Health Care Benefits
Summary Plan Description for
New York and New England Post-1986
Associate Retirees

V-B-AR-N-M-68934-1/13

Contents

Your Health Care Benefits

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

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

Medical Plans for Associate Retirees

The Verizon Medical Expense Plan for New York and New England Associates (with the Verizon Alternate Choice Plan for New York and New England Associates), as applicable to eligible associate retirees, is a component plan of:

- The Verizon Post-1995 Collectively Bargained Retiree Health Plan (Pre-1993 Retirees); and
- The Verizon Post-1995 Collectively Bargained Retiree Health Plan (Post-1992 Retirees).

Certain other provisions of the Verizon Medical Expense Plan for New York and New England Associates, as applicable to associate retirees, are described in the Other Plan Provisions of Verizon Plans Covering New York and New England Associates.

About This SPD

This document is the summary plan description (SPD) for the Verizon Medical Expense Plan for New York and New England Associates as applicable to associate retirees (the Medical Plan), as well as the Verizon Alternate Choice Plan for New York and New England Associates (the Alternate Choice Plan). The Plans are subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. This document meets ERISA's requirements for an SPD and is based on Plan provisions and bargained-for changes effective January 1, 2013, unless specifically noted otherwise. It updates and replaces all previous SPDs and other descriptions of the Medical Plan benefits and the Alternate Choice Plan benefits provided by the Plans. This SPD is a summary of these Plans.

References in this SPD to the Plan, Plans, Medical Plan, and Alternate Choice Plan refer to the applicable Verizon legal plan.

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

This SPD is divided into the following major sections:

- **Participating in the Plans.** This section explains your eligibility, eligibility for your dependents and when eligibility ends.

- **Overview of Your Options.** This section describes the medical options available to you. Refer to it when deciding which option to choose and when you need information about your coverage and benefits.

- **The Health Care Network (HCN) Option.** This section provides details of how the HCN option works.

- **The Medical Expense Plan Health Care Preferred Provider Organization (MEP-HCP) Option.** This section provides details of how the MEP-HCP option works.

- **Prescription Drug Program for the HCN and MEP-HCP Options.** This section provides details about prescription drug benefits.

- **No Coverage Option.** If you do not want Verizon-sponsored medical coverage, you can choose this option.

- **Health Maintenance Organizations (HMOs) and Medicare Advantage Plans.** This section provides some details on HMOs and Medicare Advantage Plans available through the Alternate Choice Plan.

- **National Exclusive Provider Organization (EPO) NYNE Option.** This section provides some details on the EPO available through the Alternate Choice Plan.

- **Other Benefits.** Regardless of the medical coverage option you choose, certain benefits may be available to you.

- **Continuing Coverage If Eligibility Ends**. In some cases, you and/or your dependents can continue coverage even after eligibility for the Plans ends

- **When You Become Eligible for Medicare.** Because Verizon medical benefits are handled differently if you or your dependents are eligible for Medicare, it's important to review this section carefully.

- **Coordination of Benefits.** If you're covered by more than one medical plan, special rules apply for coordinating between plans – and with Medicare.

- **Additional Information.** This section provides additional details about the Plans.

- **Administrative Information.** This section provides the administrative provisions of the Plans and your legal rights.

- **Glossary.** Certain terms used in this SPD are defined in the glossary.

Important Note

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

Verizon Benefits Center

The Verizon Benefits Center offers a website called BenefitsConnection where you'll find tools to help you manage your benefits. You can access BenefitsConnection on the Internet at www.verizon.com/benefitsconnection.

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

- Link to other provider sites. Lists of network providers for each of the Plan's options can be found via each Plan option site; for example, Anthem maintains a list of providers for the HCN and MEP-HCP options. This information is available free of charge, upon request, in paper, as well by calling Anthem at the telephone number listed on your ID card.

- Create and print personalized provider listings and maps to providers' offices for most options.

- Review details about your health care and insurance plans.

- Select and update your beneficiary designations.

- Verify your Verizon elections that are on file at the Verizon Benefits Center.

- Change your BenefitsConnection password.

- Give yourself a helpful "hint" in case you forget your password.

Verizon Benefits Center representatives are available should you have questions about your benefits. If you are eligible for Medicare, you will need to make enrollment elections with a Benefits Center representative or on the BenefitsConnection website at www.verizon.com/benefitsconnection. To reach the Verizon Benefits Center via telephone, call 1-855-4VzBens (1-855-489-2367). Via this toll-free telephone number, you also can connect with other Verizon benefit providers.

Changes to the Plans

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

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

Participating in the Plans

Eligibility

You are eligible for coverage:

- If you retired with a service or disability pension under the provisions of the Verizon Pension Plan for Associates (to the extent that it covers New York and New England Associates).

- If you terminated employment with a participating company because of a continuing disability within the meaning of the Verizon Long-Term Disability Plan for New York and New England Associates (formerly the NYNE Long-Term Disability Plan for Non-Salaried Employees) ("Verizon LTD Plan"), you were eligible at the time of termination to receive long-term disability (LTD) benefits under the Verizon LTD Plan, and you are receiving LTD benefits under the Verizon LTD Plan.

- If you are an eligible surviving dependent of a deceased employee or retiree.

You are not eligible to participate in the Plans if you receive or are eligible to receive a deferred vested pension based on the provisions of the applicable Verizon pension plan.

Eligible Dependents

Dependents must be enrolled through the BenefitsConnection website or the Verizon Benefits Center to have coverage. You can enroll your dependents who meet the Medical Plan's or Alternate Choice Plan's (subject to any exceptions for a particular Health Maintenance Organization [HMO]) definition for eligibility (see the "Dependent Eligibility Requirements" chart below), including your:

- Class I Dependents.

- Class II Dependents – Class II Dependents are eligible for coverage only if currently covered as of the Effective Date of the 2012 Memorandum of Understanding (i.e., October 19, 2012) and remain continuously eligible and enrolled; new Class II Dependents cannot be added to coverage after October 19, 2012.

- Sponsored Children – Sponsored Children are eligible for coverage only if currently covered as of the Effective Date of the 2012 Memorandum of Understanding (i.e., October 19, 2012) and remain continuously eligible and enrolled; new Sponsored Children cannot be added to coverage after October 19, 2012.

Dependent Eligibility Requirements

Dependent Class	Who They Are	Relationship
Class I Dependents	• Your legal spouse[1] (whether or not legally separated). Your legal spouse includes a person of the same sex to whom you are married under state law (see the definition of "spouse" in the "Glossary" section for more details).	• Spouse
	• Your children until the end of the calendar month in which they reach age 26. Children means children by birth, as well as legally adopted children (or children placed for adoption), stepchildren and children for whom you or your spouse is the legal guardian.	• Child
	• Your unmarried children (as defined above) beyond the end of the month in which the child reaches age 26 and who are incapable of self-support and dependent on you for support due to physical or mental disability (if the disability began before attainment of age 26 and the child was covered under the Plan continuously).	• Disabled Child
	• Your same-sex domestic partner and his or her children who meet the Plan requirements for a same-sex domestic partner (and children of a same-sex domestic partner) may be eligible for coverage under the HCN option, an HMO (if they meet the HMO's eligibility requirements), the EPO option or the MEP-HCP option. **Note:** Only the same-sex domestic partners (and children of same-sex domestic partners) who were enrolled while you were an active employee are eligible for coverage. You cannot add coverage for a new same-sex domestic partner or a new child of a same-sex domestic partner. However, you may enroll a new same-sex spouse (or new child of a spouse) after retirement, as long as you and your same-sex spouse are legally married in a state that permits same-sex marriage. This change applies as of the date of the letter agreement that applies to your particular bargaining unit. Coverage for your same-sex spouse (and eligible child of a spouse) will apply wherever you and your legally married same-sex spouse live. The child of a domestic partner may be covered until the end of the month in which the child attains age 26. For more information on eligibility requirements and tax implications, access the BenefitsConnection website or call the Verizon Benefits Center and speak with a representative.	• Domestic Partner • Domestic Partner's Child
	• Your children (as defined above and including any age requirements) who are alternate recipients under an approved	• Child

[1] The ability to add a same-sex spouse after retirement is effective as of: February 15, 2013 for CWA Plant (Verizon New York, VSC, ECS, VZA, VZAD, VCSC), CWA District 1 (VSC), CWA Local 1104 (Downstate Accounting) (Verizon New York, VCSC), CWA Local 1105 (Downstate Commercial) (Verizon New York, VCSC, VSC), CWA Local 1108 (Downstate Traffic)(Verizon New York, VCSC, VSC), CWA Local 1104 (Upstate Traffic) (formerly Local 1112) (Verizon New York), CWA Local 1113 (Upstate Accounting) (Verizon New York, VCSC, VSC), CWA Local 1302 (Central Order Bureau) (Verizon New England), CWA Local 1395 (VSC), CWA Local 1400 (New England Service Centers) (Verizon New England, VCSC, VSC); November 8, 2013 for IBEW Plant (Verizon New England Inc., VADI, Verizon Avenue, VCSC, and VSC), IBEW Traffic (Verizon New England Inc. and VSC), IBEW Accounting (Verizon New England Inc., VCSC, and VSC), and IBEW Sales (Verizon New England Inc., VADI, VCSC and VSC); and November 25, 2013 for Verizon New York (Upstate Commercial) (Verizon New York, VCSC, VSC).

Dependent Class	Who They Are	Relationship
	qualified medical child support order (QMCSO).	
Class II Dependents ***Note:*** *You cannot add new Class II Dependents after October 19, 2012. Once dropped from coverage, Class II Dependents cannot be reinstated.*	• Your unmarried children who do not qualify as Class I Dependents. • Your unmarried grandchildren. • Your unmarried brothers and sisters. • Your parents and grandparents and your spouse's (or same-sex domestic partner's) parents and grandparents. Each Class II Dependent **must** meet **all** of the following eligibility requirements: • Live in your home or in one you provide within 50 miles of you for at least 6 months a year. • Be dependent on you for support. • Have an annual gross income from all sources (other than that received from you), including Social Security, of less than $6,000.	• Class II Child • Class II Grandchild • Class II Sibling • Class II Parent/ Grandparent
Sponsored Children[2,3] ***Note:*** *You cannot add new Sponsored Children after October 19, 2012. Once dropped from coverage, Sponsored Children cannot be reinstated.*	• Your unmarried children from age 19 through the end of the calendar year in which they reach age 25 who are not full-time students or incapacitated and otherwise meet the definition of child, as described above.	• Sponsored Child

Verifying Dependent Eligibility

At the time you enroll your dependent or at any time, upon request, you may be asked to provide proof of dependent status, such as:

- A marriage certificate.
- A birth certificate.
- Guardianship/adoption papers.
- Information to verify domestic partnership, such as the completion of an Affidavit of Domestic Partnership or evidence of cohabitation.

[2] Sponsored Children are subject to their own deductibles and coinsurance, which do not accumulate toward your family deductible.

[3] LTD recipients cannot cover Sponsored Children.

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.

Important: LTD Benefit Recipients

LTD benefit recipients are not eligible to cover Sponsored Children.

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

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

Important: If You Enroll in an HMO

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

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, a civil union spouse who does not otherwise meet the definition of domestic partner, 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 generally only covers the individuals outlined in this SPD.

If Your Spouse or Same-Sex Domestic Partner Is a Verizon Employee or Retiree

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

- Children can be covered by one Verizon parent or the other, but not by both.

- You can be covered as a retiree under the Plans or as or as a dependent under another Verizon associate medical plan, but cannot be covered under more than one Verizon associate medical plan. To be covered as a dependent under another Verizon associate plan, you must choose the "No Coverage" option under the Medical Plan and the Alternate Choice Plan. However, an exception occurs if your spouse or same-sex domestic partner is a management employee or retiree; you may be covered as both a retiree under the Medical Plan and the Alternate Choice Plan and as a dependent under a Verizon management plan and do not need to waive coverage.

- Your spouse or same-sex domestic partner can be covered as an employee or a retiree under another Verizon associate medical plan or as a dependent under these Plans, but not as both. To be covered as your dependent under these Plans, your spouse or same-sex domestic partner must be eligible for and must choose the no coverage option under his or her plan.

Enrolling in the Plans

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

- **Medical Option.** You will have to choose whether to be covered under these Plans and, if you want coverage, under which option. In most instances, these are your options:

  - HCN.

  - MEP Health Care PPO (MEP-HCP).

  - HMO (available through the Alternate Choice Plan):

    - After the enrollment opportunity for 2012, if you are not eligible for Medicare and are enrolled in an HMO at the time of retirement, you and your eligible dependents can continue coverage in the HMO option for as long as the HMO is offered, provided you and/or your eligible dependents remain continuously eligible for the Plans and enrolled in the HMO.

    - After the enrollment opportunity for 2012, if you are not enrolled in an HMO at the time of retirement, then the HMO option will no longer be available to you and your eligible dependents.

    - If you are eligible for Medicare, Verizon may offer Medicare Advantage plans to you from time to time. The Medicare Advantage plans offered to you (including details pertaining to the applicable plan design), if any, will be communicated to you during annual enrollment.

- EPO:
  - Effective on October 19, 2012, no new retirees may enroll in the EPO option.
  - If you are enrolled in the EPO as of October 19, 2012, you will continue to be covered under the EPO option provided that you remain continuously eligible for the Plans and enrolled in the EPO option. If you change medical options and you are no longer enrolled in the EPO option, the EPO option will no longer be available to you and your eligible dependents.
  - If you are enrolled in the EPO option at the time of retirement and you are eligible for retiree medical coverage under the Plans, you and your eligible dependents may remain continuously enrolled in the EPO option provided that you and your dependents remain continuously eligible for the Plans and enrolled in the EPO option and are not Medicare-eligible.
- No coverage.

