Your Retiree Medical Coverage

Management employees/retirees who retire(d) on or after January 1, 2002

Certain management retirees who retired between April 1, 2001 and December 31, 2001 and elected the management retiree medical program

Contents

Introduction to your retiree medical coverage

Verizon offers access to medical coverage to help protect against the high expenses that can result from a serious illness or injury.

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

This summary plan description (SPD) describes the medical benefits available to eligible retirees, surviving spouses and dependents as of January 1, 2009. See the "Who is eligible" section for more information. [1]

This SPD can help you better understand and use your benefits. It replaces previous retiree medical SPDs and is intended to comply with U.S. Department of Labor (DOL) requirements. For a complete summary of your medical benefits, review this SPD and the related Summaries or Certificates of Coverage as described below.

If you do not meet the eligibility requirements for a company subsidy (see the "Special Rules for Retiree Subsidies" section), this SPD does not describe your benefits. If you are eligible for retiree medical benefits, you will be provided the appropriate summary materials with details about your plan benefits.

Accessing your benefits information

Your medical benefits are described in the following documents:

- This **medical SPD**.
- The **Summary of Coverage (SOC)** or **Certificate of Coverage** for the medical option you elect.
  - An SOC is available if your medical option is self-insured.
  - A Certificate of Coverage is available if your medical option is fully insured.
- The **SOC for the prescription program** for the medical option you elect.

If you are reading this SPD online, you can access your medical option SOC or prescription program SOC by clicking the links to the left.

[1] If you are employed by Verizon Wireless (other than for certain employees who transferred from Verizon to Verizon Wireless), Verizon Business, Federal Network Systems LLC (except former GTE CIC-protected employees), Verizon Avenue, Verizon Connected Solutions Inc. and any company, location or group that is not provided a company subsidy, this SPD does not describe your benefits. If you are eligible for retiree medical benefits, you will be provided separate summary materials with details about your plan benefits.

If you are reading a print SPD, you can access your medical SPD, your SOCs and other coverage details online on Your Benefits Resources™ Web site. Generally, the online documents are the most up to date. To access them, go to the Internet at www.verizon.com/benefits.

- For your SPD and SOCs – Select "Summary Plan Descriptions" from the right-hand navigation bar.

- For other coverage details – From the "Health, Insurance..." tab, click on the "Medical" link in "Your Current Coverage" near the bottom of the page and then choose "Coverage Details.".

You will need your Verizon Benefits Center User ID and password to access Your Benefits Resources and the Verizon Benefits Center.

If you want to change your User ID or password or if you have forgotten them and want to request a new User ID or password, you can do so on Your Benefits Resources Web site or by calling the Verizon Benefits Center.

For free printed copies of your SPD or SOCs, contact the Verizon Benefits Center. For a free printed copy of a Certificate of Coverage, contact the medical option administrator listed on your ID card.

About this document

Your medical program is governed by The Plan for Group Insurance. This summary plan description (SPD), along with the Summaries of Coverage (SOCs) and the Certificates of Coverage for your medical option and the prescription program, are incorporated by reference into the official plan document as the source of specific information relating to your medical benefits. See the "Administrative information" section for plan document information.

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

This document uses a variety of terms that are specifically defined under the "Medical terms to know" section. It is important that you familiarize yourself with these terms, because they help specifically describe the benefits that are available to you.

Medical plan contacts

Option	Contact	Reasons to access
Preferred provider organization (PPO), Exclusive Provider Network (EPN) and indemnity options (including prescription drugs and supplies, mental health and substance abuse treatment coverage)	See the Summary of Coverage for your medical option.	• Request coverage information. • Locate a participating provider and/or request a provider directory, free of charge. • Submit claims, if necessary. • Check on the status of a claim. • Avoid penalties if you need to provide notification or certification regarding surgery, hospitalization or certain other procedures or if you have an emergency. • Access health management services. • Call if a covered individual is pregnant. • Speak to a registered nurse. • Self-refer to a resource program.
Other medical options (including prescription drugs and supplies, and mental health and substance abuse treatment coverage, as applicable)		
• Health maintenance organization (HMO)/Exclusive provider organization (EPO) options • Point-of-service (POS) options	The plan, at the number and/or Web site shown on the back of your ID card or on the Health Plan Comparison Chart available on Your Benefits Resources Web site. When you log on to Your Benefits Resources, you can see the medical coverage detail for the option you currently are enrolled in. During benefits renewal, you can see coverage details for all of the options available to you at enrollment. Contact the plan directly for its address.	• Request coverage information. • Find the care and provider that best meets your needs. • Precertify care before you receive any treatment. • Submit claims. • Check on the status of a claim. • Avoid penalties if you need to provide notification or certification regarding surgery, hospitalization or certain other procedures or if you have an emergency.
Supplemental mental health and substance abuse treatment coverage (indemnity options – if not eligible for Medicare)	MHN Services www.mhn.com 1-800-777-7991 Mailing address: MHN Claims P.O. Box 14621 Lexington, KY 40512-4621	• Request additional coverage only after your medical option's mental health and substance abuse treatment benefits are exhausted.

Other sources for information		
Your Benefits Resources Web site Verizon Benefits Center	Via the Internet at: www.verizon.com/benefits 1-877-4VzBens Representatives are available from 8 a.m. to 6 p.m., Eastern time, Monday through Friday.	• Enroll for coverage. • Verify overall eligibility and coverage. • Review personal benefits information. • Make changes to your coverage due to a qualified change in status. • Update dependent information. • Hotlink to medical options provider sites (online only). • Create and print personalized provider listings and maps to a physician's office (online only). • Verify eligibility for COBRA coverage. • Enroll for COBRA coverage. • Notify Verizon of a COBRA qualifying event. • Update COBRA coverage due to a subsequent COBRA qualifying event.
Other sources for information		
Social Security Administration	Via the Internet at: www.medicare.gov 1-800-772-1213 Verizon Benefits Center 1-877-4VzBens	• Request information about Medicare. • Request information about how Medicare eligibility affects your benefits.
Subrogation vendor	Healthcare Recoveries Attention: Verizon Subrogation Unit P.O. Box 32200 Louisville, KY 40232 1-800-395-5568	• Request information about subrogation issues.

Who is eligible

You and your eligible dependents can enroll for retiree medical coverage.

You are eligible if...

You are eligible for the benefits described in this summary plan description (SPD) if you retire on or after January 1, 2002 and you meet the eligibility requirements described below.

You must meet the Rule of 75 (generally, your age plus at least 15 years of net credited service must total 75 "points"), as defined by the Verizon Management Pension Plan[1] to be eligible for retiree medical benefits. At the time of your retirement, you also must be one of the following:

- A regular full-time management employee who was not covered by a collective bargaining agreement.
- A regular part-time management employee who was not covered by a collective bargaining agreement.
- A west non-bargaining unit hourly employee.
- A union employee who was covered by a collective bargaining agreement under which management benefits were negotiated, with eligibility determined by the terms of the collective bargaining agreement.

OR

- If you retired between April 1, 2001 and December 31, 2001 and elected this program.

Under the following situations, you do not have to meet the Rule of 75 to be eligible for the coverage described in this SPD:

- Normal retirement age – If you are entitled to a pension under the Verizon Management Pension Plan and have reached normal retirement age (generally age 65), as defined by that plan, you are entitled to participate in this plan.
- Involuntary separation – If you are involuntarily separated, you may be entitled to participate in this plan if you meet the Rule of 73, as defined by the Verizon Management Pension Plan. Generally, your age plus net credited service must total 73 "points," and you must have at least 15 years of net credited service. You will be notified if this provision applies to you.
- Disabled employees – If you are entitled to a disability pension under your Verizon Management Pension Plan, or you are receiving benefits from the long-term disability (LTD) plan and also are entitled to Medicare benefits as a result of your disability, you are eligible for this plan.

[1] All references to the Verizon Management Pension Plan in this summary plan description include the Verizon Enterprises Management Pension Plan.

- Grandfathered Contel employees of the former GTE – If you are a grandfathered employee/ retiree of Contel, you are eligible for this plan if you satisfy the 55 years of age and 10 years of service rule, as defined by your Verizon Management Pension Plan. You also must be entitled to an early or normal retirement benefit under your Verizon Management Pension Plan.

- Employees covered by the Hawaii portion of the Verizon Management Pension Plan ("Hawaii employee") – If you are an employee who is retiring under the Hawaii plan provisions of the Verizon Management Pension Plan, you are eligible for this plan if you attain age 60 or have at least 15 years of service at retirement.

If you are eligible for Medicare

If you or your covered dependents are eligible for Medicare, be sure to read the "Coordination of benefits with Medicare" section. This section describes important information about the way the plan works if you also are covered by Medicare.

You are not eligible if...

- You were a leased employee, independent contractor or special status employee, had an individual employment contract (unless the contract or agreement specified that you **were** eligible to participate), or were not paid directly by Verizon.

- You are a terminated employee (unless you terminated under a separation program and/or a separation agreement that provides you with benefits under the medical plan for a specific amount of time).

If you were excluded from Verizon's definition of an eligible employee, you will be ineligible for benefits under the plan, even if a court, the Internal Revenue Service (IRS) or any other enforcement authority finds that you should have been considered an eligible employee.

Your dependents

Eligible dependents are your:

- Spouse (whether or not separated).

- Domestic partner, as defined by this summary plan description (SPD), and his or her unmarried children, as of the date your employment with Verizon ends. You generally cannot cover a new domestic partner or the child of a new domestic partner after retirement. However, if you marry a person of the same sex in a state that permits same-sex marriage, you will be eligible to add that person (or his or her child if also eligible) after retirement as a domestic partner.

- Unmarried children, including children for whom you are required to provide coverage under a qualified medical child support order (QMCSO). You may be able to continue coverage for your child beyond age 19 if he or she is a full-time student or disabled .

- Grandfathered class II dependents of employees of pre-merger NYNEX and pre-merger Bell Atlantic.

If you enroll in a medical option other than PPO Plus, Out-of-Area Plus, EPN or indemnity, it may not provide coverage to all of your dependents, such as a domestic partner. Contact the Verizon Benefits Center directly to confirm that your dependents are eligible for coverage.

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 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 domestic partners and their children. You must contact the Verizon Benefits Center if your domestic partner and his or her children **are** your IRS tax dependents or if you cover other dependents who **are not** IRS tax dependents.

State eligibility laws and the Employee Retirement Income Security Act of 1974 (ERISA)

States sometimes pass laws that require employee benefit plans to provide benefits and/or coverage to individuals who otherwise are not eligible. For example, a state might require an employer to provide coverage to an ex-spouse or a child who exceeds the plan age requirements who is not eligible for benefits under the company medical plan.

The federal law known as ERISA supersedes state law. As a result, the company only covers the individuals outlined in this summary plan description (SPD).

However, if you elect a fully insured medical option or HMO, the insurer or HMO may be required to comply with particular state laws. It is the insurer's or HMO's responsibility to determine whether it must comply.

Enrolling

If you are eligible for retiree medical coverage, when you notify the Verizon Benefits Center of your intent to retire, you can:

- Enroll yourself and your eligible dependents. You will have 31 days from your retirement date to make your benefit election. Your coverage begins on the first day of the month following retirement.

- Decline coverage, if you do not want retiree coverage or if you do not want coverage at retirement. Otherwise, you will receive default coverage retroactive to your retirement date. Your retiree medical coverage will default to the medical option you had as an active employee. If this option is not available, you will default to the $400 indemnity option. You can elect retiree coverage at a later date.

Anytime enrollment

You can change your election any time during the year. The coverage you elect will be effective the first day of the month following a 30-day waiting period.

For example, assume you retire as of July 30 but do not enroll in retiree medical benefits at that time. You will automatically receive default coverage. If you later decide to enroll in a different medical option on September 15, your new option will be effective November 1.

If you are enrolling or adding a dependent due to birth, adoption or placement for adoption and notify the Verizon Benefits Center within 60 days of this event, your coverage will be effective as of the date of the event, e.g. the date the child is born.

Your dependents

When you enroll your eligible dependents, you will need to provide their names, gender, birth dates and social security numbers. However, you do not need a social security number for a newborn child.

You also may be asked, at a later date, to provide proof of dependent status, such as:

- A marriage certificate.

- A birth certificate.

- Guardianship/adoption papers.

- College enrollment papers.

If you are unable to provide the required documentation, your dependent will not be covered. In addition, you may be required to reimburse Verizon for any costs associated with covering an individual who is not an eligible dependent and your, as well as your dependents', coverage may be terminated.

Special provisions apply if your spouse or domestic partner also is an eligible Verizon retiree or employee.

When your spouse or domestic partner is a Verizon retiree or employee

If your spouse or domestic partner is a Verizon retiree*, you can:	If your spouse or domestic partner is a Verizon employee, you can:
• Elect coverage for yourself. • Waive your coverage and participate in your spouse's or domestic partner's plan as a covered dependent. *Special coverage rules apply if your spouse or domestic partner is an associate retiree of the former Bell Atlantic. Please contact the Verizon Benefits Center for more details.	• Elect coverage for yourself and: — Enroll your spouse or domestic partner and any dependent children as covered dependents. — Enroll your spouse or domestic partner. — Enroll your dependent children. — Participate in your spouse's or domestic partner's plan as a covered dependent.* • Waive your coverage and: — Participate in your spouse's or domestic partner's plan as a covered dependent. — Do not participate in your spouse's or domestic partner's plan as a covered dependent. *This does not apply if your spouse is a New York/New England or Mid-Atlantic active associate or an active employee of the former GTE who bargained Mid-Atlantic CWA associate benefits, or if your spouse is a management active employee or retiree.

Your dependent children can be covered under your coverage or under your spouse's or domestic partner's coverage, but not both.

Enrollment under a qualified medical child support order (QMCSO)

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

- You do not have legal custody of the child.

- The child is not dependent on you for support.

You can enroll the child at any time.

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

If you live in more than one location

If you maintain more than one residence throughout the year, you should enroll using the address of your primary residence.

