you go in-network for your mental health and substance abuse treatment, your benefits are as follows:

- For inpatient mental health and substance abuse treatment, the Plan pays 100% of NNF.
- For outpatient mental health and substance abuse treatment, the Plan pays 100% of NNF after the \$15 copayment (\$5 if you are eligible for Medicare).

Out-of-network benefits

You also can receive your care from out-of-network specialists. If so, your benefits are as follows:

- For inpatient mental health and substance abuse treatment, the Plan pays 80% of the R&C amount after the deductible. You also are responsible for mental health treatment charges above the R&C amount. Former IBEW-represented associates have an annual 30-day maximum per plan year for mental health treatment, as well as a separate 30-day maximum per plan year for substance abuse treatment.
- For outpatient mental health treatment, the Plan pays 80% of the R&C amount after the deductible.
- For outpatient substance abuse treatment, the Plan pays 80% of the R&C amount after the deductible.

All 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 shall be considered one half-day of inpatient care. Patients who undergo detoxification also must enter a rehabilitation program to be eligible for detoxification benefits.

Pre-certification

As with any hospitalization, it is a good idea to pre-certify inpatient mental health and substance abuse treatment. Before receiving inpatient mental health or substance abuse treatment, you should call Aetna for pre-certification. (See your Important Benefits Contacts insert for the telephone number.) If you are receiving care from an in-network provider, he or she will pre-certify for you. If you are receiving care from an out-of-network provider, it is your responsibility to call for pre-certification.

The MEP-PPO option

The MEP Preferred Provider Organization (PPO) option allows you to use any licensed doctor or hospital you choose. A PPO is a network of doctors, hospitals, and other providers who agree to meet strict quality standards for treatment and utilization and provide services according to a network negotiated fee (NNF) schedule. The MEP-PPO offers the flexibility of using PPO providers or non-PPO providers for care.

When you use PPO providers, the provider will handle any pre-certification for you. When you use non-PPO providers, it is a good idea to contact your claims administrator to pre-certify all inpatient hospital stays (including inpatient mental health and substance abuse treatment). In addition, you also should pre-certify selected outpatient procedures, home health care, hospice care, private duty nursing, and stays in a skilled nursing facility. (See “Pre-certification” in the “More information about the MCN and MEP-PPO options” section for more information on pre-certification.)

See “Other covered medical services and supplies” under the “More information about the MCN and MEP-PPO options” section for information on some covered services. In addition, see “Administrative information” under the “Additional information” section for MEP-PPO option administrator information. For more information about covered services and your MEP-PPO option benefits, contact the claims administrator via the telephone number shown on your Important Benefits Contacts insert. A list of participating providers can be obtained free of charge via Your Benefits Resources Web site or by calling the telephone number shown on your Important Benefits Contacts insert or on your medical ID card. The MEP-PPO option claims administrator also has an Internet site where you can get information about participating providers online.

MEP-PPO option eligibility

The MEP-PPO option is available only if your home zip code is not in a managed care network (MCN) service area.

If a participant is eligible for Medicare (and Medicare is the participant’s primary plan), that participant’s MEP-PPO option benefits for a particular service will be reduced by the amount Medicare Parts A and B cover for that service. See the “When you become eligible for Medicare” section for more information about Medicare.

Plan details

Annual deductible

Each calendar year, before the MEP-PPO option pays benefits for medical expenses (not including prescription drugs) that are subject to the deductible, a covered individual must meet the individual annual deductible.

If your date of retirement is prior to August 3, 2003: Your annual deductible is equal to 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 not receiving a pension benefit, your deductible will be based on your annual base pay rate in effect for the last pay period prior to the date your coverage in this Plan took effect.

If your date of retirement is after August 2, 2003: Your annual deductible is equal to the deductible you had as an active employee as of the date of your retirement. Beginning January 1, 2008, the annual deductible is \$250.

If you reside outside the PPO service area, the annual deductible is \$150.

Deductible amounts for dependents also are subject to the following provisions:

- The deductible amounts for eligible covered dependents will be the same as those for the retired or disabled associate who is covering them.
- The deductible amounts for surviving dependents will be the same as those that were in effect for the retiree at the time of his or her death.

If your eligible expenses and two of your class I dependents' eligible expenses (that are applied against individual deductibles) equal the family deductible of 2½ times the individual deductible, or if three or more of your class I dependents' eligible expenses (that are applied against individual deductibles) equal the family deductible, then all deductibles are met for the remainder of the calendar year. The Plan pays benefits on behalf of a covered person after that person has met his or her individual deductible, or after the family deductible has been met.

Note:

- Only amounts paid toward individual deductibles can be added together to meet the family deductible.
- Amounts paid for care for sponsored children, sponsored parents, and grandfathered class II dependents do not count toward the family deductible. In addition, these dependents must meet their individual deductibles even if the family deductible has been met. Once the family deductible is met in a plan year, no further deductibles are required for you and your class I dependents in that plan year.

For most services and supplies obtained from PPO providers, the deductible generally does not apply (see the "MEP-PPO option coverage summary" chart for specific services). When obtained from non-PPO providers, once the deductible (individual or family) is met, the MEP-PPO option begins to pay benefits for the following services and supplies when determined to be medically necessary by the claims administrator:

- Inpatient hospital services and supplies (not including emergency care).
- Outpatient diagnostic X-rays and laboratory tests (including pre-admission testing) when billed for by a hospital or hospital-based facility.
- Maternity and newborn care, except for related physician's services and surgery.
- Mental health and substance abuse treatment.
- Services and supplies considered "other covered charges" under the Plan.

The following expenses do not apply to the deductible:

- Amounts payable when pre-admission testing is done on an inpatient basis and the inpatient admission is not considered medically necessary by the claims administrator.
- Copayments for office visits to PPO providers.
- Amounts payable when any of the surgical procedures (described under “Outpatient surgery” later in this section) are performed on an inpatient basis and the inpatient admission is not considered medically necessary by the claims administrator.
- Amounts that exceed R&C charges.
- Amounts paid for noncovered services and supplies.

In addition, the following charges are not subject to the deductible when provided by non-PPO providers and treated as “Basic” services under the Plan (however, your expenses for these services can be applied against the deductible under other covered charges):

- Charges for emergency care.
- Charges for covered surgical care services, home health care services, skilled nursing facility services and hospice care.
- Charges for outpatient diagnostic X-rays and laboratory tests.
- Charges for pre-admission testing when done on an outpatient basis and billed for by a free-standing ambulatory facility.
- Charges for anesthesia, in-hospital visits, in-hospital consultations and therapy (e.g., radiation, chemotherapy, electroshock, hemodialysis).
- Charges for physician’s services for maternity and newborn care.

Common accident provision

If two or more members of your family are injured in the same accident, the MEP-PPO option 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 dependents classified as 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 also will apply to the next year’s deductible. This feature helps you avoid paying the deductible twice within a short period of time.

Coinsurance and copayments

For some types of medical services, you are required to pay a percentage of your covered expenses and the MEP-PPO option pays the remainder. The amount you pay based on the applicable percentage (if any) is called coinsurance. Coinsurance is different from a copayment, which is a fixed dollar amount required at the time certain services are provided by PPO providers under the MEP-PPO option.

The amount you are required to pay and the amount the MEP-PPO option pays for your covered expenses will depend on the type of service you receive. See the “MEP-PPO option coverage summary” chart later in this section for the amount the Plan pays for covered services.

Office visit copayment

If you are not eligible for Medicare: Your in-network office visit copayment is \$15.

If you are eligible for Medicare: Your in-network office visit copayment is \$5.

Plan benefits

Using PPO providers

With the MEP-PPO option, generally when you use a PPO provider, you will pay a copayment for each physician office visit for an illness or injury and the Plan pays the balance. For certain preventive and routine services, coverage is 100% and no copayment is required.

When you receive your care from PPO providers, the same services and supplies as for non-PPO benefits are covered but with enhanced PPO benefits:

- For inpatient hospital admissions in a semiprivate room as well as for the covered services and supplies identified under “Basic benefits” below (describing non-PPO benefits), the PPO pays 100% of the NNF, with no deductible required.
- Many of the charges identified under “Other covered charges” later in this section also are covered at 100% with no deductible.

See the “MEP-PPO option coverage summary” chart later in this section for specific provision information.

Using non-PPO providers

The following describes coverage for certain expenses covered under the MEP-PPO option when non-PPO providers are used. Additional expenses may be covered. If you have any questions about whether an expense is covered, call the health plan’s member services telephone number shown on your ID card.

Basic benefits

The Plan pays 100% of the R&C amount for basic services obtained from non-PPO providers (subject to the annual deductible, if applicable). You pay any difference between the R&C amount and the actual charge.

The following special rules apply:

- The Plan will pay 100% of the actual charge after the deductible for the following services when a PPO provider/facility is not used:
 - Inpatient hospital admissions in a semiprivate room up to 120 days per plan year (this limit is applied to the combination of hospitalization, skilled nursing facility stays, and home health care).
 - Inpatient mental health treatment 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. For partial hospitalization and intensive outpatient treatment for substance abuse, each day of care is considered a half-day of inpatient care.
 - Facility charges for covered use of an ambulatory care facility or a birthing center.
- The plan will pay 80% of the R&C amount, and the covered person's coinsurance will be 20% after the deductible (if applicable) for the following services when a PPO provider/facility is not used:
 - Covered surgery (and associated services) performed on an inpatient basis when hospitalization is determined by the claims administrator to be not medically necessary.
 - Physicians' services in connection with the use of an emergency room for non-emergency care.
- The plan will pay 90% of the R&C amount and the covered person's coinsurance will be 10% after the deductible (if applicable) for the following services when a PPO provider/facility is not used:
 - Pre-admission testing done on an inpatient basis and when confinement is determined by the claims administrator to be not medically necessary.
- The plan will pay 98% (if applicable) of the R&C amount and the covered person's coinsurance will be 2%, for the following services when a PPO provider/facility is not used:
 - Covered surgery, except for second surgical opinions and outpatient surgery.
 - Maternity care.

Note: All outpatient surgery rules described above apply only to the covered surgical procedures described under "Outpatient surgery" later in this section.

Coinsurance amounts paid under basic benefits are rolled over and paid as other covered charges.

Other covered charges

For services covered as “other covered charges,” the plan generally pays 80% of the R&C amount after the deductible (if applicable), 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 when a PPO provider is not used.

Out-of-pocket maximum

The annual out-of-pocket maximum for the MEP-PPO option is \$1,000 per covered person, 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.
- Copayments for office visits to PPO providers.
- Copayments for in-network and out-of-network emergency room and urgent care facility visits.
- Charges that are not covered by the Plan.
- Charges in excess of the R&C charge or charges in excess of any applicable Plan maximums.
- Charges for use of a private hospital room to the extent not covered by the Plan.
- 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 to be not medically necessary.
- Expenses for prescription drugs.

Lifetime maximum

The maximum benefit payable on behalf of a covered person other covered charges incurred during the covered person’s lifetime is \$100,000. For calendar years 2009, 2010, and 2011, \$10,000 is automatically restored to the maximum for each covered person. Beginning in 2012, \$3,500 is automatically restored to the maximum for each covered person.

Paying for care and filing claims

If you use a doctor that participates in the PPO, the doctor generally will file the claim on your behalf. If you receive care from a non-PPO provider, the provider may require payment at the time of service or they may bill you. You will need to submit a claim with a copy of the bill to Aetna, Inc.

After Aetna has received the bill for your care, it will determine how much of the bill to be paid, if any. It also will 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 MEP-PPO option.

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, you should then submit a copy of the notice, plus copies of any bills you have received from the provider for the services, to Aetna. Aetna will then determine your eligible MEP-PPO option benefits and, if appropriate, send a payment to your healthcare provider. It also will 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-PPO option or Medicare.

Medicare Direct

Medicare Direct is an automatic claim filing service for Verizon participants who have Medicare as their primary carrier. Under Medicare Direct, your doctor files your medical claims with your Medicare Part B carrier. Medicare determines the portion of the claim it will pay and pays the provider directly (you will get an explanation of benefits from Medicare).

Medicare then forwards the claim for the remaining expenses directly to Aetna. Aetna then pays the provider directly. (You will get an explanation of benefits from Aetna.)

If you are enrolled in the MCN or MEP-PPO option, you are automatically enrolled in the Medicare Direct program if your Medicare number is your social security number followed by an "A." Contact Aetna member services to enroll in Medicare Direct if your Medicare number is not your social security number followed by an "A" or if you would like to enroll your Medicare-eligible dependents.

Requesting a claim form

If you need to file a claim for MEP-PPO option benefits obtained from non-PPO providers, you should contact your MEP-PPO option claims administrator for a claim form. Check your MEP-PPO option ID card or your Important Benefits Contacts insert for the correct telephone number.