- **Coverage Level.** You also will need to choose a coverage level. You have six options:
  - Pre-Medicare retiree only.
  - Pre-Medicare retiree plus one dependent.
  - Pre-Medicare retiree plus family (two or more dependents).
  - Medicare-eligible retiree only.
  - Medicare-eligible retiree plus one dependent.
  - Medicare-eligible retiree plus family (two or more dependents).

Sponsored Children must be covered under a separate level. See the “Dependent Eligibility Requirements” chart above for option rules for same-sex domestic partners and their children.

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

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

Notes for Dependent Enrollment

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

Social Security Numbers Generally Required for Enrollment

Under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), the Centers for Medicare & Medicaid Services (CMS) generally requires Social Security numbers for employees and dependents to assist with reporting under the Medicare Secondary Payer requirements. Accordingly, Verizon will request that you and your dependents provide Social Security numbers at the time of enrollment, so that Verizon can assist its health Plan administrator(s) to comply with this requirement.

To Enroll or Make Changes

Log on to the BenefitsConnection website (www.verizon.com/benefitsconnection) or call the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367). The BenefitsConnection website is available 24 hours a day, seven days a week. Benefits Center representatives are available to help you from 8:00 a.m. to 6:00 p.m., Eastern time, Monday through Friday (excluding holidays).

If You Do Not Enroll

Retirees

If you did not enroll during the 90-day initial enrollment period, you will be enrolled in the "No Coverage" option effective the first day of the month after you retire.

LTD Benefit Recipients

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

Enrollment as a Surviving Spouse or Dependent

Surviving Dependents of a Retiree

Class I and Class II Dependents who are enrolled in the Plans as of the retiree's date of death are eligible for 12 months of Company-paid coverage under the Medical Plan or the Alternate Choice Plan after the retiree's death. Note that same-sex domestic partners and children of same-sex domestic partners are treated the same as spouses and children for the purposes of survivor benefits.

After the end of the 12-month period, Class I Dependents can elect to pay the full cost to continue coverage as a surviving dependent. Class II Dependents' coverage ends at the end of the 12-month period of Company-paid coverage; eligible Class II Dependent children can then continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments (see the "Continuing Coverage If Eligibility Ends" section).

Coverage for Sponsored Children ends on the last day of the month in which the retiree dies. Sponsored Children can then continue coverage under COBRA (see the "Continuing Coverage If Eligibility Ends" section).

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

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

Surviving Dependents of an LTD Benefit Recipient

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

Changing Your Elections

Anytime Enrollment

You can change your elections at any time, as many times as necessary, for any reason. Your new coverage takes effect the first of the month following a 30-day waiting period. Here are some examples:

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

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

Annual Enrollment

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

- Take no action. Your default medical coverage, the medical option and coverage category that you elected during the prior calendar year, will take effect January 1 of the following year. If an HMO option is terminated and you fail to elect another available medical option, your default medical coverage will be the MEP-HCP option, with the coverage level that you had elected before the HMO option was terminated.
- Select a new medical option. Your new coverage will take effect January 1 of the following year.
- Select "no coverage."

Status Changes

If you have a status change (birth, marriage, divorce, etc.), you can change your coverage as of the qualifying event date within 90 days from the qualifying event. Status changes are not subject to the Anytime Enrollment waiting period.

If you do not make the change within the 90-day period, you still can use Anytime Enrollment to make changes. The new coverage is effective the first day of the month following the 30-day waiting period.

You Gain a New Dependent

If you are a retiree who gains a new, eligible dependent through marriage, birth, adoption or placement for adoption, that person is covered under your medical coverage option on the date you gain the new dependent, as long as you call the Verizon Benefits Center within 90 days of the event. Otherwise, coverage begins the first day of the month after you call the Verizon Benefits Center to enroll your dependent.

Note: You cannot add coverage for a new same-sex domestic partner or the child of a same-sex domestic partner after retirement. Effective as of February 15, 2013, November 8, 2013, or November 25, 2013 (depending on the agreement date with your union), you can add coverage for a new same-sex spouse or the child of a same-sex spouse gained after retirement, as long as you and your domestic partner are legally married in a state that permits same-sex marriage. Coverage for your same-sex spouse (and the eligible child of a same-sex spouse) will apply even if you do not reside in a state or other jurisdiction that recognizes same-sex marriage.

If you are a retiree who gains a new, eligible dependent as the result of a QMCSO, you can enroll that dependent in the Plans by calling the Verizon Benefits Center. Your election will take effect on the date the QMCSO is approved by the Verizon Benefits Center.

If you are a retiree who gains a new, eligible dependent as the result of an event other than those listed above, you can enroll that dependent in the Plans by calling the Verizon Benefits Center. Your election will take effect the first day of the month following your election.

Upon request, you will be required to provide proof of your dependents' eligibility.

You Lose a Dependent Through Death, Divorce, Legal Separation or Termination of a Same-Sex Domestic Partnership

If you lose a dependent through death, divorce or termination of a same-sex domestic partnership, coverage for that dependent ends at the end of the month in which the event occurs. However, you must call the Verizon Benefits Center to remove that dependent from your coverage. If you fail to remove your ineligible dependent, any premiums paid by you after the event will not be reimbursed and you will be responsible for any claims paid by the Plans. Further, your former dependent may lose his or her COBRA rights. For more information on COBRA, see the "Continuing Coverage If Eligibility Ends" section.

If you and your spouse become legally separated, coverage for your spouse continues, unless you call the Verizon Benefits Center to remove him or her from your coverage.

A Dependent Loses Eligibility

If a dependent loses eligibility or ceases to be a dependent under the Medical Plan or the Alternate Choice Plan in situations other than those described above, the dependent's coverage will continue until the end of the month in which the event occurs that causes the dependent to lose eligibility. If a child reaches the age 26 limit, his or her coverage will terminate at the end of the month in which he or she attains age 26.

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

When a dependent loses eligibility, you must call the Verizon Benefits Center before the dependent's coverage ends. You may have the option to decrease your coverage level. If you do so, your election will be effective on the date of the event, as long as you make your election within 90 days of the dependent's loss of eligibility. Otherwise, the election will be effective on the first day of the month following the date on which the election is made.

If you do not notify Verizon (by calling the Verizon Benefits Center), any claims incurred by your ineligible dependent will become your financial responsibility. Furthermore, if you do not disenroll your dependent within 60 days of when they become ineligible, they will lose their right to purchase continued health care benefits under COBRA. For more information on COBRA, see the "Continuing Coverage If Eligibility Ends" section.

Continuing Coverage When a Dependent Is Ineligible

Again, it is your responsibility to notify the Verizon Benefits Center within **90 days** if your dependents no longer meet eligibility requirements. Otherwise, any claims incurred by an ineligible dependent become your financial responsibility. In addition, if you fail to notify the Verizon Benefits Center of a dependent's loss of eligibility within **60 days** of when he or she became ineligible, your dependents will lose the right to purchase continued health care benefits under COBRA.

Periodically, you may be asked to provide proof of your dependents' eligibility. If such proof is not provided, those dependents or surviving dependents will lose their eligibility for the Plans. In some situations (for example, if you commit fraud or make an intentional misrepresentation of a material fact with respect to your dependent's eligibility), your dependent's coverage may be terminated retroactively. The Company may require that you reimburse the amount of any claims paid by the Plans on behalf of an eligible dependent to the extent permitted by applicable law.

You Move

If you are enrolled in an HMO or a Medicare Advantage plan and move to a location outside of your current HMO or Medicare Advantage plan's service area, you will be defaulted to the MEP-HCP option and automatically will receive a move package from the Verizon Benefits Center. You will have the opportunity to choose a new option. If you notify Verizon by calling the Verizon Benefits Center and requesting a move package and make your election within 90 days of the creation of your move package, your election will be effective on the date of your move. If you do not call within 90 days of the creation of your move package, your election will be effective on the first day of the month following the date on which the election is made.

You Become Eligible for Medicare

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

When you become Medicare-eligible, you may change your Medical Plan option. To do so, you must call the Verizon Benefits Center and make your election within 90 days after you become eligible for Medicare. Your election will be effective once your application is approved. **Note:** Your application may not be approved until after your 65th birthday. In this case, the coverage you had before you became eligible for Medicare would continue until your application is approved.

Prior to your 65th birthday (the date you become eligible for Medicare, unless you become eligible for Medicare due to a disability or end-stage renal disease), the Verizon Benefits Center will send an enrollment package to you that will describe the medical plan options available to you. If your current option is no longer available due to your being Medicare-eligible, or you wish to choose a new medical option, you will have 90 days to call the Verizon Benefits Center and speak with a representative to enroll.

- If you do not change your medical plan option during the 90-day period, you will have the following coverage effective the date you become eligible for Medicare:

  — You will continue to have coverage under the option in which you were enrolled prior to becoming Medicare-eligible if that option covers Medicare-eligible persons.

  — You will have coverage under the MEP-HCP option if the option in which you were enrolled prior to becoming Medicare-eligible does not cover Medicare-eligible persons.

Special Enrollment Rules

If you or your dependents (including your spouse or same-sex domestic partner) waived medical coverage because of other health insurance coverage, you may be able to enroll yourself or your dependents in the Plans if you or your dependents later lose that other coverage or insurance due to:

- Loss of eligibility;

- Termination of employer contributions for such coverage (however, special enrollment is not available if loss of coverage was due to your or your dependents' failure to pay for such coverage); or

- Exhaustion of COBRA coverage.

If you enroll yourself or your dependents in the Plans:

- Within 90 days of losing the other coverage, your or your dependents' coverage will be effective retroactive to the date of the event.

- After 90 days of losing the other coverage, your or your dependents' coverage will be effective the first day of the month following your enrollment.

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

- Within 90 days of the event, your coverage will be effective retroactive to the date of the event.

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

To request a special enrollment, contact the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

Cost of Coverage

Your cost for coverage is determined by:

- The date you retire (or, if you are an LTD benefit recipient, the date that your LTD benefit was certified).
- Your net credited service date.
- Your Medicare eligibility status.
- The medical option you choose.
- The number of dependents you cover.

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

If you are an LTD benefit recipient, the following cost of coverage provisions also apply to you and references to "retiree contributions" also includes contributions to be made by an LTD benefit recipient. However, the date that your LTD benefit is certified will replace the date that you retire (i.e., your "retirement date") for purposes of determining the amount that you are required to contribute.

If You Retired (or Your LTD Benefit Was Certified) On or Before January 1, 1992

The Company contribution will always cover the full cost of coverage for you and, if applicable, your enrolled Class I and Class II Dependents. You pay the full cost of medical coverage for any Sponsored Children whom you choose to cover.

If You Retired (or Your LTD Benefit Was Certified) After January 1, 1992

If Your Net Credited Service Date is Before August 3, 2008

If your net credited service date is before August 3, 2008, you will be required to contribute to obtain medical coverage. The amount that you will be required to contribute depends on the Plan year, the medical option you elect (or are defaulted into for failure to elect), your net credited service date, your Medicare status and the date you retire (or the date that your LTD benefit is certified) as described below.

Retiree Medical Caps

The Company's annual contribution toward coverage is capped (referred to as "retiree medical caps") as described below.

For 2013, 2014 and 2015, you will only be required to pay the applicable monthly retiree contribution amount (under "Monthly Retiree Contributions"), if any, for retiree medical coverage.

Beginning in 2016, your annual contribution toward retiree medical coverage will equal the **greater of**:

- The excess, if any, of the cost of coverage for the coverage category and medical option you elect over the applicable retiree medical cap described below; or

- The annual retiree contribution amounts, calculated based on the applicable monthly retiree contribution outlined in the charts below under “Monthly Retiree Contributions.”

Calculation of Retiree Medical Caps.

For Plan years beginning on and after 2016, the Company’s annual contribution toward the cost of coverage for the coverage category and medical option you elect is capped at the **greater of**:

- The COBRA contribution rates established in December 2014 for the 2015 plan year for pre-Medicare and Medicare-eligible retirees for the MEP-HCP and HCN options; and for the EPO and HMO options, no greater than the COBRA contribution rate for the HCN option; or

- The retiree medical cap contributions in the 2008 labor contracts shown in the “Retiree Medical Caps” chart as follows:

Retiree Medical Caps Chart

Coverage Category Elected by Retiree/LTD Benefit Recipient	Annual Pre-Medicare Company Contribution Cap	Annual Medicare-Eligible Company Contribution Cap
Retiree Only	$12,580	$6,330
Retiree + 1	$25,160	$12,660
Retiree + Family	$31,450	$18,990

Retiree medical caps also apply to the cost of coverage requirements for LTD benefit recipients.

Monthly Retiree Contributions

If You Retired (or Your LTD benefit Was Certified) Before January 1, 2013

If you retired (or your LTD benefit was certified) before January 1, 2013 with a net credited service date before August 3, 2008:

- If you enroll in the MEP-HCP or HCN option, you will **not** be required to pay a monthly retiree contribution during 2013, 2014 and 2015.

- If you enroll in the EPO option or an HMO option, a monthly retiree contribution will apply as outlined in the EPO and HMO chart under “Monthly Retiree Contributions” below.