Before you enroll in a managed care option (see the “Other medical options” section), call the option administrator to see if it offers reciprocal arrangements in the other geographic location where you reside. If it does, you’ll be able to receive care in both locations. If it does not, you may want to consider another medical option.

Paying for coverage

Your cost for coverage is determined by:

- The medical option you choose.
- Your eligibility for Medicare.
- The number of dependents you cover.
- The amount of your subsidy.

The exact cost of coverage is shown on Your Benefits Resources Web site when you enroll.

You are eligible for a company subsidy if:

- You were hired into a position in a participating company with management benefits on or before December 31, 2004, or you were hired before December 31, 2004 and were transferred into a position in a participating company before July 1, 2005; and
- You had 15 years of service (including an additional 18 months if eligible) as of June 30, 2006, or you reached normal retirement age (generally age 65) with five or more years of service (including 18 months of additional service) on June 30, 2006. This 18-month credit only applies to eligibility for the company subsidy and not for service toward determining if you have reached retirement eligibility (the Rule of 75).

You are not eligible for the 18 additional months of service toward determining the amount of your company subsidy if, on June 30, 2006, you were:

- Employed by a non-participating company.
- Rehired on or after January 1, 2005 and were eligible for a subsidy only on your prior service before rehire.
- An associate employee.

If you are a former GTE employee who reached retirement eligibility under the Rule of 76 (age plus service of at least 15 years totals 76) as of May 18, 2004, you will not be credited with 18 months of additional service if you elect the former GTE Retiree CHOICES program. However, you will continue to earn service toward the former GTE Retiree CHOICES program subsidy while you remain employed.

Special rules apply if you are hired or transfer into a position with management benefits on or after January 1, 2005.

A separate summary plan description will be provided to retirees who are not eligible for a company subsidy.

The company subsidy

The company contribution toward your premiums for retiree medical coverage (referred to as the company subsidy) is based on:

- The total cost of coverage for the target plan (in 2007, the $400 indemnity option).
- Your years of service (including an additional 18 months, if eligible) as of June 30, 2006.
- Whether you are eligible for Medicare.

When you become retirement-eligible, Verizon will determine your company subsidy by adding your:

- Actual years of service as of June 30, 2006; plus
- An additional 18 months of service, if eligible.

Actual years of service on June 30, 2006	**Subsidy level at actual service**	**Years of service plus additional 18 months (1.5 years)**	**Subsidy level with additional service**
12 years	0% subsidy	12 + 1.5 = 13.5	0% subsidy
14 years	0% subsidy	14 + 1.5 = 15.5	50% subsidy
28 years	72% subsidy	28 + 1.5 = 29.5	76% subsidy
28.5 years	72% subsidy	28.5 + 1.5 = 30	80% subsidy

The result is the “whole” years of service used to determine your subsidy. You will not earn service toward the company retiree medical and dental subsidy beyond June 30, 2006.

This chart illustrates your retiree medical subsidy percentage rounding down for a half year of service:

Years of service (including additional 18 months, if eligible) as of June 30, 2006	**Subsidy percentage**
30 or more	80%
29	76%
28	72%
27	68%
26	64%
25	60%
24	56%
23	52%
15 – 22	50%
<15	0%

If you don’t meet the Rule of 75 but reached normal retirement age (generally age 65) with five or more years of service under the Verizon Management Pension Plan on June 30, 2006 (including an additional 18 months of service, if eligible), you will be eligible for a 50% company subsidy.

If you had 15 or more years of service on June 30, 2006 (including the additional 18 months, if eligible) and meet the Rule of 75 by the time you separate from Verizon, you will be eligible for a company subsidy based on your years of service.

Additional changes to the subsidy effective January 1, 2008

If you retire before January 1, 2008 and you are eligible for retiree medical and dental coverage with a company subsidy, you can enroll in retiree medical and dental coverage, and Verizon will provide the service-based company subsidy regardless of your age.

Starting January 1, 2008, if you retire before age 55 and are otherwise eligible for the company subsidy, you can enroll in medical and dental coverage, but you will need to pay the full cost of your coverage until you reach age 55. Your company subsidy will begin once you reach age 55.

However, if you are involuntarily separated at any time for business reasons and meet the Rule of 73 with at least 15 years of service as of June 30, 2006, Verizon will provide the service-based company subsidy as part of your separation benefit, regardless of your age. (See "Your Severance Program" summary plan description [SPD] for more information.)

The subsidy limit

Starting January 1, 2008, the company subsidy is a fixed amount, based on the total cost of the target plan for 2007, your subsidy percentage and your Medicare-eligibility status.

An additional company contribution

The company may provide a subsidy in addition to the fixed subsidy described above. This subsidy will equal the dollar amount needed to ensure that a retiree in the target plan will have no more than a 15% increase in retiree medical contributions each year. You would receive this whether you are in the target plan or another retiree medical option. So the **dollar** amount of the company subsidy each year can vary if there is an additional company contribution resulting from an annual increase of more than 15% in the retiree contribution for the target plan.

Here are two examples:

Example

It is important to recognize the value Verizon is providing by limiting the increase in retiree contributions for the target plan to 15% on an annual basis. Compare the calculations in the first table with those in the second. Both tables assume a retiree with 30 or more years of service with an 80% subsidy on the $400 indemnity option (the target plan for 2007) and a retiree plus one election.

With 15% protection

Year	Total cost of coverage	Company subsidy	Retiree contribution	Company/retiree cost percentage	Percentage increase in retiree contributions
2007	$11,952.37	$9,561.90	$2,390.47	80%/20%	N/A
2008	$12,848.80	$10,099.76	$2,749.04	79%/21%	15%
2009	$13,748.22	$10,586.81	$3,161.41	77%/23%	15%
2010	$14,641.85	$11,006.24	$3,635.61	75%/25%	15%

Without 15% protection

Year	Total cost of coverage	Company subsidy	Retiree contribution	Company/retiree cost percentage	Percentage increase in retiree contributions
2007	$11,952.37	$9,561.90	$2,390.47	80%/20%	N/A
2008	$12,848.80	$9,561.90	$3,286.90	74%/26%	38%
2009	$13,748.22	$9,561.90	$4,186.32	70%/30%	27%
2010	$14,641.85	$9,561.90	$5,079.95	65%/35%	21%

Please note that the numbers in these examples are for illustration only; they do not reflect the actual costs or contributions.

In addition, the 15% protection is not a guarantee that retiree contributions under all available plans will not increase by more than 15% per year. Retiree contributions under any plan other than the $400 deductible target plan may increase by more (or less) than 15% per year. This is because the retiree contribution under a plan is based on the total cost of coverage for such plan less the company subsidy, and the company subsidy level is based on the cost of the target plan and not any other plan.

If, for example, the total cost of coverage under an HMO increases more rapidly than the total cost of coverage for the target plan, retiree contributions for the HMO may increase by much more than 15% per year. In addition, in any given year, the percentage increase in the retiree contribution for a plan (including the target plan) may be more than the percentage increase in the total cost of coverage for the plan, and retiree contributions for a plan may increase even though the overall cost of that particular plan remains the same or decreases.

For more information about how the subsidy limit and 15% protection are applied, please contact the Verizon Benefits Center.

Eligibility for Medicare

Once you reach age 65, the percentage of your company subsidy is applied to the total cost (fixed as of January 1, 2008) of a target plan that coordinates with Medicare. Therefore, the dollar amount you receive from your subsidy will be affected by Medicare eligibility.

Here is an example: Assume you are age 63 on January 1, 2008. The company subsidy will be calculated by multiplying your subsidy percentage by the total cost of coverage for the target plan that **does not** coordinate with Medicare. When you turn age 65 in 2010, you will be eligible for Medicare. At this time, the company subsidy amount will be determined by multiplying your subsidy percentage by the total cost of coverage for 2007 of the target plan that **does** coordinate with Medicare. When you are eligible for Medicare, the company will also provide any additional contribution necessary to ensure that a retiree under the target plan would not experience an increase in retiree contributions of more than 15% each year from and after January 1, 2008.

About your monthly costs

The actual contributions you are required to make will vary according to the healthcare option you elect. If you are in a plan with a total cost that is different from the cost under the target plan, Verizon will still provide a subsidy based on a percentage of the total cost of the target plan and you will have to pay the balance, if any, of the total cost under the plan you have elected.

At the end of each year, you will receive information on the cost of coverage (if any) for the next calendar year. The new cost will take effect January 1, and will be reflected in your bill for January or in your pension check.

Basic retiree dental coverage is provided at no cost if you elect retiree medical coverage. Supplemental dental coverage is available at a cost for employees who had 15 years of service (including the additional 18 months, if eligible) as of June 30, 2006 and retire before January 1, 2008. See "Your Retiree Dental Coverage" summary plan description (SPD) for more information about dental coverage in retirement.

Special rules for retiree subsidies

You are not eligible for **company-subsidized** retiree medical coverage if any of these situations apply:

- You had less than 15 years of service (including the 18 additional months, if eligible) as of June 30, 2006.
- You had not reached normal retirement age with five years of service (including the 18 additional months, if eligible) as of June 30, 2006.
- You were hired, or leave the company and are subsequently rehired, on or after January 1, 2005 into a position with management benefits.

However, circumstances vary, and certain rehired employees may be eligible for a subsidy based on past service:

- If you are retirement-eligible when you leave Verizon and are later rehired, you will be eligible for a company subsidy toward your retiree medical coverage based on your past service:
  - If your original retirement date was before January 1, 2005, and you were rehired on or after January 1, 2005, your company subsidy at your second retirement will be based on your service earned as of your first retirement.
  - If your original retirement date was on or after January 1, 2005, but before June 30, 2006, and you were rehired, your company subsidy at your second retirement will be based on your eligible service with a participating company that was applied toward a subsidy as of your first retirement.

— If your original retirement date is on or after June 30, 2006, and you are subsequently rehired, you will be eligible for a company subsidy at your second retirement based on your eligible service in a participating company through June 30, 2006 if you had 15 years of service (including the 18 additional months, if eligible) as of June 30, 2006. You also may be eligible for a subsidy at second retirement if you had reached normal retirement age with five years of service under the Verizon Management Pension Plan (including the 18 additional months, if eligible) as of June 30, 2006.

- If you are an employee of the former GTE with Change in Control (CIC) protection, leave Verizon and are later rehired, you will receive a subsidy based on all of your service with Verizon if you choose to participate in the former GTE retiree medical plan when you retire. To be eligible for CIC protection, you had to have been retirement-eligible under your former GTE pension plan no later than May 18, 2004. (See "Change in Control [CIC] protections for employees of the former GTE.") If you choose coverage under the Verizon retiree medical plan when you retire, the subsidy will be based only on your eligible service earned as of your prior retirement date.

If you transfer from an associate position to a management position and retire from a management position, you will:

- Be eligible for a company subsidy toward retiree welfare coverage if you had 15 years of service in your associate position as of June 30, 2006. Eligibility for and the amount of your subsidy will be based on your service as of June 30, 2006.

- Not be eligible for a company subsidy toward retiree welfare coverage if you had less than 15 years of service in your associate position as of June 30, 2006.

If you are a management employee currently working for a Verizon affiliate that does not provide a company subsidy toward retiree medical coverage and you transfer to a management position at a Verizon affiliate that provides a company subsidy:

- **Before July 1, 2005**, you remain at a participating affiliate and you subsequently retire, you will receive a company subsidy based on all of your net credited service through June 30, 2006.

- **On or after July 1, 2005**, you will not be eligible for a company subsidy toward retiree medical coverage.

If you are a management employee currently working for a Verizon affiliate that provided a company subsidy toward retiree medical coverage and you transfer to a management position at a Verizon affiliate that does not provide a company subsidy, you will be eligible for a company subsidy only if you transfer on or after July 1, 2006 and had at least 15 years of eligible service on June 30, 2006 or if you transferred before July 1, 2006 and you are retirement-eligible before your transfer.

The following chart highlights the circumstances that allow for a company subsidy toward retiree medical coverage.

All footnotes indicated in the chart are explained at the end of the chart.