Deadline for filing claims

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.

MEP-PPO option coverage summary

The table in this section provides an overview of the benefits payable for covered services and supplies provided by the MEP-PPO option. Charges in excess of R&C amounts will not be covered by the Plan. If a charge for a non-PPO covered service exceeds the R&C amount, the MEP-PPO option's reimbursement percentage will be applied to the R&C amount, and you may be responsible in full for the difference between the billed charges and the R&C amount. Although not required, you should pre-certify medical care (if you use PPO providers, the provider will handle pre-certification for you). While there is no penalty for not pre-certifying your care, each service still will be reviewed for medical necessity. Certain restrictions may apply – for more information, see the "Additional information" section.

Plan feature	Using PPO providers	Using non-PPO providers
<p>Deductible requirements</p>	<p><i>Individual:</i></p> <ul style="list-style-type: none"> • If your date of retirement is prior to August 3, 2003, 1% of your annual pension or LTD benefit in effect as of December 31 of the previous calendar year (minimum of \$25; maximum of \$150). If you are not receiving a pension benefit, your deductible will be based on your annual base pay rate in effect for the last pay period prior to the date your coverage in this Plan took effect. • If your date of retirement is after August 2, 2003, your annual deductible is equal to the deductible you had as an active employee as of the date of your retirement (grandfathered class II and sponsored dependents also pay this). Beginning January 1, 2008, the annual deductible is \$250. <p><i>Family limit:</i> 2½ times individual deductible (applies to retiree and class I dependents only)</p> <p>If you reside outside the PPO service area, the annual deductible is \$150.</p>	
<p>Lifetime maximum</p>	<p>\$100,000 per covered individual for other covered charges. For calendar years 2009, 2010, and 2011, \$10,000 is automatically restored to the maximum for each covered person. Beginning in 2012, \$3,500 automatically is restored to the maximum for each covered person.</p>	
<p>Annual out-of-pocket maximum (Per person/family, per plan year) Does not apply to 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 Plan maximums, charges for use of a private hospital room to the extent not covered by the Plan, 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 to be not medically necessary, copayments for office visits, and expenses for prescription drugs</p>	<p>\$1,000 per covered individual (does not include deductible); no family limit</p>	

Plan feature	Using PPO providers	Using non-PPO providers
When benefits are paid	Unless otherwise noted, for non-emergency care that is medically necessary, benefits are based on the NNF and the Plan pays as follows:	Unless otherwise noted, for non-emergency care that is medically necessary, benefits are based on the R&C and the Plan pays as follows:
Inpatient hospital services		
Room, board, and ancillary services	100%	100% of actual charges after deductible, if pre-certified for up to 120 days per plan After 120 days, 80% of actual charges after deductible, if pre-certified
In-hospital physician's visits	100%	98% (no deductible)
Maternity care (physician's charges for pre/postnatal care and delivery)	100%	98% (no deductible)
Newborn baby care (initial pediatric exam while mother is hospitalized); limited to class I dependents only (i.e., newborn of unmarried dependents not covered)	100%	98% (no deductible)
Skilled nursing facilities	100%	100% (no deductible) for up to 120 days per plan year ¹ After the first 120-day limit is reached, 80%, after deductible
Pre-admission testing (to determine if hospital care is necessary)	100%	<ul style="list-style-type: none"> • Inpatient: 90%, after deductible (hospital room and board charges are not covered) • Outpatient: 100% (if billed by a hospital, no deductible)
Birth centers (facility charge)	100%	100% of actual cost after deductible, if pre-certified
Hospice care (lifetime limit of 180 days, of which no more than 60 days may be for inpatient hospice)	100%	100% (no deductible), if pre-certified

¹ To calculate the 120-day limit, each day in a hospital counts as one full day, each day in a skilled nursing facility counts as one half-day, and 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).

² After 180 days, up to an additional 45 days may be authorized, as determined by the claims administrator.

Plan feature	Using PPO providers	Using non-PPO providers
Surgery and anesthesia		
Inpatient surgery	100%	98% (no deductible)
Outpatient surgery	100%	98% (no deductible)
Anesthesia	100%	98% (no deductible)
Outpatient treatments		
Doctors' office visits	For patients not eligible for Medicare: 100% after you pay \$15 copayment For patients eligible for Medicare: 100% after you pay \$5 copayment	80% after deductible
Doctors' home visits	For patients not eligible for Medicare: 100% after you pay \$15 copayment For patients eligible for Medicare: 100% after you pay \$5 copayment	80%, after deductible
X-rays and lab tests	100%, including allergy tests	100% (deductible applies if hospital charges billed for diagnostic; no deductible for preventive), including allergy tests
Radiation therapy, chemotherapy, electroshock therapy, hemodialysis	100%	100% (no deductible)
Physical, occupational, and speech therapy (duration must be prescribed by your doctor)	80% ³ after deductible	80%, after deductible
Licensed chiropractor	80% ³ after deductible, up to \$750 per calendar year (maintenance chiropractic services not covered) ⁴	80% after deductible, up to \$750 per calendar year (maintenance chiropractic services not covered) ⁴
Private duty nursing	80%, after deductible	80%, after deductible, if pre-certified

³ Coinsurance is applied to the NNF or the actual price, if less than the NNF.

⁴ The \$750 limit does not apply to former IBEW-represented associates represented by Local 827 in New Jersey or their dependents and survivors.

Plan feature	Using PPO providers	Using non-PPO providers
Preventive care services		
Well-baby/well-child exams <i>Age 0 – 2 years as prescribed</i> <i>Age over 2 – 25: 1 exam every year; includes immunizations</i>	100%	100% (no deductible)
Adult physical exams <i>Age over 25 – 49: 1 exam every 2 years</i> <i>Age 50 and over: 1 exam every year</i>	100%	100% (no deductible)
Well-woman exam <i>One well-woman exam, every year, regardless of age and with or without a Pap test, including blood count and urinalysis</i>	100%	100% (no deductible)
Immunizations and flu shot <i>One complete regimen of immunizations and one flu vaccine annually for children and adults</i>	100%	100% (no deductible)
Fecal occult test <i>Age 18 – 39: 1 every 2 years</i> <i>Age 40 and over: 1 every year</i>	100%	100% (no deductible)
Colonoscopy or sigmoidoscopy <i>Age 50 and over: 1 every 3 years</i>	100%	100% (no deductible)
Routine mammogram <i>One annual routine mammogram for women regardless of age</i>	100%	100% (no deductible)
Prostate-specific antigen test <i>For men age 18-49: 1 every 2 years</i> <i>For men age 50 and over: 1 every year</i>	100%	100% (no deductible)
Hearing aids	100% up to \$1,000 for hearing aid (and related exam and fitting) every 24 calendar	
Home health care	100%	100% (no deductible), if pre-certified for up to 120 ¹ days per plan year After the first 120-day limit is reached, 80% after deductible, if pre-certified

⁵ Hearing aids also may be available after ear surgery (if medically necessary), when purchased within 90 days of surgery. Contact the claims administrator for more information.

Plan feature	Using PPO providers	Using non-PPO providers
Mental health/substance abuse services		
Inpatient mental health treatment	For the first 30 days of confinement, 100% of actual charges after deductible. After the first 30 days, 80%, after deductible.	
Outpatient mental health	80%, after deductible	80%, after deductible
Inpatient substance abuse treatment ^{6,7}	100% of actual charges, after deductible	100% of actual charges, after deductible
Inpatient substance abuse treatment ^{6,7}	100% of actual charges, after deductible	100% of actual charges, after deductible
Other services		
Durable medical equipment	80% ³ , after deductible	80%, after deductible
Ambulance services (in the case of emergency only)	80%, after deductible	80%, after deductible
Prosthetic devices	80% ³ , after deductible	80%, after deductible
Emergency room care (within 72 hours of injury or onset of illness and only in the case of an emergency)	You pay \$25 if a true emergency (this copayment is waived if you are admitted through the emergency room)	
Urgent care	100% after you pay \$15 copayment	

⁶ No coverage for grandfathered class II dependents and sponsored dependents.

⁷ Substance abuse treatment (for PPO and non-PPO combined) is 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.

Prescription drugs	Medical Expense Plan (MEP) PPO option: using participating pharmacy ⁸	Medical Expense Plan MEP-PPO option: using nonparticipating pharmacy
Retail pharmacy (supply appropriate for up to 30 days of therapy)		
Annual deductible	No deductible required	\$50 combined for generic and brand name
Coinsurance <ul style="list-style-type: none"> • Generic • Brand-name drugs when generic is not available • Brand-name drugs when generic is available 	You pay 15% of the discounted network price (DNP) but no more than \$25 per prescription You pay 20% of the DNP but no more than \$45 per prescription You pay 30% of the DNP but no more than \$55 per prescription	You pay 15% of the retail cost but no more than \$25 per prescription You pay 20% of the retail cost but no more than \$45 per prescription You pay 30% of the retail cost but no more than \$55 per prescription
Medco Mail Service Pharmacy (supply appropriate for up to 90 days of therapy)		
<ul style="list-style-type: none"> • Generic • Brand-name drugs when generic is not available • Brand-name drugs when generic is available 	You pay \$8 copayment or the DNP, whichever is less You pay \$17 copayment or the DNP, whichever is less You pay \$25 copayment or the DNP, whichever is less	

More information about the MEP-PPO option

The following section gives more detailed information on the MEP-PPO option.

Emergency care

Emergency care is considered a covered service or supply 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 non-emergency care, the facility charges will not be covered; physician's charges will be covered as other non-emergency care if medically necessary.

⁸ Must use your prescription program ID card at a network pharmacy to get in-network benefits. You can purchase a supply appropriate for up to 30 days of therapy through an in-network pharmacy.

Hospital room and board

When you use a PPO hospital, the Plan covers room and board in a semiprivate room at 100%, and there is no maximum on the number of days allowed per calendar year.

When you use a non-PPO hospital, the Plan covers room and board in a semiprivate room under basic benefits for a maximum of 120 days per calendar year. Beginning on the 121st day of hospital confinement during the calendar year, semiprivate room and board will be covered under other covered charges at 80% of the R&C amount. The following services also count toward the 120-day maximum:

- Confinement in a skilled nursing facility, with each day of confinement counted as one half-day of hospital confinement.
- Home health care visits, with five visits counted as one day of hospital confinement.

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, the following rules apply:

- When you use a PPO hospital, Plan benefits will be 100%.
- When you use a non-PPO hospital, 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.

Surgery

The MEP-PPO option covers medically necessary surgery. This section describes approved surgical-related procedures.

Key medical/surgical coverages

The following chart briefly highlights some of the medical/ surgical provisions for the MEP-PPO option. For details on surgery coverage, see below. For additional coverage provisions, see the “MEP-PPO option coverage summary” chart earlier in this section.

Medical/surgical treatment	Using PPO providers: pays NNF	Using non-PPO providers: pays R&C
Surgery	100%	98% (no deductible)*
Second surgical opinion	100%	100%
If performed under the outpatient surgery program	100%	100%
If performed inpatient and it was covered under the outpatient surgery program	100%, if medically necessary	80%, after deductible
In-hospital physicians' visits	100%	98% (no deductible)
Consultations	For patients not eligible for Medicare: 100% after you pay \$15 copayment For patients eligible for Medicare: 100% after you pay \$5 copayment	98% (no deductible)
Anesthesia	100%	98% (no deductible)
Maternity care (physicians' charges for pre/postnatal care and delivery)	100%	98% (no deductible)
Newborn baby care (initial pediatric exam while mother is hospitalized); limited to class I dependents only (i.e., newborn of unmarried dependents not covered)	100%	98% (no deductible)
X-rays and lab tests	100%	100%, including allergy tests
Radiation therapy, chemotherapy, electroshock therapy, hemodialysis	100%	100%

* If surgery performed by a non-PPO provider must be provided on an inpatient basis because of medical necessity, eligible services will be covered at 98% of the R&C amount.

Outpatient surgery

When you use a PPO provider, all outpatient surgical procedures as well as diagnostic X-ray, laboratory, and other associated expenses are covered at 100%, with no deductible applied.

When you use a non-PPO provider and eligible surgical procedures are performed on an outpatient basis, your benefits vary depending on whether or not the surgical procedure is covered by the outpatient surgical program:

- When the following eligible surgical procedures are performed on an outpatient basis, the Plan will pay 100% of the R&C amount for that surgery:
 - 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 some surgery).
 - Varicose vein ligation.
 - Digestive system.
 - Male genital system procedures.
 - Female genital system procedures.
 - Maternity care and delivery.
 - Eye and ocularadnexa procedures.
 - Ear surgery.