If You Retired (or Your LTD Benefit Is certified) On or After January 1, 2013

If you retire (or your LTD benefit is certified) on or after January 1, 2013 with a net credited service date before August 3, 2008, you will be required to pay a monthly retiree contribution towards the cost of coverage based on the medical option you elect as outlined in the "Monthly Retiree Contributions" charts that follow.

HCN and MEP-HCP Options Monthly Contributions

For 2013 and 2014, if you retired (or your LTD benefit was certified) on or after January 1, 2013 with a net credited service date before August 3, 2008, you will be required to pay the following monthly retiree contribution based on your coverage category and Medicare eligibility:

Coverage Category Elected by Retiree/LTD Benefit Recipient	Pre-Medicare Monthly Retiree Contribution	Medicare-Eligible Monthly Retiree Contribution
Retiree Only	$35.00	$17.50
Retiree + 1	$60.00	$30.00
Retiree + Family	$60.00	$30.00

For each plan year beginning on and after January 1, 2015, the monthly retiree contribution will increase by 6 percent when compared to the applicable monthly retiree contribution for the previous plan year. For example, if you retired on or after January 1, 2013, are Medicare-eligible and enroll in the MEP-HCP option, you will pay a Medicare-eligible monthly retiree contribution in 2015 of $18.55 ($17.50 + 6 percent) for retiree only coverage; and you will pay a Medicare-eligible monthly retiree contribution in 2016 of $19.66 ($18.55 + 6 percent) for retiree only coverage.

EPO and HMO Options Monthly Contributions

If you elect the EPO or an HMO option and have a net credited service date before August 3, 2008, you will pay a monthly retiree contribution towards the cost of coverage. Your contribution for plan years 2013 through 2015 may vary by option, but will be no greater than the following:

2013

Coverage Category Elected by Retiree/LTD Benefit Recipient	Pre-Medicare Monthly Retiree Contribution	Medicare-Eligible Monthly Retiree Contribution
Retiree Only	$67.50	$33.75
Retiree + 1	$105.00	$52.50
Retiree + Family	$135.00	$67.50

2014

Coverage Category Elected by Retiree/LTD Benefit Recipient	Pre-Medicare Retiree Monthly Contribution	Medicare-Eligible Retiree Monthly Contribution
Retiree Only	$75.00	$37.50
Retiree + 1	$115.00	$57.50
Retiree + Family	$150.00	$75.00

2015

Coverage Category Elected by Retiree/LTD Benefit Recipient	Pre-Medicare Monthly Retiree Contribution	Medicare-Eligible Monthly Retiree Contribution
Retiree Only	$82.50	$41.25
Retiree + 1	$125.00	$62.50
Retiree + Family	$165.00	$82.50

All Medical Options – Retiree Contributions in 2016

As described above, beginning in 2016, your annual contribution toward retiree medical coverage will equal the **greater of**:

- The excess, if any, of the cost of coverage for the coverage category and medical option you elect over the retiree medical cap described earlier in this section under “Retiree Medical Caps”; or

- The annual retiree contribution amounts, calculated based on the applicable monthly retiree contribution outlined in the charts above under “Monthly Retiree Contributions.”

If Your Net Credited Service Date Is August 3, 2008 or Later

If your net credited service date under your pension plan is August 3, 2008 or later (and you did not qualify for any Company-subsidized retiree medical coverage upon your initial employment termination), the Company’s annual contribution is dependent on your eligibility for Medicare:

- If you **are not** eligible for Medicare, you will receive an annual contribution equal to $480 for each full year of your net credited service that commences on or after August 3, 2008, up to a maximum of 30 years.

- If you **are** eligible for Medicare, you will receive an adjusted contribution that is not less than 50 percent of the contribution paid by pre-Medicare retirees with the same net credited service.

Special Note for Same-Sex Domestic Partner Coverage

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

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

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

Paying for Coverage

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

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

When Participation Ends

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

Retiree and LTD Benefit Recipient Coverage

Re-Employment of a Retiree

Coverage ends on the last day of the month in which you are re-employed by the Company or an affiliate in a position that is other than occasional or supplemental.

When you subsequently retire:

- If you had been retired for 90 days or less before being rehired, you will be treated as a newly retired participant.

- If you had been retired for more than 90 days before being rehired, you will be covered again under the Plans, subject to the terms and conditions that apply to individuals who retired on your initial retirement date.

LTD Benefits End

If you are an LTD benefit recipient, your coverage ends on the last day of the month in which you are no longer eligible for LTD benefits under the applicable Company-sponsored LTD plan, unless you are eligible for coverage as a retiree.

Note: If you lose coverage because you are no longer eligible for LTD benefits, you are not eligible for COBRA continuation coverage.

Cancellation of Coverage

If you cancel coverage, your coverage will end on the last day of the month in which you elect to cancel coverage.

Failure to Submit Payment (If Required)

If you are required to make a payment and it is not received on time, coverage will end on the first day of the month for which payment is not received.

Dependent Coverage

A dependent’s or surviving dependent’s coverage will end on the earliest date described in the following section. Your dependent or surviving dependent may be able to continue coverage under COBRA (see the “Continuing Coverage If Eligibility Ends” section).

Retiree’s or LTD Benefit Recipient’s Coverage Ends

If the retiree’s or LTD benefit recipient’s coverage ends for any reason except when the retiree or LTD benefit recipient dies, coverage for all dependents also will end at the same time.

Retiree Dies

Coverage for any Class I and Class II Dependents who are enrolled on the date of the retiree's death will continue until the last day of the 12-month period following the month in which the retiree dies. Coverage also will continue for the newborn child of a deceased retiree who is born subsequent to the retiree's death.

After the end of the 12-month period:

- Coverage for Class I Dependents can be continued as surviving dependents under the Plan by paying the full cost.

- Coverage for eligible Class II Dependent Children can be continued under COBRA (see the "Continuing Coverage If Eligibility Ends" section).

Coverage for any Sponsored Children of the retiree will end on the last day of the month in which the retiree dies. Sponsored Children can continue coverage under COBRA.

LTD Benefit Recipient Dies

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

Dependent or Surviving Dependent Ceases to Meet the Eligibility Requirements

Coverage for a dependent or a surviving dependent will end on the earlier of either the date the dependent is covered as an employee or retiree under any Company-sponsored medical plan, or the last day of the month in which the dependent or surviving dependent no longer qualifies as a dependent under the Plans, subject to the following (note that HMOs may have different eligibility requirements):

- Coverage for your spouse ends on the last day of the month in which he or she becomes divorced from you.

- Coverage for a legally separated spouse will end on the last day of the month following the date you elect coverage to end.

- Coverage for a same-sex domestic partner ends on the last day of the month he or she fails to meet the definition of a same-sex domestic partner.

- Coverage for a child ends on the last day of the month in which he or she reaches age 26.

- Coverage for a disabled child ends on the last day of the month in which he or she no longer meets the definition of a disabled child, assuming the disabled child is older than age 26.

- Coverage for a child under a QMCSO ends on the date you no longer are required to provide coverage for this child or, if earlier, the date the child no longer would be eligible for coverage.

- Coverage for a Class II Dependent ends on the earlier of the last day of the month in which he or she fails to meet the support requirements applicable to Class II Dependents (see the "Dependent Eligibility Requirements" chart in the "Participating in the Plans" section).

- Coverage for a Sponsored Child ends on the earlier of the last day of the calendar year in which he or she reaches age 25, or the first day of the month for which a required payment is not received.

- Coverage for a child of a same-sex domestic partner ends on the last day of the month in which the child reaches age 26, or the last day of the month in which the child otherwise fails to meet the definition of a child of a same-sex domestic partner (or the same-sex domestic partner no longer meets the definition of a same-sex domestic partner).

Extended Benefits

If You or Your Dependents Are Hospitalized

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

Continuation of Coverage Under COBRA

In some instances, a person whose eligibility for coverage under the Medical Plan and the Alternate Choice Plan ends, still may be able to continue coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments. See the "Continuing Coverage If Eligibility Ends" section for more information.

Certificate of Creditable Coverage

When any person's coverage under the Plans ends for any reason, including the end of COBRA continuation coverage, the Verizon Benefits Center will send that person a Certificate of Creditable Coverage, free of charge, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This certificate may help the person receive coverage under another plan. Specifically, this certificate may help reduce or eliminate exclusionary periods of coverage for pre-existing conditions under the other plan.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. You also will be provided with a certificate, free of charge, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. To request a certificate, access the BenefitsConnection website or call the Verizon Benefits Center.

Surviving Dependents

In addition to the information under "Dependent Coverage," coverage for a surviving dependent will end on the earliest of the following dates:

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

- The date the Plans are terminated with respect to a participating company or with respect to surviving dependents;

- The first day of the month for which a required contribution is not received in a timely manner; or
- The date coverage would otherwise end because the surviving dependent ceases to be an eligible dependent.

Overview of Your Options

Plan Options

The Verizon Medical Expense Plan for New York and New England Associates gives you a choice of different types of medical options to meet your needs.

As a participant in the Medical Plan or the Alternate Choice Plan, you have one or more of these options available depending on where you live (see the "Dependent Eligibility Requirements" chart in the "Participating in the Plans" section for information on option rules for same-sex domestic partners and their children):

- **Health Care Network (HCN) option.** With the HCN option, you can seek in-network care or out-of-network care. When you receive care through the network, you will receive the highest level of benefits available. If you receive medically necessary covered services outside the network, you still will receive benefits, but at a reduced level of coverage and higher out-of-pocket costs. You pay no annual deductible for in-network services. In addition, preventive care services are covered at 100 percent on an in-network basis without a copay.

- **MEP Health Care Preferred Provider Organization (MEP-HCP) option.** Like the HCN option, you can seek in-network care or out-of-network care. The MEP-HCP option consists of a network of providers that have agreed to charge a network negotiated fee (NNF) for certain services. You have a choice each time you need medical care – you can receive your care in-network from providers/facilities that participate in the preferred provider organization (PPO). When you use PPO providers, you receive a higher level of benefit coverage and, because charges are based on the NNF, rather than the maximum allowed amount (MAA) charges, your out-of-pocket medical costs are lower. Your financial payment for medical care, if any, is based on the discounted fee rather than MAA charges, and it may consist of a fixed copay rather than deductible and variable coinsurance, depending on the type of service provided. In addition, preventive care services (both in-network and out-of-network) are covered at 100 percent.

- Under the Alternate Choice Plan, the **National Exclusive Provider Organization (EPO) NYNE option**. The EPO option provides care through a network of participating providers. Generally, you must use providers in the EPO network for your expenses to be covered. The EPO option is not available to new enrollees. If you are enrolled in the EPO option as of October 19, 2012, you will continue to be eligible for coverage under the EPO option provided that you remain continuously eligible for the Alternate Choice Plan and enrolled in the EPO option. If you are not Medicare-eligible and are enrolled in the EPO option at retirement, you and your eligible dependents can continue coverage in the EPO option for as long as the EPO option is offered, provided you and/or your eligible dependents remain continuously enrolled in the EPO option. If you change medical options and are no longer enrolled in the EPO option, you will no longer be eligible to re-enroll in the EPO option.

- Under the Alternate Choice Plan, a **Health Maintenance Organization (HMO) option.** If you are not Medicare-eligible and are enrolled in an HMO at the time of retirement, you and your eligible dependents can continue coverage in the option for as long as the HMO is offered, provided you and/or your eligible dependents remain continuously eligible for the Medical Plan and Alternate Choice Plan and enrolled in the HMO. If you change medical options and are no longer enrolled in the HMO, the HMO will no longer be available to you and your eligible dependents. If you are not enrolled in a HMO option when you retire, you cannot enroll in an HMO option as a retiree.

  Under an HMO, you'll usually need to choose one of the HMO's doctors to be your primary care physician (PCP). Your PCP will then coordinate all your medical care. If you join an HMO, your care usually will be covered only if it is received through your PCP and other providers affiliated with the HMO. **You typically do not receive coverage for care not coordinated through your PCP, unless care is received for a true emergency.**

  If you are eligible for Medicare, you may be able to join a Medicare HMO, if offered in your area. See the "Health Maintenance Organizations (HMOs) and Medicare Advantage Plans" section for more information.

  If you are eligible for Medicare and want to join an HMO, your choice will be limited to Medicare Advantage HMOs. Your enrollment materials will explain which Medicare Advantage HMOs are available. If you select a Medicare Advantage HMO, you usually will choose a PCP who coordinates your care within the Medicare Advantage HMO. To be covered, your care usually must be received through your PCP and other doctors and hospitals associated with the Medicare Advantage HMO. **You typically do not receive coverage for care not coordinated through your PCP, unless care is received for a true emergency.**

- **No coverage.** You have the option to elect no medical coverage for you and your dependents.

When You're Eligible for Medicare

You can enroll in Medicare during a seven-month period that begins three months before and ends three months after the month in which you reach age 65. Medicare Part B is optional, and you can disenroll, if you wish.

However, you should enroll in Part B coverage because your Verizon plan will determine benefits assuming that you do have Medicare Part B coverage and you have received your Part B benefits. Your Verizon plan then pays any remaining balance up to the plan maximum, so the total amount paid does not exceed the amount the Verizon plan would have paid on its own. If you are not enrolled in Medicare Parts A and B, you may not receive the maximum amount of benefits you may be entitled to receive.

Which Option Is Best for You?