Employee Group[1]	Access only	Subsidy on eligible service[2] before rehire or transfer	Subsidy on eligible service as of June 30, 2006	Subsidy on all service
New hire on or after January 1, 2005	X			
Active management employee in a former participating company hired before January 1, 2005 and remaining in the former participating company:				
• Less than 15 years of service (including additional 18 months, if eligible) on June 30, 2006	X			
• 15 years of service (including additional 18 months, if eligible) on June 30, 2006			X	
• Normal retirement age with 5 years of service on June 30, 2006			X	
• Less than normal retirement age on June 30, 2006, retires at normal retirement age under a pension plan but does not have the Rule of 75	X			
• fGTE CIC-protected plan (Rule of 76 as of May 18, 2004)				X
Hire • Mandatory Portability Agreement (MPA) management or former associate employees • met the MPA requirements for service recognition:				
• Hired into fBA portability company – does not waive MPA				
➢ Retirement-eligible under prior MPA company		X		
➢ Not retirement-eligible under prior MPA company	X			
• Hired into fBA portability company • waives MPA	X			
• Hired into fBA company that is not a portability company	X			
• Hired into fGTE company	X			
Rehire on or after January 1, 2005 of management or associate retiree who was retirement-eligible at first termination:				
• Verizon Medical Plan		X		
• fGTE CIC-protected plan (Rule of 76 as of May 18, 2004)				X
Rehire on or after January 1, 2005 of management or associate employee who was **not** retirement-eligible at first termination	X			
Rehire • Divested employees				
• Retirement-eligible for retiree medical from Verizon at divestiture				
➢ Verizon Medical Plan		X		
➢ fGTE CIC-protected plan (Rule of 76 as of May 18, 2004)				X
• Not retirement-eligible for retiree medical from Verizon at divestiture	X			
Promotion • associate to management participating company				
• Hired as an associate prior to January 1, 2005 and promoted to management before July 1, 2006				
➢ 15 years of service (with additional 18 months, if eligible) on June 30, 2006			X	
➢ Less than 15 years of service (with additional 18 months, if eligible) on June 30, 2006	X			

Employee Group[1]	Access only	Subsidy on eligible service[2] before rehire or transfer	Subsidy on eligible service as of June 30, 2006	Subsidy on all service
• Hired as an associate prior to January 1, 2005 and promoted to management on or after July 1, 2006				
➢ 15 years on June 30, 2006 (**not** eligible for additional 18 months)			X	
➢ Less than 15 years on June 30, 2006, but 15+ at promotion	X			
➢ Less than 15 years on June 30, 2006 and less than 15 at promotion	X			
• Hired as an associate on or after January 1, 2005 and later promoted to management	X			
• fGTE associate already retirement-eligible with the Rule of 76 as of May 18, 2004 under fGTE CIC-protected plan				X
Insourced employees	X			
Transfer from an 80% affiliate that provides only access to retiree medical (e.g., VZB, VCS, VZ Avenue and FNS) to a participating company	X[3]			
• Already retirement-eligible with the Rule of 76 as of May 18, 2004 under fGTE CIC-protected plan				X
Transfer from 80% affiliate with retiree medical subsidies to 80% affiliate without retiree medical subsidies				
• Initial transfer to access-only affiliate occurs before July 1, 2006				
➢ Already retirement-eligible under Verizon retiree medical plan at transfer date		X		
➢ Not retirement-eligible under Verizon retiree medical plan at transfer date	X			
➢ VCS employees grandfathered through December 31, 2005 and retirement-eligible by December 31, 2005 will remain grandfathered, but no additional subsidy after December 31, 2005		X		
➢ Transfer to Verizon Business on or after January 6, 2006 and prior to July 1, 2006 and has 15 years of service (with additional 18 months) as of June 30, 2006			X	
• Initial transfer to access-only affiliate occurs after June 30, 2006				
➢ 15 years of service on June 30, 2006 (with additional 18 months, if applicable)			X	
➢ Less than 15 years (with 18 additional months, if applicable) on June 30, 2006	X			
• Already retirement-eligible with the Rule of 76 as of May 18, 2004 under fGTE CIC-protected plan				X

Employee Group[1]	Access only	Subsidy on eligible service[2] before rehire or transfer	Subsidy on eligible service as of June 30, 2006	Subsidy on all service
Transfer from 80% affiliate with retiree medical subsidies (not retirement-eligible) to 80% affiliate without retiree medical subsidies and returns to 80% affiliate with retiree medical subsidies				
• Initial transfer to access-only affiliate occurs before July 1, 2006				
➢ Already retirement-eligible under Verizon retiree medical plan at transfer date		X[4]		
➢ Not retirement-eligible under Verizon retiree medical plan at transfer date	X			
➢ Transfer to Verizon Business on or after January 6, 2006 and prior to July 1, 2006			X	
• Initial transfer to access-only affiliate occurs after June 30, 2006				
➢ 15 years of service on June 30, 2006 (with additional 18 months if applicable)			X	
➢ Less than 15 years (with 18 additional months, if applicable) on June 30, 2006	X			
• Already retirement-eligible with the Rule of 76 as of May 18, 2004 under fGTE CIC-protected plan				X
Verizon Wireless employee transferred to or hired/rehired by Verizon Communications participating company				
• Employee directly transferred from fGTE to Verizon Wireless on or after July 10, 2000 and before January 1, 2002		X[5]		
• Employee transferred from fGTE to Verizon Wireless on or after January 1, 2002 and before July 1, 2006		X[6]		
• fGTE CIC-protected plan (Rule of 76 as of May 18, 2004)		X[7]		
• Employee directly transferred from a fBA company or Verizon company to Verizon Wireless before July 1, 2006		X[6]		
• Employee in a participating company on June 30, 2006 with 15 years of service (with additional 18 months, if applicable) directly transferred from Verizon to Verizon Wireless on or after July 1, 2006			X[8]	
• Employee in a participating company on June 30, 2006 with less than 15 years of service (with additional 18 months) directly transfers from Verizon to Verizon Wireless on or after July 1, 2006	X[8]			
• No prior fBA or fGTE service and transfers from Verizon Wireless to a Verizon Communications participating company	X			

Contact the Verizon Benefits Center if you have questions about these special rules.

Footnote 1 – Relates to general rules

In addition to the specific rules outlined for each employee group, these general principles apply unless otherwise indicated in the matrix or the footnotes:
(i) Service at non-participating companies will not count toward the subsidy.
(ii) If the employee had less than 15 years of service, including the 18-month enhancement if eligible, on June 30, 2006, the employee will not be eligible for a subsidy.
(iii) Employees not already eligible for a subsidy and not earning service toward a subsidy on June 30, 2006 cannot later become eligible for a subsidy.
(iv) For former GTE CIC-protected employees (retirement-eligible under the GTE pension plan's Rule of 76 as of May 18, 2004), the employee will continue to earn service toward a subsidy while working for a non-participating company and for service after June 30, 2006. However, the employee is not eligible for the additional 18 months of service granted on June 30, 2008, and the additional service earned applies only to the former GTE Retiree CHOICES program.
(v) For complicated employee work histories, it may be necessary to refer to more than one matrix cell as well as the eligibility criteria.

Example:

Hired at GTE Service Corporation (Verizon Corporate Services Group Inc.) at age 28	January 1, 1990	Employee begins earning service toward subsidy.
Transfers to Verizon Wireless	January 1, 2003	Employee stops earning service.
Transfers to Verizon Services Organization	January 1, 2006	Employee again earns service toward the subsidy through June 30, 2006. Employee has 15 years of service on June 30, 2006 based on 13 years at Verizon Corporate Services Group plus 2 years at Verizon Services Organization (6 months at Verizon Services Organization plus 18 additional months).
Transfers to Verizon Business	January 1, 2011	Employee continues to earn service toward eligibility for retiree medical.
Retires from Verizon Business	January 1, 2020	Employee is eligible for a subsidy based on 15 years toward the subsidy and 27 years of eligibility service. Subsidy is based on 15 years of service (13 years at Verizon Corporate Services Group, plus 2 years after return to Verizon Services Organization [6 months at Verizon Services Organization plus 18 additional months]). The employee has 27 years toward retirement eligibility based on 13 years at Verizon Corporate Services Group, plus 5 years at Verizon Services Organization, plus 9 years at Verizon Business.

Footnote 2 – Relates to general rules

If initial termination or transfer from a Verizon participating company (or hire from a Portability Company) is after June 30, 2006, only eligible service through June 30, 2006 is counted toward subsidy, if any.

Example:

Hired at GTE Florida at age 25	January 1, 1982	Employee begins earning service toward subsidy.
Transfers to Verizon Connected Solutions (VCS)	January 1, 2007	Eligible for subsidy at transfer based on 25 years of retirement eligibility service and 50 years of age. Subsidy based on 26 years of service (24.5 years at Verizon Florida plus 18 additional months).
Retires from VCS	January 1, 2009	Employee is eligible for subsidy based on 26 years toward the subsidy and 27 years of eligibility service. Subsidy is based on 24 years, 6 months from January 1, 1982 through June 30, 2006, plus 18-month enhancement. The employee has 27 years toward retirement eligibility (25 years at Verizon Florida plus 2 years at VCS – the 18-month enhancement does not apply toward eligibility service).

Footnote 3 – Relates to Transfer from an 80% affiliate that provides only access to retiree medical (e.g., VZB, VCS, VZ Avenue and FNS) to a participating company

Employees who transfer to a participating company before July 1, 2005 will be eligible for a retiree medical subsidy based on all service through June 30, 2006 as long as they remain in a participating company. Employees who transfer to a participating company on or after July 1, 2005 will not be eligible for a subsidy. Certain former GTE employees working at non-participating companies may be eligible for a subsidy if the employee is CIC-protected.

Example 1:

Hired at MCI at age 30	January 1, 1991	No retiree medical offered.
Acquired by Verizon Business	January 6, 2006	No retiree medical offered at acquisition date. (Access to purchase retiree medical now is available for retirement-eligible employees.)
Transfers to Verizon Services Operations	January 1, 2009	Employee earns service toward retirement eligibility, but is not eligible for a subsidy.
Retires from Verizon Services Operations	January 1, 2021	Employee is retirement-eligible based on 30 years of eligibility service and 60 years of age and may purchase retiree medical by paying the full cost.

Example 2:

Hired at Federal Network Systems at age 32	January 1, 1991	No retiree medical offered at date of hire.
Transfers to Verizon Virginia	January 1, 2006	Employee is not eligible for retiree medical subsidy since employee did not have previous participating company service. The Verizon retiree medical plan does not allow new entrants on or after January 1, 2005, unless employee transfers from a non-participating company to a participating company before July 1, 2005.
Retires from Verizon Virginia	January 1, 2021	Employee is retirement-eligible based on 30 years of eligibility service and 62 years of age. (Access to purchase retiree medical now is available for retirement-eligible employees.)

Example 3:

Hired at Federal Network Systems at age 32	January 1, 1991	No retiree medical offered at date of hire.
Transfers to Verizon Virginia	January 1, 2005	FNS service is counted in determining subsidy since employee transferred before July 1, 2005.
Retires from Verizon Virginia	January 1, 2021	Employee is eligible for a subsidy based on 17 years toward the subsidy and 30 years of eligibility service. Subsidy is based on 14 years at FNS, plus 3 years in Verizon Virginia (1.5 years from January 1, 2005 through June 30, 2006, plus 18 additional months). The employee has 30 years toward retirement eligibility based on 14 years at FNS, plus 16 years at Verizon Virginia.

Footnote 4 – Relates to transfer from 80% affiliate with retiree medical subsidies to 80% affiliate without retiree medical subsidies and returns to 80% affiliate with retiree medical subsidies

The employee may again earn service toward a subsidy after returning to a participating company with retiree medical if the return is before July 1, 2006, but the period at the non-participating company will be excluded unless the employee returned before July 1, 2005. If the employee returned before July 1, 2006, and again earned service toward the subsidy, only the service earned through June 30, 2006, will be used to determine the subsidy, if any. The employee will be able to earn additional eligibility service.

Example 1:

Hired at Verizon Maryland at age 28	January 1, 1986	Employee begins earning service toward subsidy.
Transfers to Verizon Connected Solutions (VCS)	January 1, 2000	VCS is a non-participating company. Employee is not eligible for a subsidy since the employee was not retirement-eligible before transfer.
Transfers to Verizon Maryland	January 1, 2006	Transfer date is before subsidy freeze date; therefore, the employee again earns service toward the subsidy through June 30, 2006, but the period of service at VCS is excluded in determining the amount of the subsidy. Employee reaches retirement eligibility at Verizon Maryland.
Retires from Verizon Maryland	January 1, 2010	Employee retires at age 52. The employee is eligible for a subsidy at age 55 based on 16 years toward the subsidy and 24 years of eligibility service. Subsidy is based on 14 years at Verizon Maryland, plus 2 years after return to Verizon Maryland (6 months from January 1, 2006 through June 30, 2006, plus 18 additional months). (VCS time is excluded for purposes of determining the subsidy.) The employee has 24 years toward retirement eligibility based on 14 years at Verizon Maryland, plus 6 years at VCS, plus 4 years at Verizon Maryland.

Example 2:

Hired at Verizon Virginia at age 25	January 1, 1985	Employee begins earning service toward subsidy.
Transfers to Verizon Connected Solutions	January 1, 2000	VCS is a non-participating company on date of transfer. Employee is not eligible for a subsidy since the employee was not retirement-eligible before transfer and did not meet retirement eligibility before December 31, 2005.
Transfers to Verizon Virginia	January 1, 2008	The employee is not eligible for a subsidy since the employee was not eligible before transfer to the non-participating company, and was not earning service toward a subsidy on June 30, 2006.
Retires from Verizon Virginia	January 1, 2015	Employee is not eligible for a subsidy, but may purchase retiree medical at the full cost. The employee has 30 years toward retirement eligibility based on 15 years at Verizon Virginia, plus 8 years at VCS, plus 7 years at Verizon Virginia.

Footnote 5 – Relates to Employees directly transferred from fGTE to Verizon Wireless on or after July 10, 2000 and before January 1, 2002

For employees who transferred from a former GTE company before January 1, 2002, the company subsidy, if any, will be based on the employee's service with fGTE/Verizon Communications prior to transfer, and service with Verizon Wireless through May 18, 2004.

Example 1:

Hired at GTE Wireless at age 36	January 1, 1998	Employee begins earning service toward subsidy.
Transfers to Verizon Wireless	July 10, 2000	Employee continues to earn service at Verizon Wireless for subsidy and eligibility through January 1, 2003. (fGTE employees earn service at Verizon Wireless through earlier of transfer back to Verizon or May 18, 2004.)
Transfers to Verizon South	January 1, 2003	Employee continues to earn service for subsidy and eligibility through June 30, 2006, and for eligibility only on and after July 1, 2006.
Retires from Verizon South	January 1, 2018	Employee is not eligible for a subsidy, but may purchase retiree medical. Employee did not have 15 years as of June 30, 2006. Service as of June 30, 2006 was only 10 years based on 2 years, 6 months at GTE Wireless, plus 2 years, 6 months at Verizon Wireless, plus 5 years at Verizon South through June 30, 2006 (3 years 6 months plus 18-month enhancement). The employee has 20 years toward retirement eligibility based on 2 years, 6 months at GTE Wireless, plus 2 years, 6 months at Verizon Wireless, plus 15 years at Verizon South.

Example 2:

Hired at GTE Wireless at age 32	January 1, 1995	Employee begins earning service toward subsidy.
Transfers to Verizon Wireless	July 10, 2000	Employee continues to earn service at Verizon Wireless for subsidy and eligibility through May 18, 2004.
Transfers to Verizon New Jersey	January 1, 2010	Employee is not eligible for a subsidy. Employee will again begin earning service toward eligibility for access to retiree medical.
Terminates from Verizon New Jersey	January 1, 2015	Employee is not eligible for retiree medical. Employee does not have 15 years of eligibility service or 75 points. (Eligibility service totals 14 years, 4 months based on 5 years, 6 months at GTE Wireless, plus 3 years, 10 months at Verizon Wireless, plus 5 years at Verizon New Jersey.)