In addition, the Plan also will pay 100% of the R&C amount for diagnostic X-ray, laboratory, and other associated expenses with no deductible applied.

If you receive an outpatient surgical procedure not listed above, the non-PPO Plan will pay 98% of the R&C amount, with no deductible applied.

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

- When non-PPO providers are used, the Plan will pay 98% of the R&C amount for surgery and associated expenses with no deductible applied. The remaining 2% of the R&C amount required when non-PPO providers are used will not be considered under other covered charges and will not count toward the out-of-pocket expense maximum.
- Hospital room and board will not be considered a covered service or supply under the Plan.

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 Medical Expense Plan (MEP) PPO option, up to three consultations may be covered by the Plan, including associated X-rays and laboratory tests. (The third consultation is covered only if the second consultation does not confirm the need for surgery.) Second surgical opinion consultations provided by PPO providers are covered at 100%, while consultations from non-PPO providers are paid at 100% of the R&C amount.

If the second surgical opinion is nonconcurring, the MEP-PPO option will cover a third surgical opinion and associated diagnostic tests on the same basis as a second surgical opinion. If you receive a second or third surgical opinion, contact your health plan's member services for more information on filing claims.

Multiple procedures

The Plan will pay 100% for covered surgery performed by a PPO provider.

When performed by a non-PPO provider, the following rules will apply to 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 R&C amount.
- 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 will be treated independently, except that only one charge for use of the operating room and one charge for anesthesia will be covered under the Plan.

Use of an assistant surgeon

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

Sterilization procedures

An initial voluntary sterilization procedure or a reversal of such a procedure for a male or female covered person will be covered under the Plan, without restriction as to waiting periods, doctor's approval, etc.

Sex-change procedures

A transsexual operation will be covered under the Plan 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 shall determine medical necessity for this case.

Oral surgery

The following oral surgery is covered under the Plan:

- Oral surgery performed for the treatment of diseases, injuries, and defects of the mouth, the jaws, and associated structures.
- The 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.
- Removal of impacted teeth in a dentist's or oral surgeon's office or 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 under the Plan 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 necessity (such as cysts, carcinoma, etc.) or as otherwise provided under "Mastectomies and breast reconstruction" below.

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 considered covered services or supplies under the Plan, 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.

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.

Mental health treatment

MEP-PPO coverage for you and your eligible class I dependents includes treatment for mental health. Grandfathered class II dependents and sponsored dependents are not eligible for outpatient mental health treatment.

Inpatient mental health treatment, including physician visits and medication, will be covered as basic services for the first 30 days of a single confinement. After the first 30 days, inpatient mental health treatment is covered as other covered charges. Inpatient mental health admissions separated by fewer than 180 days will be considered a single confinement.

For outpatient mental health treatment, the Plan pays 80% of NNF after the deductible when a PPO provider is used or 80% of the R&C amount after the deductible when a non-PPO provider is used.

Covered outpatient mental health services include:

- Services rendered by a physician, a 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

MEP-PPO coverage for you and your eligible class I dependents includes treatment for substance abuse. Grandfathered class II dependents and sponsored dependents are not eligible for substance abuse treatment.

The following treatment will be covered under the Plan:

- To be covered, inpatient detoxification must be followed by rehabilitation at a state-licensed facility approved by the claims administrator.
- 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.

Benefits for PPO and non-PPO substance abuse treatment combined 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.

Note: Professional fees billed separately by private practitioners under an inpatient program are not eligible for reimbursement under the Plan. 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 requirements

If you receive your care from a PPO provider, the provider will handle any pre-certification for you. When you receive care from a non-PPO provider, as with any hospitalization, it is a good idea to pre-certify inpatient mental health and substance abuse treatment. Before receiving inpatient mental health or substance abuse treatment, you should call Aetna for pre-certification. (See your Important Benefits Contacts insert for the telephone number.)

No coverage option

You can elect no coverage under the Plan only if you have other Verizon medical coverage (i.e., coverage under a spouse's plan).

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

More information about the MCN and MEP-PPO options

The following sections give more detailed information on certain benefits provided by the Plan, regardless of whether you are in the managed care network (MCN) or the Medical Expense Plan (MEP) preferred provider organization (PPO). However, when you receive in-network care under the MCN or when you use a PPO provider under the MEP-PPO option, your provider will pre-certify your care.

The provisions described in this section generally do not apply to health maintenance organizations (HMOs). If you participate in an HMO, you should contact your HMO for more information on the HMO's provisions.

Pre-certification

Although not required, all admissions to hospitals or healthcare facilities, including inpatient hospital stays (including inpatient mental health and substance abuse treatment), hospice care, and stays in a skilled nursing facility, should be pre-certified by the claims administrator. The claims administrator will review the case and determine whether the proposed service or supply will be covered as medically necessary under the Plan. (No benefits will be paid for services and supplies found not to be medically necessary.) 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. (See "Claims and appeals procedures" in the "Additional information" section for more information.)

For the MCN:

- If you receive in-network care, your provider will handle pre-certification.
- If you receive out-of-network care, you, a family member or your physician should pre-certify your care by calling the claims administrator via the telephone number shown on your Important Benefits Contacts insert or via the pre-certification number on the back of your ID card.

For the MEP-PPO option:

- If you receive care from a PPO provider, your provider will handle pre-certification.
- If you receive care from a non-PPO provider, you, a family member or your physician should pre-certify your care by calling the claims administrator via the telephone number shown on your Important Benefits Contacts insert.

The following special pre-certification rules apply for both the MCN and the MEP-PPO options:

- Emergency admissions (including admissions for mental health 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.
- 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 the notifications for maternity admissions 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.

Concurrent review

Concurrent review is the review by the claims administrator of the covered person's condition while hospitalized to determine whether the inpatient confinement will continue to be covered as medically necessary. 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 a covered person enrolled in the MEP-PPO option is hospitalized in a PPO hospital, no further action is required on that person's part. If a covered person is hospitalized in an out-of-network facility under the MCN option, or is hospitalized in a non-PPO facility under the MEP-PPO and 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 MCN or the MEP-PPO option, 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 "Claims and appeals procedures" in the "Additional information" section 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.

Individual Case Management (ICM) Program

The ICM Program is a voluntary program designed to provide a covered person with coverage for care in the most cost-effective treatment setting, with the goal of maintaining or enhancing the quality of the covered person's life. The covered person and his or her family and physician must all be in agreement with any approved alternative healthcare setting before a plan is implemented under the ICM Program. The ICM Program does not prescribe the type of medical care to be provided – all decisions related to the type of medical care remain with the covered person and his or her family and physician.

The ICM Program is available to you and your dependents who have high costs or chronic medical conditions, such as:

- Spinal cord injury.
- High-risk neonates.
- Acute psychiatric illness.
- Long-term infections.
- Cancer.
- Stroke.
- Severe head trauma.

The ICM Program provides the following services:

- Evaluates the covered person's current healthcare setting.
- Recommends coverage of alternatives to the covered person's current healthcare setting.
- Provides for any transfer to an approved alternative healthcare setting in a timely fashion.
- Determines coverage for treatment that might otherwise not be covered under the Plan when hospitalization or more expensive healthcare treatment can be avoided.
- Coordinates with physicians on a more cost-effective administration of a covered person's physician-prescribed care.

If you or your dependents qualify for the ICM Program, you will be identified through the pre-certification process. In addition, you or your doctor can contact the claims administrator to request participation in the ICM Program. Contact the claims administrator for more information.

The disease management program

In addition to the ICM Program, there is a separate voluntary disease management program for covered persons with asthma, diabetes or cardiac care. The program offers disease assessment, educational materials, and access to a nurse for consultation 24 hours a day. For more information, contact the Health Management Corporation.

National Medical Excellence Network

You or your covered dependents who need a high-risk procedure may elect to use one of the hospitals included in the National Medical Excellence Network established by the claims administrator. High-risk procedures include organ or bone marrow transplants and other procedures, as determined by the claims administrator. Plan benefits for the hospitalization and transplant procedure shall be determined in the same way, regardless of whether a National Medical Excellence Network facility is used for the transplant. In addition, when a transplant procedure is performed at a designated National Medical Excellence Network facility, the Plan will pay reasonable travel and accommodation expenses (up to \$10,000) for the covered person and one companion.

Preventive care

To keep you well and help you avoid more serious medical problems in the future, both the MCN and MEP-PPO options cover certain preventive care services. See the “MCN coverage summary” chart and the “MEP-PPO option coverage summary” chart for covered services.

Maternity and newborn care

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.

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.

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.

The following maternity care services are covered under the Plan:

- Antepartum care, including prenatal services (such as initial and subsequent history, physical exams, routine urinalysis, 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 NNF for the MCN [in-network], 80% of the R&C after the deductible for the MCN [out-of-network] or 100% of the NNF for the MEP-PPO option when a PPO facility is used, or 100% of actual charges after the deductible when a non-PPO facility is used).
- One pediatric examination of the eligible newborn child while the mother is hospitalized.
- Circumcision of the eligible newborn child.

Reproductive and fertility treatments

Under the MEP-PPO option (when either a PPO provider or non-PPO provider is used) and the MCN (in-network only), you or your covered spouse (or same-sex domestic partner) are covered for advanced reproductive technologies. Advanced reproductive technologies (ART) and fertility treatments are those medical procedures, treatments, and prescriptions used to assist in reproduction (such as approved forms of in vitro fertilization, GIFT, ZIFT, and artificial insemination), which are approved by the treating MEP-PPO option or MCN (in-network) physician and which are pre-authorized by the claims administrator as being medically appropriate for individuals in similar circumstances. ART procedures are covered under the MEP-PPO option or MCN (in-network only) if you or your spouse or same-sex domestic partner has a diagnosis of infertility.

You must contact the claims administrator for authorization to receive any benefits for this care. Coverage is limited to a lifetime family maximum of \$20,000 (prescription drugs associated with this provision will count toward the lifetime family maximum).

The following procedures are excluded from coverage:

- Procedures performed or services provided out-of-network under the MCN.
- Procedures when you and/or your spouse or same-sex domestic partner has had a previous sterilization procedure, with or without surgical reversal.
- Charges incurred by your spouse or same-sex domestic partner who is not covered by the MEP-PPO option or MCN option.
- Charges for a surrogate parent.

Hospital

In-hospital visits

In-hospital visits will be covered if provided during a covered confinement for the treatment of a condition not related to routine maternity care. Covered visits are limited to one visit by a physician per day, per specialty.

Under the MEP-PPO option, covered in-hospital visits are considered basic benefits, except in-hospital visits by a physician after the first visit each day will be considered other covered charges.

Visits for the purposes of customary pre- and postoperative care will not be considered covered services or supplies under the Plan.

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, a referral, which means the transfer of a patient from one physician to another for definitive treatment, will not be considered a consultation under the Plan, and staff consultations required by hospital rules or regulations will not be covered. Plan benefits payable for in-hospital consultations will not include reimbursement for travel expenses or loss of income.

Under the MEP-PPO option, covered in-hospital consultations are considered basic benefits.

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 considered a covered service or supply under the Plan, provided the following conditions are met:

- The tests are necessary and consistent with the diagnosis and treatment of the condition.
- The covered person is physically 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.

Home health care services

Note: When non-PPO providers are used, under the MEP-PPO option, these covered home health care charges are considered basic benefits until the 120-day hospital maximum per plan year has been reached; then, these charges are considered other covered charges.

The following home health care services and supplies are considered 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 ambulance service that would normally be rendered without 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 nonskilled 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 rehospitalization of the covered person would be required.
- Therapeutic and diagnostic services, including diagnostic X-rays, and laboratory, and pathology exams that would be considered covered if provided to the covered person while a hospital inpatient, but that 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 dietician, subject to approval of the claims administrator.
- Rental or purchase (if the purchase price is less than the 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.

In addition, covered services and supplies will include one visit per week by the attending physician during a covered person's approved home health care admission, unless additional visits are determined to be medically necessary by the claims administrator; visits by the attending physician will be covered even if billed for directly by the attending physician.

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. The claims administrator may authorize additional home health care for up to 30 days at a time. The claims administrator may request any information deemed necessary in its review of a proposed treatment plan or an extension of such a plan. 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 a verbal authorization and must commence within 72 hours of the covered person's discharge from the hospital.
- 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 of home health care treatment.

The following home health care services are **not** considered covered under the Plan:

- 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 facility services

Note: When non-PPO providers are used, under the MEP-PPO option, these covered skilled nursing facility charges are considered basic benefits until the 120-day hospital maximum per plan year has been reached; then, these charges are considered other covered charges.

