Your Healthcare Benefits (Active Associates)

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Your Healthcare Benefits

Verizon medical coverage is designed to protect you and your family from the financial burden of large medical bills while giving you the flexibility to choose an option that meets your needs to manage your share of expenses. This document describes your medical options under the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates (the Plan), as well as Health Maintenance Organizations (HMOs). The Plan includes:

- Medical coverage options from which to choose, depending on your home zip code.
- 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.

About This SPD

This document is the summary plan description (SPD) for the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates. It 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 Associates. Plan 550 provides other benefits to eligible employees, as described in the "Administrative Information" section. The Plans are 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, which of your dependents are eligible to be covered, 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.
- **The Managed Care Network (MCN) Option.** This section provides details of how the MCN option works.
- **The MEP Preferred Provider Organization (PPO) Option.** This section provides details of how the MEP-PPO option works.
- **The No Coverage Option.** If you do not want bargained-for medical coverage, you can choose this option only if you have other Verizon 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.** If you're covered by more than one medical plan, special rules apply for coordinating between plans.
- **Health Maintenance Organization (HMO).** This section provides some details on 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 About You page on the Verizon eWeb or 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. 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 formally are adopted and officially are 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 associates and their families are eligible for medical benefits and who is responsible for the cost. Please note that this is an overview only. See the "Cost of Coverage" section for more information.

When an Associate Is:	**Then:**
Regular or term full-time with less than 3 months of net credited service	Associate pays full cost
Regular or term full-time with at least 3 months of net credited service	Company pays full cost
Regular or term part-time hired before January 1, 1981 with at least 3 months of net credited service	Company pays full cost
Regular or term part-time hired on or after January 1, 1981 with at least 3 months of net credited service, working: • 25 hours or more per week • 17-24 hours per week • Less than 17 hours per week	• Company pays full cost; associate pays nothing • Company pays half cost; associate pays half cost • Company pays nothing; associate pays full cost
Regular or term part-time with less than 3 months of net credited service	Associate pays full cost

Note: You are not eligible to participate in this Plan if one of the following applies:

- You are paid by a temporary staffing or placement agency or other vendor or third party.
- You are employed under the terms of a written agreement with the Company as an independent contractor or consultant.
- You are paid through accounts payable instead of the payroll system.
- You are a working retiree.
- You are an occasional employee.

In addition, if a court, the Internal Revenue Service or any other enforcement authority or agency finds that an independent contractor or leased employee should be treated as a regular employee of a participating company, for example, for purposes of W-2 income reporting or tax withholding, such individual is nonetheless expressly excluded from the definition of eligible employee and is expressly ineligible for benefits under the Plan.

You are eligible for Plan coverage after you have completed three months of net credited service if you are employed by a Verizon participating company and are either a regular or term full-time or part-time CWA-represented or IBEW-represented Mid-Atlantic associate. A term associate's employment is not intended to last more than 36 months. A term associate's employment ends upon completion of the specific project for which he or she is hired.

"Service" is based on net credited service provisions of the Verizon Pension Plan for Mid-Atlantic Associates. Also, if you have less than three months of net credited service, you may choose to start coverage earlier by paying the full premium cost (see "Initial Enrollment by Newly Hired Associates" under the "Enrolling in the Plan" section for more information). For former GTE employees who are covered under the Plan due to a collective bargaining agreement between the Company and the Union, "service" will include the former GTE service that is credited as part of the agreement.

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, including your:

- 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.

Dependent Eligibility Requirements

Dependent Class	Who They Are	Relationship
Class I Dependents	• Your legal spouse (a legally separated spouse is not eligible). Spouse – the employee's legal partner in marriage by civil ceremony, religious ceremony or common law (to the extent common law is recognized under state law). Coverage for a spouse will end at the end of the month in which the spouse becomes legally separated or divorced from you. Any spouse by common-law marriage recognized by the state will be treated as a rightful spouse unless you show proof of legal divorce or relevant court documents from the spouse or the spouse waives his or her rights in writing. Under Verizon's definition, legal separation occurs when a husband and wife generally are living in separate dwellings and a legal proceeding or court order pertaining, but not limited to divorce, support, custody, property division or the like, where the couple has signed an agreement to that extent. The Plan's definition of legal separation is applicable in all states, including those which do not recognize legal separation under state law. A spouse who is considered separated under the terms of one Company benefit Plan will be considered separated for all Plans. If you are separated or divorced, you will be considered separated or divorced for purposes of all Plans sponsored by Verizon. In such case, the dependent spouse would cease to be eligible for coverage under the bargained-for Medical Plan. The spouse no longer eligible would be able to purchase continued medical coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), based upon the separation date as specified in the court order.	• Spouse
	• Your unmarried children until the end of the calendar year in which they reach age 19, provided they receive more than 50% of their support from you. Children means children by birth, as well as legally adopted children (or children placed for adoption, stepchildren who live in your home, and children who live in your home and for whom you or your spouse is the legal guardian or has legal custody.	• Child
	• Your unmarried children (as defined above) from age 19 through the end of the calendar year in which they reach age 25 and are full-time students at an accredited educational institution, provided they receive more than 50% of their support from you. Coverage lasts until the end of the month they no longer qualify as full-time students or, if earlier, the end of the calendar year in which they reach age 25.	• Full-Time Student
	• 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 covered as a child or full-time student and they were covered continuously).	• Disabled Child
	• 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.	• Domestic Partner • Domestic Partner's Child
	• Your unmarried children (as defined above and including any age requirements) who are alternate recipients under an approved qualified medical child support order (QMCSO).	• Child

Dependent Class	Who They Are	Relationship
Sponsored Children[1]	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.	Sponsored Child
Sponsored Parents[1]	A parent who was added to the Plan after December 31, 1989 and who meets all of the following eligibility requirements: • 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.	Sponsored Parent
Grandfathered Class II Dependents[1] ***Note:*** *You cannot add new Class II Dependents. Once dropped from coverage, Grandfathered Class II Dependents cannot be reinstated.*	Your Grandfathered Class II Dependents are dependents who were continuously enrolled on or before December 31, 2000 and must be one of the following: • 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 their 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 their support.	• Class II Parent • Class II Child • Class II Grandparent • Class II Sibling

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.

[1] 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.

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 affiliates, the following rules apply:

- Children can be covered by one Verizon parent or the other, but not by both.
- You can be covered as an employee under this Plan or as a dependent under another Verizon associate medical plan, but cannot be covered as more than one of these. To be covered as a dependent under another Verizon 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 an employee 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; however, you will still be required to pay the working spouse/same-sex domestic partner surcharge under this Plan (see "Working Spouse/Same-Sex Domestic Partner Surcharge" under the "Cost of Coverage" section for more information).

Enrolling in the Plan

Initial Enrollment by Newly Hired Associates

If you are an eligible associate, you will have the opportunity to enroll yourself and your eligible dependents when you are initially eligible for the Plan. When you enroll, you will need to make two choices:

- **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:
  - 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.
  - MEP-PPO, if your home zip code is outside the MCN service area.
  - An HMO, if your home zip code is in one of the bargained-for HMO service areas, or you may be able to "opt-in" even if you live outside the HMO's service area.

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 instead may 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 at the telephone number shown on the Health Plan Comparison Charts available on Your Benefits Resources Web site at your initial enrollment and during benefits renewal.