If the fGTE employee returns to Verizon Communications in a participating affiliate, and the return is before June 30, 2006, the employee will earn additional service toward the subsidy from date of return to Verizon Communications through June 30, 2006, but the time at Verizon Wireless after May 18, 2004 will not be recognized for any purpose. The employee must have 15 years as of June 30, 2006, with the 18-month enhancement, if applicable, to be eligible for a subsidy.

Example:

Hired at GTE Wireless at age 28	January 1, 1992	Employee begins earning service toward subsidy.
Transfers to Verizon Wireless	July 10, 2000	Employee earns service for subsidy and eligibility through May 18, 2004. Employee is not retirement-eligible.
Transfer to Verizon Southwest	January 1, 2005	Employee again earns service toward subsidy through June 30, 2006, and toward retirement eligibility.
Retires from Verizon Southwest	January 1, 2017	Employee retires at age 53. Employee is eligible for a subsidy at age 55 based on 15 years toward the subsidy and 24 years of eligibility service. Subsidy is based on 8 years, 6 months at GTE Wireless, plus 3 years, 10 months at Verizon Wireless, plus 3 years at Verizon Southwest (1.5 years from January 1, 2005 through June 30, 2006 plus 18-month enhancement). The employee has 24 years toward retirement eligibility based on 8 years, 6 months at GTE Wireless, plus 3 years, 10 months at Verizon Wireless, plus 12 years at Verizon Southwest. Service after May 18, 2004 at Verizon Wireless is not recognized for any purpose.

Footnote 6 – Relates to:

- Employees directly transferred from fGTE to Verizon Wireless on or after January 1, 2002 and before July 1, 2006; and
- Employees directly transferred from a fBA company or a Verizon company to Verizon Wireless any time before July 1, 2006. Employees are eligible for a subsidy, if any, based on service prior to transfer to Verizon Wireless.

For employees who transferred from fGTE to Verizon Wireless on or after January 1, 2002, and before January 1, 2005, or from a former Bell Atlantic company, the company subsidy, if any, will be based on the employee's service with fGTE or fBA and Verizon Communications (whether or not in a participating company) prior to the earlier of January 1, 2005 or direct transfer to Verizon Wireless. Service on and after January 1, 2005 with a Verizon Communications non-participating company will not count toward the subsidy. Service after return to Verizon Communication in a participating affiliate and before July 1, 2006 will be added to prior Verizon Communications service previously recognized for subsidy purposes. If the employee returns on or after July 1, 2006, and was not eligible for a subsidy prior to transfer to Verizon Wireless, the employee will be eligible for access to purchase retiree medical once the employee meets retirement eligibility.

Example 1:

Hired at Verizon New York at age 25	January 1, 1988	Employee begins earning service toward subsidy.
Transfers to Verizon Wireless	January 1, 2003	Employee stops earning service and is not retirement-eligible.
Terminates from Verizon Wireless	January 1, 2013	Employee is not eligible for retiree medical.

Example 2:

Hired at Verizon California at age 28	January 1, 1991	Employee begins earning service toward subsidy.
Transfers to Verizon Wireless	January 1, 2002	Employee stops earning service and is not retirement-eligible.
Transfers to Verizon California	January 1, 2004	Transfer date is before freeze date; therefore, the employee again earns service toward the subsidy through June 30, 2006.
Retires from Verizon California	January 1, 2017	Employee is eligible for a subsidy at age 55 based on 15 years toward the subsidy and 24 years of eligibility service. Subsidy is based on 11 years at Verizon California, plus 4 years after return to Verizon California (2.5 years from January 1, 2004 through June 30, 2006 plus 18-month enhancement). The employee has 24 years toward retirement eligibility based on 11 years at Verizon California, plus 13 years after return to Verizon California. Service at Verizon Wireless is not recognized for any purpose.

Footnote 7 – Relates to Employees who directly transfer to Verizon Wireless and who are eligible under the fGTE CIC-protected plan (Rule of 76 as of May 18, 2004)

The employee's service with fGTE and Verizon Communications will count toward the subsidy. If the employee transferred directly to Verizon Wireless before January 1, 2002, service with Verizon Wireless will count through May 18, 2004 toward eligibility and the subsidy. Service with Verizon Wireless after May 18, 2004 will be excluded for purposes of retirement eligibility and the subsidy regardless of whether the employee remains at Verizon Wireless or returns to Verizon Communications. If the employee returns to a Verizon Communications participating company, the employee will again earn service toward a subsidy before July 1, 2006 for the Verizon retiree medical plan. The employee also will earn service toward a subsidy for the former GTE Retiree CHOICES program after return to Verizon Communications, whether in a participating or non-participating company, whether before or after July 1, 2006.

Example 1:

Hired at GTE Wireless at age 36	January 1, 1984	Employee begins earning service toward subsidy.
Transfers to Verizon Wireless	July 10, 2000	Employee earns service for subsidy and eligibility through May 18, 2004. Employee reaches retirement eligibility (Rule of 76) in January, 2004.
Retires from Verizon Wireless with former GTE benefits	January 1, 2007	Employee is eligible for a subsidy based on 20 years toward the subsidy and 20 years of eligibility service. Subsidy is based on 16 years, 6 months at GTE Wireless, plus 3 years, 10 months at Verizon Wireless. Employee is not eligible for the 18-month enhancement since the employee is not actively employed at a Verizon participating company on June 30, 2006. The employee has 20 years toward retirement eligibility based on 16 years, 6 months at GTE Wireless, plus 3 years, 10 months at Verizon Wireless. Service after May 18, 2004 at Verizon Wireless is not recognized for any purpose.

If a fGTE employee returns to a Verizon non-participating company on or after January 1, 2005, the employee will be eligible for the Verizon Retiree Medical Plan; however, the subsidy, if any, for the Verizon plan will be based only on prior fGTE/Verizon Communications service, and if applicable, Verizon Wireless service prior to May 18, 2004.

Example 2:

Hired at GTE South at age 36	January 1, 1981	Employee begins earning service toward subsidy. Employee reaches retirement eligibility on January 1, 2001.
Transfers to Verizon Wireless	January 1, 2001	Employee earns service for subsidy and eligibility through May 18, 2004.
Transfers to Federal Network Systems (FNS)	January 1, 2005	Employee does not earn additional service toward Verizon retiree medical subsidy since FNS is a non-participating company. However, employee continues to earn service toward fGTE Retiree CHOICES program since employee met the Rule of 76 by May 18, 2004. Employee earns service toward retirement eligibility under both the Verizon medical and the fGTE Retiree CHOICES programs.
Retires from FNS	January 1, 2008	Employee has choice of : • Verizon retiree medical subsidy based on 23 years (20 years at GTE South plus 3 years, 4 months at Verizon Wireless) • fGTE Retiree CHOICES subsidy based on 26 years (20 years at GTE South plus 3 years, 4 months at Verizon Wireless, plus 3 years at FNS) The employee has 26 years toward retirement eligibility based on 20 years at GTE Wireless plus 3 years, 4 months at Verizon Wireless, plus 3 years at FNS.

If a fGTE employee transfers to Verizon Wireless on or after January 1, 2002, the employee will not earn any service while at Verizon Wireless for the subsidy.

Example 3:

Hired at GTE South at age 32	January 1, 1982	Employee begins earning service toward subsidy. Employee reaches retirement eligibility in January, 2004.
Transfers to Verizon Wireless	January 1, 2005	Employee stops earning service.
Transfers to Verizon Virginia	January 1, 2008	Employee again earns service toward retiree medical eligibility. Employee earns service toward subsidy for fGTE Retiree CHOICES program, but not for the Verizon retiree medical program.
Retires from Verizon Virginia	January 1, 2014	Employee has choice of : • Verizon retiree medical subsidy based on 23 years at GTE South prior to transfer • fGTE Retiree CHOICES subsidy based on 29 years (23 years at Verizon South plus 6 years at Verizon Virginia) The employee has 29 years toward retirement eligibility based on 23 years at GTE South, plus 6 years at Verizon Virginia.

Footnote 8 – Relates to Employee directly transferred from Verizon to Verizon Wireless on or after July 1, 2006 who was employed by a participating company on June 30, 2006

If the employee transferred to Verizon Wireless on or after July 1, 2006 and has remained at Verizon Wireless through December 21, 2007, or transferred to Verizon Wireless after December 21, 2007, Verizon Wireless service will count toward eligibility, provided the employee does not take a distribution from the Verizon Communications retirement plan, but the employee will not be credited with additional service for the subsidy, if any.

Example 1:

Hired at Verizon New Jersey at age 40	January 1, 2001	Employee begins earning service toward subsidy. Service toward subsidy determined through June 30, 2006, plus 18-month enhancement. (5.5 years at Verizon New Jersey plus 18 months totals 7 years -- not eligible for subsidy).
Transfers to Verizon Wireless	January 1, 2007	Continues to earn service toward retirement eligibility, but not for the subsidy, since employee remained at Verizon Wireless through December 21, 2007.
Retires from Verizon Wireless	January 1, 2019	Employee is not eligible for a subsidy, but may purchase retiree medical from Verizon New Jersey. The employee has 18 years of eligibility service based on 6 years at Verizon New Jersey plus 12 years at Verizon Wireless.

Example 2:

Hired at Verizon Pennsylvania at age 34	January 1, 1991	Employee begins earning service toward subsidy. Service toward subsidy determined through June 30, 2006, plus 18-month enhancement.
Transfers to Verizon Wireless	January 1, 2008	Employee continues to earn service toward retirement eligibility, but not for the subsidy.
Retires from Verizon Wireless	January 1, 2022	Employee is eligible for a subsidy based on 17 years (15.5 at Verizon Pennsylvania plus 18 months). The employee has 31 years of eligibility service based on 17 years at Verizon Pennsylvania, plus 14 years at Verizon Wireless.

When coverage begins

When you retire, if you enroll for coverage or receive default coverage, medical coverage begins on the first day of the month following retirement.

If you elect no coverage when you retire, then later enroll for retiree medical, coverage begins on the first day of the month following a 30-day waiting period.

If you enroll your dependents when you enroll yourself, their coverage is effective on the day your coverage begins.

Changing your coverage

Your election generally stays in effect until you change it.

You can drop coverage or change your option or the dependents you cover at any time during the year. However, if you change options mid-year, you may have to meet deductibles and out-of-pocket maximums under both options.

Your new election takes effect the first day of the month following a 30-day waiting period. Your current coverage remains in effect during the waiting period. You can make changes through Your Benefits Resources Web site or by calling the Verizon Benefits Center.

Here are some examples of when a change will be effective:

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

Special rules apply if you're changing from or electing a Medicare Advantage (MA) Plan, also referred to as Medicare HMOs, including Medicare Advantage Prescription Drug (MA-PD) Plans. You need to complete and return an HMO enrollment form, which will be sent to you by the Verizon Benefits Center. The health plan will need to approve the form and return it to the Benefits Center. If the form is received by Benefits Center by the 15th of the month, your coverage will be effective on the first of the following month. If it is received after the 15th, then there will be a delay in your enrollment. Enrollment into and out of other Medicare plans, such as standalone Medicare Prescription Drug Plans, may be more restrictive.

To make a change due to a qualified change in status or in certain other circumstances, listed below, go to Your Benefits Resources Web site or call the Verizon Benefits Center. If you notify the Verizon Benefits Center within 60 days of the status change, your new coverage will take effect as of the date of the change. If you notify the Verizon Benefits Center after 60 days, your new coverage will take effect the date of the notification.

Qualified changes in status

A qualified change in status is a specific change in circumstance that affects eligibility for coverage. Changes to coverage must be due to and consistent with the qualified change in status:

- You get married, divorced, or legally separated and the separation causes a loss of eligibility under your spouse's plan, or your marriage is annulled.
- Your spouse or dependent dies.
- You gain a domestic partner, or lose one through separation or death.

- You have a baby, adopt or have a child placed in your care for adoption.

- Your dependent gains or loses eligibility status (for example, becomes a legal dependent, attains age 19, or starts or quits school).

- You, your spouse or your dependent moves to a new place of residence, resulting in a loss or gain of eligibility for coverage.

- You, your spouse or your dependent has a change in employment status resulting in a loss or gain of eligibility for coverage. For example, one of you:

  — Takes or returns from an unpaid leave of absence.

  — Switches from full-time to part-time employment (or vice versa).

  — Begins or ends employment. (This provision does not apply if rehired within 30 days.)

  — Switches from hourly to management (or vice versa).

  — Is involved in a strike or lockout.

  — Experiences a change in worksite.

Special enrollment rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you additional flexibility in **whom** you can enroll due to marriage, birth, adoption or placement for adoption:

- **New or non-enrolled spouse/new child:** If you are enrolled, you can enroll your spouse when you marry. In addition, you can enroll your spouse or a child who becomes your eligible dependent as a result of the birth, adoption or placement for adoption.

Other changes in circumstance

Certain other events also permit you to change your coverage during the year. The change you make must be consistent with the event:

- A qualified medical child support order (QMCSO) requires you, your spouse or your domestic partner to provide healthcare coverage for a dependent.

- You, your spouse or your dependent becomes eligible for or loses Medicare or Medicaid coverage.

- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage from another employer for you, your spouse or your dependent is exhausted.

Deductibles and out-of-pocket maximums when you change options

If you change medical options during the year, you are responsible for full payment of any deductible or out-of-pocket maximum under your new option. In most cases, a new option will not recognize any amounts you paid toward your former option's deductible or out-of-pocket maximum.

However, there may be certain cases when the new option will recognize and apply these payments toward your new deductible and out-of-pocket maximum. Contact the new option administrator to determine if this is possible. However, in no event will the former option recalculate any claims incurred or return any amounts that you previously paid because of this provision.