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

- If you want to save on health care costs, but still want the flexibility to choose non-network doctors in certain situations, think about selecting the bargained-for plans – the HCN or MEP-HCP option. Both options use the Anthem Blue Cross and Blue Shield ("Anthem") PPO provider network. You can confirm your desired provider participates in the network through the BenefitsConnection website or on Anthem's website.

  — For the HCN option, if you seek medically necessary care in-network, you'll pay a copay for office visits, with most other medically necessary in-network care covered at 90 percent. However, if you prefer to choose your own doctors, you have the option to pay more to receive covered medically necessary care from an out-of-network provider.

  — For the MEP-HCP option, if you seek medically necessary care from PPO providers, you'll pay a copay for office visits, with most other medically necessary in-network care covered at 90 percent after a deductible. However, you have the option to pay more to receive covered, medically necessary care from an out-of-network provider.

- If you instead elect to remain enrolled in an HMO, in most cases, you pay only a copay of no more than $20 for each office visit to your primary care physician and $25 for each visit to a specialist (and no more than $75 for each emergency room visit). The HMO covers most other medically necessary services at 100 percent. Provisions for Medicare HMOs may be different.

- Before electing the HCN option, the MEP-HCP option or an HMO, be sure to check with the administrator to see which doctors and hospitals belong to the network and which will be available to you. If you visit doctors and hospitals outside the network, your medically necessary care will be covered at the lower rate (HCN or MEP-HCP option) or not at all (HMOs – unless you have a true emergency). Therefore, you'll want to be sure that the doctors and hospitals in the network are right for you.

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

You can confirm if your desired provider participates in the network through the BenefitsConnection website.

Comparing Your Medical Plan Options

	HCN		MEP-HCP		HMO	EPO
Coverage Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**		
You have a PCP who directs your care	No	No	No	No	Yes; for most HMOs	No
You need referrals from your PCP before you receive care	No	No	No	No	Yes; for most services and in most HMOs	No
You can receive covered care anywhere in the United States	Yes	Yes	Yes	Yes	No	Yes
You are covered for emergencies	Yes	Yes	Yes	Yes	Yes	Yes
You must pay a deductible before the Plan pays benefits for certain services	No	Yes	Yes or no, depending on the service	Yes or no, depending on the service	No	No
You pay a per-visit copay for most care	Yes or no, depending on service	No (except for emergency room care and urgent care)	Yes or no, depending on the service	No (except for emergency room care and urgent care)	Yes	Yes
You pay a percentage of your covered care in coinsurance for certain services	Yes	Yes	Yes	Yes	No; most services are covered at 100% after the copay	No; most services are covered at 100% after the copay
You may have to pay bills and submit claims for reimbursement	No	Yes	No	Yes	No	No
The Plan has an annual out-of-pocket maximum	Yes	Yes	Yes	Yes	Generally, not applicable	No

For additional information pertaining to your HCN and MEP-HCP options, please refer to the specific coverage summary charts in the “HCN Option Coverage Summary” and the “MEP Health Care PPO (MEP-HCP) Option Coverage Summary” sections.

The Health Care Network (HCN) Option

With the Health Care Network (HCN) option, you have a choice each time you need medical care – you can receive in-network or out-of-network care. Depending on your choice, costs will vary, as shown under the "HCN Option Coverage Summary" chart later in this section. When you receive your care through the network, you will receive the highest level of benefits available. If you receive medically necessary covered services outside the network, you still will receive benefits, but at a reduced level of coverage and higher out-of-pocket costs. Preventive care is covered on an in-network and out-of-network basis, as described under "Preventive Care Services" in the "HCN Option Coverage Summary" chart later in this section.

See the chart under "HCN Option Coverage Summary" later in this section for information on covered services, and the chart under "Claims and Appeals Procedures" in the "Additional Information" section for the HCN administrator. For more information about covered services and your HCN benefits, access the BenefitsConnection website or contact the claims administrator at the telephone number listed on your ID card.

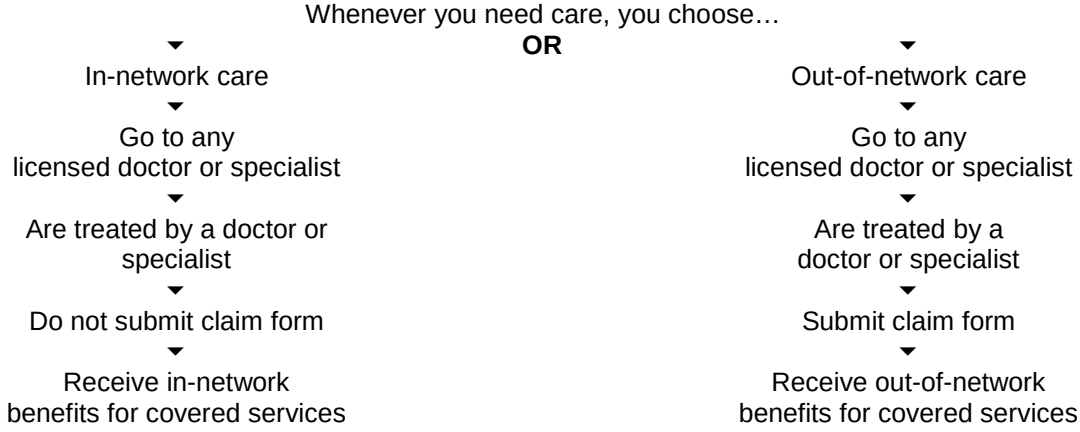
How the HCN Option Works

When you need care, visit a licensed health care provider of your choice. Depending on whether you seek in-network or out-of-network care, the HCN option works differently.

With respect to medical benefits, the administrator for the HCN option is Anthem. The HCN option uses Anthem's network of service providers. To the extent that there is no in-network service provider for a specific covered service or supply within a 40-mile radius of your home zip code, you and your eligible dependents will be eligible for the in-network provisions applicable to the specific medical option in which you are enrolled (i.e., either the in-network provisions of the HCN or the MEP-HCP option).

A list of participating providers in the HCN option can be obtained free of charge via Anthem's website or upon request, in paper, as well as by calling Anthem at the phone number listed on your ID card.

The chart below describes how the HCN option works.



In-Network Benefits

Generally, when your primary care physician, if applicable, provides your care or refers you to another in-network doctor, you will pay a copay for each office visit, including surgical procedures performed in the doctor's office. The HCN option then typically pays 90 percent of the network negotiated fee (NNF) for most other eligible expenses, including hospital expenses, surgery, outpatient laboratory tests and outpatient X-rays. When you receive covered, medically necessary care in-network, there are no deductible charges and no balance billing.

In-Network Copays

A copay is a flat dollar amount you pay for covered expenses. When you seek in-network care under the HCN option, you pay a $20 copay for each primary care physician's home or office visit and a $25 copay for each specialist's home or office visit. The copay for an individual who is Medicare-eligible is $10 for each primary care physician's home or office visit and $15 for each specialist's home or office visit. The copay for each urgent care facility visit is $20 ($10 if you are Medicare-eligible). There is a $75 copay ($25 if you are Medicare-eligible) for emergency care in a hospital's emergency room (if you are admitted to the hospital, your copay is waived).

Out-of-Network Benefits

Whenever you need medical care, you can use any doctor or hospital you choose, but benefits are lower if you choose a doctor or hospital that is not part of the network. The out-of-network portion of the HCN option requires an annual deductible before it will pay benefits. Then, the HCN option typically pays 70 percent of the MAA charges for most other eligible expenses and you pay 30 percent of the MAA in coinsurance. You also are responsible for amounts above the MAA.

Out-of-Network Deductible

Each calendar year, you must meet an annual deductible before the HCN option begins to pay benefits for covered services under the out-of-network portion of the option. This deductible applies to all covered services or supplies provided under the HCN option on an out-of-network basis in a year. The individual and family deductibles for the years 2013 through 2015 are shown in the table below. The family annual deductible is satisfied when any combination of individual family member deductibles equals the applicable family annual deductible, within a calendar year; however, you or your dependent will never satisfy more than your own individual amount.

Out-of-Network Annual Deductible		
Year	**Individual**	**Family**
2013	$700	$1,750
2014	$700	$1,750
2015	$725	$1,812.50

Note:

- Only amounts paid toward individual deductibles can be added together to meet the family deductible.

- Amounts paid for care for Sponsored Children and Class II Dependents do not count toward the family deductible. In addition, these dependents must meet their individual deductibles even if the family deductible has been met. Once the family deductible is met in a plan year, no further deductibles are required for you and your Class I Dependents in that plan year.

The following expenses do not apply to the deductible:

- Amounts paid for in-network care.

- Copays for visits to urgent care facilities or emergency rooms.

- Expenses for prescription drugs.

- Amounts paid for noncovered services and supplies by the Medical Plan.

- Charges that exceed the maximum allowed amount (MAA), the network negotiated fee (NNF), or other Medical Plan limits.

- Expenses for LASIK services.

- Amounts payable when pre-admission testing is done on an inpatient basis and the inpatient admission is not considered medically necessary by the claims administrator.

- Amounts payable for a covered surgery (and associated X-ray, laboratory, anesthesia, and other expenses) when the surgery is performed on an inpatient basis and inpatient admission is not considered medically necessary by the claims administrator.

Out-of-Network Coinsurance

After you satisfy the annual deductible, the HCN option typically pays 70 percent of MAA charges and you pay the difference between the actual charges and the amount the HCN option pays for most covered expenses, including:

- Physician office visits.

- Laboratory/X-rays.

- Hospital charges.

- Surgery.

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

- The HCN option will pay 80 percent of the MAA with no deductible for covered preventive care services obtained on an out-of-network basis. Out-of-network preventive care services will be covered according to the age and frequency provisions of the Affordable Care Act;

- The HCN option will pay 90 percent of the submitted amount for covered ambulance service in the event of an emergency as defined by the claims administrator or you obtain proper pre-authorization from the claims administrator. The HCN will pay 80 percent of the MAA for covered ambulance services for nonemergency services; and

- The HCN option will pay for covered bereavement counseling visits under the mental health care benefit provisions, to the extent that such visits are determined by the HCN claims administrator to be a covered service or supply. Contact your HCN claims administrator for details on Plan reimbursement.

When you use an out-of-network provider, it is your responsibility to contact HCN Member Services to pre-certify all inpatient hospital stays (including inpatient mental health and substance abuse treatment). In addition, you must also pre-certify selected outpatient procedures, home health care, hospice care, private duty nursing and stays in a skilled nursing facility. (See the “Pre-Certification Requirements” section for more information on pre-certification.)

Annual Out-of-Pocket Maximum

There is financial protection if you have large expenses. If an individual’s share of covered expenses exceeds the out-of-pocket maximum in a calendar year (including the annual deductible), the HCN option will pay 100 percent of the NNF or MAA, as applicable, amount for most additional covered expenses for that individual for the rest of the calendar year. You are responsible for all amounts above the MAA.

The out-of-pocket maximums that apply to covered services or supplies obtained on an in-network basis or out-of-network basis under the HCN option for the years 2013 through 2015 are shown in the table below. Expenses that apply towards the out-of-pocket maximum are aggregated between in-network and out-of-network expenses to reach the applicable out-of-pocket maximum. The family annual out-of-pocket maximums can be satisfied by any combination of family members within a calendar year; however, you or your dependent will never satisfy more than your own individual amount. Amounts paid towards the deductible will apply towards the annual out-of-pocket maximum.

	Out-of-Pocket Annual Maximum			
	In-Network		Out-of-Network	
Year	Individual	Family	Individual	Family
2013	$1,000	$2,500	$1,800	$4,500
2014	$1,000	$2,500	$1,800	$4,500
2015	$1,050	$2,625	$1,850	$4,625

The following expenses cannot be used to satisfy the out-of-pocket maximum (nor are they paid at 100 percent once the out-of-pocket maximum is reached):

- Charges that exceed MAA, NNF or other Medical Plan limits;
- Charges for services and supplies that are not covered by the Medical Plan;
- Flat dollar copays for medical care;
- Additional amounts you pay if you do not follow pre-certification program procedures (see the "Pre-Certification Requirements" section);
- Expenses for prescription drugs; and
- Amounts for LASIK services.

Special Transition Rules

These special transition rules apply if you elect the HCN option during your initial enrollment period or during "Anytime Enrollment."

If You Are Pregnant

- **At "Anytime Enrollment":** If you (or a covered dependent) are pregnant immediately before January 1 of the plan year (the calendar year) for which you are enrolling in benefits and your doctor is not in the HCN option, you may continue with your current OB/GYN until you are released from the physician's care for that pregnancy or choose to see a network physician. Either way, your pregnancy benefits will be paid at the in-network level. You must contact the HCN's Member Services between December 1 of the current plan year and January 31 of the new plan year to request these transition benefits.

- **At initial enrollment:** If you (or a covered dependent) are pregnant when you enroll in the HCN option and your doctor is not in the HCN option network, you may continue with your current OB/GYN until you are released from the physician's care for that pregnancy or choose to see a network physician.

Either way, your pregnancy benefits will be paid at the in-network level. You must contact the HCN's Member Services within 60 days of your coverage effective date to request these transition benefits.

You must call the Verizon Benefits Center to enroll your newborn. If you call within 90 days of your child's birth, coverage will be effective as of the date of birth; if you call after 90 days, coverage will be effective as of the first day of the month following the enrollment.

If You Are Hospitalized

If you (or a covered dependent) are hospitalized or receiving care that is an alternative to hospitalization (as determined by the claims administrator) for a specific illness or condition immediately before your coverage effective date, you will be covered under your current medical option (but only for that specific condition) until you are discharged for that condition. You must contact the HCN's Member Services to request this extension of benefits.