- No coverage:
  - If you are a full-time associate or part-time associate scheduled to work 25 or more hours per week, you can elect no coverage only if you are covered as a dependent under another Verizon Medical Plan. Full-time associates include those regularly scheduled to work 25 or more hours a week, or an associate who is scheduled to work less than 25 hours a week who has been employed continuously by the Company since before January 1, 1981.
  - If you are a part-time IBEW associate scheduled to work less than 25 hours a week or you are any other eligible part-time associate who has not been employed continuously by the Company since before January 1, 1981, you can elect no coverage for any reason.

- **Coverage Level.** You also will need to choose a coverage level. You have three options:
  - Yourself only.
  - Yourself plus one dependent.
  - Yourself plus two or more dependents.

Note: You and any eligible dependent you choose to enroll must be covered under the same option, unless you and your dependents are covered as COBRA qualified beneficiaries. (When COBRA first is elected, all qualified beneficiaries must choose the option they were covered under on the date of the qualifying event. However, during any benefits renewal period occurring during the COBRA period, each qualified beneficiary can make his or her own coverage election and does not have to be in the same Plan option as the employee.)

When you first are hired (and prior to your attainment of three months of service), you will have the option to enroll yourself and your eligible dependents by contacting the Verizon Benefits Center. You pay the full premium cost during this interim period before the Company starts contributing toward the cost of coverage. To enroll in this interim coverage, you must enroll within 31 days of the date the Verizon Benefits Center creates your enrollment package. You can stop your medical coverage during your first three months by calling the Verizon Benefits Center. Your coverage will end effective the first of the month following your request to cancel. If you stop coverage, you will not be able to re-enroll in coverage until your three-month enrollment opportunity unless you have a change in status.

Before you attain three months of service, the Verizon Benefits Center will send you enrollment materials with your medical options listed. You will need to choose your coverage option and, if applicable, your coverage category, and authorize any payroll deductions before your enrollment deadline. If you enroll by the deadline, your elections are effective on the first day of the month in which you attain three months of net credited service; otherwise, you will be assigned the applicable option described in the "If You Do Not Enroll" section below.

Also, the following special rules apply:

- If you are changing from a management position to a full-time associate position or a part-time associate position in which you are scheduled to work 25 or more hours per week, your coverage begins the first day of the month following the date your payroll changes for the change in position. If you are changing to a part-time position in which you are scheduled to work less than 25 hours per week, you must enroll to have coverage; otherwise, you will default to no coverage.

- If you are changing from a part-time associate position in which you are scheduled to work less than 25 hours per week to a full-time position or part-time position in which you are scheduled to work 25 or more hours per week and are enrolled in a medical option, your current coverage will continue and you will receive a confirmation of coverage reflecting the reduction in your cost. If you want to make a change to the coverage shown on your confirmation of coverage, you must do so by contacting the Verizon Benefits Center within 14 days.

- If you terminate your employment and later are re-employed by a participating company, your net credited service for purposes of eligibility is defined under the Verizon Pension Plan for Mid-Atlantic Associates. However, if immediately prior to your re-employment you were a retired participant, you will receive immediate eligibility for coverage. **Note:** Only a former retiree who is not a working retiree can become a participant again.

- To cover your dependents, regardless of your employment status, you must contact the Verizon Benefits Center. You will need to provide each dependent's name, date of birth, and Social Security number. If you enroll eligible dependents before your enrollment deadline, their coverage begins the same date as your coverage. Otherwise, coverage begins the first day of the month after you enroll them.

How Do I Enroll or Make Changes?

Log on to Your Benefits Resources Web site or call the Verizon Benefits Center at the telephone number listed 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

Interim Three-Month Period

If you elected to purchase coverage during your initial interim three-month period and do not re-enroll during your three-month enrollment opportunity, your current coverage option and category automatically will be continued.

If you did not elect to purchase coverage during your initial interim three-month period and do not enroll at your three-month enrollment opportunity, you will be assigned the following:

- If you are a full-time associate, a part-time associate scheduled to work 25 or more hours per week or a part-time associate who has been employed continuously by the Company since before January 1, 1981, you will have coverage for yourself only under the MCN option if your home zip code is in the MCN service area or the MEP-PPO option if your home zip code is outside the MCN service area.

- If you are an eligible part-time associate who has not been employed continuously by the Company since before January 1, 1981 and you are scheduled to work less than 25 hours a week, you will be assigned the no coverage option.

Enrollment As a Surviving Spouse or Dependent

Class I and Grandfathered Class II Dependents are eligible for 24 months of Plan coverage that's fully paid for by the Company after an employee's death. (Note that same-sex domestic partners are treated the same as spouses for the purposes of survivor benefits.) After the end of the 24-month period, coverage for Class I Dependents can be continued under the retiree health plan (but are charged active rates). Class I Dependents pay the full cost for this continued coverage. Class II Dependents' coverage ends at the end of the 24-month period of Company-paid coverage. Class II Dependent Children then can continue coverage under COBRA and its subsequent amendments (see the "Continuing Coverage if Eligibility Ends" section for more information).

Coverage for Sponsored Children and Sponsored Parents ends on the last day of the month in which the associate dies. Sponsored Children can continue coverage under COBRA (see the "Continuing Coverage if Eligibility Ends" section for more information). Sponsored Parents are not eligible to continue medical coverage.

Changing Your Elections

Benefits Renewal

Each year during the benefits renewal period, you will have an opportunity to change your elections. Elections made during the benefits renewal period take effect on the following January 1 and remain in effect through December 31 of that year, unless you change during the year due to a change in status.

Status Changes

Between benefits renewal periods, you may be able to change your medical option and covered dependents if you or a dependent has a change in status that affects eligibility for coverage. An election change can be made due to a change in status if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan. (The change in elections must be consistent with the change in status.) Elections made due to status changes remain in effect until you make a change during a benefits renewal period or due to another status change.

You Gain a New Dependent

If you gain a new eligible dependent through marriage, acquisition of a same-sex domestic partner, birth, adoption or placement for adoption, that person automatically is 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: If you disenroll a same-sex domestic partner, you must wait 60 days before you can enroll a new same-sex domestic partner.

If you gain 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 gain a new eligible dependent as the result of an event other than those listed above – for example, a dependent child age 23 starts attending school full-time after a period of ineligibility due to age – 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.

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, 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 a dependent loses eligibility as a Class I Dependent but would be eligible for coverage as a Sponsored Child, you must notify Verizon of the change (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.

You Move

If you move, you must notify your department of your address change. After payroll registers your move, you automatically will receive a move package from the Verizon Benefits Center if you move to a location outside of your current option's service area and you will have the opportunity to choose a new option. If you notify Verizon (by calling the Verizon Benefits Center) 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.

Special Enrollment Rules

If you or your dependents (including your spouse or same-sex domestic partner) waive 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, Verizon makes a contribution toward your bargained-for benefits. For eligible associates with at least three months of net credited service, the Company contribution covers the full cost of medical coverage for you and, if applicable, your enrolled Class I Dependents and Grandfathered Class II Dependents. Note that if your spouse or same-sex domestic partner is employed and you cover him/her under your Plan, you may be required to pay the working spouse/same-sex domestic partner surcharge (see the "Working Spouse/Same-Sex Domestic Partner Surcharge" section below). You're an eligible associate if you have at least three months of net credited service and are:

- A regular or term associate working at least 25 hours a week.
- A part-time associate hired before January 1, 1981 and employed continuously by the Company since that date.

If you have not been employed continuously by the Company since before January 1, 1981 and you work at least 17 but less than 25 hours a week, the Company contributes 50 percent of the amount it contributes for full-time employees.