Your medical plan options

If you are under age 65 and not eligible for Medicare

You can choose from options that are similar to those of active employees, including:

- No coverage option. If you have coverage from another source, you may elect no Verizon medical coverage. You may be required to show proof of the other coverage.

  If you waive medical coverage, you will not receive prescription or mental health and substance abuse treatment coverage.

- Preferred provider organization (PPO) option.

- Exclusive Provider Network (EPN) option.

- $400 indemnity option.

- $2,500 indemnity option.

- Other medical options.

The specific medical options available to you depend on where you live and are listed in your benefits renewal materials on Your Benefits Resources Web site.

If you are age 65 or Medicare-eligible

Once you reach age 65, benefits are coordinated with Medicare:

- No coverage option. If you have coverage from another source, you may elect no Verizon medical coverage. You may be required to show proof of the other coverage.

  If you waive medical coverage, you will not receive prescription or mental health and substance abuse treatment coverage.

- $400 indemnity option.

- $1,000 indemnity option.

- $2,500 indemnity option.

- Other medical options.

The specific medical options available to you depend on where you live and are listed in your enrollment materials on Your Benefits Resources Web site.

Covered healthcare services, supplies and expenses

The options cover medically necessary healthcare services, supplies and expenses related to an illness or injury, and certain other services, supplies and expenses (e.g., preventive care and infertility treatments).

For coverage details on the medical option in which you enroll, refer to the Summary of Coverage (SOC) or Certificate of Coverage (COC) for that option. These documents also have information on how to contact the option administrator for things such as coverage or claims questions, provider referrals, provider directories free of charge, preauthorization or other health services. You also will find the specific definition of medically necessary.

Refer to the "Accessing your benefits information" section for information on how to access the SOC or COC for your option.

Preferred provider organization (PPO) option

The PPO has two options. Each option has a different network:

- **PPO Plus.** This option uses the Choice Plus network.

- **Out-of-Area Plus.** This option uses the Options PPO network, which is available only if you live outside of the Choice Plus network area.

UnitedHealthcare administers the PPO option.

How the PPO networks work

A PPO is a network of healthcare providers who agree to meet strict quality standards and provide services according to a network negotiated fee (NNF) schedule.

The amount the option pays is based on whether or not you use providers that participate in the network.

Here is a brief summary of the PPO option. For details, review the Summary of Coverage (SOC). See “Accessing your benefits information” for directions on obtaining an SOC.

	PPO Plus option		Out-of-Area Plus option
Deductible (per calendar year) • Individual • Family maximum	$1,000 per individual 3 individual deductibles per family		$1,000 per individual 3 individual deductibles per family
Out-of-pocket maximum (per calendar year) • Individual • Family maximum	$2,000 per individual 3 individual out-of-pocket maximums per family		$2,000 per individual 3 individual out-of-pocket maximums per family
Lifetime maximum	Unlimited (in-network) $1 million (out-of-network)		Unlimited (in-network) $1 million (out-of-network)
Provider network	You may use PPO or non-PPO providers, but this option usually pays higher benefits when you use PPO providers.		You may use any provider you choose and receive the same benefits.
Coinsurance for most expenses	**PPO provider**	**Non-PPO provider**	
Deductibles or copayments may be required, and exceptions and limitations may apply.	100% or 80%	100% or 60% of usual and customary charges	100% or 80%
Coverage for physician office visits	100% after $15 copayment	60% of usual and customary charges after deductible	80% after deductible

If you participate in the PPO option, you also are eligible for dental coverage, prescription coverage and mental health and substance abuse treatment coverage.

Exclusive Provider Network (EPN) option

The Exclusive Provider Network (EPN) has two options. Each option has a different network:

- **EPN**. This option uses the Aetna Select (Open Access) network. You must use a network provider to receive benefits. Check with Aetna before seeing a provider to determine if a provider is in the network. When you use network providers, benefits are based on network negotiated fees (NNF).

- **Out-of-area EPN**. This option uses the Aetna Open Choice PPO with Rural PPO network. It is available **only** if you live outside the EPN network area. You can use any provider you choose; however, you generally will pay more when you use out-of-network providers. When you use network providers, benefits are based on network negotiated fees. When you use out-of-network providers, benefits are based on the actual charge, up to the usual and customary limit. You are responsible for paying any amount for non-covered services.

The options cover the same health services, with no deductible or lifetime maximum benefit. Under either option, you pay a copayment for office visits and outpatient laboratory and X ray services. You also pay an inpatient hospital admission copayment each time you are admitted to the hospital. You pay coinsurance for other covered services. There is an out-of-pocket maximum that limits the amount of coinsurance you pay each year.

How the EPN networks work

An Exclusive Provider Network (EPN) is a network of healthcare providers who agree to meet strict quality standards and provide services according to a network negotiated fee (NNF) schedule. The NNF schedule determines the maximum amount a provider can charge. When you use an EPN provider, you must show your ID card to receive the network negotiated fee charge. In general, there are no claim forms to fill out when you use an EPN provider. Otherwise, you will need to complete a claim form.

Here is a brief summary of the EPN option. For details, review the Summary of Coverage (SOC). See “Accessing your benefits information” for directions on obtaining an SOC.

	EPN option	Out-of-Area EPN option
Deductible (per calendar year)	No deductible	No deductible
Out-of-pocket maximum (per calendar year) • Individual • Family	$1,000 per individual $3,000 per family	$1,000 per individual $3,000 per family
Lifetime maximum	No lifetime maximum	No lifetime maximum
Provider network	You can visit any in-network doctor or specialist you choose.	You may use any provider you choose and receive the same benefits.
Coinsurance for most expenses	100% or 90%	100% or 90%
Copayments may be required, and exceptions and limitations may apply.		
Coverage for doctor office visits (including OB/GYN)	100% after $15 copayment	100% after $15 copayment
Coverage for specialist office visits (including mental health providers)	100% after $25 copayment	100% after $25 copayment

If you participate in the EPN option, you also are eligible for dental coverage, prescription coverage and mental health and substance abuse treatment coverage.

Indemnity options

UnitedHealthcare (UHC) administers the indemnity options. Each option covers the same services, supplies and expenses, but the annual deductible, out-of-pocket maximum and premium amounts vary. You can choose among the:

- $400 indemnity option.
- $1,000 indemnity option.
- $2,500 indemnity option.

How the indemnity options work

Under the indemnity options, UHC offers a network of healthcare providers who agree to meet strict quality standards and provide services according to a network negotiated fee (NNF) schedule.

The options pay a percentage of covered charges whether or not you use network providers. If your provider belongs to the UHC network, you generally will pay less because benefits for covered services and supplies are based on usual and customary limits when you use non-network providers.

Here is a brief summary of the indemnity options. For details, review the Summary of Coverage (SOC). See “Accessing your benefits information” for directions on obtaining an SOC.

	Indemnity option
Deductible (per calendar year) • $400 option — Individual — Family maximum • $1,000 option — Individual — Family maximum • $2,500 option — Individual — Family maximum	 $400 per individual 3 individual deductibles per family $1,000 per individual 3 individual deductibles per family $2,500 per individual 2 individual deductibles per family
Out-of-pocket maximum (per calendar year) • $400 option — Individual — Family maximum • $1,000 option — Individual — Family maximum • $2,500 option — Individual — Family maximum	 $3,000 per individual 3 individual out-of-pocket maximums per family $2,000 per individual 3 individual out-of-pocket maximums per family $10,000 per individual 2 individual out-of-pocket maximums per family
Lifetime maximum	$1 million
Provider network	You may use any provider you choose and receive the same benefits.

	Indemnity option
Coverage for most expenses Deductibles or coinsurance may be required, and exceptions and limitations may apply. See your SOC for additional information.	100%, 80% or 70%
Coverage for physician office visits	80% or 70% after deductible

If you participate in an indemnity option, you also are eligible for dental coverage, prescription coverage, mental health and substance abuse treatment coverage and supplemental mental health and substance abuse treatment coverage if you are not eligible for Medicare.

Other medical options

Depending on where you live, additional options may be available to you:

- Health maintenance organization (HMO)/exclusive provider organization (EPO) options.
- Point-of-service (POS) options.

General coverage information is provided later in this section. See “Accessing your benefits information” for directions on obtaining detailed information on your benefit option.

How HMOs/EPOs work

An HMO/EPO is an organized healthcare delivery system providing comprehensive healthcare through selected physicians, hospitals and other providers. Services usually are covered only if you receive care from HMO/EPO providers.

For HMOs, you typically choose a primary care physician (PCP) from a list provided by the HMO when you enroll for coverage, and that physician or facility coordinates all your healthcare requirements. You and your doctor (PCP or specialist) make all decisions about your medical care.

EPOs generally do not require you to select a PCP or obtain a PCP referral to see a specialist.

How point-of-service (POS) options work

You have a choice each time you access medical care – you can receive in-network or out-of-network care. When you receive in-network care, your out-of-pocket costs are lower. If you use out-of-network providers, your out-of-pocket costs will be higher.

General coverage information

Each option administrator is an independent organization with its own contract provisions, benefits and network providers. Review the plan materials carefully – the Summary of Coverage (SOC) or Certificate of Coverage (COC) documents – for details. See “Accessing your benefits information” for directions on obtaining a Certificate or Summary of Coverage.

You also can find information on the Health Plan Comparison Chart available by logging on to Your Benefits Resources Web site or by calling the Verizon Benefits Center.

You also are eligible for:

- Prescription coverage provided by the option or through Verizon's prescription program.

- Mental health and substance abuse treatment coverage. For program details, see the SOC or COC for your medical option.

Emergency coverage
Refer to the plan materials available from your medical option administrator or the Verizon Benefits Center to obtain information about coverage.

Vision care coverage
Refer to the plan materials available from your medical option administrator or the Verizon Benefits Center to obtain information about coverage.

Dental coverage
When you enroll for Verizon retiree medical coverage, you have basic dental coverage as well as any dental or oral surgical coverage provided by your medical option. Supplemental dental coverage also may be available to persons who retire before January 1, 2008. See "Your Dental Coverage" summary plan description (SPD) for more information about dental coverage in retirement.

Prescription drugs
If you participate in the PPO option, the EPN option, an indemnity option or certain other medical options, your prescription coverage is administered by Medco. You can find details in the prescription program Summary of Coverage (SOC). See the "Accessing your benefits information" section for information on how to access this document.

If you participate in certain other options, your prescription coverage is offered through the medical option described in the Certificate of Coverage (COC) or SOC for that option.

Mental health and substance abuse coverage
The program provides treatment for mental health disorders and substance abuse. You can find details about the program in the SOC for your medical plan option. See the "Accessing your benefits information" section for information on how to access this document.

Supplemental benefit for mental health and substance abuse treatment
Verizon has designated a special administrator, currently MHN, to provide additional benefits if you have exhausted the applicable benefit limits for mental health and substance abuse treatment under the medical options. The covered person or the medical option administrator must inform MHN that the option'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 care is medically necessary. If MHN determines that benefits are payable, they are paid at 50%. See the "Medical plan contacts" section for contact information.

This supplemental benefit is not available if you are eligible for Medicare.

Coordination of benefits when you are not eligible for Medicare

If you or your dependents are covered by more than one medical plan (for example, a Verizon medical option and your spouse's plan), you should understand how plans work together to pay for covered services. The coordination of benefits provision is designed to prevent duplicate payments for the same expenses. In other words, you generally cannot be reimbursed twice for an expense that is covered by both plans.

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

- **Who pays first?** The "primary" plan pays benefits first:
  - Generally, the Verizon plan is primary when you (the Verizon retiree) are the patient. However, if you work after retirement and have coverage through another employer, that coverage will likely pay first.
  - If your spouse or domestic partner is the patient and is covered by both a Verizon plan and other group coverage, your spouse's or domestic partner's plan pays first.
  - If your child is the patient and is covered by both a Verizon plan and your spouse's or domestic partner's plan, the decision about which plan pays first is determined by the "birthday rule":
    - The Verizon plan pays first if your (the retiree's) birthday (month/day) comes before your spouse's or domestic partner's in the calendar year (for example, if your birthday is March 1 and your spouse's birthday is August 1).
    - If you and your spouse or domestic partner have the same birthday, the plan covering you or your spouse or domestic partner longer pays first.
    - If your spouse's or domestic partner's plan does not use the birthday rule, the rules of his or her plan determine which plan pays first.
  - In the case of divorce, the plan of the parent with custody of the child generally pays first:
    - If the parent with custody remarries, that parent's plan still pays benefits first.
    - If a court decree gives financial responsibility to the parent without custody, that parent's plan pays benefits first.
  - If your spouse's or domestic partner's plan does not have any coordination of benefits guidelines, that plan pays benefits first.

- **When Verizon pays second:** It will pay the difference between what it normally would pay if there were no coordination (after any deductible or copayment) and what the primary plan pays.

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

When your spouse or domestic partner is a Verizon retiree

If both you and your spouse or domestic partner have Verizon retiree medical coverage, the birthday rule determines primary coverage.

Please note: Special coverage rules apply if your spouse or domestic partner is an associate retiree of the former Bell Atlantic. Please contact the Verizon Benefits Center for more details.

Coordination of benefits with Medicare

This section applies to you if you are a Medicare eligible retiree or a Medicare eligible dependent, even if you are not enrolled in Medicare. Understanding the information it contains will help you avoid larger out-of-pocket expenses.

Medicare eligibility

You generally become eligible for Medicare at these times:

- The first day of the month in which you reach age 65.
- If you become disabled and have received social security disability benefits for 24 months.
- If you have End Stage Renal Disease (ESRD).

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

Whether your Verizon medical plan or Medicare is the primary payer or the secondary payer depends, in part, on your (the covered retiree's) employment status. Since individuals who are eligible for and enroll in the medical coverage described in this summary plan description (SPD) are retirees or dependents of retirees, Medicare generally is the primary coverage if you are Medicare eligible.