The following services and supplies are covered under the Plan, provided they are medically necessary and billed for by a skilled nursing facility:

- Semiprivate 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 occur within 14 days of a prior hospital stay of at least three days, and the admission must be for the continued treatment of the same illness or injury for which the covered person was in the same hospital. In addition, admission to a skilled nursing facility must be approved in advance by the claims administrator. Physicians' medical visits in a skilled nursing facility are limited to one per day. The following skilled nursing facility services are not considered covered under the Plan:

- 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.

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 also will 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.

Prescription drug program

Your prescription coverage includes:

- A retail prescription benefit.
- A mail-order benefit.

This program is self-funded by Verizon Communications Inc. The retail and mail-order prescription benefit is administered by Medco. Medco works with Liberty Medical to dispense Medicare Part B prescriptions by mail. (Orders are assigned to Liberty Medical after being placed with Medco.)

Retail prescription benefit

You can get up to a 30-day supply of medication at a retail pharmacy. It is your decision to use either a participating or non-participating pharmacy each time you need short-term medications.

Using a participating pharmacy

When you use a participating pharmacy, you pay:

- For a generic drug, you'll pay 15% (but not more than \$25) of the discounted network price (DNP) for each prescription drug.
- For a brand-name drug when a generic is not available, you'll pay 20% of the DNP (but not more than \$45) per prescription.
- For a brand-name drug when a generic is available, you'll pay 30% of the DNP (but not more than \$55) per prescription.

The DNP is a negotiated price, which generally is lower than the retail price of the drug. To ensure you receive the discounted price, you will need to show your ID card at the time of purchase.

If your doctor prescribes more than a 30-day supply, the maximums do not apply and you are responsible for the cost of the additional supply.

You pay your share of the bill at the pharmacy, so you do not need to file a claim form.

Using a retail non-participating pharmacy

When you use a non-participating pharmacy, you pay an annual \$50 per person prescription deductible.

You will then be reimbursed at the same percentages as in-network prescriptions, but based on the retail cost of the drug, so your costs could be much higher.

You pay the full bill at the pharmacy and file a claim for reimbursement.

Mail-order benefit

You can obtain up to a 90-day supply of medication delivered to your home by mail, as follows:

- For a generic drug, you'll pay \$8 or the DNP, whichever is less, for each prescription drug.
- For a brand-name drug when a generic is not available, you'll pay \$17 or the DNP, whichever is less, per prescription.
- For a brand-name drug when a generic is available, you'll pay \$25 or the DNP, whichever is less, per prescription.

There is no deductible for mail-order prescriptions.

Initial orders

There are three ways to order a prescription by mail:

- Access Medco's Web site and follow the instructions to order a new prescription. Your prescription will be filled by Medco or Liberty Medical, as appropriate.
- Send your original prescription and your payment to Medco using an order envelope.
- Have your doctor call 1-888-EASYRX1 (1-888-327-9791) for instructions on faxing the prescription.

Your prescription will be sent to your home by United States Postal Service mail or UPS within 14 days of the date that you mailed the prescription to Medco.

If you can't wait two weeks to receive your medication, ask your physician to write two prescriptions – one that you can use at your local pharmacy and one for your ongoing supply that you can use for the home delivery pharmacy.

Refills

There are three ways to order refills:

- Access Medco's Web site and follow the instructions for refilling prescriptions.
- Call Medco at the number listed on your Important Benefits Contacts insert.
- Mail your payment to Medco using an order envelope.

What is covered

The prescription program covers the following items. If you have questions about covered charges, you should contact Medco. See your Important Benefits Contacts insert for contact information.

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

Medically necessary means appropriate with regard to general medical standards and effective in prevention, diagnosis or treatment according to accepted clinical evidence, as determined by the claims administrator.

- Biologicals, immunization agents, and vaccines.

- Allergy sera, at a retail pharmacy.

- Diabetes therapy.

- Insulin needles and syringes.

- Diabetic kits (insulin, apparatus, and supplies), available through Medco. 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 is made too soon, 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.

- Medications with special considerations. Some medications in the following treatment categories have limitations or considerations for age, gender or supply amounts.

- Premenstrual conditions.

- Asthma.

- Erectile dysfunction.

- Acne.

- Flu prevention and treatment.

- Irritable bowel syndrome.

- Contraceptives.

- Cancer.

- Pulmonary arterial hypertension.

- Hormone replacement.

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 through mail order.

Generic medications

Generic prescription drugs have the same chemical makeup, but usually cost 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.

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 prescription claims" section for more information.

Medications that require a coverage review

Certain medications must undergo a coverage review before they are covered under the prescription program.

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 a coverage review, call Medco. For faster approval or if you or your doctor has a question, you or your doctor can contact the Medco coverage review unit (see your Important Benefits Contacts insert for contact information). Usually, 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.

Examples of drugs subject to a coverage review include those in the categories listed below. The list changes from time to time as new drugs are approved, new clinical guidelines for appropriate use are developed or problems are identified.

- Acne therapy.
- Alzheimer's therapy.
- Antidepressants (Prozac weekly).
- Appetite suppressants and other weight loss medications.
- Diabetes medications (Glucophage XR).
- Erectile dysfunction medications.
- Erythroid stimulants (correct anemia in patients with dialysis, HIV, etc.).
- Hepatitis C.
- Human growth hormones.
- Interferons (treat immune disorders and infections).
- Miscellaneous dermatologicals.
- Myeloid stimulants (fight infection and treat low white-blood cell counts).
- Platelet proliferation stimulants.

Quantity dispensing limits

Some medications are limited to specific quantities, such as the number of pills or total dosage. The quantity is based on guidelines approved by the U.S. Food and Drug Administration and published by the manufacturer, as well as accepted medical practice. If your medication is prescribed for quantities or doses outside these guidelines, a coverage review may be required to determine whether the medication meets the Plan's coverage criteria.

When a review is complete, Medco will notify you and your doctor of the decision. If coverage is approved, the letter will inform you of the length of time of your coverage approval. If the medication is not covered under the Plan, the letter will include the reason for the denial and how to submit an appeal if you choose.

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

- Cholesterol medications (Crestor).
- Anti-influenza agents.
- Erectile dysfunction agents.

- Migraine medications.
- Proton pump inhibitors.

Medicare Part B medications and supplies

Certain prescriptions are eligible for coverage by both Medicare Part B and your Verizon prescription benefit.

Retail prescription coverage

You need to show your Medicare ID card when you use a retail pharmacy. If your prescription is eligible for Medicare Part B coverage, after you meet the Medicare Part B deductible, the retail pharmacy will bill Medicare and submit any costs not paid by Medicare to Medco for coverage under your Verizon prescription benefit. You will not need to take any additional action other than show your Medicare ID card. **Your out-of-pocket cost will not be any more than it would have been under the current process.**

Mail-order prescription coverage

You will continue to order your initial prescriptions in the same way you do today. If your prescription is eligible for Medicare Part B coverage, after you meet the Medicare Part B deductible, Medco will transfer your prescription request to Liberty Medical, a mail-order pharmacy that specializes in Medicare Part B. Liberty will provide you with instructions on how to order refills if you need them. **Your out-of-pocket cost will not be any more than it is today.**

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 or pregnancy, except those identified under "What is covered."
- Therapeutic devices, bandages, heat lamps, braces or artificial appliances. However, the Plan may cover 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.
- Charges for the administration or injection of any drug.
- 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.
- Blood or blood plasma.¹
- Medication you receive in a hospital or outpatient surgical center.^{1, 2}
- Medication you receive while you are a patient in a skilled nursing facility or similar institution when medications provided by those institutions are covered by a medical plan, including Medicare.^{1, 2}
- Prescriptions refilled in excess of the number of times the doctor specified or any refill dispensed after one year from the doctor’s original order.
- Mifeprex, for termination of intrauterine pregnancy.
- Over-the-counter (OTC) contraceptives, jellies, creams, foams, and devices.
- Ostomy supplies.

Filing prescription claims

If you use a participating retail pharmacy or mail order, you do not have to file claims. You need to show your ID card when you use a participating retail pharmacy.

If you use a non-participating retail pharmacy, you need to submit claims to Medco.

If your claim is denied, you have a right to appeal. See the “If a benefit is denied” section for information on filing an appeal.

Claims for compound medications

There are two ways to submit claims for compound medications:

- Take the prescription to a participating retail pharmacy, and ask the pharmacist to submit the claim directly to Medco so that you only need to make your copayment at the time of service. If you use mail order, no claims need to be submitted. Please note, however, that mail-order pharmacies can fill only certain prescriptions for compound medications. Contact Medco to determine which medications can be filled. See your Important Benefits Contacts insert for contact information.

¹ May be covered under the Verizon Medical Plan. Claims should be submitted to the appropriate claims administrator.

² Medications administered while you are an inpatient at a hospital, skilled nursing care facility or similar facility generally are covered under your medical option – not the prescription program. However, prescriptions filled at a pharmacy associated with a personal care facility, such as a nursing home, are covered under the prescription program. Benefits are based on whether the retail pharmacy is a participating or non-participating pharmacy.

- If you paid the entire cost of your compound medication, you will need to submit a claim form to Medco to receive reimbursement.

You must send in your pharmacy receipt, as well as a list of all the ingredients in the medication and each ingredient's National Drug Code (NDC), which your pharmacist can provide. (See the claim form for details.)

If you submit a claim, you will be responsible for any cost differences between what the pharmacy charges and what the Plan allows for reimbursement.

If your claim is denied, you have a right to appeal.

Other covered medical services and supplies

Call member services for information on other covered services and supplies, including:

- Ambulance services (surface transportation only).

Note: Air transportation or other transportation in lieu of an ambulance also may be considered a covered service or supply by the claims administrator (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.

Under the MEP-PPO option, these covered services are considered other covered charges.

- Anesthesia. However, anesthesia and its administration is **not** considered a covered service or supply in the following cases:

— 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.

Under the MEP-PPO option, covered anesthesia and one in-hospital visit by an anesthesiologist per day of confinement are considered basic benefits. Covered in-hospital visits by an anesthesiologist in excess of one per day will be considered other covered charges.

- 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).

Under the MEP-PPO option, blood and blood derivatives, when covered as described above, are considered other covered charges.

- Chiropractic care.

Under the MEP-PPO option, chiropractic care is considered other covered charges.

- Diagnostic X-rays and laboratory tests. The following special coverage rules apply:
 - Allergy tests are considered covered services and supplies.
 - When covered X-rays and laboratory tests are hospital-billed, they are subject to the deductible, if applicable.
 - Benefits for diagnostic tests in connection with covered chiropractic care will be covered as any other diagnostic test covered under the Plan. However, these tests will be counted against the chiropractic care maximum.

Under the MEP-PPO option, diagnostic X-rays and laboratory tests, when covered as described above, are considered basic benefits.

- Durable medical equipment. The rental of durable medical or surgical equipment when prescribed by a physician for treatment of a diagnosed medical condition. Surgical stockings prescribed by a physician are covered; however, reimbursement is limited to four pairs per covered person, per plan year.

The following replacements are not covered under the Plan:

- 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.

Under the MEP-PPO option, durable medical equipment, when covered as described above, is considered other covered charges.

- Eyeglasses and hearing aids. An initial pair of lenses after eye surgery or an initial hearing aid following ear surgery will be covered if purchased within 90 days of the surgery.

Under the MEP-PPO option, eyeglasses and hearing aids, when covered as described above, are considered other covered charges.

- Obesity treatments.

Under the MEP-PPO option (using either PPO or non-PPO providers) and MCN (in-network only), you will be covered for medically necessary treatment of clinical (morbid) obesity and prescription appetite suppressants when pre-authorized by the claims administrator. Coverage includes medically necessary nutritional counseling when prescribed by a physician and furnished by a licensed dietician or nutritionist, for conditions for which dietary adjustment has a therapeutic role, up to \$500 each year.

Note: Under the MEP-PPO option, the type of service associated with covered obesity treatment (hospital charges, physician's charges, laboratory charges, etc.) determines whether the treatment is covered as basic or as an other covered charge. Contact the claims administrator for more information.

- Physical, speech, and occupational therapies. Physical, speech or occupational therapy is covered only to the extent necessary to restore function lost due to illness or injury and only if the duration of therapy has been prescribed by a doctor.

Under the MEP-PPO option, these therapies, when covered as described above, are considered other covered charges.

- Private duty nursing.

Under the MEP-PPO option, private duty nursing is considered other covered charges.

- Prostheses. 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 that the claims administrator determines to still be functional or able to be repaired will **not** be covered by the Plan.

Under the MEP-PPO option, prostheses, when covered as described above, are considered other covered charges.