If you have not been employed continuously by the Company since before January 1, 1981 and you work less than 17 hours a week, you can enroll for coverage if you call the Verizon Benefits Center and agree to pay the full cost.

You pay the full cost of medical coverage for 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.

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.

Note that all employee contributions are paid on an after-tax basis.

Working Spouse/Same-Sex Domestic Partner Surcharge

You pay a $40 monthly contribution for your spouse's or same-sex domestic partner's coverage if:

- He or she is eligible for medical coverage from another employer.
- He or she does not enroll in his or her employer's medical plan.

You don't have to pay the monthly contribution if:

- Your spouse or same-sex domestic partner elects individual medical coverage under his or her employer's (not Verizon's) medical plan. If your spouse or domestic partner meets this criteria but has secondary coverage under the Verizon Medical Plan, the surcharge will not apply to that secondary coverage.
- Your spouse's or same-sex domestic partner's gross base wage rate on an annualized basis as of the previous July 1 is $25,000 or less.
- Your spouse or same-sex domestic partner is required to contribute $900 or more per year for individual medical coverage with his or her employer.

Note that if there are multiple medical options available to your spouse/same-sex domestic partner under his or her employer's plan and any one of them is less than $900, then the surcharge applies if he or she does not enroll in the employer's plan.

You must notify the Verizon Benefits Center within 31 days if the working spouse/same-sex domestic partner surcharge applies to you.

You are also responsible for notifying the Verizon Benefits Center of any change in your spouse's or same-sex domestic partner's employment status or the availability of medical coverage from the other employer if such change would affect your monthly contributions.

Note that the working spouse/same-sex domestic partner surcharge also applies if your spouse or same-sex domestic partner is a Verizon management employee whom you cover under your associate Plan. However, it does not apply if both you and your spouse or same-sex domestic partner are Verizon associate employees.

Certification of a Spouse/Same-Sex Domestic Partner

If you elect to cover your spouse/same-sex domestic partner as a dependent under the Plan, you will be required to verify if the working spouse/same-sex domestic partner surcharge applies.

If your spouse/same-sex domestic partner experiences a change in employment status where the surcharge should be applied, you are responsible for notifying the Verizon Benefits Center within 31 days. The change will be effective the first of the month following notification.

If your spouse/same-sex domestic partner experiences a change in employment where the surcharge no longer applies, you must notify the Verizon Benefits Center as soon as possible. Upon such notification, the Verizon Benefits Center will waive (prospectively) the surcharge, as soon as administratively possible, as well as provide written verification of your declaration. Upon notification, the surcharge will be waived effective with the first of the month following notification.

When Participation Ends

This section explains when participation in the Plan ends for you, your dependents and your survivors. For information on continuing coverage and COBRA, see the “Continuing Coverage if Eligibility Ends” section.

Associate:	
Leaves of Absence	In general, if you go on a leave of absence, your coverage continues in accordance with Company guidelines. Typically, coverage ends on the last day of the month in which the leave begins, except as noted below:
Leaves of Absence Under the Family and Medical Leave Act	The Company complies with the Family and Medical Leave Act of 1993 (FMLA). All leaves of absence qualifying under the FMLA will be administered in accordance with the terms of the FMLA. Coverage may be continued during approved leaves, as provided in Company policy. Call the Verizon Benefits Center for details.
Leaves of Absence Under the Uniformed Services Employment and Reemployment Rights Act	All military leaves of absence qualifying under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) will be administered in accordance with the terms of USERRA.
Union Leaves of Absence	Coverage can be continued according to your collective bargaining agreement.
Anticipated Disability Leaves of Absence, Care of Newborn Child (CNC) Leaves of Absence and Dependent Care Leaves of Absence	Verizon will pay the amount it normally does for your coverage. If you contribute to the cost of your medical coverage, however, you must continue making contributions during your leave. The Company will bill you monthly for these charges.
Education Leaves of Absence or Personal Leaves of Absence	Coverage for you and eligible dependents will end on the last day of the month in which your leave begins.
Change in Employment Status	If your employment status changes from associate to management status, coverage under the Plan will end on the last day of the month in which you become a management employee of Verizon or an affiliate of Verizon. You will have an opportunity to make an election into another plan. However, if prior to your change in employment status, you were enrolled under an HMO and you do not make a new election, you and any enrolled dependents will remain covered under that HMO until the end of the year in which the change in employment status occurred (you also will be required to pay any required contributions).
Long-Term Disability (LTD)	Coverage under the Plan will end on the last day of the month in which you begin to receive benefits under the Verizon Long Term Disability Plan for Non Salaried Employees. On the first day of the month that you begin to receive LTD benefits, you are covered under the retiree health plan and the coverage rules that apply to retiree participants. **Note:** LTD participants cannot add new dependents, unless pregnant at the time they were first enrolled in the Plan; in this case LTD benefit recipients may enroll the newborn child.

Associate:	
Voluntary Termination Under the Income Security Plan	Your coverage will end in accordance with the following: • If you are entitled to a service pension under a qualified defined benefit retirement plan maintained by Verizon or an affiliate of Verizon, your coverage will terminate on the last day of the month in which you terminate your employment. • If you are not entitled to a service pension under a qualified defined benefit retirement Plan maintained by Verizon or an affiliate of Verizon, and you have: — At least 1 year of net credited service (as defined by the Verizon Pension Plan for Mid-Atlantic Associates), your coverage will end on the last day of the 6-month period following the last day of the month in which your employment ends. — Less than 1 year of net credited service (as defined by the Verizon Pension Plan for Mid-Atlantic Associates), your coverage will end on the last day of the month in which your employment ends.
Involuntary Termination	If your employment involuntarily ends due to a workforce adjustment, if you are terminated with preferential rights of rehire and if you are not entitled to a service pension under a qualified defined benefit retirement plan maintained by Verizon or an affiliate and you have: • 5 or more years of net credited service (as defined by the Verizon Pension Plan for Mid-Atlantic Associates)[1], your coverage under the Plan will end on the last day of the twelfth month following the last day of the month in which your employment ends. • At least 1 but less than 5 years of net credited service (as defined by the Verizon Pension Plan for Mid-Atlantic Associates[1]), your coverage will end on the last day of the third month following the last day of the month in which your employment ends. • Less than 1 year of net credited service (as defined by the Verizon Pension Plan for Mid-Atlantic Associates)[1], your coverage will end on the last day of the month in which your employment ends.
Cancellation of Coverage	If you cancel coverage, your coverage will end on the last day of the month in which you elect to cancel coverage.
Failure to Submit Payment (if Required)	If you are required to make a payment, and it is not received on time, coverage will end on the first day of the month for which it is not received.
Plan Termination	Although Verizon does not intend to terminate the Plan, were the Plan to be terminated, all coverage would end on the date of termination.
Other Termination of Employment	If your employment is terminated for any reason not specified above, coverage under the Plan will end on the last day of the month in which your employment is terminated.

[1] For former GTE employees who are covered under the Plan due to a collective bargaining agreement between the Company and the Union, "service" will include the former GTE service that is credited as part of the agreement.