Paying for Out-of-Network Care and Filing Claims

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

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

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

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

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

If the Patient Is Eligible for Medicare

If the patient is eligible for Medicare (and Medicare is the patient's primary plan), you or your health care provider should submit the bill for the care to Medicare. Medicare will then pay its portion of the bill. After Medicare pays its portion, you will receive a Medicare Summary Notice showing how much Medicare has paid.

After you receive your Medicare Summary Notice, you should then submit a copy of the notice, plus copies of any itemized bills you have received from the provider for the services, to Anthem. Anthem will then determine your eligible HCN option benefits and, if appropriate, send a payment to your health care provider. It also will send you an EOB statement. The EOB shows how much of the bill the Plan paid and how much (if any) remains for you to pay. After you receive the EOB, you should receive a new bill from your medical provider for any remaining amount not covered by the HCN option or Medicare.

Medicare Crossover

Medicare Crossover is an automatic claim filing service for Verizon participants who have Medicare as their primary coverage. Under Medicare Crossover, your doctor files your medical claims with your Medicare Part B claims administrator. Medicare determines the portion of the claim it will pay and pays the provider directly (you will get an EOB from Medicare if you owe any money).

Medicare then forwards the claim for the remaining expenses directly to Anthem. Anthem then pays the provider directly. (You will get an EOB from Anthem if you owe any money.)

If you are enrolled in the HCN option, you are automatically enrolled in the Medicare Crossover program if your Medicare number is your Social Security number followed by an "A." Contact Anthem Member Services to enroll in Medicare Crossover if your Medicare number is not your Social Security number followed by an "A" or if you would like to enroll your Medicare-eligible dependents.

Requesting a Claim Form

If you need to file a claim for HCN benefits, you should contact your HCN claims administrator for a claim form. You can call your claims administrator via the telephone number shown on your ID card.

Deadline for Filing Claims

If you need to file a claim, you should submit your claims as soon as possible after receiving a health care service. The deadline for submitting claims is 15 months after the date the service was received.

HCN Option Coverage Summary

The table in this section provides an overview of the benefits payable for covered services and supplies provided by both the in-network and out-of-network portions of the HCN option. (See "In-Network Benefits" and "Out-of-Network Benefits" earlier in this section for an explanation of in-network and out-of-network coverage rules.)

Keep in mind, if you utilize out-of-network providers, charges in excess of the MAA will not be covered by the Plan. If a charge for a covered service exceeds the MAA, the Plan will apply its reimbursement percentage only to the amount within the MAA limit, and you may be responsible in full for the difference between the billed charges and the MAA. Certain other restrictions may apply – see the "Additional Information" section.

HCN Option Feature	In-Network (Benefits Are Based on the NNF)	Out-of-Network (Benefits Are Based on the MAA)
Annual Deductible Requirements[1]	None	**Individual/Family** 2013: $700/$1,750 2014: $700/$1,750 2015: $725/$1,812.50
Annual Out-of-Pocket Maximum Family annual out-of-pocket maximums are satisfied by any combination of family members within a calendar year; but an enrolled retiree or eligible dependent will never satisfy more than his/her individual amount. Excludes charges as outlined in the "Annual Out-of-Pocket Maximum" section above (combined in- and out-of-network).	**Individual/Family** 2013: $1,000/$2,500 2014: $1,000/$2,500 2015: $1,050/$2,625	**Individual/Family** 2013: $1,800/$4,500 2014: $1,800/$4,500 2015: $1,850/$4,625
Lifetime Maximum Benefit	None	None

[1] Family annual deductible is satisfied when any combination of individual family member deductibles equals the applicable family annual deductible within a calendar year; however, an enrolled retiree or eligible dependent will never satisfy more than his or her own individual amount.

HCN Option Feature	In-Network (Benefits Are Based on the NNF)	Out-of-Network (Benefits Are Based on the MAA)
When Benefits Are Paid	For covered care received from a network provider, benefits are based on the NNF and the Plan pays the following:	For covered nonemergency care provided on an out-of-network basis, benefits are based on the MAA and the Plan pays the following:
Inpatient Hospital Services		
Room and Board (in a semiprivate room of a hospital or in an intensive care unit; confinement in a private room may be covered in certain limited situations, as determined by the claims administrator)	90%	70% after deductible, pre-certification required
In-Hospital Physician's Visits (limited to 1 visit per day; visits for customary pre- and post-operative care are not covered; visits also are subject to the claims administrator's established limits)	90%	70% after deductible
X-Rays and Lab Tests	90%	70% after deductible, pre-certification required
Maternity Care (prenatal and postnatal)	100% after $20 copay ($10 copay if Medicare-eligible) – initial visit only for physician's professional charges and delivery; other inpatient hospital services covered at 90%	70% after deductible, pre-certification required
Newborn Baby Care (initial pediatric exam while mother is hospitalized)	90%	70% after deductible
Skilled Nursing Facilities (limit of 120 days per plan year; limit combined in- and out-of-network; every day of confinement in a skilled nursing facility will count as one half day)	100%; pre-certification required	70% after deductible, pre-certification required
Birthing Centers	90%	70% after deductible, pre-certification required

HCN Option Feature	In-Network (Benefits Are Based on the NNF)	Out-of-Network (Benefits Are Based on the MAA)
Hospice Care (excluding bereavement counseling, which may be covered under the mental health care benefit provisions to the extent that such visits are determined to be a covered service or supply – contact your claims administrator for more information; lifetime limit of 180 days, of which no more than 60 days may be for inpatient hospice care[2]; limit combined in and out-of-network)	100%; pre-certification required	70% after deductible, pre-certification required
Surgery and Anesthesia[3]		
Second Opinion (and third opinion, if second is nonconcurring)	100% after $20 copay for each second opinion provided by a primary care physician (PCP)/ $25 copay for each second opinion provided by a specialist (If Medicare-eligible, $10 copay for a PCP/$15 copay for a specialist)	Not covered
Inpatient Surgery	90%; pre-certification required	70% after deductible, pre-certification required
Outpatient Surgery	90%; for outpatient surgery performed in a facility; 100% after $20 copay for each outpatient surgery performed in a PCP's office/$25 copay for each outpatient surgery performed in a specialist's office (If Medicare-eligible, $10 copay for a PCP/$15 copay for a specialist)	70% after deductible, pre-certification required
Anesthesia	90%	70% after deductible

[2] After 180 days and the individual would otherwise have to be admitted to a hospital, then up to an additional 45 days may be authorized, as determined by the claims administrator, to be used for either home or inpatient hospice care, provided the 60-day inpatient limit has not been exhausted.

[3] Multiple surgical procedures are an exception to the rules described here.

HCN Option Feature	In-Network (Benefits Are Based on the NNF)	Out-of-Network (Benefits Are Based on the MAA)
Outpatient Treatments		
Doctors' Office Visits	100% after $20 copay (PCP)/$25 copay (specialist) (If Medicare-eligible, $10 copay for a PCP/$15 copay for a specialist)	70% after deductible
Doctors' Home Visits	100% after $20 copay (PCP)/$25 copay (specialist) (If Medicare-eligible, $10 copay for a PCP/$15 copay for a specialist)	70% after deductible
X-Rays and Lab Tests	100% after $20 copay ($10 copay if Medicare-eligible) for outpatient radiology and diagnostic laboratory tests performed in a physician's office or an outpatient facility	70% after deductible
Radiation Therapy, Chemotherapy, Electroshock Therapy, Hemodialysis	90% if done in a hospital outpatient facility; 100% after $20 copay ($10 copay if Medicare-eligible) if done in physician's office	70% after deductible; pre-certification required
Physical, Occupational and Speech Therapy (duration must be prescribed by your doctor and approved by the claims administrator; number of visits based on medical necessity	90% for therapy visits and services; 100% after $20 copay for evaluations ($10 copay if Medicare-eligible)	70% after deductible
Licensed Chiropractor (number of visits based on medical necessity; limited to $750 per plan year per individual; limit combined in- and out-of-network; maintenance services not covered)	100% after $20 copay ($10 copay if Medicare-eligible)	70% after deductible

HCN Option Feature	In-Network (Benefits Are Based on the NNF)	Out-of-Network (Benefits Are Based on the MAA)
Home Health Care (limited to 120 visits per plan year; pre-certification required; limit combined in- and out-of-network; for purposes of the 120-day limit, every 5 home health care visits will count as 1 day)	100%; pre-certification required	70% after deductible; pre-certification required
Preventive Care Services		
Preventive Care	100%; coverage limited to the coverage, age and frequency provisions of the Affordable Care Act	80%; no deductible; coverage limited to the coverage, age and frequency provisions of the Affordable Care Act
In-network preventive care services will be covered according to the coverage, age and frequency provisions of the Affordable Care Act. While not legally applicable to out-of-network preventive care services, out-of-network preventive care services will be covered according to the coverage, age and frequency provisions applicable to in-network preventive care benefits under the Affordable Care Act. The Affordable Care Act requires that certain preventive care items and services be covered in-network with no cost sharing (i.e., no copay, coinsurance or deductible). For details regarding which preventive care items and services are covered and at what level of cost sharing, contact Anthem at 1-855-869-8139 or www.anthem.com/verizon.		
Colon Cancer Screenings (routine) • Routine fecal occult blood • Routine barium enema • Routine sigmoidoscopy	100%	80%
Colonoscopy (routine) Facility and anesthesia services billed for routine colonoscopy covered at the same benefit level as the colonoscopy	100%	80%
Preventive Care X-rays and Lab Tests (routine) • Includes bone density testing • Includes cholesterol screenings • Includes routine vision and hearing screenings	100%	80%
Exam – routine adult physical, including routine gynecological exams	100%	80%
Exam – well-child care (through age 18)	100%	80%

HCN Option Feature	In-Network (Benefits Are Based on the NNF)	Out-of-Network (Benefits Are Based on the MAA)
Hearing Exam (routine)	100%	80%
Immunizations – child and adult (routine) Travel immunizations are not covered	100%	80%
Mammography (routine)	100%	80%
Pap Smear (routine)	100%	80%
Prostate Cancer Screening – PSA (routine)	100%	80%
Contraceptives Covered Under Women's Preventive Care – Affordable Care Act: IUDs, injections for Depo-Provera, diaphragm fittings and any other FDA-approved birth control devices; covered based on the diagnosis restriction within the Affordable Care Act. In addition, other FDA-approved contraceptive benefits will be provided in network with no cost sharing through your pharmacy benefit. Please see the "Prescription Drug Program for the HCN and MEP-HCP Options" section for details.	100%	80%

HCN Option Feature	In-Network (Benefits Are Based on the NNF)	Out-of-Network (Benefits Are Based on the MAA)
Mental Health/Substance Abuse Services		
Inpatient Mental Health Treatment	90%	70% after deductible; pre-certification required
Outpatient Mental Health Treatment	100% after $20 copay ($10 copay if Medicare-eligible)	70% after deductible
Inpatient Substance Abuse Treatment	90%	70% after deductible; pre-certification required
Outpatient Substance Abuse Treatment	100% after $20 copay ($10 copay if Medicare-eligible)	70% after deductible
Other Services		
Durable Medical Equipment	90%; pre-certification required for items over $5,000	70% after deductible; pre-certification required for items over $5,000
Ambulance Services	• 90% of submitted amount if an emergency; • 80% of NNF (in-network) or MAA (out-of-network) if nonemergency	
Prosthetic Devices	90%; pre-certification required for items over $5,000	70% after deductible; pre-certification required for items over $5,000
Hearing Aids[4]	100%, up to $1,000 for hearing aid (and related exam and fitting) every 24 calendar months.	
Emergency Room Care	100% after $75 copay ($25 copay if Medicare-eligible); this copay is waived if you are admitted to the hospital	
Urgent Care Facility	100% after $20 copay ($10 copay if Medicare-eligible)	
Infertility – coverage includes advanced reproductive technology such as GIFT, ZIFT and artificial insemination	$20,000 per family (combined with prescription drugs); 90%; pre-certification required	Not covered

[4] In addition to routine hearing aid coverage, hearing aids may be available after ear surgery (if medically necessary) or after accidental injury. Contact the claims administrator for details.

More Information About the HCN Option

The following section gives more detailed information on the HCN option

Mental Health and Substance Abuse Treatment

Mental health and substance abuse treatment coverage for HCN participants is offered through Anthem, which gives you the option to seek in-network or out-of-network care. Benefit levels are higher if you receive your care in-network.

Eligibility

All participants in the HCN option are covered for mental health and substance abuse treatment benefits.

In-Network Benefits

Your care is considered in-network if a provider who belongs to Anthem's network delivers it and the care is arranged through Anthem's individual assessment program.

When you call Anthem, you will speak with a trained counselor who will make a confidential assessment of your situation and refer you to the appropriate network specialist in your area. As long as your Anthem counselor arranges your care, you will be covered at in-network rates for inpatient and outpatient care. When you receive inpatient mental health or substance abuse treatment and receive care from a therapist or hospital in Anthem's network, it's covered at 90 percent of the NNF. Plus, you pay no more than a $20 copay ($10 copay if you are Medicare-eligible) for outpatient treatment.

Counselors are available 24 hours a day, 365 days a year. You can call Anthem at the telephone number shown on your ID card.

Out-of-Network Benefits

Your care is considered out-of-network if it is received from a provider who does not belong to Anthem's network.