When the Verizon medical plan is secondary to Medicare, it pays benefits as if you are enrolled in Medicare Parts A and B, regardless of whether you actually are enrolled or receive Medicare benefits. Therefore, **it is critical that you and your dependents enroll in Medicare Parts A and B as soon as you are eligible, and stay enrolled.**

An overview of Medicare

Medicare is a government program administered by the Centers for Medicare and Medicaid Services (CMS) that provides basic medical coverage. It has several parts:

- Part A helps pay for medically necessary inpatient hospital care, post-hospital skilled nursing facility stays, home health care and hospice care. A monthly contribution, or premium, generally is not required to participate in Medicare Part A. However, in some cases – for example, if your earnings have been too low or sporadic to provide you with Medicare Part A benefits – you will not automatically receive Medicare Part A benefits, but you may be able to obtain Medicare Part A coverage by paying a monthly premium.
- Part B helps pay for medically necessary physicians' services, outpatient medical and surgical services, diagnostic X rays and laboratory tests, and other outpatient services. A monthly premium is required to receive coverage. Most individuals entitled to Medicare Part A automatically are enrolled in Medicare Part B. You pay a monthly premium for Medicare Part B, which is deducted from your social security check.

Medicare Part B enrollment is voluntary, but...
CMS considers Medicare Part B a voluntary benefit. Since Medicare Part B coverage is voluntary, CMS or the Social Security Administration will give you an opportunity to disenroll from Medicare Part B, and may even tell you that "you do not have to have Medicare Part B coverage." While this is true, disenrolling from Medicare Part B can have adverse consequences if Medicare is your primary coverage. When you retire, become disabled or have ESRD, you will need to ensure that you enroll, and remain enrolled, in Part B to avoid missing important benefits under the Verizon retiree medical plan. **If you are eligible for Medicare, your Verizon medical plan pays benefits as if you are enrolled in Medicare Parts A and B, regardless of whether you actually are enrolled or receive Medicare benefits.** So, it is critical that you and your dependents enroll in Medicare Parts A and B as soon as you are eligible.

- Sometimes referred to as Medicare Part C, Medicare Advantage plans are alternative systems of healthcare that combine delivery of care and payment to promote cost-effective healthcare. Verizon only offers Medicare Advantage plans to individuals who have terminated or retired from Verizon and their dependents. The Medicare Advantage plans sponsored by Verizon have contracts with CMS to provide benefits under the Medicare program.

- Part D provides prescription drug coverage. Unlike Parts A and B, you probably should not enroll in Part D. Why? The Verizon prescription coverage outlined in the annual Notice of Creditable Coverage and listed as "creditable" is, on average, as good as or better than the standard Medicare prescription drug coverage. Accordingly, if you maintain enrollment in this Verizon prescription coverage, you will not need to pay extra if you later decide to enroll in a Medicare prescription drug plan (PDP). Verizon will send you a notice before each November 15th that outlines what prescription drug coverage options are "creditable" and what enrolling in a non-creditable plan means to you. A monthly premium generally applies; however, special rules apply if you are a low income individual as defined by CMS. If you enroll in a Medicare Advantage prescription drug plan, you are generally enrolled automatically in Medicare Part D.

For purposes of the "Coordination of benefits with Medicare" section, Medicare premium means Part A, Part B and Part D premiums, as applicable.

For more information about Medicare, contact the Social Security Administration or the Verizon Benefits Center. See the "Medical plan contacts" section for contact information.

Medicare when enrolled in an indemnity option

If you are enrolled in Medicare and an indemnity option, Medicare coverage works similarly to the indemnity option. You are responsible for paying your Medicare deductible before Medicare will begin paying for covered expenses. Then, Medicare pays your healthcare provider for medical services, based on the Medicare allowable charge.

The amount you are responsible for paying depends on whether or not your doctor or other provider has agreed to the Medicare allowable amount. The Medicare allowable amount is the amount Medicare pays for services or supplies, based on a Medicare-approved fee schedule. This agreement between your doctor and Medicare is called Medicare assignment.

- If your doctor accepts Medicare assignment, the doctor will accept payment from Medicare for services based on the fee schedule amount as "payment in full." You will be responsible for the amount Medicare does not cover (usually 20%). You do not have to file a claim with Medicare.

- If your doctor does not accept Medicare assignment, you will be responsible for the difference between the amount on the Medicare fee schedule and the amount the doctor charges. However, Medicare allows the doctor to charge you only 15% more than the fee schedule. This is called a limiting charge. If a doctor charges you more, you are not responsible for paying the amount over the limit. You will have to file a claim with Medicare.

- If you use a provider who "opts out" of Medicare, they must notify you. This means that the provider does not participate in Medicare at all and the 15% limiting charge will not apply. If you decide to use a provider who "opts out of Medicare," Verizon will coordinate as if you have used a Medicare provider. This means that you may be responsible for medical expenses that Medicare would have paid had you used a provider who participates in the Medicare program.

How the indemnity options coordinate with Medicare

If you are covered under an indemnity option, Medicare is your primary coverage and pays benefits as described above.

Your indemnity option is your secondary plan, and benefits are coordinated. When coordinating your benefits with Medicare, **Verizon assumes you have both Parts A and B Medicare coverage, even if you have not enrolled. Verizon also assumes that you utilize a Medicare provider.**

When expenses are not covered by Medicare

When expenses are **not** covered by Medicare, but **are** covered by Verizon, you will need to meet your Verizon option's deductible before receiving benefits.

There are some expenses that Medicare does not cover, or has limits on, that are covered under the Verizon options, such as:

- Prescription medication (unless you are enrolled in Medicare Part D).

- Hospital stays over Medicare limits.

- Private duty nursing for medical treatment over Medicare limits.

If you have questions on coordinating with Medicare, call the Verizon Benefits Center.

Filing Medicare claims

If your provider accepts assignment, you do not need to file a claim with Medicare.

If your provider does not accept assignment, you will need to file a claim with Medicare. After processing your claim, Medicare will send you an explanation of benefits (EOB), which is a description of how Medicare arrived at the payment amount. Then:

- If you are enrolled in a UnitedHealthcare option, Medicare will then send the claim to UnitedHealthcare for payment. You will not have to file a claim under your medical option. For more information, call UnitedHealthcare at the number listed on your ID card.

- If you are enrolled in another option, you should file a claim under your medical option.

Plans that coordinate with Medicare

There are two kinds of plans available once you become eligible for Medicare:

- With a **Medicare Supplement plan**, you retain Medicare as your primary coverage and continue to pay your Medicare Part B premiums. Your Verizon Medicare Supplement plan coordinates coverage with Medicare.

- With a **Medicare Advantage plan**, you withdraw from traditional Medicare coverage and agree to have all of your healthcare expenses provided by the plan. In most cases, these plans are HMOs. Remember, even in this case, you still need to continue to pay for your Part B premiums.

Medicare Supplement Plans

If your plan is a Medicare Supplement HMO, the plan offers you a network of doctors, hospitals, healthcare facilities, laboratories, pharmacies and other healthcare providers who have agreed to work together to provide healthcare services to Medicare-eligible people. Generally, Medicare Supplement HMOs work the same way other HMOs do:

- You receive healthcare that meets strict standards of quality.

- You choose a primary care physician (PCP) to coordinate your care through the network.

- You receive comprehensive care from a network of healthcare providers at a cost usually lower than the cost of traditional indemnity Medicare coverage.

- You have no bills or claim forms to fill out.

In most Medicare Supplement HMOs, it is preferable to receive all care through the HMO's network. If you receive care from a provider outside the HMO's network, Medicare will cover that expense, but your Medicare Supplement HMO (and Verizon) will not.

If you are enrolled in a Medicare Supplement HMO, Medicare continues to be your primary source of coverage, and the Medicare Supplement HMO will coordinate with Medicare.

As you are considering a Medicare Supplement HMO, you should talk to the plan's member services department to make sure you understand what expenses are covered by the plan that may be different from coverage under original Medicare.

If you enroll in a Medicare Supplement HMO, you must continue to pay Medicare Part B premiums.

Medicare Advantage Plans

This is a managed care option that offers Medicare-eligible individuals cost-effective alternatives to original Medicare coverage or a Medicare Supplement plan. To enroll in a Medicare Advantage plan, you must be enrolled in both Medicare Part A and Medicare Part B and in most cases, Medicare Part D.

If you enroll in a Medicare Advantage HMO that offers Part D, it is referred to as an MA-PD. If you enroll in a Medicare Advantage HMO, you generally must use your primary care physician (PCP) in order to receive benefits. Medicare Advantage HMOs provide the same types of services as Medicare and non-Medicare HMOs, but with a focus on the special needs of Medicare-eligible members. When you need care during the year, you pay only a small copayment or none. Even if you enroll in a Medicare Advantage HMO, keep your Medicare card. You will need it if you later choose to enroll in a medical plan option that is not a Medicare Advantage HMO.

Differences between original Medicare and Medicare Supplement or Medicare Advantage coverage

The difference between coverage under a Medicare Supplement plan, a Medicare Advantage plan and original Medicare coverage is the expanded benefits you typically receive and the lower costs you typically have when you enroll in a Medicare Supplement plan or a Medicare Advantage plan.

Here is an overview of some of the differences:

- Medicare Supplement plans and Medicare Advantage plans generally offer comprehensive benefits for preventive care, such as routine physicals and mammograms. Although Medicare covers routine mammograms, routine physicals – which include immunizations – are not covered under Medicare.

- Medicare Supplement plans and Medicare Advantage plans cover the cost of most medical services, such as hospitalization, surgery, lab tests, doctors' office visits and prescription drugs. Medicare imposes limitations on certain medical services.

- If the plan is an HMO and you use the HMO's network, you pay small copayments – generally, $5 to $15 – and the Medicare Supplement HMO or Medicare Advantage HMO pays the rest. In addition, there are no deductibles to pay and no lifetime maximum or usual and customary limits to worry about. With traditional Medicare coverage, you must meet a deductible before the plan begins to pay benefits, and after you meet the deductible, you share the cost of expenses.

- Some Medicare Supplement plans and Medicare Advantage plans provide dental, hearing and vision benefits. Medicare does not cover most dental, hearing and vision care.

Who is eligible

You are eligible to enroll in a Medicare Supplement plan or a Medicare Advantage plan if you are:

- Medicare-eligible (when you reach age 65 or before age 65 under certain circumstances, such as disability);
- Currently eligible for Verizon medical plan coverage as explained in this summary plan description (SPD);
- Enrolled in Medicare Parts A and B; and
- A permanent resident of the plan's service area (which means you are not away from your primary residence for more than 90 consecutive days each year).

Dependent eligibility

Coverage for your dependents is based on which Medicare option you choose:

- If you enroll in a Medicare Advantage plan, coverage for your dependents is as follows:
  - Family members who are Medicare-eligible all may select the same Medicare option – or different Medicare options – provided at least one Medicare-eligible family member is enrolled in a Medicare Advantage plan. Then, other family members may enroll in another Medicare Advantage plan (if available), if they prefer, while still others may select other Medicare options that are not Medicare Advantage plans.
  - Family members who are not Medicare-eligible must all elect the same non-Medicare option.
- If you enroll in an indemnity option or Medicare Supplement plan coverage for your dependents is as follows:
  - If you and your spouse (or other dependents) are all Medicare-eligible and have coverage through Verizon, you must all enroll in the same indemnity option or Medicare Supplement plan.

If you are age 65 or over and your spouse or some of your other dependents are under age 65, you must enroll yourself and all Medicare-eligible family members in the same indemnity option or Medicare Supplement plan, and all non-Medicare-eligible family members in the same indemnity option or plan for people not yet eligible for Medicare.

When coverage ends

Coverage ends for you or a dependent at the times listed below.

A Certificate of Creditable Coverage is provided when coverage ends.

For you

Your coverage ends on the:

- Day you no longer meet the eligibility requirements (including any amendments to such requirements).
- Last day for which you paid for coverage if you stop making required payments.
- Date your or your dependent's eligibility ended if you misrepresent your or your dependent's eligibility status.
- Day you die. Your dependents may continue retiree medical coverage at retiree costs for as long as they remain eligible.
- Day the plan ends or the official plan document is amended to eliminate coverage for all participants or a group of participants that includes you.

When coverage ends, you may be eligible to continue it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

For your dependents

Your dependent's coverage ends on the:

- Day your coverage ends (excluding your death).
- Last day for which you paid for coverage if you stop making required payments.
- Day your dependent no longer meets the eligibility requirements.
- Day your dependent begins active military duty. (You or your dependent must notify the Verizon Benefits Center before active duty begins.)
- Day your dependent becomes eligible as an employee or retiree under another Verizon medical plan.
- Day the plan ends or the official plan document is amended to eliminate coverage for all dependents or for a group of dependents that includes your dependents.

When coverage ends, your dependents may be eligible to continue it under COBRA.

If a dependent loses eligibility – for example, you get divorced or your child reaches the age limit for eligibility – you must call the Verizon Benefits Center within 60 days to cancel coverage.

If you do not:

- Deductions continue but no coverage is provided.
- You will not be reimbursed for payments you made during the period that your dependent was not eligible.

In addition, if you do not notify the Verizon Benefits Center within 60 days, your dependent may lose his or her right to continue coverage under COBRA.

Certificate of Creditable Coverage

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

The certificate:

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

Verizon provides a certificate, free of charge, if:

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

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

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

Change in Control (CIC) protections for employees of the former GTE

At the time of the GTE shareholder approval of the Bell Atlantic and GTE merger, a Change in Control provision was triggered under The Plan For Group Insurance (commonly referred to as the GTE Retiree CHOICES program) for certain employees of the former GTE. The protection triggered upon the Change in Control applies only to eligible former GTE participants.

Who is protected?

Generally, you will be eligible for CIC protection if you were an employee of the former GTE and met the below requirements for retirement eligibility by the earlier of your retirement date or May 18, 2004:

- Met your former GTE pension plan's Rule of 76 with at least 15 years of service;
- Had been involuntarily separated and meet your former GTE pension plan's Rule of 74 with at least 15 years of service; or
- Reached normal retirement age (generally age 65) with five or more years of service.