Dependent:	
Associate's Coverage Ends	If the employee's coverage ends for any reason except for when the employee dies, coverage for all dependents will end at the end of the month in which the employee's coverage ends.
Associate Dies	If an employee dies, coverage for his or her Class I and Grandfathered Class II Dependents who are enrolled on the date of the associate's death will continue until the last day of the 24-month period following the month in which the employee dies. Coverage also will continue for the newborn child of a deceased employee who is born subsequent to the employee's death. After 24 months, certain dependents can elect coverage under the retiree plan. Coverage for the associate's Sponsored Children and Sponsored Parents will end on the last day of the month in which the associate dies.
Dependent Ceases to Meet the Eligibility Requirements of His or Her Dependent Class	A dependent's coverage will end on the earlier of the date the dependent is covered as an employee or retiree under any bargained-for Medical Plan and the last day of the month in which the dependent no longer qualifies as a dependent under the Plan, subject to the following (note that HMOs may have different eligibility requirements): • Coverage for your spouse ends on the last day of the month in which he or she legally becomes separated or divorced 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. • Coverage for a full-time student ends on the earlier of the last day of the calendar year in which the student reaches age 25 or the last day of the month in which he or she no longer qualifies as a full-time student because he or she reduces his or her course load to a level below full-time, as defined by the educational institution, graduates or otherwise leaves school for reasons other than his or her illness or injury (excluding 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 the employee no longer is required to provide coverage for this child or, if earlier, the date the child no longer would be eligible for coverage. • 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. • 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 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 support requirements applicable to Sponsored Parents, 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 (plan 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 the child otherwise fails to meet the definition of a child of a same-sex domestic partner (or the same-sex domestic partner no longer meets the definition of a domestic partner).

Extended Benefits

If You Are Receiving Short-Term Disability Benefits

Coverage will continue during the period you are receiving short-term disability benefits if you are an active employee and as long as you continue to make any required contributions.

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), Verizon 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 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.

Overview of Your Options

Plan Options

The Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates 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 still will receive benefits, but at a reduced level of coverage and higher out-of-pocket costs.

- **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 and not on the negotiated rates and benefit levels may be different. (See “The MEP-PPO Option” section for additional information.)

- **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 then will 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.**

- **No coverage**, only if you have other Verizon medical coverage. If you are a full-time or part-time associate scheduled to work 25 or more hours per week, or an associate who is scheduled to work less than 25 hours a week who has been employed continuously by the Company since before January 1, 1981, you can elect no coverage only if you are covered as a dependent under another bargained-for Medical Plan. If you are an eligible part-time associate who has not been employed continuously by the Company since before January 1, 1981 and are scheduled to work less than 25 hours a week, you can elect no coverage for any reason.

Opting-In

If you live outside the service area of the MCN, you may opt-in to the MCN. That is, you can 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. 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 are 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 are 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 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 R&C charges.
- If you instead select an HMO, in most cases, you pay a copayment of no more than $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 check with the claims administrator 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 look at 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 emergencies	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
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 pertaining to your MCN and MEP-PPO options, please refer to the specific coverage summary charts under the “MCN Coverage Summary” and “MEP-PPO Option Coverage Summary” sections.

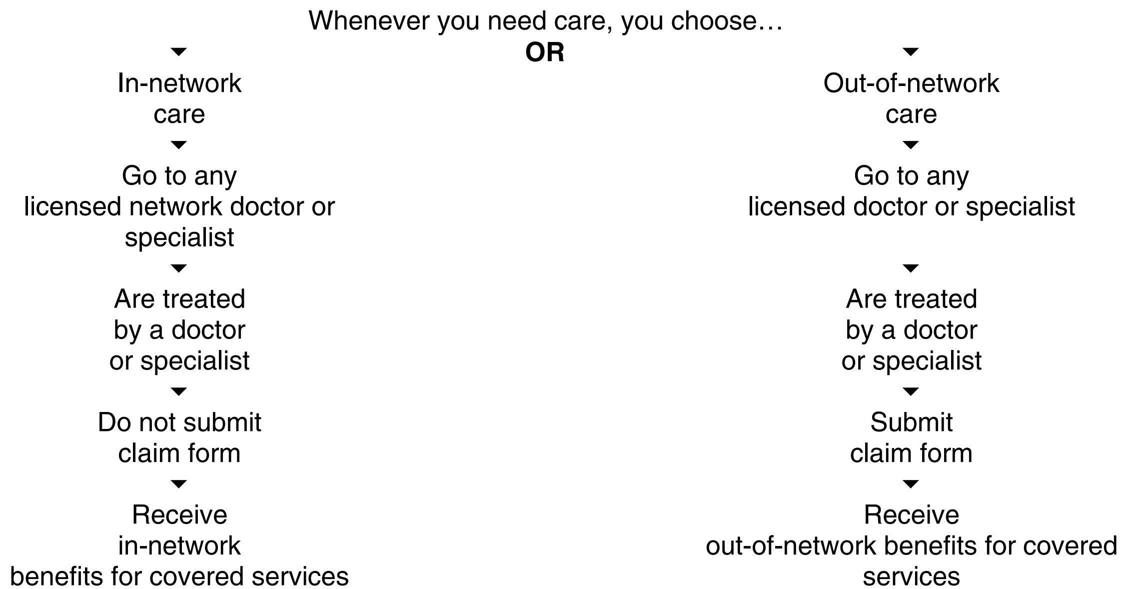
The Managed Care Network (MCN) Option

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 listed 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 percent. For more complete information, contact Aetna, Inc. at the telephone number listed 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 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 IBEW-represented employees 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 percent of the R&C charges and you pay 20 percent 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 percent 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 percent of the R&C amount and you will pay 40 percent 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 percent 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 diagnosis and treatment of the condition).

- The Plan will pay 100 percent 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” under 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 percent 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 percent 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.

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.

	Benefits	
Plan Feature	**In-Network (Benefits Are Based on 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 amount 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 for active associate employees	

	Benefits	
Plan Feature	**In-Network (Benefits Are Based on NNF):**	**Out-of-Network (Benefits Are Based on the R&C):**
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)
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 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 NNF):	**Out-of-Network (Benefits Are Based on the R&C):**
Outpatient Services		
Doctors' Office Visits	100% after you pay $15 per visit	80% after deductible
Doctors' Home Visits	100% after you pay $15 per visit	80% after deductible
X-rays and Lab Tests	100% (you pay $15 copayment 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 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
Preventive Care Services		
Well-Baby/Child Exams Age 0-2 years as prescribed Age over 2-25: 1 exam every year; includes immunizations	100% after you pay $15 per visit	80% (no deductible)[4]
Adult Physical Exams Age 25-50: 1 exam every 2 years Age 50 and over: 1 exam every year	100% after you pay $15 per visit	80% (no deductible)[4]
Well-Woman Exam 1 well-woman exam, every year, regardless of age and with or without a Pap test, including blood count and urinalysis	100% after you pay $15 per visit	80% (no deductible)[4]
Immunizations and Flu Shot 1 complete regimen of immunizations and 1 flu vaccine annually for children and adults	100% after you pay $15 per visit	80% (no deductible)[4]
Fecal Occult Test Age 18-39: 1 every 2 years Age 40 and over: 1 every year	100%	80% (no deductible)[4]
Colonoscopy or Sigmoidoscopy Age 50 and over: 1 every 3 years	100%	80% (no deductible)[4]

[3] The $750 limit does not apply to IBEW employees represented by Local 827 in New Jersey or their dependents and survivors.
[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 NNF):	Out-of-Network (Benefits Are Based on the R&C):
Preventive Care Services *continued*		
Routine Mammogram 1 annual routine mammogram for women regardless of age	100%	80% (no deductible)[4]
Prostate Specific Antigen Test Age 18-49: 1 every 2 years Age 50 and over: 1 every year	100%	80% (no deductible)[4]
Hearing Aids	100% up to $1,000 for hearing aid (and related exam and fitting) every 24 calendar	
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	100% after you pay $15 per visit	80% after deductible
Inpatient Substance Abuse Treatment[7,9]	100%	80% after
Outpatient Substance Abuse Treatment[7,9]	100% after you pay $15 per visit	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 ($5 if you are eligible for Medicare) 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 IBEW-represented associates: Out-of-network inpatient mental health care 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 IBEW-represented associates: Benefits for out-of-network inpatient substance abuse are limited to 30 days per covered person, per plan year.