- Wigs or hairpieces (synthetic, human hair or blended) prescribed by a physician for hair loss in conjunction with injury, disease or treatment of a disease as determined by the claims administrator. The Plan covers one wig per calendar year, up to a maximum of \$300 per wig. You must pre-certify the purchase and use a participating provider, if applicable. Wigs and hairpieces are not covered for male or female pattern baldness, natural or premature aging, physiological conditions, or any other condition that is not considered to be a medical disorder. Wig styling is not covered by the Plan.

Under the MEP-PPO option, wigs or hairpieces, when covered as described above, are considered other covered charges.

- Therapy (such as radiation therapy, chemotherapy, and electroshock therapy).

Under the MEP-PPO option, these therapies are considered basic benefits.

- Cardiac rehabilitation treatment. Treatment under a cardiac rehabilitation program is covered for:

— 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.

Treatment under a cardiac rehabilitation program must be approved in advance by the claims administrator.

Medical expenses not covered

The following are some of the expenses that the Plan does not cover. 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 that are not medically necessary.
- 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.
- 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.

- 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 when determined to be medically necessary by the claims administrator.
- Removal of impacted teeth, if hospitalization is medically necessary.
- Hospitalization that is primarily for physical therapy, or speech therapy that could have been provided on an outpatient basis.
- Hospitalization that is primarily 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.
- Hospitalization for surgery when that surgery is not medically necessary.
- Facility charges for use of an emergency room for non-emergency care.
- 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, nursing home, half-way house or hotel.
- Acupuncture when used for therapeutic purposes.
- Diagnostic X-rays, 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.
- Reproductive and fertility treatment, unless approved by your doctor and pre-authorized by the claims administrator as medically appropriate for the individual's circumstances (see "Reproductive and fertility treatments" earlier in this section for covered services). (Services are not covered out-of-network under the MCN.) Services not covered are the financial responsibility of the patient.
- Services or supplies related to weight control (even if prescribed by a physician), with the exception of covered obesity treatment, as described earlier in this section.

- Services or supplies that are determined by the claims administrator to be not 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 administrator 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.
- Preventive care services beyond regular scheduled Plan benefits.
- 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 “standby” 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.
- 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, except as specifically provided under the Plan (see the “MCN coverage summary” chart and the “MEP-PPO option coverage summary” chart).
- Routine foot care (such as removal of corns and calluses [except in connection with diabetes], orthopedic shoes, insoles, and arch supports), except custom molded orthotics, when determined to be medically necessary by the Plan administrator.
- 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 “Prescription drug program” earlier in this section) 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.
- 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.
- Miscellaneous equipment, including:
 - 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.
 - Handrails.
 - 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.
- Wigs, except as specifically provided under the Plan.

Other exclusions

- Charges in excess of the R&C charge 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 patients at any time they are not covered by the Plan are the financial responsibility of patients.
- 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.
 - The removal of impacted teeth in a dentist's or oral surgeon's office or when use of a hospital or ambulatory surgical facility is medically necessary, as determined by the claims administrator.
- Items that are considered capital improvements to the home, such as electrical wiring and plumbing.

When you become eligible for Medicare

Once you're eligible for Medicare, it is your primary plan – the plan that pays benefits first, before Verizon coverage. Because Verizon medical benefits are handled differently if you or your dependents are eligible for Medicare, it's important to review this section carefully.

General information about Medicare

You become eligible for Medicare when you reach age 65 (or before age 65 under certain circumstances, such as disability). Medicare is a government-funded program that provides you with basic medical coverage.

Medicare is made up of two parts: Part A and Part B.

- **Part A** covers hospitalization and similar services. If you are receiving social security benefits when you turn age 65, you are automatically enrolled in Part A. If you are age 65 or close to age 65 and have not begun receiving social security benefits, you must apply for Part A. (If you're not applying for social security benefits, you can enroll separately in Medicare benefits.)
- **Part B** covers outpatient and doctors' visits, as well as many other services. You pay a monthly premium for Medicare Part B, which will be deducted from your social security check.

You can enroll in Medicare during a seven-month period that begins three months before and ends three months after the month in which you reach age 65. Medicare Part B is optional, and you can disenroll, if you wish. **However, you should enroll in Part B coverage because your Verizon plan will determine benefits assuming that you do have Medicare Part B coverage and you have received your Part B benefits. Your Verizon plan then pays any remaining balance up to the Plan maximum, so the total amount paid does not exceed the amount the Verizon plan would have paid on its own. If you are not enrolled in Medicare Parts A and B, you may not receive the maximum amount of benefits you may be entitled to receive.**

The following chart shows what Medicare Parts A and B cover:

Part A	Part B
Inpatient hospitals	Physicians' services
Posthospital skilled nursing facilities	Outpatient hospital services
Home health care	Diagnostic X-rays and lab tests
Hospice care	Other outpatient services

Under both Part A and Part B, you have a deductible to meet and copayments to make. These amounts change each year. In addition, from time to time, the government changes the services and supplies covered under Medicare.

Reimbursement of Medicare premiums

The Plan will reimburse a portion of the required Medicare Part B premium for retirees eligible for a service or disability pension, your spouse, and eligible disabled class I dependents, provided that:

- The individual for whom reimbursement is paid is enrolled in Medicare Part B.
- Medicare is primary coverage for the individual for whom reimbursement is paid.

Your spouse and eligible disabled class I dependents also are eligible for the reimbursement during the 12-month period of coverage following your death.

Medicare and the coordination of benefits

The rules for coordination of benefits (COB) when a retiree or dependent is covered by more than one medical plan are described in the “Coordination of benefits” section. However, for covered persons eligible for or entitled to Medicare, the Plan is automatically considered the primary plan and Medicare is secondary with respect to the following persons entitled to Medicare:

- A covered person who is eligible for or entitled to Medicare because of end-stage renal disease. In this case, Medicare will be the secondary plan and the Verizon-sponsored medical plan will be primary for the first 30 months of Medicare entitlement. After the first 30 months of Medicare entitlement because of end-stage renal disease, Medicare will become the primary plan and the Verizon-sponsored medical plan will become secondary.
- For all other persons entitled to Medicare, Medicare is primary and the Verizon-sponsored medical plan is the secondary plan. Benefits are coordinated as follows:
 - The Verizon-sponsored medical plan determines the benefit amount it would pay if there were no other coverage, and then subtracts any benefits payable under Medicare.
 - The Verizon-sponsored medical plan takes into account the benefits you are or would be eligible to receive from both Medicare Parts A and B.

Note: When covered persons eligible for or entitled to Medicare also are covered under a Verizon medical plan for active employees, or an active employee plan through a spouse’s/ same-sex domestic partner’s employer, the active employee plan is considered the primary plan and Medicare is secondary, until the active employee coverage is no longer available.

Coordination of benefits

How coordination works

If you or your eligible dependent is covered by more than one medical plan, special rules apply for determining who pays benefits first (the primary plan) and how benefits are determined when another plan is secondary (pays benefits after the primary plan). This section describes these rules.

The coordination of benefits (COB) feature eliminates duplicate payments for the same service when you or your dependents are covered by more than one medical plan. When benefits coordinate, one plan will pay benefits first (the primary plan), another second (the secondary plan), and so on. This section does not apply to benefits payable under the prescription drug program.

When the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Post-1989 Associate Retirees (the Plan) is primary, it pays benefits up to the limits described in this summary plan description (SPD). When the Plan is secondary, the claims administrator for this Plan subtracts the primary plan's payment from the actual amount charged. The Plan's secondary payment and the primary plan's payment, added together, will never exceed the amount of actual charges (100%). (Under the managed care network [MCN] or MEP preferred provider organization [PPO], benefits for covered services or supplies received on an in-network basis or from a PPO provider will not exceed the applicable network negotiated fee [NNF].) The Verizon claims administrator pays the lesser of what would have been paid if the Plan was primary, or the difference between the actual charge and amount paid by the primary plan. If you have coverage through a health maintenance organization (HMO), the reasonable cash value of each service provided under your coverage will be deemed the benefit paid for purposes of the COB provisions of the Plan.

Priority of payment

Under the Plan's COB provisions, the order of payment is as follows:

- A plan that covers a patient as an active, inactive or former associate pays before a plan that covers the patient as a dependent.
- For a dependent child, Verizon uses the "birthday rule." This means that if a child is covered by both parents' group medical coverage, the parent whose birthday falls first during the calendar year pays benefits first. So, if the mother's birthday is April 27 and the father's birthday is October 23, the mother's plan pays benefits first. The parents' age has no effect on whose plan pays benefits first. If, however, the plan covering the parent who is not a plan participant does not use the birthday rule, that plan (not this Plan) pays benefits first.
- In the case of a divorce or separation, the plan of the parent with court-ordered financial responsibility for the dependent child pays benefits for the child first. If there is no court order establishing financial responsibility or if both parents have joint legal custody, the plan of the parent with physical custody of the child pays first. If the court order provides they have joint physical custody, the birthday rule applies.

Note: If both parents elect coverage under a Verizon-sponsored medical plan, their child can be covered under only one parent's plan.

When the previous rules do not establish an order of benefit determination, the plan that covers the person as an active employee is the primary plan, and the plan that covers the person as an inactive or former associate is the secondary plan. If this rule does not establish an order of benefit determination, the plan that has covered the person for the longer period of time is the primary plan, and the plan that has covered the person for the shorter period of time is the secondary plan.

A plan that does not have a COB feature is considered the primary plan.

See “Medicare and the coordination of benefits” in the “When you become eligible for Medicare” section for information for those eligible for Medicare.

Subrogation and third-party reimbursement

If you recover any charges for covered expenses from a third party (for example, as a result of a lawsuit from an automobile accident), the Plan’s provision for subrogation and reimbursement takes effect. Under these procedures, the claims administrator’s subrogation vendor tries to recover money that has been paid (or should be paid) on behalf of a third party (the other driver, in this example) whose negligence or wrongful actions caused illness or injury to a Plan participant. In this example of a car accident, should the Plan provide benefits because of your accident, the Plan has the right to recover the amount of those benefits from the negligent person or by obtaining a reimbursement from that person’s insurance company – or from you if settlement amounts have been paid to you by the negligent person or his or her insurer.

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.

The subrogation and reimbursement provisions also mean that if you make a liability claim against a third party after you have received benefits from the Plan, you must include the amount of those benefits as part of the damages you claim. If the claim proceeds to a settlement or judgment in your favor, you must reimburse the Plan for the benefits you received. You and your dependents must grant a lien to the Plan and you and your dependents must assign to the Plan any benefits received under any insurance policies or other coverages. As a condition of eligibility for benefits, you and your dependents must agree to cooperate with the claims administrator’s subrogation vendor in carrying out the Plan’s subrogation and reimbursement rights. Cooperation means you must respond promptly and fully with inquiries from the claims administrator’s subrogation vendor and take what action the claims administrator’s subrogation vendor requests to help recover the value of benefits provided under the Plan. If you don’t, any amounts which could have been recovered through subrogation may be deducted from future Plan payments. In any case, Verizon will require payment from you only for amounts recovered that are net of your legal costs related to the action.

The covered person must sign any documents requested by the Plan to enable the Plan to exercise its rights under this provision.

The Plan is not responsible for your legal costs.

Right of recovery

If, for any reason, the Plan pays a benefit that is larger than the amount allowed, the claims administrator has a right to recover the excess amount from the person or agency who received it. The person receiving benefits must produce any instruments or papers necessary to ensure this right of recovery.

Health maintenance organizations (HMOs) and Medicare HMOs

As an alternative to the managed care network (MCN) and MEP preferred provider organization (PPO) options, you may elect to join an HMO. 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.

How HMOs typically work

When you join an HMO, all your care generally 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're 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 Plan's coverage provisions. Upon request, you'll 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.

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. Contact the Verizon Benefits Center for additional information and eligibility restrictions.

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.

Supplemental behavioral health benefits

The company has designated a special administrator, currently 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.

Your costs

Generally, all you pay for care in an HMO is a copayment of \$15 (no more than \$50 for emergency room, which is waived if admitted) each time you receive care. However, there is a \$150 per admission hospital copayment. Most 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 most non-Medicare HMOs

Prescription drug coverage for most Verizon-sponsored non-Medicare HMOs is provided by Medco – instead of by the HMOs. The health plan comparison charts you receive at the time you choose your health plan will indicate whether or not Medco is your prescription drug provider.

The Medco prescription drug program

The Medco prescription drug program for non-Medicare HMOs is the same as that for the MCN and MEP-PPO options. See "Prescription drug program" in the "More information about the MCN and MEP-PPO options" section for details of the program.

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). 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 only pay a small copayment or none. 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 (formerly Medicare+Choice) service area. A Medicare Advantage HMO is approved by the Centers for Medicare & Medicaid Services, a division of the Social Security Administration, 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 HMOs.** This type of option is offered to you only if you live outside the Medicare Advantage service areas. A Medicare Supplemental HMO typically **coordinates** with original Medicare. If you're 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; 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.