When you receive pre-certification for inpatient mental health treatment and substance abuse detoxification or rehabilitation, coverage is at 70 percent of MAA charges, after the deductible is met. If inpatient mental health treatment is not pre-certified and the claims administrator determines it is not medically necessary, the treatment will not be covered.

Emergency Mental Health and Substance Abuse Treatment

If you or a covered dependent needs emergency mental health or substance abuse treatment, you should go to the nearest psychiatric emergency facility treatment center or hospital emergency room. There's no need to call Anthem first. However, within 48 hours of admission (or the next business day, if later), you or your representative must contact Anthem and a true emergency must be determined to receive in-network benefits.

Once your condition has stabilized, you must transfer to an in-network facility for your care to be covered at in-network levels. If you remain in an out-of-network facility, you must call Anthem for certification for your care to be covered.

For any out-of-network mental health and substance abuse care that requires an inpatient treatment, you (or someone representing you) must call Anthem to pre-certify treatment. If you fail to pre-certify your care, your benefits will be as follows:

- If Anthem determines that the care was clinically necessary, you will receive 70 percent of the benefit that you would have received had your care been pre-certified; or
- If Anthem determines that the care was not clinically necessary, no benefits will be paid.

Excluded Services and Supplies

The following services and supplies are not covered under the mental health and substance abuse program:

- Accommodations, services or supplies that are not clinically necessary nor medically necessary;
- Exams or treatments required only as part of legal proceedings;
- Personal convenience or comfort items, including televisions, telephones, first-aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- Experimental or investigative services;
- Treatment for chronic, intractable pain at a pain control center or through a pain control program;
- More than one outpatient visit in the same day;
- Custodial, home or convalescent care, rest cures and institutional care that's intended primarily to control or change the patient's environment; and
- Travel, whether or not recommended or prescribed as part of treatment.

Pre-Certification Requirements

To receive benefits under the HCN option, you or your provider must certify in advance (pre-certify) the following services and supplies by calling the claims administrator via the telephone number shown on your ID card:

- Inpatient hospitalization;
- Use of a birthing center;
- Confinement in a skilled nursing facility;
- Home health care or hospice care;
- Private duty nursing; and
- Certain outpatient procedures, services and tests, as determined by the claims administrator.

All admissions to hospitals or a health care facility must be pre-certified by the claims administrator. The following special rules apply:

- Emergency admissions must be certified by the claims administrator no later than 48 hours after admission or the next business day, whichever is later; and

- For out-of-network maternity admissions, you need to contact your claims administrator if the stay is longer than 48 hours for a vaginal birth or longer than 96 hours for a cesarean section.

Obtaining Pre-Certification

To pre-certify a procedure, you, a family member or your physician must contact the claims administrator. The claims administrator will review the case and determine whether the proposed service or supply will be covered as medically necessary under the HCN option. The claims administrator then will notify the physician and the covered person of its decision. If you or your physician disagrees with the claims administrator's decision, you can appeal the decision. (See "Claims and Appeals Procedures" in the "Additional Information" section.)

Reimbursement Rules With Pre-Certification

If you obtain pre-certification and the claims administrator determines that your service or supply is medically necessary, the HCN option will pay the regular level of benefits up to the number of days for inpatient treatment certified by the claims administrator.

Reimbursement Rules Without Pre-Certification

If you fail to receive proper pre-certification for a service that requires pre-certification, your claim(s) will be suspended to request medical records. If the medical records are not received within 21 days, your claim will be denied and your care will not be covered by the Medical Plan. However, once the medical record information is received, your claim can be re-opened and only medically necessary services will be paid.

In the case of an emergency or maternity admission (other than an admission to a birthing center), you must notify the claims administrator of the admission within two days; otherwise hospital and physician benefits for the unapproved days will be suspended, as described above. The suspension in benefits will not apply, however, to a maternity admission for charges incurred during the first 48 hours of a stay resulting from a vaginal delivery or 96 hours for a cesarean section.

Emergency Care

If you need emergency care, go to the nearest emergency facility. You pay a $75 copay ($25 if Medicare-eligible) for each emergency room visit. However, the copay is waived if you are admitted to the hospital.

The emergency room should be used only for true medical emergencies. If you are admitted to a hospital through the emergency room, you or a family member must call Member Services within 48 hours to certify the admission.

If you don't notify Member Services within 48 hours, you'll have to satisfy the out-of-network deductible. If you go to an emergency room and the condition is determined not to be an emergency, the nonemergency care will not be covered.

Preventive Care Services

The HCN option covers a wide array of preventive care items and services with no copay, coinsurance or deductible on an in-network basis and no copay, 80 percent coinsurance, and no deductible on an out-of-network basis.

At a minimum, coverage is based on frequency, age and other limitations under the Affordable Care Act. Under the Affordable Care Act, preventive care services include routine physicals, screening tests, immunizations, mammograms, colonoscopies and other items and services that are designed to detect and treat medical conditions to prevent avoidable illness and premature death. Preventive care services also include certain services for women: well-woman visits, screening for gestational diabetes, testing for the human papilloma virus, counseling for sexually transmitted diseases, counseling and screening for human immune-deficiency virus, FDA-approved contraceptive methods and counseling as prescribed for women, breastfeeding support, supplies and counseling, and screening and counseling for interpersonal and domestic violence, as defined in guidelines from the U.S. Department of Health and Human Services, Health Resources and Services Administration. When preventive and non-preventive care is provided at the same office visit, special rules apply regarding whether or not the cost sharing for preventive care services will be imposed.

You should contact the claims administrator to confirm services are covered for preventive care services subject to the cost sharing described above.

Special Rules for Surgery Coverage

The following rules apply to surgery coverage:

- Cosmetic surgery is covered only if required to correct an accidental injury or illness that occurs while the individual is covered by the Medical Plan, or to correct a child's congenital defect if the child is born while his or her parent is covered by the Medical Plan. Reconstructive surgery after a mastectomy also is covered (as described below).

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

- Dental surgery is covered only as a result of accidental injury to sound, natural teeth while the individual is covered by the Plan. Inpatient hospitalization for other dental surgery is covered only if a physician other than a dentist certifies that hospitalization is necessary to safeguard the individual's life or health due to another physical condition. In all cases, hospitalization must be pre-certified under the regular Plan provisions.

- For surgery involving multiple surgical procedures, the following rules apply:

  — If two or more surgical procedures are performed through the same incision or through two incisions in the same operative field, benefits will be paid only for the major procedure. However, this does not apply to bilateral surgical procedures described below. (A surgical procedure is bilateral if it involves both of two symmetrical organs and unilateral if it involves one of two symmetrical organs.)

- If two or more surgical procedures are performed through more than one incision and in separate operative fields, regular HCN benefits will be paid for the major procedure. The secondary procedures will be paid at 50 percent of the regular Medical Plan benefit. Total benefits will not exceed the actual charges for all procedures, multiplied by the applicable payment percentage.

- If bilateral procedures are performed during the same operative session through more than one incision, regular benefits will be payable for both procedures, up to 150 percent of the regular HCN benefit for a unilateral surgical procedure of the same type. Total benefits will not exceed the actual charges for all procedures, multiplied by the applicable payment percentage.

- Human organ and tissue transplants will be considered covered services or supplies under the HCN option, subject to the following:

  - When the recipient and donor both are covered persons under the HCN option, benefits will be provided to both parties.

  - When the recipient is a covered person under the HCN option but the donor is not, benefits will be provided to both to the extent that benefits are not provided to the donor under any other plan.

  - When the donor is a covered person under the HCN option but the recipient is not covered under a plan that provides benefits for donor expenses, benefits will be provided to the donor for his or her expenses only. No benefits will be provided to the recipient. Benefits will be payable to the donor except as specified by the claims administrator.

  - When diagnostic evaluation and procurement of human organs or tissue for transplant is needed, the HCN option will pay benefits. No benefits will be paid for the purchase of any human organ or tissue for transplant.

Second Surgical Opinions

Because there are risks involved with any surgical procedure, it's important to get a second opinion when surgery is recommended. A second surgical opinion, after a current recommendation for covered surgery, will be considered a covered service or supply under the HCN option. You will pay a $20 copay for a second opinion from your PCP ($10 copay if you are Medicare-eligible) or a $25 copay for a second opinion from a specialist ($15 copay if you are Medicare-eligible) on an in-network basis. When the second surgical opinion is nonconcurring, the HCN option will cover a third surgical opinion and associated diagnostic tests on the same basis as a second surgical opinion. To be covered, a doctor who is a network provider must provide the second and third opinions.

Maternity and Newborn Care

Benefits for maternity care will be provided to covered persons regardless of when the pregnancy began. Benefits will not be provided for services rendered after coverage has ended, even if the pregnancy began before coverage ended.

Care given to the newborn child during the mother's stay and in the infant's nursery will be covered if the child is a Class I Dependent.

The Medical Plan will cover a hospital stay for a mother and her eligible newborn for 48 hours for a vaginal delivery and for 96 hours for a cesarean section. However, with the consent of the mother, a physician may discharge the mother and newborn sooner than this. Longer stays will be covered if considered medically necessary by the claims administrator, subject to pre-certification requirements. The following newborn care services are covered under the HCN option:

- One pediatric examination of the eligible newborn while the mother is hospitalized; and

- Circumcision of the eligible newborn (including pre- and post-operative services) regardless of where the circumcision is performed, when performed by a physician.

Reproductive and Fertility Treatments (In-Network Only)

Under the HCN option (in-network only), you or your covered spouse (or same-sex domestic partner) is covered at 90 percent of the NNF for advanced reproductive technologies. Advanced reproductive technologies and fertility treatments are those medical procedures, treatments and prescriptions used to assist in reproduction (such as approved forms of in-vitro fertilization, GIFT, ZIFT and artificial insemination), which are approved by the treating HCN (in-network) physician and which are pre-authorized by the claims administrator as being medically appropriate for individuals in similar circumstances. Advanced reproductive technologies procedures are covered under the HCN option (in-network) only if you or your spouse or same-sex domestic partner has a diagnosis of infertility.

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

The following procedures are excluded from coverage:

- Procedures performed or services provided out-of-network;

- Procedures when you and/or your spouse or same-sex domestic partner has had a previous sterilization procedure, with or without surgical reversal;

- Charges incurred by your spouse or same-sex domestic partner who is not covered by the HCN option; and

- Charges for a surrogate parent.

Covered Hospital Services and Supplies

The hospital services and supplies covered under the HCN option are listed below:

- Room and board in a semiprivate room of a hospital or in an intensive care or cardiac care unit (confinement in a private room may be covered in certain limited situations, as determined by the claims administrator).

- Special diets.

- General nursing care (excluding care by private duty nurses).

- Routine nursery care of an eligible Class I newborn child while the mother is hospitalized for maternity care.
- Use of operating, delivery, recovery and treatment rooms and equipment.
- Drugs and medicines for use in a hospital, which at the time of admission to the hospital are listed in the U.S. Pharmacopoeia or National Formulary or are commercially available for purchase and readily obtainable by the hospital.
- Dressings, ordinary splints and casts.
- X-ray examinations.
- X-ray therapy, chemotherapy, radiation therapy and electroshock therapy.
- Laboratory services.
- Oxygen and oxygen therapy.
- Electrocardiograms (EKGs) and electroencephalograms (EEGs).
- Physical therapy, occupational therapy and hydrotherapy.
- Anesthesia and its administration.
- Plasma processing and administration of blood and blood plasma, but not the supply of blood or blood plasma. Please contact your HCN claims administrator for further details.
- Dialysis treatment.
- Sera, vaccines, biologicals, intravenous preparations and visualizing dyes.
- Services of physicians and technicians employed by or under contract to the hospital.
- Diagnostic laboratory and X-ray examinations performed under a program of pre-admission testing.

Excluded Hospital Services and Supplies

The following are not considered covered services and supplies under the HCN option:

- Hospital inpatient care if the confinement is for dental treatment or services, except in the cases of:

  — Dental care when a physician other than a dentist certifies that hospitalization is medically necessary.

  — Dental surgery for accidental injury to the natural, healthy teeth while the individual is covered by the Plan.

- Hospitalization that is primarily for diagnostic tests, X rays, laboratory exams, EKGs, EEGs or physical therapy.

- Hospitalization that is for convalescent care, custodial or sanitarium care or rest cures.

- Hospitalization charges incurred when you are not covered by the Plan; e.g., hospitalization that begins after coverage has ended.

- Saturday and Sunday room and board charges for admissions on Friday and Saturday that are not emergency or maternity admissions, or admission for surgery scheduled on the day immediately following admission, unless pre-certified by the claims administrator.

- Hospitalization when the stay primarily becomes rehabilitative in nature provided that hospital charges for rehabilitation in a facility, which is part of a hospital, are covered when the physician's diagnosis is such that rehabilitation cannot be provided on an outpatient basis, such as in the case of a stroke or spinal injury.

Other Covered Medical Services and Supplies

Call the claims administrator for information on other covered services and supplies, including:

- Acupuncture when performed by a physician in relation to covered surgery.

- Ambulance services.

- Anesthesia and its administration when administered by a physician (or a legally qualified anesthetist or nurse anesthetist) other than the operating room physician or the surgeon's assistant.

- Blood and blood derivatives (to the extent not donated by the covered person, a family member or a donor in the covered person's name). **Note:** Please contact your claims administrator for further details.