Prescription Drugs	Using a Participating	Using a Non-Participating 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.

- 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.

[11] 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.

- — 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 percent 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 percent of 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 percent for emergency use of an ambulance (whether or not you use a network ambulance service).

- The Plan will pay 100 percent of NNF for the non-emergency, medically necessary use of an ambulance when you use a network ambulance service.

- The Plan will pay 80 percent 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 percent of the charge (80 percent 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 percent of the charge (80 percent 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 percent of the R&C amount for that surgery (if performed on an out-of-network basis). The MCN also will pay 80 percent 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 percent of the NNF, regardless of whether the surgery is performed on an inpatient or outpatient basis. The Plan also will pay 100 percent, 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 percent of the R&C amount for surgery and associated expenses, subject to the deductible.
- The remaining 40 percent 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 percent 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 percent of the applicable NNF for covered surgery rendered on an in-network basis under the MCN.

Use of 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 whether the operation is medically necessary.

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 both are 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/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 only for inpatient mental health care.

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 (IBEW-represented associates have a 30-day annual maximum per covered individual)
Outpatient treatment	100% of NNF after $15 copayment	80% of the R&C amount
Substance Abuse Treatment		
Inpatient	100% of NNF	80% of the R&C amount (IBEW-represented associates have a 30-day annual maximum per covered individual)
Outpatient treatment[2]	100% of NNF after $15 copayment	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.

[1] $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.

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.

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 percent of NNF.

- For outpatient mental health and substance abuse treatment, the Plan pays 100 percent of NNF after the $15 copayment.

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 percent of the R&C amount after the deductible. You also are responsible for mental health treatment charges above the R&C amount. 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 percent of the R&C amount after the deductible.

- For outpatient substance abuse treatment, the Plan pays 80 percent 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, Inc. 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” under 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 listed 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.

Plan Details

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 in effect for the plan year. Beginning January 1, 2008, the annual deductible is $250.

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

However, if your eligible expenses and two of your Class I Dependents’ eligible expenses (that are applied against individual deductibles) equal the family deductible of 2-1/2 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” under the “More Information About the MEP-PPO Option” 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 for the amount the Plan pays for covered services.

Office Visit Copayment

The office visit copayment is $15.

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 percent 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 percent of the NNF, with no deductible required.

- Many of the charges identified under "Other Covered Charges" later in this section are also covered at 100 percent with no deductible.

See the "MEP-PPO Option Coverage Summary" chart 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 percent 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 R&C and the actual charge.

The following special rules apply:

- The Plan will pay 100 percent 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 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 one half-day of inpatient care.

  — Facility charges for covered use of an ambulatory care facility or a birthing center.

- The Plan will pay 80 percent of the R&C amount and the covered person's coinsurance will be 20 percent 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 percent of the R&C amount and the covered person's coinsurance will be 10 percent 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 percent (if applicable) of the R&C amount and the covered person's coinsurance will be two percent 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" in the "More Information About the MEP-PPO Option" 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 percent of the R&C amount after the deductible (if applicable), and your coinsurance is the remaining 20 percent. 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 percent 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.

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, Inc. has received the bill for your care, it will determine your eligible MEP-PPO option benefits and, if appropriate, send a payment to your healthcare provider (unless the bill clearly is marked “paid,” in which case, payment will be sent to you). 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.

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 covered service obtained from a non-PPO provider exceeds the R&C amount, the Plan’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 – see the “Additional Information” section.

Plan Feature	Using PPO Providers	Using Non-PPO Providers
Deductible Requirements	*Individual:* $250 (beginning January 1, 2008) (Grandfathered Class II and Sponsored Dependents pay this too) *Family Limit:* 2-1/2 times individual deductible (applies to employee and Class I Dependents only)	*Individual:* $250 (beginning January 1, 2008) (Grandfathered Class II and Sponsored Dependents pay this too) *Family Limit:* 2-1/2 times individual deductible (applies to employee and Class I Dependents only) If you reside outside the PPO service area, the annual deductible is $150
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	$1,000 per covered individual (does not include deductible); no family limit	$1,000 per covered individual (does not include deductible); no family limit
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:	Unless otherwise noted, for non-emergency care that is medically necessary, benefits are based on the R&C and the Plan pays:
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 year[1] After 120 days, 80% of actual charges, if pre-certified
In-Hospital Physicians' Visits	100%	98% (no deductible)
Maternity Care (physicians' charges for pre/postnatal care and delivery)	100%	98% (no deductible)

[1] To calculate the 120-day limit, each day in a hospital counts as a 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).

Plan Feature	Using PPO Providers	Using Non-PPO Providers
Inpatient Hospital Services cont.		
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), if pre-certified for up to 120 days per plan year[1] After the first 120-day limit is reached, 80% after deductible, if pre-certified
Pre-Admission Testing (to determine if hospital care is necessary)	100%	Inpatient: 90% after the deductible (hospital room and board charges are not covered) Outpatient: 100% (if billed by a hospital, deductible applies)
Birthing 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 care)[2]	100%	100% (no deductible), if pre-certified
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	100% after you pay $15 copayment	80% after deductible
Doctors' Home Visits	100% after you pay $15 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)

[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
Outpatient Treatments cont.		
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
Preventive Care Services		
Well-Baby/Child Exams Age 0-2 years as prescribed Age over 2-25: 1 exam every year; includes immunizations	100%	100% (no deductible)
Adult Physical Exams Age 25-50: 1 exam every 2 years Age 50 and over: 1 exam every year	100%	100% (no deductible)
Well-Woman Exam 1 well-woman exam, every year, regardless of age and with or without a Pap test, including blood count and urinalysis	100%	100% (no deductible)
Immunizations and Flu Shot 1 complete regimen of immunizations and 1 flu vaccine annually for children and adults	100%	100% (no deductible)
Fecal Occult Test Age 18-39: 1 every 2 years Age 40 and over: 1 every year	100%	100% (no deductible)
Colonoscopy or Sigmoidoscopy Age 50 and over: 1 every 3 years	100%	100% (no deductible)
Routine Mammogram 1 annual routine mammogram for women regardless of age	100%	100% (no deductible)
Prostate Specific Antigen Test Age 18-49: 1 every 2 years Age 50 and over: 1 every year	100%	100% (no deductible)
Hearing Aids	100%, up to $1,000 for hearing aid (and related exam and fitting) every 24 calendar months[5]	

[3] Coinsurance is applied to the NNF or the actual price, if less than the NNF.
[4] The $750 limit does not apply to IBEW employees represented by Local 827 in New Jersey or their dependents.
[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
Preventive Care Services cont.		
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
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 Treatment[6]	80% after deductible	80% after deductible
Inpatient Substance Abuse Treatment[6,7]	100% of actual charges after deductible	100% of actual charges after deductible
Outpatient 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 case of emergency only)	80%[3] 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)	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 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	MEP-PPO Option: Using Participating Pharmacy[8]	MEP-PPO Option: Using Non-Participating 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 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 percent 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 percent 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 percent 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 percent.
- When you use a non-PPO hospital, Plan benefits will be 90 percent 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.