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 option that is not a Medicare HMO.

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 Managed Care Network and Medical Expense Plan for Mid-Atlantic Post-1989 Associate Retirees and ordinary Medicare.

There are no special enrollment or disenrollment guidelines for a Medicare Supplemental HMO. If you are enrolling yourself or your dependent in a Medicare Advantage HMO for the first time, an HMO enrollment form must be completed for yourself and each Medicare-eligible dependent. If you or a dependent are disenrolling from a Medicare Advantage HMO, an HMO disenrollment form must be completed for yourself and each Medicare-eligible dependent. Your election will not be effective immediately, but 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 option.

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.

How to enroll

When enrolling in a Medicare HMO, you may enroll via Your Benefits Resources Web site or by calling the Verizon Benefits Center and speaking with a representative.

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 is Medicare-eligible, the following rules apply:

- Your Medicare-eligible family members must all select the same option.
- All family members who are not Medicare-eligible must select the same option.

Note: If you choose to elect no coverage if you have other Verizon medical coverage (i.e., coverage under a spouse's plan), your family members also must elect no coverage.

Changes to HMO options

The HMO benefits design, administrators, and service areas may change from time to time. However, any changes will be made in correspondence with the benefits renewal period. Review your health plan comparison charts you receive during benefits renewal for any Plan changes.

Other benefits

The benefits described in this section are provided without regard to the medical option you choose. Eligibility rules are described below.

The bounty program

The bounty program is a cost-containment program that rewards covered persons for helping the claims administrator recover amounts that were billed improperly by healthcare providers.

Eligibility

The bounty program is available to all retirees and their dependents.

Program requirements

Under the program, a covered person will receive 50% of the amount that was overpaid by the Plan, but not more than \$1,000 for each provider's bill as long as the charge meets the following requirements:

- The charge must be incurred by the retiree or one of his or her dependents enrolled in the managed care network (MCN) or the Medical Expense Plan (MEP) preferred provider organization (PPO) option.
- The charge must have been assigned to the provider by the covered person and the covered person's provider must have submitted a claim for the charge directly to the claims administrator.

The covered person must:

- Report the erroneous charge(s) to the claims administrator within 30 days after payment of the claim.
- Obtain corrected bills from the provider.
- Submit a copy of the original bill (identifying the errors) and a copy of the corrected bill.

Excluded charges or errors

A payment will not be paid under the bounty program if one or more of the following situations occur:

- The covered person's provider submits the claim to the claims administrator.
- The error is the result of incorrect processing by the claims administrator.
- The claim is a duplicate of a previously processed claim.
- The claim is for an occupational injury covered by Workers' Compensation.
- The provider corrects the bill before the covered person contacts the claims administrator.

- Medicare has made payment on the claim.
- The Plan is not the primary payer of the claim.
- The charge was made by a health maintenance organization (HMO).

Reimbursement of Medicare premiums

Medicare Part B reimbursement of \$29.90 per month is available to retired associates eligible for a service or disability pension, enrolled spouses, and eligible disabled class I dependents. To qualify for reimbursement, Medicare must be your primary plan (as defined in the “When you become eligible for Medicare” section). Contact the Verizon Benefits Center for more information.

Laser vision correction (LASIK) discount

If you enroll in a medical coverage option, you and your covered dependents will have access to a discounted LASIK network through Davis Vision, Inc. You pay the full cost of any service, but you’ll be charged a reduced rate. For additional information, contact Davis Vision directly. Amounts paid by an individual for LASIK services do not count against Plan deductibles or out-of-pocket expense maximums.

Continuing coverage if eligibility ends

Generally, your coverage or a dependent's coverage will end when your eligibility or a dependent's eligibility for the Plan ends. In some circumstances, however, coverage can be continued for a period of time if you agree to pay the cost.

Continuation of coverage under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments provides special rules that allow you and your eligible dependents (qualified beneficiaries) to continue coverage for a period of time after coverage would otherwise end. Special COBRA rules would apply if Verizon were ever to become bankrupt. For more information, contact the Plan administrator.

Eligible dependents include your spouse or same-sex domestic partner and children covered at the time coverage would otherwise end. **Note:** Same-sex domestic partners and children of same-sex domestic partners are not included under COBRA rules, but Verizon has chosen to extend COBRA-like coverage to same-sex domestic partners and children of same-sex domestic partners in the same manner as an eligible covered spouse and children. Also, if you have or adopt a child or if a child is placed with you for adoption during the continuation period, you can add coverage for that child who then will become a qualified beneficiary. During the continuation period, you or your dependent must pay the full cost of the coverage on an after-tax basis, plus a 2% administrative charge.

Coverage continuation is available in the following situations:

- **If you, your covered spouse or same-sex domestic partner, or dependent child loses coverage under the Plan, or 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.
- **If your covered spouse or same-sex domestic partner or dependent child becomes ineligible for coverage** under the Plan because you become legally separated or divorced, your same-sex domestic partnership ends, or you die, your spouse or same-sex domestic partner or children will have the opportunity to continue coverage for up to **36 months from the date coverage would otherwise have ended.**
- **If your covered dependent child becomes ineligible for coverage** under the Plan because of that child's age, loss of student status or marriage, your dependent child can continue Verizon coverage for up to **36 months from the date coverage would otherwise have ended.**
- **If your covered dependent loses coverage** under the Plan because you elect to be covered by Medicare, your dependents can continue coverage for up to **36 months from the date coverage would otherwise have ended.**

This 36-month period will run concurrent with (not in addition to) any period of continuation coverage provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Note: If the company's medical coverage changes during the period that your spouse or your dependents are continuing coverage under your Plan, the changes apply to their COBRA coverage as well.

Notification requirements

To be eligible for COBRA continuation coverage, you or a dependent must notify the Verizon Benefits Center within 60 days from the later of the date of the event that causes your dependent to lose coverage or the date coverage ends. Your dependent also has 60 days to make a decision as to whether he or she will elect continued coverage. This 60-day period begins on the later of the date that coverage ends or the date the written notice of the right to continue coverage is provided to your dependent. If he or she elects continued coverage, that coverage will be effective on the date that prior coverage ended.

It is your responsibility to notify the company **within 60 days** when a spouse or dependent child becomes ineligible for coverage, so he or she can receive information about continued coverage opportunities.

Paying for continued coverage

Your dependent or someone on his or her behalf has 45 days from the date of your election to continue coverage under COBRA to make the first payment. The first payment will include payment for coverage prior to the date of the election. Payments will be due regularly thereafter. If your dependent fails to make a required payment, coverage will end 30 days after the required payment was due but not paid.

How continued coverage could end

Continued coverage will end for your dependents on the date the earliest of these situations occur:

- The period of continued coverage expires.
- The Plan is terminated by the company.
- You or your dependent does not make the required monthly payments on a timely basis.
- You or your dependent becomes eligible for coverage under another group medical plan (for example, a new employer) after electing COBRA, unless the new plan has a pre-existing condition limitation or exclusion that applies to your dependent. If a pre-existing condition does apply, this Plan will be primary only for covered services and supplies related to that condition; this Plan will be secondary for all other covered services and supplies.
- You or your dependent becomes entitled to Medicare after electing COBRA.

If you have questions

If you have questions about COBRA or wish to enroll, contact the Verizon Benefits Center. You can access COBRA information via Your Benefits Resources Web site. You also can call the Verizon Benefits Center via the telephone number shown on your Important Benefits Contacts insert.

Conversion to an individual policy

Conversion to individual coverage may be available at the end of the COBRA continuation period. However, the coverage may not be as comprehensive as the plan, and you'll have to pay the premiums based on an individual policy rate. To make this conversion without providing proof of good health, you must file an application and make the first premium payment within 31 days of the termination of Verizon coverage.

Additional information

Claims and appeals procedures

The authority and discretion to designate each of the claims and appeals administrators is granted to the Verizon Employee Benefits Committee (VEBC) and the Verizon Claims Review Committee (VCRC), and to the individuals who chair each of these committees.

At the time of publication of this summary plan description (SPD), there are several claims and appeals administrators for the Plan. The VEBC or the VCRC may change these designations at any time.

There are two types of claims: eligibility claims and benefit claims. See “If a benefit is denied” later in this section for more information.

Claims regarding eligibility to participate in the Plan

At this time, for eligibility-related claims, the claims and appeals administrator is the VCRC.

Eligibility claims should be directed to the Verizon Claims Review Unit at:

Verizon Claims Review Unit
P.O. Box 1438
Lincolnshire, IL 60069-1438

Eligibility appeals should be directed to the Verizon Claims Review Committee c/o the Verizon Claims Review Unit at:

Verizon Claims Review Committee
c/o Verizon Claims Review Unit
P.O. Box 1438
Lincolnshire, IL 60069-1438

The **Verizon Benefits Center** works under the direction of the VCRC, which has discretionary authority to determine claims and appeals related to eligibility and enrollment in the Plan.

Claims regarding scope/amount of benefits under the Plan

At this time, for benefit-related claims, the VCRC has delegated its authority to finally determine claims to the health plans. The following table lists the claims and appeals administrators who have discretionary authority to decide claims and appeals for Plan benefits (not including health maintenance organizations [HMOs]):

Coverage	Claims and appeals administrators
Managed care network (MCN) (for hospital, surgical and medical benefits)	Aetna, Inc.
Medical Expense Plan (MEP) preferred provider organization (PPO) (for hospital, surgical and medical benefits)	Aetna, Inc.
Prescription drug program	Medco

If you choose an HMO, your HMO will handle claims and appeals related to benefits provided through the HMO. If your HMO prescription drug program is carved out to Medco, Medco will handle your prescription drug claims and appeals. The vast majority of HMOs have accepted the responsibility of being the claims fiduciary. If your HMO has not, you will be notified in your claim denial notice, which will indicate that you should appeal to the VCRC. In such an instance, the VCRC will be the claims and appeals fiduciary (i.e., final decision-maker at the appeal level) for your benefit-related claim or appeal.

The addresses of the claims and appeals administrators for the Plan are listed above. If you have a claim or appeal, you should contact the appropriate claims and appeals administrator for the type of claim or appeal you have.

The claims and appeals administrators have discretionary authority to:

- Interpret the Plan based on its 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 either the claims or appeals administrator.

The claims and appeals administrators have discretionary authority to decide claims under the Plan and review and resolve any appeal of a denied claim. In case of an appeal, the claims and appeals administrators' decisions are final and binding on all parties to the full extent permitted under applicable law, unless the participant or a beneficiary later proves that a claims and appeals administrator's decision was an abuse of administrator discretion.

If a benefit is denied

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 the Medical Plan.

The following information applies for “group health” or “health” claims. “Group health” or “health” refers to medical options – including mental health and substance abuse care, prescription drugs and vision care – and dental options. The steps that you or your authorized representative is required to take to file a group health claim or appeal are outlined in the following chart. The steps vary slightly depending on the type of claim involved.

First, you must determine what type of claim you have:

- ***Post-service***
A claim for reimbursement of medical services already received. This is the most common type of claim.
- ***Pre-service***
A claim for a benefit for which coverage review 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 nonurgent care were applied, the delay: (1) could 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.

Second, you must determine whether you have an “eligibility” claim or a “benefit” claim.

An eligibility claim is a claim to participate in a plan or option or to change an election to participate during the year. An example of an eligibility claim is a claim to switch from an indemnity-type plan to an HMO mid-year. A benefit claim is a claim for a particular benefit under a plan. It will typically include your initial request for benefits. An example of a benefits claim is a claim to receive coverage for a particular type of surgery. However, for prescription benefits, your initial request for benefits does not trigger this procedure. Instead, this procedure does not apply until your pharmacist denies your request for prescription benefits.