CIC-protected employees of Verizon Communications who were actively employed on June 30, 2006 are not eligible to receive the additional 18 months of service under the GTE Retiree CHOICES program that was granted on June 30, 2006 toward the retiree medical subsidy. However, CIC-protected employees continue to earn service toward a subsidy after June 30, 2006 for the GTE Retiree CHOICES program. The 18 months of additional service granted on June 30, 2006 applies only to the subsidy amount determined under the Verizon retiree medical plan.

What is the nature of the protection?

Whether or not you actually retired by May 18, 2004, your coverage will be provided under the Verizon retiree medical plan when you retire. However, if this Verizon retiree benefits program is amended in the future such that it provides less value than the former GTE Retiree CHOICES program, you will be able to enroll in the former GTE Retiree CHOICES program or a comparable program. This provision does not guarantee that you will receive the same benefit options or providers of benefits, such as a particular HMO, or preserve amounts of copayments, deductibles, coinsurance, out-of-pocket maximums and so on. Specifically, Verizon may, in the ordinary course of business:

- Add, delete or change the providers of benefits;
- Change, increase or decrease copayments, deductibles and other requirements for coverage and benefits; and/or
- Make other changes in administration or changes in the program's design and its coverage and benefits.

If you elect the GTE Retiree CHOICES program, you cannot later elect the Verizon retiree medical plan unless you have been rehired and again become eligible for the Verizon retiree medical plan.

If you are eligible for CIC protections, the former GTE Retiree CHOICES medical program is protected for life for you. That is, the company can never terminate that benefit, except as described above. This Verizon retiree benefits program can be modified or terminated by the company at any time; thus, there is no lifetime protection for the Verizon program.

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

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

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

What is COBRA continuation coverage?

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

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

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

COBRA qualified beneficiaries

- **Covered retirees.** You are eligible for COBRA continuation if you lose your coverage under the medical plan because Verizon commences Chapter 11 bankruptcy proceedings.

- **Spouse of covered retiree.** Your spouse is eligible for COBRA continuation if he or she loses coverage under the medical plan because of one of the following qualifying events:

  — You die.

  — You become divorced.

  — Verizon commences Chapter 11 bankruptcy proceedings.

- **Dependent children.** Dependent children are eligible for COBRA continuation if they lose coverage under the medical plan because of one of the following qualifying events:

  — The parent-covered retiree dies.

  — The parents become divorced.

  — The child loses eligibility for coverage as a "dependent child" under the medical plan.

  — Verizon commences Chapter 11 bankruptcy proceedings.

Although not entitled to legal rights under COBRA, Verizon offers domestic partners and children of domestic partners continuation coverage, as outlined in this section[1]. For this purpose, a domestic partner will be offered coverage "like" a spouse's coverage, and a child of a domestic partner will be offered coverage "like" a child of a covered retiree.

When COBRA coverage is available

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

Notification of qualifying events

When the qualifying event is the death of the covered retiree, a beneficiary, spouse or family member needs to notify the Verizon Benefits Center (the COBRA administrator) of the qualifying event. See the "Medical plan contacts" section for the telephone number. Verizon will require death certificate documentation. Note that your dependents may elect to continue their retiree medical coverage following your death, instead of electing COBRA continuation coverage.

For other qualifying events (divorce of the retiree and spouse or a dependent child losing eligibility for coverage as a dependent child), **you or the qualified beneficiary must notify** the Verizon Benefits Center within 60 days after the qualifying event. See the "Medical plan contacts" section for contact information. If you or the qualified beneficiary fails to notify the Verizon Benefits Center within 60 days after the qualifying event, your dependent will not be entitled to elect COBRA continuation coverage.

How COBRA coverage is offered

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

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

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

Your eligible dependents have 60 days from the date coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect continued participation under COBRA. If your eligible dependents fail to elect COBRA coverage within the applicable timeframe, they will lose the opportunity to continue coverage under COBRA.

[1] A child of a domestic partner can be a qualified beneficiary if he or she also is an Internal Revenue Service (IRS) tax dependent of the employee.

How long COBRA coverage lasts

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

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

In the case of a bankruptcy proceeding, COBRA continuation coverage generally lasts for the covered retiree until the date of the covered retiree's death. For a spouse, surviving spouse or dependent child, COBRA continuation coverage ends on the earlier of:

- The date of the spouse's, surviving spouse's or dependent child's death; or
- 36 months after the date of the covered retiree's death.

COBRA qualifying events

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

[1]If you die while you are a covered retiree, your dependents can elect retiree medical and dental with the same employer contribution effective prior to your death. If your dependents elect to continue coverage under COBRA, they will not be eligible for retiree medical and dental coverage later.

Your eligible dependents have 60 days from the date coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect continued participation under COBRA. If your eligible dependents fail to elect COBRA coverage within the applicable timeframe, they will lose the opportunity to continue coverage under COBRA.

What COBRA coverage costs

COBRA participants must pay monthly premiums for coverage.

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

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

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

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

If your spouse or dependent elects COBRA continuation coverage:

- Your spouse or dependent can keep the same level of coverage you had as a covered retiree or choose a lower level of coverage.

- Your spouse's or dependent's coverage is effective as of the date of the qualifying event. However, if he or she waives COBRA coverage and then revokes the waiver within the 60-day election period, his or her elected coverage begins on the date he or she revokes the waiver.

- Your spouse or dependent may change his or her coverage:

  — If he or she has a qualified change in status.

  — If he or she has a change in circumstance recognized by the Internal Revenue Service (IRS) and Verizon.

- Your spouse or dependent may enroll any newly eligible child under the plan rules.

When COBRA coverage ends

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

- You or any of your covered dependents become covered under another medical plan not offered by Verizon, provided the plan does not have a legally valid pre-existing condition exclusion or limitation affecting the qualified beneficiary. If it does, Verizon COBRA coverage for that pre-existing condition continues as long as you pay the premium.

- Your spouse or dependent fails to make contributions by the due date as required.

- Verizon stops providing any medical benefits to any employee.

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

If you have questions

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

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

Administrative information

This section contains important information about how your benefits are administered and funded. It also contains information about your rights and responsibilities as a participant and steps you can take if certain situations arise. See the “Your rights under ERISA” section for more information.

Plan name/identification

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

The Plan for Group Insurance is a welfare plan providing the medical benefits highlighted in this summary plan description (SPD) and described in the applicable Summary of Coverage (SOC) or Certificate of Coverage (COC). The plan is listed with the U.S. Department of Labor under Verizon Communications Inc.’s employer identification number: 23-2259884.

The plan number for The Plan for Group Insurance is 580.

Plan documents

The plan documents consist of:

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

Collective bargaining agreements

If you are a retiree who is covered by a collective bargaining agreement under which management benefits were negotiated, the terms of your benefits also are governed by a collective bargaining agreement between Verizon and your union. You and your beneficiaries may review the collective bargaining agreement at your location if at least 50 participants customarily are working there. You also can request a copy by writing to the plan administrator. See the “Additional plan information” section for plan administrator contact information.

Additional plan information

Plan sponsor/employer	Verizon Communications Inc. One Verizon Way Basking Ridge, NJ 07920
Plan administrator	The Verizon Employee Benefits Committee (VEBC) and/or the Chairperson of the VEBC c/o Verizon Benefits Center P.O. Box 1457 100 Half Day Road Lincolnshire, IL 60069-1457 1-877-4VzBens
Claims administrators	**Enrollment and eligibility claims and appeals:** Verizon Claims Review Committee (VCRC) c/o Verizon Claims Review Unit P.O. Box 1438 Lincolnshire, IL 60069-1438 1-877-4VzBens **Benefit claims and appeals:** **Medical plan** **PPO Plus, Out-of-Area Plus, and indemnity options** UnitedHealthcare Insurance Company P.O. Box 740803 Atlanta, GA 30374-0803 **EPN and Out-of-Area EPN options** Aetna Member Services P.O. Box 981106 El Paso, TX 79998-1106 **Other medical options** Includes prescription drugs/supplies and mental health/substance abuse treatment coverage, as applicable. Contact the specific option administrator directly for its address. When you file a claim, the plan will notify you if it is not the claims administrator. Claims should be filed with MHN only if MHN is the administrator or if you have exhausted the applicable benefit limits for mental health and substance abuse treatment under your medical option. See the "Supplemental benefit for mental health and substance abuse treatment" section for additional information. **Prescription program** Medco P.O. Box 650322 Dallas, TX 75265-0322

Participating company	For this version of the summary plan description, all Verizon domestic companies, except Verizon Wireless (other than for certain employees who transferred from Verizon to Verizon Wireless), Verizon Business, Federal Network Systems LLC (except former GTE CIC-protected employees), Verizon Avenue and any company, location or group specifically excluded from participation by plan amendment. Employees of Verizon Connected Solutions (formerly Bell Atlantic Communications and Construction Services, Inc. [BACCSI]) are not eligible for this retiree medical plan. However, if you worked for a Verizon company that participates in this retiree medical plan before transferring to the former BACCSI, then met the requirements for retirement by December 31, 2005, you will be eligible for this retiree medical plan. Contact the Verizon Benefits Center (at the address above) to determine whether a particular Verizon affiliate is a participating company in the plan and to request that affiliate's address.
Agent for service of legal process	The plan administrator, at the address listed above. With respect to benefits funded through a trust, legal process also may be served on the trustee.
Plan year	January 1 – December 31

The claims administrator and its authority to review claims

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

The claims administrator has:

- The authority to make final determinations regarding eligibility and benefit claims under the plan.
- Discretionary authority to:
  - Interpret the plan based on provisions and applicable law and make factual determinations about claims arising under the plan.
  - Determine whether a claimant is eligible for benefits.
  - Decide the amount, form and timing of benefits.
  - Resolve any other matter under the plan that is raised by a participant or a beneficiary or that is identified by the claims administrator.

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

Funding and source of contributions

The Plan for Group Insurance is funded by employer and retiree contributions, with benefits paid from company revenues and the GTE Non-Union Retirees Benefits Plan Trust. The trustee for the GTE Non-Union Retirees Benefits Plan Trust is:

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

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

Option	Funding information and source of contributions
PPO Plus or Out-of-Area Plus option	Self-insured Employer and retiree contributions
EPN option	Self-insured Employer and retiree contributions
Other options	Self-insured and insured Employer and retiree contributions
Supplemental mental healthcare – MHN	Self-insured Employer and retiree contributions
Prescription program	Self-insured Employer and retiree contributions

Self-insured plan options

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

Insured plan options

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

Filing claims

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

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

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

Benefit claims and appeals are divided into four categories:

- ***Post-service***
  A claim for reimbursement of services already received. This is the most common type of claim.

- ***Pre-service***
  A claim for a benefit for which prior authorization is required by the plan.

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

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

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
Step 1:				
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) must write to your health plan. See the "Medical plan contacts" section for contact information or refer to the telephone number and/or Web site shown on the back of your ID card or the Health Plan Comparison Chart available on Your Benefits Resources Web site. Your initial request for benefits, sometimes submitted by your provider, is considered a claim for benefits. 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 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

General procedure	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 Claims Review Unit or health plan may notify you within **(see columns to the right)** that additional information is needed.	30 days	15 days	Decision will be based on information provided, unless the concurrent care claim involves urgent care; see urgent care time frame.	24 hours
You will have **(see columns to the right)** to provide the additional information. Otherwise, the claim will be decided based on information originally provided.	45 days	45 days		48 hours
If you provide additional information, you will be notified of the decision by the Claims Review Unit or health plan within **(see columns to the right)**.	The time period remaining for the initial claim	The time period remaining for the initial claim		48 hours

General procedure	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 Claims Review Unit or the health plan will notify you either in writing or 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 written 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 (or a statement that this information will be provided free of charge, upon request).
- The plan's appeal procedures.

If your **urgent care** claim is denied, the Claims Review Unit or the health plan will notify you by telephone. Within 3 days of this oral denial, you will receive a written denial notice, as explained under the general procedure. The denial notice also will explain the expedited review process.

Step 2:

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

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

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

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

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
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, free of charge, to all documents relating to your appeal. If you have an appeal for **eligibility** (i.e., you wrote to the 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 claims administrator will consult with a healthcare professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request.	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 claims administrator. At the time your claim is denied, the Claims Review Unit or the health plan will give you instructions about how to file your appeal, including who the claims administrator is. You must identify that you are appealing an urgent care claim.

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
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 claims administrator's receipt of your appeal.	**Eligibility appeals:** 60 days **Benefit appeals:**[1] 60 days, if the claims administrator provides 1 level of mandatory appeal 30 days, if the claims administrator provides 2 levels of mandatory appeal	**Eligibility appeals:** 30 days **Benefit appeals:**[1] 30 days, if the claims administrator provides 1 level of appeal 15 days, if the claims administrator provides 2 levels of appeal	**Eligibility and benefit appeals:** Before a reduction or termination of benefits would occur If the concurrent claim involves urgent care, 72 hours[2]	**Eligibility and benefit appeals:** 72 hours[2]

How you will be notified of the appeal decision
If your appeal is **approved**, the Claims Review Committee or the claims administrator will notify you in writing.

If your appeal is **denied**, in whole or in part, the Claims Review Committee or the claims administrator 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 (or a statement that this information will be provided free of charge, upon request).
- The plan provisions on which the denial was based.
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
Step 3:				
How to proceed if necessary When the Verizon Claims Review Committee is the claims administrator, i.e., the Verizon Claims Review Committee reviewed your appeal, only 1 mandatory appeal is available. Verizon will not review your matter again, unless new facts are presented. You have a right to bring a civil action. As a reminder, the Verizon Claims Review Committee is the claims administrator for all eligibility appeals and benefit appeals for a handful of self-insured health plans. When a health plan is the claims administrator, the health plan may offer: • 1 mandatory appeal. • 2 mandatory appeals. • 1 mandatory appeal and 1 voluntary appeal. If the claims administrator offers 1 level of mandatory appeal, the claims administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action. If the claims administrator offers 2 levels of mandatory appeal, you may appeal to the claims administrator a second time. You must submit your second appeal within 180 days from the date that you received the denial of your first appeal. Some health plans provide a shorter time frame, such as 60 days, as explained in your denial notice. In addition, the claims administrator will provide you with an independent medical review, upon request, in conjunction with this second and final appeal. If the claims administrator offers 1 level of mandatory appeal and 1 level of voluntary appeal, you may appeal to the claims administrator a second time. The claims administrator will provide you with information regarding its voluntary appeal, if it applies. As indicated in “footnote 1,” you are not required to file a voluntary appeal before filing a civil action; however, you may find it helpful.				
If the claims administrator 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 claims administrator’s receipt of your second and final appeal. If this appeal is denied, the claims administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action.	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.