Medical/Surgical Treatment	Using PPO Providers: Pays NNF	Using Non-PPO Providers: Pays R&C
Surgery Second surgical opinion under second surgical opinion program If performed under the outpatient surgery program If performed inpatient and it was covered under outpatient surgery program	100% 100% 100% 100% if medically necessary	98% (no deductible)* 100% 100% 80% after deductible
In-Hospital Physicians' Visits	100%	98% (no deductible)
Consultations	100% after you pay $15 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 laboratory tests	100%	100% (including allergy tests)
Radiation Therapy, Chemotherapy, Electroshock Therapy, Hemodialysis	100%	100%

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 percent, 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 percent 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.

* 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 percent of the R&C amount.

— Male genital system procedures.

— Female genital system procedures.

— Maternity care and delivery.

— Eye and ocular adnexa procedures.

— Ear surgery.

In addition, the Plan also will pay 100 percent 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 percent of the R&C amount, with no deductible applied.

The following special rules apply to only those procedures listed above and if 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 percent of the R&C amount for surgery and associated expenses with no deductible applied. The remaining 2 percent 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 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 percent, while consultants from non-PPO providers are paid at 100 percent 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 percent 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 percent 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 shall 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 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 both are 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/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 less than 180 days will be considered a single confinement.

For outpatient mental health treatment, the Plan pays 80 percent of NNF after the deductible when a PPO provider is used or 80 percent 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.) as part of 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 half a 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, your provider will handle all 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, Inc. for pre-certification. (See your Important Benefits Contacts insert for the telephone number.)

The No Coverage Option

If you are a full-time associate or part-time associate scheduled to work 25 or more hours per week, you can elect no coverage only if you are covered as a dependent under another Verizon Medical Plan. Full-time associates include those regularly scheduled to work 25 or more hours a week, or an associate who is scheduled to work less than 25 hours a week who has been employed continuously by the Company since before January 1, 1981.

If you are an eligible part-time associate scheduled to work less than 25 hours a week who has not been employed continuously by the Company since before January 1, 1981, you can elect no coverage for any reason.

If you are a part-time associate scheduled to work less than 25 hours a week, who has been employed by the Company after January 1, 1981, you can enroll after you complete three months of net credited service. You may elect to pay the required cost for coverage by contacting the Verizon Benefits Center. Otherwise, you will not have coverage.

If you elect no coverage for a calendar year, you will not have medical coverage under the Plan for that calendar year unless you have a status change that affects your eligibility for coverage, which allows you to make a change (see "Changing Your Elections" for more information).

EAP Coverage Continues

Note that if you choose the no coverage option, you still will be covered under the Employee Assistance Program (EAP) provisions of the Plan. See "The Employee Assistance Program Through VZ-*LIFE* (Life Initiatives for Employees)" under the "Other Benefits" section for more information.

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 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 to be not medically necessary.) The claims administrator then will 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 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 periodically will 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 the "Additional Information" section for information on claims and appeals.)

Medical decisions regarding 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 all must 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 charts under the "MCN Coverage Summary" and "MEP-PPO Option Coverage Summary" sections 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 percent of NNF for the MCN [in-network], 80 percent of the R&C after the deductible for the MCN [out-of-network] or 100 percent of the NNF for the MEP-PPO option when a PPO facility is used, or 100 percent 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 that, 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 post-operative 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 physically is present for the test.
- The admission is not canceled or postponed except:
  - As a result of a second surgical opinion.
  - As a result of the test findings themselves.
  - For other medical reasons.

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 normally would 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 non-skilled personal care to the covered person (e.g., assisting with self-administered medication, nutritional needs, and exercises), and certain domestic care (e.g., changing the bed, doing laundry, and cooking meals for the covered person only), but only to the extent the claims administrator determines that without such care rehospitalization of the covered person would be required.
- Therapeutic and diagnostic services, including diagnostic X-rays, laboratory, and pathology exams that would be considered covered if provided to the covered person while a hospital inpatient, but are provided on an outpatient basis by a home health care agency because the services require special equipment not readily available in the covered person's home.
- Services of a licensed or registered speech pathologist and/or audiologist.
- Maternity care.

- Medical social services provided by a licensed social worker.
- Medical/surgical supplies.
- Nursing care furnished by an R.N. or an L.P.N.
- Nutritional guidance provided by a qualified licensed 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 it deems 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 normally is 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 essentially are 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 the 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 the 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 primarily is 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/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:

- Anti-influenza agents.
- Cholesterol medications (Crestor).
- Erectile dysfunction agents.
- Migraine medications.
- Proton pump inhibitors.

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]

[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.

- 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.

- 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 anesthetist per day of confinement are considered Basic benefits. Covered in-hospital visits by an anesthetist 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 primarily is for physical therapy or speech therapy that could have been provided on an outpatient basis.

- Hospitalization that primarily is for X-ray, laboratory and other diagnostic studies, electrocardiograms or electroencephalograms, including pre-admission testing when confinement during such tests is not medically necessary.

- Saturday and Sunday room and board charges for admissions on Friday or Saturday that are not emergency admissions.

- Tests performed on an inpatient basis when the same tests had been performed on a pre-admission basis, unless re-testing 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 primarily is 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 individuals circumstances (see “Reproductive and Fertility Treatments” 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 under the “Other Covered Medical Services and Supplies” 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 “stand-by” in the event complications might occur.

- Surgical or routine maternity care visits while hospitalized to the extent those visits are considered part of the surgeon’s or obstetrician’s fee, as determined by the claims administrator.

- The administration of anesthesia by the surgeon, assistant surgeon or physician who also renders diagnostic tests, performs surgery or provides any other service for the same procedure.

- 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 “Preventive Care Services” in the “MCN Coverage Summary” and “MEP-PPO Option Coverage Summary” charts).

- 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 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.

  — Hand rails.

  — Heating pads.

  — Heating units for swimming pools.

  — Humidifiers.

  — Hypo-allergenic 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 the patient at any time they are not covered by the Plan are the financial responsibility of the patient.
- Services or supplies for which there is no legal obligation to pay.
- Services for which the physician or other provider does not customarily bill his or her patient.
- Services or supplies provided as a result of injury or illness due to an act of war, declared or undeclared, that occurs after the individual becomes covered under the Plan.
- Hospital room, board, and ancillary services or supplies when hospital confinement is or becomes primarily rehabilitative, except as specifically provided under inpatient substance abuse treatment, unless the diagnosis and condition of the covered person are such that rehabilitation cannot be provided on an outpatient basis. However, use of a facility that is part of a hospital or an approved skilled nursing facility is a covered service or supply when rehabilitation is medically necessary, as determined by the claims administrator, due to an accidental injury, spinal injury or an illness such as a stroke.
- Treatment on or to the teeth except for:
  - Treatment when incurred due to an accidental injury to the natural healthy teeth occurring while the individual is a covered person under the Plan (excluding any claim for accidental injury when such claim totals $250 or less).
  - Surgical procedures for TMJ dysfunction.
  - Dental treatment in a hospital when a physician other than a dentist certifies that hospitalization is medically necessary.
  - 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.

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 Associates (the Plan) is primary, it pays benefits up to the limits described in this summary plan description (SPD). When the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates is secondary, the claims administrator for this Plan subtracts the primary plan's payment from the actual amount charged. The Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates' secondary payment and the primary plan's payment, added together, never will exceed the amount of actual charges (100 percent). (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 they would have 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 the HMO will be deemed the benefit paid for purposes of the coordination of benefits 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 employee 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 parent's 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, then 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 will apply.