- Chiropractic care has a $20 copay ($10 copay if Medicare-eligible), for services with a licensed chiropractor on an in-network basis. Chiropractic care is covered on an out-of-network basis at 70 percent of the MAA, after the deductible. The maximum benefit (combined in- and out-of-network) is $750 per calendar year. Maintenance chiropractic services are not covered.

- Dental services when required as a result of an accidental injury to sound, natural teeth that occurs while the individual is covered by the Plan.

- Diabetic kits (available by mail service pharmacy through the prescription drug program).

- Diagnostic services.

- Durable medical equipment.

- Obesity treatment (covered in-network only), includes surgery, for medically necessary treatment of clinical obesity and prescription appetite suppressants. Coverage includes medically necessary nutritional counseling when prescribed by a physician and furnished by a licensed dietician or nutritionist, for conditions for which dietary adjustment has a therapeutic role, up to $500 each year per participant.

- Physical, speech and occupational therapies.

- Podiatric services (when the services performed are covered services common to medicine and podiatry, as determined by the claims administrator).

- Prostheses, including replacement if necessary for a change in physical condition due to an illness or injury or for a child due to normal growth. Covered services and supplies also include:

  — Eyeglasses or contact lenses following intraocular surgery or intraocular injury, including exams for prescribing and fitting such eyewear;

  — Hearing aid (and related exam and fitting) every 24 months (up to $1,000), as well as the initial hearing exam and one hearing aid on each ear following accidental injury or following a surgical operation or separate surgical operations on the ear; and

  — Accessories for artificial arms and legs, built-up shoes for postpolio patients, and corrective shoes specifically constructed from a mold of the patient's foot.

Note: Coverage excludes dental appliances, unless required as part of treatment for accidental injury of sound, natural teeth for which benefits are paid by the Plan and a cataract lens replacement, unless necessary due to a lens prescription change.

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

- Home health care services, subject to pre-certification.

- Skilled nursing facility services, subject to pre-certification.

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

Medical Expenses Not Covered by the HCN Option

The following are some of the expenses that the HCN option does not cover. Additional expenses may not be covered. If you have any questions about whether an expense is covered, call the claims administrator.

- Services or supplies that are not medically necessary, as determined by the claims administrator;
- Dental treatment, except as a result of accidental injury to sound, natural teeth that occurs while the individual is covered by the HCN option.
- Charges for any care, treatment, service or supply (except charges related to elective or therapeutic abortions or sterilizations) other than one that is being required for necessary treatment of the covered individual's injury or illness and certified by a physician or professional provider who is attending the covered individual.
- Care in a nursing home, home for the aged, convalescent home or rehabilitative facility. However, the Plan does cover care in a skilled nursing facility, hospice or facility for inpatient substance abuse treatment.
- Hospitalization for convalescent care, custodial or sanitarium care or rest cures.
- Cosmetic surgery (or drugs used for cosmetic purposes), unless required to correct an accidental injury or illness that occurs while the individual is covered by the Plans, or to correct a child's congenital defect if the child is born while his or her parent is covered by the Plans. Reconstructive surgery after a mastectomy is covered, as described under "Special Rules for Surgery Coverage" earlier in this section.
- Care provided before coverage begins or after coverage ends.
- Charges or services the individual is entitled to obtain without cost, in accordance with any government laws or regulations except Medicare.
- Charges for services or supplies provided for any condition covered by Workers' Compensation laws or for any other occupational condition, ailment, injury or illness occurring on the job if:
  - The covered person's employer furnishes, pays for or provides reimbursement for such charges.
  - The covered person's employer makes a settlement for such charges.
  - The covered person waives or fails to assert his or her rights respecting such charges.
- Services relating to testing, treatment or training for learning disabilities or developmental delays.
- Education or job training.
- Services or supplies provided as a result of injury or illness due to an act of war that occurs after the individual becomes covered by the Plan.

- Personal services, such as barber services, guest meals, radio and television rentals, telephone, etc.

- Charges which the participant has no legal obligation to pay.

- Charges during a continuous hospital confinement that began before the person's coverage began.

- Charges in excess of the MAA or the NNF, as applicable, or in excess of any applicable maximum, as determined by the claims administrator.

- Any medical observation or diagnostic study when no illness or injury is revealed, unless the covered person had a definite symptomatic condition of illness or injury other than hypochondria and the medical observation and diagnostic studies were not undertaken as a matter of routine physical examination or health checkup. This exclusion does not apply to preventive care, Pap tests or mammograms.

- Any service or supply for experimental or investigational purposes, including drugs or other care. However, effective as of January 1, 2014, because the medical options offered under the Plan are not grandfathered, you will be eligible for coverage of routine costs for items and services furnished in connection with your participation in an approved clinical trial. The clinical trial must relate to the treatment of cancer or another life-threatening disease or condition. Contact your benefits administrators for details.

- Eyeglasses (or related exams), except when initially required because of surgery or injury.

- Eye surgery to correct refractive errors.

- Services rendered by a member of the covered person's immediate family.

- Services or supplies that do not meet currently accepted standards of medical practice and are not approved for general use by one of the following:

  — The U.S. Food and Drug Administration (FDA).

  — The Agency for Healthcare Research and Quality (AHRQ) guidelines.

  — The Centers for Medicare & Medicaid Services, a division of the Social Security Administration.

  — Evidence-based guidelines from recognized medical specialty societies (for example, American College of Physicians, American Academy of Pediatrics, American Academy of Family Physicians, the American College of Obstetricians and Gynecologists and the American College of Physicians/American Society of Internal Medicine).

  — The U.S. Preventive Services Task Force.

  — Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

  — The National Cancer Institute.

- The Council of Medical Specialty Societies (CMSS).
- The U.S. Surgeon General.
- The U.S. Department of Public Health.
- The National Institute of Health.
- The Office of Technology Assessment.

- Any surgery, treatment or diagnostic procedure that is considered experimental or investigational by the claims administrator.
- Admitting fees and deposits.
- Artificial means of conception, except as otherwise covered by the plan as described in the “Reproductive and Fertility Treatments (In-Network Only)” section.
- Vitamins and minerals, except as provided by the HCN option.
- Telephone consultations, missed appointments and completion of claim forms.
- Services or supplies for which the covered person recovers the cost by legal action, insurance proceeds or settlement from a third party or from the insurer of a third party.
- Treatment of sexual dysfunction that does not have a physiological or organic basis.
- Sex change surgery or treatment for gender identity disorders.
- Treatment of temporomandibular joint (TMJ) dysfunction syndrome, except as provided by the claims administrator.
- Acupuncture, unless performed by a physician in relation to covered surgery.
- Reversal of sterilization.
- Marriage, family, child, career, social, adjustment, pastoral or financial counseling.
- Speech therapy, except as a result of loss of speech from an injury or illness.
- Charges for maintaining an environment suitable for preventing the worsening of a medical condition.
- Primal therapy, Rolfing, psychodrama, megavitamin therapy, bioenergentic therapy, vision perception training or carbon dioxide therapy.
- Convenience items.

- Custodial nursing care.
- Athletic club dues.
- Wig styling.
- Nutritional formulas or food supplements (however, exempt infant formula may be considered a covered drug under the prescription drug program).
- Routine foot care, unless medically necessary, as defined by the claims administrator.
- Non-prescription drugs.

The MEP Health Care PPO (MEP-HCP) Option

The MEP-HCP option is administered by Anthem Blue Cross and Blue Shield ("Anthem").

A preferred provider organization (PPO) is a network of doctors, hospitals and other providers who agree to meet strict quality standards for treatment and utilization and provide services according to a network negotiated fee (NNF) schedule. The PPO offers the flexibility of going in or out of the PPO network for care.

The MEP-HCP option uses Anthem's network of service providers. To the extent that there is no in-network service provider for a specific covered service or supply within a 40-mile radius of your home zip code, you and your eligible dependents will be eligible for the in-network provisions applicable to the specific medical option in which you are enrolled (i.e., either the in-network provisions of the HCN or MEP-HCP options.)

Note: For more information about covered services, contact the claims administrator via the telephone number listed on your medical ID card. A list of participating providers in the MEP-HCP option can be obtained free of charge via the BenefitsConnection website or by calling Anthem via the telephone number listed on your ID card.

Plan Details

Copays

A copay is a flat dollar amount that you pay for covered expenses. When you seek in-network care under the MEP-HCP option, your copay is $20 for each primary care physician's home or office visit ($10 copay if you are Medicare-eligible). When you seek in- or out-of-network care, the copay for each urgent care facility visit is $20 ($10 if you are Medicare-eligible) and a $75 copay ($25 if you are Medicare-eligible) applies for emergency care in a hospital's emergency room (if you are admitted to the hospital, your copay is waived).

Annual Deductible

Each calendar year before the MEP-HCP option pays benefits for medical expenses (not including prescription drugs) obtained on an in-network or out-of-network basis that are subject to the deductible, a covered individual must meet the annual deductible in effect for the plan year. Expenses that apply towards the deductible are combined between in-network and out-of-network expenses to reach the applicable deductible.

The Plan pays benefits on behalf of a covered person after that person has met his or her individual deductible, or after the family deductible has been met. If you retire before January 1, 2013, if expenses applied toward the deductible for covered family members (you, your Class I and Class II Dependents) total the family deductible (2½ times the individual deductible), then no further individual deductibles apply for the remainder of the calendar year. If you retire on or after January 1, 2013, the family annual deductible is satisfied when any combination of individual family member deductibles equals the applicable family annual deductible within a calendar year. However, you or your dependent will never satisfy more than your own individual amount.

Note:

- Only amounts paid toward individual deductibles can be added together to meet the family deductible.

- Amounts paid to meet the individual deductible for Sponsored Children do not count toward the family deductible. A Sponsored Child must meet the individual deductible even if the family deductible has been met.

If your date of retirement is prior to August 3, 2003: Your annual deductible is equal to 1 percent of your annual pension benefit in effect on December 31 of the previous calendar year, subject to a minimum of $25 and a maximum of $150 (family deductible is 2½ times the individual deductible).

If your date of retirement is after August 2, 2003 and before January 1, 2013: Your annual deductible is equal to the deductible you had as an active employee as of the date of your retirement:

- Between August 3, 2003 and December 31, 2005: $150 individual/$375 family.

- Between January 1, 2006 and December 31, 2007: $200 individual/$500 family.

- Between January 1, 2008 and December 31, 2012: $250 individual/$625 family.

If your date of retirement is on or after January 1, 2013: The individual and family deductibles for the years 2013 through 2015 are shown in the table below.

Year	Annual Deductible			
	In-Network		Out-of-Network	
	Individual	Family	Individual	Family
2013	$400.00	$1,000.00	$650.00	$1,625.00
2014	$450.00	$1,125.00	$700.00	$1,750.00
2015	$475.00	$1,187.50	$725.00	$1,812.50

If you are receiving LTD benefits, your annual deductible is equal to 1 percent of your LTD benefit in effect on December 31 of the previous calendar year, subject to a minimum of $25 and a maximum of $150.

If you are a dependent of a retiree or LTD benefit recipient, your annual deductible is the same as the deductible for the retiree or LTD benefit recipient.

If you are a surviving dependent of a deceased associate or retiree, your deductible is equal to the deductible that applied to the deceased associate or retiree, as applicable, at the time of his or her death.

The following expenses do not apply toward meeting the deductible:

- Copays for office visits.
- Copays for visits to urgent care facilities or emergency rooms.
- Any charges for failing to pre-certify health care when pre-certification is required.
- Expenses for prescription drugs.
- Amounts paid for noncovered services and supplies.
- Amounts in excess of MAA, NFF, or other Medical Plan limits.
- Expenses for LASIK services.

Note: There is a separate annual deductible of $50 for prescription drugs when a non-participating pharmacy is used. See the "Prescription Drug Program for the MEP-HCP Option" section for information.

Common Accident Provision

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

Year-End Carryover

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

Coinsurance

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

The amount you are required to pay and the amount the MEP-HCP option pays for your covered expenses will depend on the type of service you receive. See the "MEP Health Care PPO (MEP-HCP) Option Coverage Summary" chart later in this section for the amount the Medical Plan pays for covered services.

Plan Benefits

In-Network Benefits

When you use an in-network provider, you will pay a copay for each physician home or office visit for an illness or injury and the MEP-HCP option pays the balance. For preventive care services, coverage is 100 percent of the NNF and no copay is required. Preventive care services will be covered according to the coverage, age, and frequency provisions of the Affordable Care Act. For other services such as hospitalization, the MEP-HCP option generally pays 90 percent of the NNF after you meet the deductible.

See the “MEP Health Care PPO (MEP-HCP) Option Coverage Summary” chart later in this section for specific provision information.

Using Non-PPO Providers

The MEP-HCP option typically pays 70 percent of the MAA for services obtained from non-PPO providers (subject to the annual deductible, if applicable). You pay any difference between MAA and the actual charge.

Annual Out-of-Pocket Maximum

There is a financial protection if you have large expenses. If an individual’s share of covered expenses exceeds the out-of-pocket maximum in a calendar year (including the deductible), the MEP-HCP option will pay 100 percent of the NNF or MAA as applicable for most additional covered expenses for that individual for the rest of the calendar year. You are responsible for all amounts above the MAA.

The annual out-of-pocket expense maximums that apply to covered services or supplies obtained on an in-network basis or out-of-network basis under the MEP-HCP option for the years 2013 through 2015 are shown in the table below. Expenses that apply towards the out-of-pocket maximum are aggregated between in-network and out-of-network expenses to reach the applicable out-of-pocket maximum. The family annual out-of-pocket maximums can be satisfied by any combination of family members within a calendar year; however, you or your dependent will never satisfy more than your own individual amount. Amounts paid towards the deductible will apply towards the annual out-of-pocket maximum.