[1]If the claims administrator provides more than 1 level of mandatory appeal, the response time frame is shorter, as noted above. The claims administrator also may offer a **voluntary** level of appeal. You are not required to file a voluntary appeal before filing a civil action; however, you may find it helpful. The claims administrator will provide you with information regarding its voluntary appeal, if it applies. A voluntary appeal is not subject to the same time frames as mandatory appeals.
[2]If the claims administrator provides 2 mandatory appeals, both appeals must occur within the 72-hour time frame.

Your rights under ERISA

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

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue healthcare coverage for yourself, your spouse/domestic partner and/or your other eligible dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

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

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

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

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

Assistance with your questions

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

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

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

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

HIPAA privacy rights

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

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

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

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

- The Verizon health plans may disclose your Protected Health Information to healthcare providers to assist them in connection with their treatment or payment activities. In addition, the Verizon health plans may disclose your Protected Health Information to other entities subject to the HIPAA Privacy Rule to assist them with their payment activities or certain of their healthcare operations. For example, the Verizon health plans might disclose your Protected Health Information to a healthcare provider when needed by the provider to render treatment to you.

- Other than as permitted or required by law, the Verizon health plans will not use or disclose your Protected Health Information without your written authorization. If you authorize a Verizon health plan to use or disclose your Protected Health Information, you may revoke that authorization in writing at any time. If you revoke the authorization, the Verizon health plan no longer will use or disclose your Protected Health Information for the reasons covered by your written authorization. Your revocation will not affect any uses or disclosures a Verizon health plan already has made prior to the date the Verizon health plan receives notice of the revocation.

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

- You have the right to request that a Verizon health plan restrict uses and disclosures of your Protected Health Information to carry out payment or healthcare operations.

- You have the right to request that a Verizon health plan communicate with you in a certain way if you feel that the disclosure of your Protected Health Information could endanger you.

- You have the right to inspect and obtain a copy of your Protected Health Information.

- If you believe that 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 at 1-877-4VzBens. 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.

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

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

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

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

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

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

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

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

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

For more information on mastectomy coverage, call the Member Services Department of your managed healthcare organization if you participate in an HMO/EPO/POS option, Aetna if you participate in the EPN option or UnitedHealthcare if you participate in PPO Plus, Out-of-Area Plus or an indemnity option.

Verizon's rights and responsibilities

For this section, "you" or "your" means a plan participant, including the covered Verizon employee or retiree, another covered person, such as an eligible dependent, a legal representative or the estate or heirs of a covered person (sometimes collectively referred to as "you" or "your").

Reimbursement

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

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

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

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

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

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

- Acknowledge that the plan has first priority against the proceeds of any such settlement, arbitration award, verdict or other amounts you receive.
- Acknowledge that any proceeds of settlement or judgment, including your claim to such proceeds held by you or any other person, are being held for the benefit of the plan.
- Assign to the plan any benefits you may have under any automobile policy or other coverage, to the extent of the plan's claim for reimbursement.

- Cooperate with the plan and its agents, provide relevant information and take actions that the plan or its agents reasonably request to assist the plan in making a full recovery of the value of benefits paid.

- Consent to the plan's right to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the plan's rights under this section.

- Consent to the plan's right to deduct from any future benefits otherwise payable under the plan the value of benefits advanced under this section to the extent not recovered by the plan.

- Agree to not take any action that prejudices the plan's rights of reimbursement.

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

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

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

Subrogation

This section applies when another party (including insurance carriers who are so financially liable) is, or may be considered, liable for your injury, illness or other condition, including death, and the plan has advanced benefits. Subrogation is similar to reimbursement, but allows the plan to "step into your shoes" and obtain a benefit from a third party who was negligent or responsible for your injury or illness. This occurs when the plan has to pay a benefit due to your injury, illness or other condition but would not have owed the payment, if the third party had not caused the problem.

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

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

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

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

If you are a covered person under a self-insured plan option, you can contact the subrogation vendor directly with questions. See the "Medical plan contacts" section for contact information. If you are a covered person under an insured plan option, you can contact the claims administrator with questions. See the "Additional plan information" section for contact information.

Verizon's right of recovery

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

If you are eligible for subsidized retiree medical benefits

If you are or become eligible for subsidized retiree medical benefits and the plan administrator is unable to recover an overpayment by other means, Verizon may suspend the amount it pays toward your retiree medical premium and that amount will be redirected to this plan. This means that Verizon will not contribute toward your retiree medical coverage until this plan is fully repaid. While your retiree medical premium is suspended, you must pay the total amount of this premium to continue your retiree medical coverage. If you choose not to pay the total amount of your retiree medical premium each month, your retiree medical coverage will be terminated.

If you have questions or you would like to receive a copy of the actual plan provision relating to overpayments, call the Verizon Benefits Center.

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

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

Disclaimer

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

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

Accordingly, Verizon has the discretion to offer or terminate any medical plan option and may change the benefits design, administrators and service areas of any option. Review the Health Plan Comparison Chart available on Your Benefits Resources Web site for any plan changes.

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

The plan administrator may transfer the obligation to provide benefits under the plan or a component benefit (and assets related thereto, if it desires) to another entity in connection with a business transaction, including but not limited to a sale of a business unit or a portion thereof, the sale of any assets, a spin-off transaction, an outsourcing arrangement or a joint venture.

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

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

Medical terms to know

Children

Your eligible children are your or your domestic partner's unmarried children who live in your home, until they marry or reach age 19, whichever is earlier.

You or your domestic partner must be the child's:

- Natural parent.
- Adoptive parent.
- Stepparent.
- Legal guardian.

Special rules apply if your child is a full-time student or disabled.

Disabled child

You can cover your physically, mentally or developmentally disabled child if he or she is all of the following:

- Unmarried.
- Living with you.
- Fully dependent on you for financial support (i.e., the disability prevents the child from working to support himself or herself).

The plan administrator or its delegate must determine that the child meets the requirements above before the child will be covered. In addition, you may be asked to provide periodic certification of your child's continuing disability status.

Domestic partner

You and your domestic partner must meet all of the following. You are:

- Each other's sole same-sex domestic partner.
- Not married to anyone else; i.e., neither of you is married to anyone else.
- Both at least 18 years old and mentally competent to enter into a marriage contract.
- Not related by blood to the degree of closeness that would prohibit your legal marriage in the state in which you reside.
- Living (and have lived) together in the same principal residence for at least six months and intend to do so indefinitely.
- Jointly responsible for each other's common well-being and financial obligations.

This partner can be the domestic partner you had at the time you retired or the domestic partner with whom you are joined in a state-recognized marriage after your retirement.

If at any time you do not meet all of the above criteria, you and/or your domestic partner must notify the Verizon Benefits Center of the change in status within 60 days. (See the "Medical plan contacts" section for contact information.)

You may be subject to taxes on imputed income for the coverage you choose for your domestic partner and his or her children.

Generally, an opposite-sex relationship does not meet the domestic partnership requirements. However, in specific, limited instances, the company has a legal, contractual obligation to offer domestic partnership benefits to a couple in an opposite-sex relationship, provided the partners are registered with a governmental entity pursuant to state or local law authorizing the registration.

If you and your domestic partner of the same or opposite sex have registered with a governmental entity, such as the state of California, your registered domestic partner (even if the individual is of the opposite sex) will be entitled to coverage, if coverage of domestic partnerships is part of Verizon's contractual arrangement with a particular municipality or state.

Examples include:

- You worked in the city of Los Angeles, California or worked on a contract between Verizon and the city of Los Angeles. Then, you may cover a registered same- or opposite-sex domestic partner and his or her children, subject to the dependent eligibility requirements described in this summary plan description (SPD).
- You worked in the city or county of San Francisco, California, at a location owned by the city or county of San Francisco, or at a location outside of the city or county of San Francisco where work between Verizon and the city or county of San Francisco was taking place (you did not have to be performing work related to the contract, provided you were at a location where such work was being performed). Then, you may cover a registered same- or opposite-sex domestic partner and his or her children, subject to the dependent eligibility requirements described in this SPD.

- You worked in the city of Seattle, Washington or at an office located on property outside the city of Seattle that was owned or rightfully occupied by the city of Seattle and where Verizon's presence on such property was connected to a contract with the city of Seattle (you did not have to be performing work related to the contract, provided you were at a location where such work was being performed). Then, you may cover a registered same- or opposite-sex domestic partner and his or her children, subject to the dependent eligibility requirements described in this SPD.

Other examples may exist from time to time. Therefore, you should contact the Verizon Benefits Center to confirm whether or not you meet these specific instances.

Full-time student

Your eligible child age 19 or older can be covered until age 25 or for six months after leaving school, whichever is earlier, if he or she satisfies both of these conditions:

- Is a full-time student (according to the school's definition of full time) at an accredited secondary school, college, university or nursing school.

- Remains unmarried and dependent on you for support.

To continue coverage, you must certify the child's full-time student status each year.

Grandfathered class II dependents (NYNEX)

Grandfathered class II dependents are:

- Your unmarried:

  — Children who do not qualify as class I dependents.

  — Grandchildren.

  — Brothers or sisters.

  — Parents and grandparents and your spouse's parents and grandparents.

- Your domestic partner's parents or grandparents.

A class II dependent must meet all of the following:

- Have been enrolled on or before December 31, 1997.

- Live in your home, or in one you provide near you, for at least six months before he or she became covered under the plan and throughout the period he or she is covered under the plan.

- Be dependent on you for more than 50% support.

- Have annual income from all sources (other than that received from you), including social security, of less than $7,800.

New class II dependents cannot be added. In addition, if you drop class II dependents, they cannot be enrolled in the future.

Grandfathered class II dependents (Bell Atlantic)

Grandfathered class II dependents are your unmarried:

- Children who do not qualify as class I dependents.
- Grandchildren.
- Brothers or sisters.
- Parents and grandparents and your spouse's parents and grandparents.

A class II dependent must meet both of the following:

- Have been enrolled on or before December 31, 1989.
- Be dependent on you for more than 50% support.

New class II dependents cannot be added. In addition, if you drop class II dependents, they cannot be enrolled in the future.

Illness

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

Injury

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

Insured or self-insured

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

- Click on "Health, Insurance..." from the main navigation bar on the top of the page.
- Click on the "Medical" link in "Your Current Coverage" near the bottom of the page and then choose "Coverage Details."
- Scroll down to "Insured Status."

If this section states "fully insured," you should call the medical option administrator to request a free Certificate of Coverage. If the section states "self-insured," call the Verizon Benefits Center to request a free Summary of Coverage.

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

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

[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.

Medicare allowable charge

The Medicare allowable charge is the fee set as reasonable for a covered medical service as determined by Medicare. This is the amount a provider is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a provider.

Mental health disorder

A mental health disorder is a disorder that, in manifestation, cause, symptoms or treatment, is mental in nature. This includes nervous disorders, neuroses, psychoneuroses, psychopathies, psychoses, personality disorders (classified as an Axis I Disorder in the *Diagnostic and Statistical Manual of Mental Disorders* [Fourth Edition-Text Revision] by the American Psychiatric Association [DSM-IV-TR]) and any other mental or emotional disease or disorder.

The mental health disorder also must:

- Involve a clinically significant behavioral or psychological syndrome or pattern.
- Be associated with a painful symptom, such as distress.
- Impair a person's ability to function in one or more major life activities.

Net credited service

Your net credited service (NCS) is service earned under the Verizon Management Pension Plan. For details on how this service is counted, refer to the pension summary plan description.

Pre-existing condition

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

Primary care physicians (PCPs)

In most health maintenance organizations (HMOs), you must choose a PCP to coordinate your care.

Typically, you choose a PCP or facility from a directory – available free of charge – or by accessing the plan's Web site. Your PCP manages your healthcare by serving as your main caregiver and, when necessary, referring you to a specialist. Your PCP also handles the necessary paperwork and approvals for any required hospital admissions.

It is a good idea to have a PCP even if one is not required by the HMO you choose. That way you have at least one doctor with full knowledge of your health history.

Qualified medical child support order (QMCSO)

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

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

Rule of 73
Rule of 73 means your age plus net credited service as defined by the Verizon Management Pension Plan or the Verizon Enterprises Management Pension Plan must total 73 “points,” you must have at least 15 years of net credited service and you must be involuntarily terminated.

Rule of 75
Rule of 75 means your age plus net credited service as defined by the Verizon Management Pension Plan or the Verizon Enterprises Management Pension Plan must total 75 “points,” and you must have at least 15 years of net credited service.

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

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

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

Years of service
If you were a participant in either the Verizon Management Pension Plan or the Verizon Enterprises Management Pension Plan, years of service means years of net credited service as defined by your pension plan for purposes of determining eligibility for retiree welfare coverage. Your net credited service as of June 30, 2006 is used to determine your company subsidy.

If you are not a participant in a pension plan, service is measured from your date of hire to your date of separation from service for determining eligibility for retiree welfare coverage. You do not earn years of service for a company subsidy.

If you were a management employee actively earning retiree medical credits on June 30, 2006, Verizon enhanced your subsidy for the Verizon retiree medical plan by calculating your June 30, 2006 subsidy percentage by adding an additional 18 months of service. The 18 months of service is not added to your service for determining eligibility for retiree welfare coverage.