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 above 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 employee 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.

For Those Eligible for Medicare

For covered persons eligible for or entitled to Medicare, the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates automatically is 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 Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates will be primary for the first 30 months of Medicare entitlement. After the first 30 months of Medicare eligibility because of end-stage renal disease, Medicare will become the primary plan and the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates will become secondary.

- For Medicare entitlement due to age for active employees and their spouses.

- For Medicare entitlement due to disability for employees (with coverage under the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates due to current employment status) and their family members.

For all other persons entitled to Medicare, Medicare is primary and the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates is the secondary plan. Benefits are coordinated as follows:

- The Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates determines the benefit amount it would pay if there were no other coverage, and then subtracts any benefits payable under Medicare.

- The Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates takes into account the benefits you are (or would be) eligible to receive from both Medicare Parts A and B – whether or not you are enrolled in Part B. **So, it is important to enroll in Part B when you first become eligible.**

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)

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

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

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 at benefits renewal, 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 then will decide whether to treat you or to refer you to other doctors or medical facilities within the Plan'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 percent 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 percent by the HMO. Typically, you will not receive any bills for care and all claims will be handled directly by the HMO.

Prescription Drug Coverage for HMOs

Prescription drug coverage for most bargained-for 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 is the same as that for the MCN and MEP Preferred Provider Organization (PPO) options. See "Prescription Drug Program" under the "More Information About the MCN and MEP-PPO Options" section for details of the program.

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 Employee Assistance Program Through VZ-LIFE (Life Initiatives for Employees)

The Employee Assistance Program (EAP) is a professional and confidential program to help you resolve personal problems before they negatively affect your health, relationships with others or job performance. EAP services include telephonic counseling, face to face counseling and educational information, including referrals to community services.

The EAP is offered at no cost to you and your eligible dependents.

Eligibility

You and family members living in your home (including a same-sex domestic partner and his/her children) are eligible to use the EAP automatically on your first day of work, regardless of which medical option you enroll in, or if you elect no medical coverage.

Change in Employment Status

If your employment status changes from associate to management, you and your eligible dependents will remain eligible for the EAP under the management medical plan.

Termination of Coverage

You and your dependents no longer are eligible for the EAP when your employment terminates unless you elect to continue medical benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Accessing Services

If you or your dependents want to use EAP services, call VZ-*LIFE's* toll-free telephone number at any time, seven days a week. (See your Important Benefits Contacts insert for the telephone number.) You also can access VZ-*LIFE* via the Web at www.verizon.com/life.

EAP Services

Services provided by the EAP include:

- ***Assistance with Personal, Family, and Work Issues.*** When you call the EAP, you will speak with an experienced and specially trained counselor who will assist you in getting the help you need. EAP counseling is confidential. Depending on your situation, the counselor may suggest additional face-to-face sessions with a counselor in your community to help you reach your goals. Your EAP provides up to five counseling sessions during a calendar year for each household member. (Surviving dependents receive up to five visits for each specific problem per year. If the surviving dependent has a second new problem, he/she will receive an additional five visits.) If you and your counselor decide that you require additional professional help, the counselor will assist you in obtaining care through your medical plan or other community resources.

- ***Consultative and Critical Incident Services.*** The EAP offers support to managers, Union representatives, and coworkers who want to offer employees a way to resolve personal problems before they have a negative impact at work.

  The EAP also is available (telephonically and on-site) to assist managers and employees during and after a traumatic workplace event. Workplace trauma is any critical incident experienced by personnel, producing intense emotional reactions that have the potential to interfere with job functions.

  Some examples of critical incidents include:

  — Violent or catastrophic events (shooting, assaults, accidents, natural disasters, terrorist or hostage acts).

  — The serious injury, illness or death of an employee.

  — Any distressing occurrence attracting unusual media attention.

- ***Financial Counseling.*** You and your eligible dependents can receive a referral from the EAP for financial counseling.

EAP Services Not Provided

The EAP does not provide the following services:

- Counseling required by any state or federal judicial office or other governmental agency mandating that an individual undergo counseling.

- Evaluations or recommendations to be used in child custody or abuse proceedings, criminal proceedings, Workers' Compensation proceedings or legal actions of any kind.

The EAP counselor will not have the authority to release an employee from work for any reason or to make recommendations regarding an employee's "fitness for duty."

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 for by health care providers.

Eligibility

The Bounty Program is available to all employees and their dependents.

Program Requirements

Under the program, a covered person will receive 50 percent 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 employee or one of his or her dependents enrolled in the Managed Care Network or the MEP-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 is available to employees and eligible dependents with end-stage renal disease after the first 30 months of Medicare coverage. 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. 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 your dependent's eligibility for the Plan ends. In some circumstances, however, coverage can be continued after eligibility ends.

Important Note

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 can also call your COBRA administrator via the Verizon Benefits Center or via the telephone number shown on your Important Benefits Contacts insert.

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 otherwise would 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 that 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.) Sponsored Dependents and Grandfathered Class II Dependents who are not your children are not eligible for continuation of coverage. 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 for the coverage on an after-tax basis, plus a two percent administrative fee, or 150 percent of the Company's cost during the 11-month period for which you have coverage because you (or your eligible dependent) are disabled.

Coverage continuation is available in the following situations:

- **If your coverage ends because of termination of employment (except for gross misconduct) or retirement (including disability retirement) or because of a reduction in your work hours**, you and your covered dependents can continue coverage for up to 18 months from the day coverage otherwise would end. In addition, if you continue coverage and have or adopt a child or a child is placed with you for adoption during the COBRA continuation period, you can add coverage for that child, with coverage beginning immediately and lasting up to the end of your original 18-month coverage period.

  If a dependent who is continuing coverage otherwise would become ineligible for coverage during the original 18-month coverage period because of your death, divorce or legal separation or the loss of dependent status, that dependent may elect to continue coverage for up to **36 months from the day coverage originally would have ended**.

These 18- and 36-month periods will run concurrent with (not in addition to) any period of continuation coverage provided through the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you or a covered dependent who is continuing coverage becomes totally disabled during the first 60 days of the COBRA continuation period (or, for a totally disabled child born to, adopted or placed for adoption with a covered employee during the COBRA continuation period, during the first 60 days after the birth, adoption or placement of the child) a special rule applies. If the Social Security Administration determines that you or your enrolled dependent is disabled within the first 60 days of COBRA continuation coverage and the qualified beneficiary notifies the Company within 60 days of the Social Security Administration's determination and within the first 18 months of COBRA continuation coverage, coverage can be continued for you or your covered dependent for up to a total of **29 months from the date coverage originally otherwise would have ended**.

If the disabled person is among those electing continuation coverage, the cost for the additional 11 months of coverage will equal 150 percent of the cost to provide the coverage. If the disabled individual is not among those electing continuation coverage, those who elect continuation coverage will pay for the entire 29-month period at 102 percent of the cost to the Plan.

- **If your covered spouse (or same-sex domestic partner) or dependent child becomes ineligible for coverage** under the Plan because you legally become separated or divorced, your same-sex domestic partner relationship 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 otherwise would 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 otherwise would have ended**.

- **If your dependent loses coverage** under the Plan because, while you are an active employee, you elect to be covered by Medicare, your dependents can continue coverage for up to **36 months from the date coverage otherwise would have ended**.

Note: If the Company's healthcare coverage changes during the period that you, your spouse or your dependents are continuing coverage, the changes apply to your COBRA coverage and are applicable under your medical option.