The following chart applies to **medical** claims:

	Special rules			
	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 group health plan administrator. To obtain contact information for the Plan, you should refer to the telephone number and/or Web site shown on the back of your ID card or the health plan comparison charts 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're applying. • The reason(s) for the request. • Relevant documentation. <p>To file an urgent care claim, you should call the Verizon Benefits Center at 1-877-4VzBens or your health plan. In addition, you must state that you are filing an urgent care claim.</p>				
<p>What happens if you don't 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 an appropriate time period of receipt of the claim (see columns to the right).</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>

	Special rules			
	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
If you provide additional information, you will be notified of the decision by the Verizon Claims Review Unit or the health plan administrator within an appropriate time period (see columns to the right) .	The time period remaining for the initial claim	The time period remaining for the initial claim		48 hours
<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 generally will notify you by telephone.</p> <p>If your claim is denied, in whole or in part, the Claims Review Unit or the health plan will notify you in writing, except for urgent care.</p> <p>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. • The Plan's appeal procedures. 				<p>If your claim is denied, the health plan will notify you via 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>

	Special rules			
	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
Step 2:				
<p>About appeals and the claims fiduciary Before you can bring any action at law or at 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.</p> <p>WARNING: A failure to submit, in the appeal process, all facts, arguments, and documents that are relevant to your appeal can result in the court dismissing your action on the grounds that you failed to present such facts, arguments, and documents in the appeal process.</p> <p>The Claims Review Committee 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 your health plan has not accepted this responsibility, you will be notified in your claim denial notice, which will indicate that you should appeal to the Claims Review Committee.</p> <p>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.</p>				
<p>How to file an appeal If your claim is denied and you want to appeal it, you must file your appeal within an appropriate time period from the date you receive notice of your denied claim (see columns to the right). 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>	180 days	180 days	Within a reasonable period of time, considering the time period scheduled for reduction or termination of benefits	180 days You may orally file your appeal with the Verizon Claims Review Unit or the contact identified by your health plan administrator. At the time your claim is denied, the Verizon Claims Review Unit or your health plan administrator will give you instructions about how to file your appeal. You must identify that you are appealing an urgent care claim.

	Special rules			
	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
<p>How to file an appeal cont. If you have an appeal for benefits (i.e., you wrote to your health plan at explained at Step 1), write to the contact identified by your health plan administrator in your claim denial notice. 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 Review Committee or the health plan administrator will consult with a healthcare professional who has appropriate relevant experience. Upon request:</p> <ul style="list-style-type: none"> • You are entitled to learn the identity of such an expert. • You are entitled to copies of any healthcare professional's report. • You will be provided with any documents used by the plan to come to the determination of your case. 				

	Special rules			
	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 an appropriate time period of the Claims Review Committee's or the health plan's receipt of your appeal (see columns to the right).</p>	<p>Eligibility appeals: 60 days</p> <p>Benefit appeals:¹ 60 days, if the health plan provides 1 level of mandatory appeal</p> <p>30 days, if the health plan provides 2 levels of mandatory appeal</p>	<p>Eligibility appeals: 30 days</p> <p>Benefit appeals:¹ 30 days, if the health plan provides 1 level of mandatory appeal</p> <p>15 days, if the health plan 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, the Claims Review Committee will notify you in writing.</p> <p>If your appeal is denied, in whole or in part, the Claims Review Committee or the health plan will notify you in writing. 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. • 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." 				
<p>Step 3:</p>				
<p>How to proceed if necessary If you had an eligibility appeal that was denied by the Claims Review Committee, Verizon will not review your matter again, unless new facts are presented. You have a right to bring a civil action.</p> <p>WARNING: A failure to submit, in the appeal process, all facts, arguments, and documents that are relevant to your appeal can result in the court dismissing your action on the grounds that you failed to present such facts, arguments, and documents in the appeal process.</p> <p>If you had a benefit appeal that was denied by a group health plan administrator that offers 1 mandatory level of appeal, the group health plan administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action.</p>				

¹ If your health plan provides more than one level of appeal, the response time frame is shorter, as noted above. A few Verizon Health Plans 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 health plan 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.

² If your health plan provides two mandatory appeals, both appeals must occur within the 72-hour time frame.

	Special rules			
	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
<p>WARNING: A failure to submit, in the appeal process, all facts, arguments, and documents that are relevant to your appeal can result in the court dismissing your action on the grounds that you failed to present such facts, arguments, and documents in the appeal process.</p> <p>If you had a benefit appeal that was denied by a group health plan administrator that offers 2 mandatory levels of appeal, you may appeal to the health plan 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, your health plan will provide you with an independent medical review, upon request, in conjunction with this second and final appeal.</p>				
<p>The following provision applies if the health plan provides 2 levels of mandatory appeal:</p>				
<p>When you will be notified of the second and final appeal decision You will receive a response within an appropriate time frame of the health plan administrator's receipt of your second and final appeal (see columns to the right). If this appeal is denied, the health plan administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action.</p> <p>WARNING: A failure to submit, in the appeal process, all facts, arguments, and documents that are relevant to your appeal can result in the court dismissing your action on the grounds that you failed to present such facts, arguments, and documents in the appeal process.</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.

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) and its subsequent amendments. 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 Plan documents and, if applicable, 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 (SPD). 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 you with a copy of this summary annual report.
- Continue group health coverage if there is a loss of coverage under the Plan as a result of a status change (see "Changing your elections" for more information).
- Obtain a Certificate of Creditable Coverage (see "When participation ends" for more information).

In addition to establishing rights for Plan participants, ERISA imposes certain duties upon the persons 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 benefit or exercising your rights under ERISA. If your claim for a benefit is denied or ignored in whole or in part, you have the 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 them 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 Plan 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 status of a medical child support order, you may file suit in 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 to be frivolous).

Assistance with your questions

If you have any questions about the ERISA-covered 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 publication 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 the 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. You may view the notice on the Web site and/or print a paper copy from the Web site.

You may also request a paper copy of the notice by calling the Verizon Benefits Center. Have your User ID 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 a.m. until 6 p.m., Eastern time, Monday through Friday.

Creditable Prescription Drug Coverage Notice

This notice has information about your Verizon prescription drug coverage and prescription drug coverage available January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage. **This notice applies to you and/or your covered family members that are eligible for Medicare prescription drug benefits.**

- As of January 1, 2006, new Medicare prescription drug plans were available to everyone with Medicare.
- Verizon has determined that the prescription drug coverage option(s) listed in this summary plan description is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.
- Read this notice carefully – it explains the options you have under Medicare for prescription drug coverage, and can help you decide whether or not you want to enroll.
- You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you enroll. Read this notice carefully – it explains your options.

Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Creditable coverage

Verizon has determined that the option(s) described in this summary plan description is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. **Because this Verizon prescription drug option(s) is, on average, at least as good as the standard Medicare prescription drug coverage, you can enroll in this coverage and not pay extra if you later decide to enroll in a Medicare prescription drug plan.**

Because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan at any time in the future. Each year, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15 and December 31.

If you do decide to enroll in a Medicare prescription drug plan, you will continue to be eligible to receive Verizon prescription drug coverage.

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 prescription drug plan will not provide additional value to you.

If you elect a Medicare prescription drug plan, the benefits will be coordinated with your Verizon prescription drug plan coverage. In the majority of cases, electing a Medicare prescription drug plan will **not** provide you with additional value.

Medicare prescription drug plans 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 prescription drug plan, Medicare has strict rules with regard to whether you can disenroll even if you realize that the coverage is not value-added to you. Generally, you would need to wait until the next year's enrollment period. So, you should strongly consider whether to enroll in a Medicare prescription drug plan, unless you are sure that the coverage will provide additional value to you. In the majority of cases, it will not.

When Verizon prescription drug coverage ends

You should also know that if you drop or lose your coverage with Verizon and don't enroll in a Medicare prescription drug plan after your current coverage ends, you may pay more to enroll in a Medicare prescription drug plan later. If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month after your initial enrollment period that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until next November to enroll.

For more information

If you need additional information, access the Your Benefits Resources Web site or contact the Verizon Benefits Center.

Please address any written correspondence to:

Verizon Benefits Center
100 Half Day Road
P.O. Box 1457
Lincolnshire, IL 60069-1457

Note: You may receive this notice at other times in the future, such as before the next period you can enroll for a Medicare prescription drug plan, or if your Verizon prescription drug coverage changes. You also may request a copy at any time by calling the Verizon Benefits Center.

For more information about Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is available in the “Medicare & You” handbook from Medicare. Handbooks are mailed to all people eligible for Medicare each October. You may also be contacted directly by Medicare prescription drug plans. More information about Medicare prescription drug plans is also available from the following sources:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance program (see your copy of the “Medicare & You” handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice if you have creditable Verizon prescription drug coverage. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount. Of course, enrollment in a non-creditable Verizon prescription drug option will not prevent you from paying a higher premium, if you go 63 days or longer without Medicare prescription drug coverage.

Administrative information

Administrative information about the Plan is provided in this section.

Important telephone numbers

You can connect to the Verizon Benefits Center and other Verizon benefit providers by calling the toll-free number shown on your Important Benefits Contact insert. If you prefer, you can call the benefit providers directly via the telephone numbers shown on your Important Benefits Contacts insert.

Plan sponsor/employer

The Plan sponsor/employer is:

Verizon Communications Inc.
One Verizon Way
Basking Ridge, NJ 07920

Plan administrator

The Plan administrator is:

Chairperson of the VEBC
c/o Verizon Benefits Center
P.O. Box 1457
100 Half Day Road
Lincolnshire, IL 60069-1457

Telephone number: 1-877-4VzBens and follow the instructions to reach the Verizon Benefits Center.

You may communicate to the Plan administrator in writing at the address above. However, for questions about Plan benefits, you should contact the Verizon Benefits Center. The Verizon Benefits Center administers enrollment and handles participant questions, requests, and certain benefit claims, but it is not the Plan administrator. Claims relating to the scope and amount of benefits under the Plan are administered by the administrators listed below.

The Plan administrator or a person designated by the administrator has the full and final discretionary authority to publish the Plan document and benefit plan communications, to prepare reports and make filings for the Plan, and to otherwise oversee the administration of the Plan. However, the Plan's benefits administrator or a benefits representative can answer most of your day-to-day questions.

Do not send any benefit claims to the Plan administrator or to the Verizon legal department. Instead, submit them to the claims administrator for the Plan (see "Claims and appeals procedures" earlier in this section).

Benefits administrators

The benefits administrators have the authority and responsibility to perform daily administration of benefits under the Plan. You can call the benefits administrators via the telephone numbers shown on your Important Benefits Contacts insert.

- Aetna, Inc.,
- Davis Vision, Inc.
- Health Management Corporation.
- Medco.
- Vision Service Plan.

Claims and appeals administrators

There are several claims and appeals administrators for the Plan.

The claims administrator has the authority to make final determinations regarding claims for benefits.

The claims administrator is authorized to determine eligibility for benefits and interpret the terms of the Plan in its sole discretion, and all decisions by the claims administrator are final and binding on all parties.

Verizon Claims Review Committee (VCRC)

The **VCRC** is responsible for enrollment and eligibility claims. The VCRC can be reached at the following address:

Verizon Claims Review Committee
c/o Verizon Benefits Center
P.O. Box 1438
100 Half Day Road
Lincolnshire, IL 60069-1438

You can call the Verizon Benefits Center via the telephone number shown on your Important Benefits Contacts insert.

The administrators listed here are the benefits administrators responsible for authorizing benefit payments, considering appeals, resolving questions, obtaining records, filing reports, and the distribution of information to Plan participants. See your Important Benefits Contacts insert for the telephone numbers.

Coverage	Benefits administrators
Managed care network	Aetna, Inc. P.O. Box 981106 El Paso, TX 79998-1106
Medical Expense Plan	Aetna, Inc. P.O. Box 981106 El Paso, TX 79998-1106
Prescription drug program Medco is the claims and appeals administrator for the retail program and the mail service pharmacy. Medco is responsible for authorizing benefit payments, considering appeals, resolving questions, maintaining records, filing reports, and distributing information to Plan participants.	Medco 8111 Royal Ridge Parkway Irving, TX 75063
Disease management program	Health Management Corporation P.O. Box 26016 Richmond, VA 23260

HMOs

Under an HMO option, your HMO is the benefits administrator responsible for exercising the discretion to determine benefit payments, and it also is the claims administrator for claims relating to the scope or amount of benefits under this option. You should check the literature you receive from your HMO for its address and telephone number. If your HMO prescription drug program is carved out to Medco, Medco is the claims and appeals administrator for the prescription drug portion of your coverage. The vast majority of HMOs have accepted the responsibility of being the claims fiduciary. If your HMO has not, you will be notified in your claim denial notice, which will indicate that you should appeal to the VCRC. In such an instance, the VCRC will be the claims and appeals fiduciary (i.e., final decision-maker at the appeal level) for your benefit-related claim or appeal.

Qualified medical child support orders (QMCSOs)

The Verizon Benefits Center is responsible for the administration of QMCSOs and can be reached at the following address:

Verizon Benefits Center
P.O. Box 1457
100 Half Day Road
Lincolnshire, IL 60069-1457

You can contact the Verizon Benefits Center via the telephone number shown on your Important Benefits Contacts insert.

Plan funding

Except for certain HMO benefits, the Plan is not financed by an insurance company, nor are Plan benefits guaranteed under a contract of insurance. The claims and appeals administrators listed earlier in this section do not insure or guarantee Plan benefits.

Except for certain HMO benefits, the company has the discretion to pay claims out of the general assets of the company, and certain benefits are currently funded through a trust.