Notification Requirements

To be eligible for COBRA continuation coverage (for yourself or a dependent), you must notify the Verizon Benefits Center within 60 days from the later of the date of the event that causes you or your dependent to lose coverage or the date coverage ends. You also have 60 days to make your decision as to whether you 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 you (or your dependent). If you elect continued coverage, that coverage will be effective on the date your prior coverage ended.

If you are terminated or lose coverage because of a reduction in work hours, you'll receive additional information from Verizon about your opportunity to continue coverage under COBRA. It's your responsibility, however, to notify Verizon **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 Your Continued Coverage

You have 45 days from the date of your election to continue coverage under COBRA to make your first payment. The first payment will include payment for your coverage prior to the date of your election. Payments will be due regularly thereafter. If you fail to make a required payment, your coverage will end 30 days after the required payment was due but not paid.

How Continued Coverage Could End

Continued coverage will end for you or 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 do not make the required monthly payments on a timely basis.
- You or a 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 you or your dependent. If a pre-existing condition exclusion applies, this Plan will be primary as to the excluded condition only and will be the secondary plan to all other coverage.
- You or a dependent becomes entitled to Medicare after electing COBRA.
- You or a dependent ceases to be disabled during the special 11-month extension for a disabled individual.

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 is 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 different 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 (for hospital, surgical and medical benefits)	Aetna, Inc.
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 ten 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:				
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. 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. You must include: • A description of the benefits for which you are applying. • The reason(s) for the request. • Relevant documentation.				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.
What happens if you do not follow procedure If you misdirect your claim, but provide sufficient information to an individual who is responsible for Verizon benefits administration, you will be notified of the proper procedure within **(see columns to the right)** of receipt of the claim.	Not applicable. Response time frame does not begin until claim is properly filed.	5 days	Not applicable. Response time frame does not begin until claim is properly filed. If claim involves urgent care, 24 hours.	24 hours

	Special Rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
When you will be notified of the claim decision You will be notified of the decision within **(see columns to the right)** of the Verizon Benefits Center's receipt of your Claim Initiation Form or the health plan's receipt of your claim.	30 days This period may be extended for 15 days. You will be notified within the initial 30-day period.	15 days This period may be extended for an additional 15 days. You will be notified within the initial 15-day period.	A time period sufficiently in advance of the reduction or termination of coverage to allow you to appeal and obtain a response to that appeal before your coverage is reduced or terminated. For concurrent care that is urgent, within 24 hours (provided that you submitted a claim at least 24 hours in advance of reduction or termination of coverage); otherwise, within 72 hours.	72 hours
Failure to provide sufficient information procedure If you fail to provide sufficient information, the claim may be decided based on the information provided. However, the Verizon Claims Review Unit or health plan may notify you within **(see columns to the right)** that additional information is needed. You will have **(see columns to the right)** to provide the additional information. Otherwise, the claim will be decided based on information originally provided. If you provide additional information, you will be notified of the decision by the Verizon Claims Review Unit or health plan within **(see columns to the right)**.	30 days 45 days The time period **remaining** for the initial claim.	15 days 45 days The time period **remaining** for the initial claim.	Decision will be based on information provided, unless the concurrent care claim involves urgent care; see urgent care time frame.	24 hours 48 hours 48 hours

	Special Rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
How you will be notified of the claim decision If your claim is approved, the Verizon Claims Review Unit or the health Plan generally will notify you by telephone. 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. Your denial notice will contain: • 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.				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.
Step 2:				
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. **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.** 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 the 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. 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.				

	Special Rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
How to file an appeal If your claim is denied and you want to appeal it, you must file your appeal within **(see columns to the right)** from the date you receive notice of your denied claim. You may request access to all documents relating to your appeal. If you have an appeal for **eligibility** (i.e., you wrote to the Verizon Claims Review Unit at Step 1), write to the address specified on your claim denial notice. If you have an appeal for **benefits** (i.e., you wrote to your health plan at Step 1), write to the contact identified by your health plan in your claim denial notice. You should include: • A copy of your claim denial notice. • The reason(s) for the appeal. • Relevant documentation. 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: • 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.	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 the health plan administrator will give you instructions about how to file your appeal. You must identify that you are appealing an urgent care claim.

<table>
<tr><th></th><th colspan="4">Special Rules</th></tr>
<tr><th></th><th>Post-service claim</th><th>Pre-service claim</th><th>Concurrent care claim</th><th>Urgent care claim</th></tr>
<tr>
<td>When you will be notified of the appeal decision
You will be notified of the decision within (see columns to the right) of the Claims Review Committee's or the health plan's receipt of your appeal.</td>
<td>Eligibility appeals:
60 days

Benefit appeals:[1]
60 days, if health Plan provides 1 level of mandatory appeal

30 days, if health Plan provides 2 levels of mandatory appeal</td>
<td>Eligibility appeals:
30 days

Benefit appeals:[1]
30 days, if health Plan provides 1 level of mandatory appeal

15 days, if health Plan provides 2 levels of mandatory appeal</td>
<td>Eligibility and benefit appeals:

Before a reduction or termination of benefits would occur

If the concurrent claim involves urgent care, 72</td>
<td>Eligibility and benefit appeals:

72 hours[2]</td>
</tr>
<tr>
<td colspan="5">How you will be notified of the appeal decision
If your appeal is approved, the Claims Review Committee or the health plan will notify you in writing.

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:
• 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."</td>
</tr>
</table>

[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 the claims administrator 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**
Step 3:				
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. **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.** 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. **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.** 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.				
The following provision applies if the health Plan provides 2 levels of mandatory appeal:				
When you will be notified of the second and final appeal decision You will receive a response within **(see columns to the right)** of the health plan administrator's receipt of your second and final appeal. 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. **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.**	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.

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
100 Half Day Road
P.O. Box 1457
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. But, 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 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, most of your day-to-day questions can be answered by the Plan's benefits administrator or a Benefits Center Representative.

Do not send any benefit claims to the Plan administrator or to the Verizon legal department. Instead, submit them to the appropriate claims administrator for the Plan (see the "Additional Information" section for more information).

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 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
100 Half Day Road
P.O. Box 1438
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 Corp. 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 is also 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
100 Half Day Road
P.O. Box 1457
Lincolnshire, IL 60069-1457

You also 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 currently are 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 Associates, 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 summary, Verizon Plan 550 provides other benefits to Mid-Atlantic associate employees of Verizon (including Connected Solutions Inc. technicians) who will receive their own version of the SPD. Medical benefits are provided under the component Plans referred to as the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates and the Connected Solutions Managed Care Health Plan. Dental benefits are provided under the component Plans referred to as the Verizon Dental Expense Plan for Mid-Atlantic Associates. Vision benefits are provided under the component Plans referred to as the Verizon Vision Care Plan for Mid-Atlantic Associates and the Connected Solutions Vision Care Plan. Dental and vision 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 earlier in this section for the Plan administrator.

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 usually are admitted for less 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 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 employee 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 is 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.

F

Full-Time Associate

A full-time associate is an employee who is regularly scheduled to work 25 or more hours a week. Also, a part-time employee who is not a member of IBEW Local 1944 and who has been continuously employed since December 31, 1980 is considered a full-time associate.

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 Associates.

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 primarily is 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

An employee and his or her spouse legally are 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 employee 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

Part-Time Associate

A part-time associate is an employee who is regularly scheduled to work less than 25 hours a week.

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 Associates.

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 must wait 60 days before enrolling a new partner.

The employee 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.