The trustee is:

Bank of New York Mellon
One Mellon Bank Center
Room 151-1335
Pittsburgh, PA 15258

A list of HMOs that may insure certain benefits is available on request from the Plan administrator.

Plan identification

Medical coverage is provided through the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Post-1989 Associate Retirees, which is a component plan of Verizon Plan 550. It is a welfare plan that is a group health plan, listed with the Department of Labor under two numbers: The employer identification number (EIN) is 23-2259884, and the Plan number (PN) is 550.

In addition to the benefits described in this SPD, Verizon Plan 550 provides other benefits to Mid-Atlantic associate retirees of Verizon who will receive their own version of the SPD. Dental benefits are provided under the component plans referred to as the Verizon Dental Expense Plan for Mid-Atlantic Post-1989 Associate Retirees and Verizon's Bell Atlantic Dental Expense Plan. Life insurance benefits are provided under the component plan referred to as the Verizon Life Insurance Plan for Mid-Atlantic Associate Retirees. Dental and life insurance benefits are described in separate SPDs.

Plan year

Plan records are kept on a plan-year basis, which is the same as the calendar-year basis.

Agent for service of legal process

The agent for service of legal process is the Plan administrator. Legal process must be served in writing to the Plan administrator at the address stated for the Plan administrator earlier in this section.

In addition, a copy of the legal process involving this Plan should be delivered to:

Verizon Legal Department
Employee Benefits Group
Verizon Communications Inc.
One Verizon Way
Basking Ridge, NJ 07920

Legal process also may be served on the trustee.

Official Plan document

This SPD is a summary of the official Plan documents.

Collective bargaining agreements

The terms of your benefits may also be governed by a collective bargaining agreement between Verizon and your Union. You and your beneficiaries may review the collective bargaining agreement at your location and you also can request a copy by writing to the Plan administrator.

Participating companies

The following is a list of participating companies as of January 1, 2009. This list may change from time to time.

- Verizon Advanced Data Inc.
- Verizon Delaware Inc.
- Verizon Maryland Inc.
- Verizon New Jersey Inc.
- Verizon Pennsylvania Inc.
- Verizon Services Corp.
- Verizon Virginia Inc.
- Verizon Washington, D.C. Inc.
- Verizon West Virginia Inc.
- Verizon Avenue, Inc.
- Verizon Corporate Services Corp.

Glossary

A

Accidental injury

An injury caused by a chance event or unknown causes.

Ambulatory surgical facility

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

Basic benefits

Basic covered services and supplies under the Medical Expense Plan (MEP) preferred provider organization (PPO) option.

Brand-name drug

Brand-name drugs are patented by their manufacturers, so only their makers can sell them – usually at a high retail price. But when the patent expires, these same drugs can be produced as generics by other makers, who often sell them at a much lower price.

C

Chiropractor

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

Clinical psychologist

A psychologist who is licensed or certified in the state where the service is provided and has a doctoral degree in psychology with at least two years of clinical experience in a recognized health setting.

COBRA

A federal law (Consolidated Omnibus Budget Reconciliation Act of 1985 and its subsequent amendments) allowing continuation of health plan coverage for a period of time at the participant's expense if a participant loses Plan coverage because of certain qualifying events.

Coinsurance

The percentage of the reasonable and customary (R&C) charge that you pay for a covered service or supply.

Copayment

A fixed dollar amount you pay for certain services or supplies if you are enrolled in the managed care network (MCN), the MEP-PPO option or a health maintenance organization (HMO).

Covered person

Any retiree and his or her dependents enrolled in the Plan, or any eligible individual who has elected coverage under COBRA.

Covered services

The services, treatments or supplies identified as payable in the official Plan document. Covered services must be medically necessary (as determined by the claims administrator) to be payable.

Custodial care

Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters.

D

Deductible

The amount of the network negotiated fee (NNF) or reasonable and customary (R&C) charge for covered expenses you pay before certain options pay benefits for specific care.

Discounted network price (DNP)

The price negotiated with a pharmacy by the benefits administrator of the prescription drug program. A covered person pays a portion of this price when he or she purchases medications at a network pharmacy with a prescription drug ID card.

E

Educational or developmental

A service or supply, the primary purpose of which is to provide the covered person with training in the activities of daily living, instruction in scholastic skills such as reading and writing, preparation for an occupation, treatment for a learning disability, or to promote development beyond any level of function previously demonstrated.

Emergency care

The first treatment provided in a hospital's emergency room after an accidental injury or the onset of a sudden, serious, and life-threatening illness that requires hospital care, as determined by the claims administrator because:

- Care cannot be provided safely and adequately other than in a hospital.
- Adequate care is not available elsewhere in the area at the time and place needed.

- If hospital care is not given, the covered person's condition could (as determined by the claims administrator) reasonably be expected to result in:

- Loss of life or limb.
- Significant impairment to a bodily function.
- Permanent dysfunction of a body part.

Experimental or investigational

A service or supply, the medical use of which still is under study and is not yet recognized throughout the medical profession in the United States as safe and effective for diagnosis and treatment, as determined by the claims administrator. This includes but is not limited to:

- All phases of clinical trials.
- All treatment protocols based on or similar to those used in clinical trials.
- Drugs approved by the U.S. Food and Drug Administration (FDA) under its Treatment Investigational New Drug regulation.
- FDA-approved drugs used for unrecognized treatment indications.

A drug, device, procedure or treatment shall be determined to be experimental (or investigational) if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-review literature to substantiate its safety and effectiveness for the illness or injury involved.
- If approval is required by the FDA, such approval has not been granted for marketing.
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes.
- The written protocol or protocols or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

G

Generic drug

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

H

HMO

A health maintenance organization (HMO) that has entered into a written contract with Verizon with the purpose of being included as a coverage option under the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Post-1989 Associate Retirees.

Home health care

Care provided in a covered person's home when his or her condition is such that hospitalization would have been medically necessary if home health care were not available.

Hospice care

Inpatient or home care given to a terminally ill covered person, by or under arrangement with a hospice care agency, to enable the covered person to be as comfortable, alert, and capable of participating in life as is possible.

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 is primarily a place for rest, a place for the aged or a nursing home.

I

Illness

A non-occupational bodily disorder.

Imputed income

Most dependents are considered Internal Revenue Service (IRS) tax dependents. You do not pay imputed income for IRS tax dependents.

If you cover a same-sex domestic partner, a domestic partner's child or another person who is not considered an IRS tax dependent, Verizon is required to report income for you that reflects the value of the coverage for tax-reporting purposes. This is known as imputed income. You will receive a W-2 annually for the value of coverage for any dependent who is not an IRS tax dependent.

Verizon assumes all dependents are IRS tax dependents, except same-sex domestic partners and their children. You must contact the Verizon Benefits Center if your same-sex domestic partner and his or her children are your IRS tax dependents or if you cover other dependents who are not IRS tax dependents.

Injury

A non-occupational bodily injury.

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 younger than the employee covering the child.
- Is unmarried (i.e., has not filed a joint tax return during the calendar year at issue).
- 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 or stepsister or niece or nephew.¹
- 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 same-sex 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 same-sex domestic partner is not a “relative” in the traditional sense, he or she may meet the definition of “qualifying relative.”

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

¹ If a parent does not claim a qualifying child, then a non-parent can claim the child, as long as the non-parent's adjusted gross income is higher than the highest adjusted gross income of any parent of the child.

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 former associate or his or her spouse intends to live separately.

M

Medically necessary

A service or supply provided by a hospital, physician or other provider of healthcare services to diagnose or treat an illness or injury, which service or supply is consistent with the covered person's condition and which meets all of the following tests, as determined by the claims fiduciary:

- It must be ordered by a physician.
- It must be recognized throughout the provider's profession as safe, appropriate, effective, and essential; it must be required for the diagnosis or treatment of the particular illness or injury; and it must be employed appropriately in a manner and setting consistent with generally accepted United States medical standards.
- It must be the most efficient and economical service or supply that can safely be provided.
- It must be neither educational or developmental nor experimental or investigational in nature.

Services or supplies that are provided only because an unnecessary service or supply is being provided shall not be considered medically necessary.

In the case of a hospital stay, in addition to meeting the above tests, the length of the stay and hospital services and supplies shall be considered medically necessary only to the extent that the claims fiduciary determines them to be not allocable to the scholastic education or vocational training of the covered person.

A service or supply furnished to a newborn child shall not be considered medically necessary for medical care of a diagnosed illness or injury, unless the service or supply meets either of these conditions:

- It is furnished for the medical care of a diagnosed illness (including a congenital defect or birth abnormality) or injury and meets all of the foregoing tests.
- It is furnished immediately after the child's birth and is one of the following:
 - Hospital room and board.
 - Other supplies and nonprofessional services furnished to newborns by the hospital for medical care in that hospital.

The foregoing definition shall be applied solely for purposes of determining Plan benefits and not for determining what type of medical care should be provided; all decisions related to the type of medical care to be provided shall be made independently by the covered person and the covered person's physician.

N

Network negotiated fee (NNF)

The NNF is the fee the provider has agreed with the claims administrator to accept as payment in full for covered services or supplies provided on an in-network basis under the MCN or when provided by a PPO provider under the MEP-PPO option.

Non-occupational injury

A non-occupational injury is an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit.
- Result in any way from an injury which does.

O

Other covered charges

A category of coverage under the MEP-PPO option that includes services and supplies that are not covered under basic benefits. Examples of other covered charges include ambulance service, X-rays and lab tests, durable medical equipment, and physical, occupational, and speech therapy.

Out-of-pocket maximum

The maximum amount you will have to pay in one plan year for covered expenses.

Outpatient treatment

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

P

Participating company

Verizon or any corporation or partnership which is an affiliate of Verizon which has elected to participate in the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Post-1989 Associate Retirees.

Participating retail pharmacy

A retail pharmacy that belongs to the Medco Select National Network.

Physician or doctor

A person (either an M.D. or a D.O.) who is licensed to practice medicine, prescribe and administer drugs, or perform surgery. A physician also means a certified and licensed psychologist when providing psychological services in connection with mental health treatment. The person must act within the scope and authority of his or her license.

Primary care physician (PCP)

With coverage in an HMO, you generally must choose a PCP. This doctor is responsible for providing your healthcare and coordinating your care with other specialists as needed.

R

Reasonable and customary (R&C) charge

The R&C charge is the lesser of the actual charge or the maximum fee allowance for a covered service or supply. The benefits administrator determines the R&C charge.

The maximum fee allowance is determined by taking into consideration the following:

- The fee most commonly charged by a majority of providers in a given geographic area where those providers have similar training in the performance of the procedures.
- The fee normally charged by that provider for a similar service or supply.
- The amount charged for unusual circumstances or complications requiring additional time, skill, and experience in connection with that particular medical service, supply or procedure.

S

Same-sex domestic partner

To qualify as a class I dependent, your same-sex domestic partner must meet all of the following criteria:

- Is an adult of the same sex as you.
- Is not married to anyone else.
- Is not the same-sex domestic partner of anyone else.
- Is your only same-sex domestic partner and intends to remain so indefinitely.
- Is not related to you by blood that would prevent marriage under the law.
- Lives with you in the same permanent residence.
- Is jointly responsible, along with you, for one another's welfare and for basic living expenses.
- Is at least 18 years old and competent to contract under the law.

In addition, if you disenroll your partner, you cannot re-enroll him or her, and you cannot add a new same-sex domestic partner.

You must agree to notify the Verizon Benefits Center if your partner no longer meets the criteria listed above.

Skilled nursing facility

A facility that provides medically necessary, continuous professional nursing supervision to covered persons who are not in the acute phase of illness but require primarily convalescent, rehabilitative or restorative services. The facility also may include intermediate, residential or long-term care units. Beds must be set up and staffed in a unit specifically designated for this service. The facility must meet requirements as described in the Plan document.

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 Plan uses this definition, even if state or local laws define spouse differently.

Sudden, serious, and life-threatening illness

Severe symptoms that occur unexpectedly and that require immediate and urgent medical attention. Examples include, but are not limited to, an apparent heart attack, severe shortness of breath, severe allergic reactions, severe bleeding, obvious fractures, and sudden loss of consciousness. The claims administrator makes the determination as to what qualifies.

W

Working retiree

A former associate of a participating company (other than Verizon Delaware Inc. or Verizon Pennsylvania Inc.) who was represented by CWA immediately prior to leaving the company and:

- Who retired on a service pension or who elected a service pension cashout under the Verizon Pension Plan for Mid-Atlantic Associates.
- Who is re-employed by a participating company after 90 or more calendar days of retirement.
- Whose re-employment lasts 120 days or less in a calendar year.