	Out-of-Pocket Annual Maximum			
	In-Network		Out-of-Network	
Year	Individual	Family	Individual	Family
2013	$1,050	$2,625	$2,000	$5,000
2014	$1,100	$2,750	$2,000	$5,000
2015	$1,150	$2,875	$2,050	$5,125

The following expenses do not count toward the out-of-pocket maximum, nor will they be paid at 100 percent after a covered person reaches the applicable out-of-pocket maximum:

- Copays for office visits.
- Copays for visits to urgent care facilities or emergency rooms.
- Charges for services or supplies that are not covered by the Medical Plan.
- Charges in excess of the NNF, MAA or other Medical Plan limits.
- Amounts you pay if you fail to pre-certify medical services.
- Expenses for prescription drugs.
- Amounts you or your covered dependents pay for LASIK services.
- Charges in excess of obesity and fertility treatment maximums.

Paying for Care and Filing Claims

If the Patient Is Not Eligible for Medicare

If you participate in the MEP-HCP option and use a PPO doctor, the doctor generally will file the claim on your behalf.

If you participate in the MEP-HCP option and receive out-of-network care, the provider may require payment at the time of service or they may bill you. You will need to submit a claim with a copy of the bill to Anthem.

After Anthem receives the bill for your care, Anthem will determine your benefits and, if appropriate, reimbursement will be made. Anthem also will send you an Explanation of Benefits (EOB) statement. The EOB shows how much of the bill the Plan paid and how much (if any) remains for you to pay. After you receive the EOB, you should receive a new bill from your medical provider for any remaining amount not covered by the Plan. (An EOB will not be sent to you if you do not owe any money.)

If the Patient Is Eligible for Medicare

If the patient is eligible for Medicare (and Medicare is the patient's primary plan), you or your health care provider should submit the bill for the care to Medicare. Medicare then will pay its portion of the bill. After Medicare pays its portion, you will receive a Medicare Summary Notice showing how much Medicare has paid.

After you receive your Medicare Summary Notice, you should then submit a copy of the notice, plus copies of any bills you have received from the provider for the services, to Anthem. Anthem then will determine your eligible benefits and, if appropriate, send a payment to your health care provider. It also will send you an EOB statement. The EOB shows how much of the bill the Plan paid and how much (if any) remains for you to pay. After you receive the EOB, you should receive a new bill from your medical provider for any remaining amount not covered by the MEP-HCP or Medicare.

Medicare Crossover

Medicare Crossover is an automatic claim filing service for Verizon participants who have Medicare as their primary coverage. Under Medicare Crossover, your doctor files your medical claims with your Medicare Part B claims administrator. Medicare determines the portion of the claim it will pay and pays the provider directly (you will get an EOB from Medicare if you owe any money).

Medicare then forwards the claim for the remaining expenses directly to Anthem. Anthem then pays the provider directly. (You will get an EOB from Anthem if you owe any money.)

If you are enrolled in the MEP-HCP option, you are automatically enrolled in the Medicare Crossover program if your Medicare number is your Social Security number followed by an "A." Contact Anthem Member Services to enroll in Medicare Crossover if your Medicare number is not your Social Security number followed by an "A" or if you would like to enroll your Medicare-eligible dependents.

Requesting a Claim Form

If you need to file a claim for benefits obtained from non-PPO providers, you should contact Anthem for a claim form. Check your MEP-HCP ID card for the telephone number.

Deadline for Filing Claims

You should submit your claims as soon as possible after receiving a health care service. The deadline for submitting claims is 15 months after the date the service was received.

MEP Health Care PPO (MEP-HCP) Option Coverage Summary

The table in this section provides an overview of the benefits payable for covered services and supplies provided by the in-network and out-of-network portions of the MEP-HCP option.

Charges in excess of the MAA will not be covered by the MEP-HCP option. If a charge for a covered service obtained from a non-PPO provider exceeds the MAA, the MEP-HCP option's reimbursement percentage will be applied to the MAA, and you may be responsible in full for the difference between the billed charges and the MAA. You must pre-certify medical care, as specified in the "Pre-Certification Requirements" section. Certain other restrictions may apply – for additional information, see the "Additional Information" section. See "Medical Expenses Not Covered by the MEP Health Care PPO (MEP-HCP) Option" for a list of expenses that are not covered.

<table>
<tr><th>MEP-HCP Option Feature</th><th>Using PPO Providers (Benefits Are Based on the NNF)</th><th>Using Non-PPO Providers (Benefits Are Based on the MAA)</th></tr>
<tr><td>Annual Deductible Requirements[1]
Combined in- and out-of-network</td><td colspan="2">Individual Annual Deductible
• If your date of retirement is prior to August 3, 2003, 1% of your annual pension benefit in effect as of December 31 of the previous calendar year (minimum of $25; maximum of $150).
• If your date of retirement is after August 2, 2003 and before January 1, 2013, your annual deductible is equal to the deductible you had as an active employee as of the date of your retirement:
8/3/2003 – 12/31/2005: $150
— 1/1/2006 – 12/31/2007: $200
— 1/1/2008 – 12/31/2012: $250
• If your date of retirement is on or after January 1, 2013:
<table>
<tr><th></th><th colspan="2">Individual Annual Deductible</th></tr>
<tr><th></th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td>2013</td><td>$400</td><td>$650</td></tr>
<tr><td>2014</td><td>$450</td><td>$700</td></tr>
<tr><td>2015</td><td>$475</td><td>$725</td></tr>
</table>
• If you are receiving LTD benefits, 1% of your annual LTD benefit in effect as of December 31 of the previous calendar year (minimum of $25; maximum of $150).
• If you are a surviving dependent of an employee or retiree, your deductible is equal to the deductible that applied to the deceased employee or retiree at the time of his or her death.
Family Annual Deductible: 2½ times individual deductible.</td></tr>
<tr><td>Annual Out-of-Pocket Maximum
Combined in- and out-of-network
Family annual out-of-pocket maximums can be satisfied by any combination of family members within a calendar year, but an individual will never satisfy more than his or her own individual amount.

Applies on a calendar-year basis. Does not apply to other services listed in the “Annual Out-of-Pocket Maximum” section above.</td><td>Individual/Family
2013: $1,050/$2,625
2014: $1,100/$2,750
2015: $1,150/$2,875</td><td>Individual/Family
2013: $2,000/$5,000
2014: $2,000/$5,000
2015: $2,050/$5,125</td></tr>
<tr><td>Lifetime Maximum Benefit</td><td>None</td><td>None</td></tr>
</table>

[1] Family annual deductible is satisfied when any combination of individual family member deductibles equals the applicable family annual deductible within a calendar year; however, an enrolled associate or eligible dependent will never satisfy more than his or her own individual amount.

MEP-HCP Option Feature	Using PPO Providers (Benefits Are Based on the NNF)	Using Non-PPO Providers (Benefits Are Based on the MAA)
When Benefits Are Paid	Unless otherwise noted, for care that is medically necessary, benefits are based on the NNF and the Plan pays:	Unless otherwise noted, for care that is medically necessary, benefits are based on the MAA and the Plan pays:
Inpatient Hospital Services		
Room and Board	90% after deductible	70% after deductible; pre-certification required
In-Hospital Physician's Visits (does **not** include visits for customary pre- and postoperative care or for eye exams or the fitting of eyeglasses, and are subject to other limits set by the claims administrator)	90% after deductible	70% after deductible
X-Rays and Lab Tests	90% after deductible	70% after deductible
Maternity Care (including associated in-hospital physician's services and surgery for prenatal and postnatal)	100% after $20 copay ($10 copay if Medicare-eligible) – initial visit only for physician's professional charges and delivery; other inpatient hospital services covered at 90% after deductible	70% after deductible
Newborn Baby Care (initial pediatric exam while mother is hospitalized; limited to Class I Dependents– i.e., newborn of Children not covered; if newborn is not released with mother, a separate deductible and coinsurance applies)	90% after deductible	70% after deductible
Skilled Nursing Facilities[2]	100%; no deductible; pre-certification required	70% after deductible; pre-certification required
Birthing Centers[2]	90% after deductible	70% after deductible; pre-certification required

[2] Members who retired between August 9, 1986 and January 1, 1987 do not have these benefits.

MEP-HCP Option Feature	Using PPO Providers (Benefits Are Based on the NNF)	Using Non-PPO Providers (Benefits Are Based on the MAA)
Hospice Care (excluding bereavement counseling visits, which may be covered under the mental health care benefit provisions to the extent that such visits are determined to be a covered service or supply – contact your claims administrator for more information)[2]	100%; no deductible; pre-certification required	70% after deductible; pre-certification required
Surgery and Anesthesia		
Second Opinions	100% after $20 copay ($10 copay if Medicare-eligible)	70% after deductible
Inpatient Surgery	90% after deductible; pre-certification required	70% after deductible; pre-certification required
Outpatient Surgery	90% after deductible for outpatient facility; 100% after $20 copay ($10 copay if Medicare-eligible) if done in a physician's office	70% after deductible
Anesthesia	90% after deductible	70% after deductible
Outpatient Treatments		
Doctors' Home or Office Visits	For patients not eligible for Medicare: 100% after $20 copay For patients eligible for Medicare: 100% after $10 copay	70% after deductible
X-Rays and Lab Tests	100% after $20 copay ($10 copay if Medicare-eligible)	70% after deductible
Radiation Therapy, Chemotherapy, Electroshock Therapy, Hemodialysis	90% after deductible for hospital outpatient facility; 100% after $20 copay ($10 copay if Medicare-eligible) if provided in a physician's office	70% after deductible
Physical, Occupational and Speech Therapy (duration must be prescribed by your doctor)	80% after deductible; number of visits based on medical necessity	70% after deductible; number of visits based on medical necessity

MEP-HCP Option Feature	Using PPO Providers (Benefits Are Based on the NNF)	Using Non-PPO Providers (Benefits Are Based on the MAA)
Licensed Chiropractor (limit combined in-and out-of-network)	80% after deductible; limited to 60 visits per plan year (not to exceed 1 visit per day)	Maximum benefit payable limited to $92 per visit; you are responsible for $20 copay plus difference between $92 flat fee and cost of service; limited to 60 visits per plan year (not to exceed 1 visit per day)
Home Health Care	100%; no deductible; pre-certification required	70% after deductible; pre-certification required
Preventive Care Services		
Preventive Care	100%; no deductible; coverage limited to the coverage, age and frequency provisions of the Affordable Care Act	100%; no deductible; coverage limited to the coverage, age and frequency provisions of the Affordable Care Act
In-network preventive care services will be covered according to the coverage, age and frequency provisions of the Affordable Care Act. While not legally applicable to out-of-network preventive care services, out-of-network preventive care services will be covered according to the coverage, age and frequency provisions applicable to in-network preventive care benefits under the Affordable Care Act. The Affordable Care Act requires that certain preventive care items and services be covered in-network with no cost sharing (i.e., no copay, coinsurance or deductible). For details regarding which preventive care items and services are covered and at what level of cost sharing, contact Anthem at 1-855-869-8139 or www.anthem.com/verizon.		
Colon Cancer Screenings (routine) • Routine fecal occult blood • Routine barium enema • Routine sigmoidoscopy	100%; no deductible	100%; no deductible
Colonoscopy (routine) Facility and anesthesia services billed for routine colonoscopy covered at the same benefit level as the colonoscopy	100%; no deductible	100%; no deductible
Preventive Care X-Rays and Lab Tests (routine) • Includes bone density testing • Includes cholesterol screenings • Includes routine vision and hearing screenings	100%; no deductible	100%; no deductible
Exam – routine adult physical, including routine gynecological exams	100%; no deductible	100%; no deductible

MEP-HCP Option Feature	Using PPO Providers (Benefits Are Based on the NNF)	Using Non-PPO Providers (Benefits Are Based on the MAA)
Exam – well-child care (through age 18)	100%; no deductible	100%; no deductible
Hearing Exam (routine)	100%; no deductible	100%; no deductible
Immunizations – child and adult (routine) Travel immunizations are not covered	100%; no deductible	100%; no deductible
Mammography (routine)	100%; no deductible	100%; no deductible
Pap Smear (routine)	100%; no deductible	100%; no deductible
Prostate Cancer Screening – PSA (routine)	100%; no deductible	100%; no deductible
Contraceptives Covered Under Women's Preventive Care – Affordable Care Act: IUDs, injections for Depo-Provera, diaphragm fittings and any other FDA-approved birth control devices; covered based on the diagnosis restriction within the Affordable Care Act. In addition, other FDA-approved contraceptive benefits will be provided in network with no cost sharing through your pharmacy benefit. Please see the "Prescription Drug Program for the HCN and MEP-HCP Options" section for details.	100%; no deductible	100%; no deductible
Allergy Testing	100% after $20 copay ($10 copay if Medicare-eligible)	70% after deductible
Mental Health/Substance Abuse Services Mental health and substance abuse benefits are administered by Anthem, which provides a network for participating providers at discounted rates. See "Mental Health and Substance Abuse Treatment" later in this section for details.		
Inpatient Mental Health Care	90% after deductible	70% after deductible; pre-certification required
Outpatient Mental Health Care	100% after $20 copay ($10 copay if Medicare-eligible)	70% after deductible

MEP-HCP Option Feature	Using PPO Providers (Benefits Are Based on the NNF)	Using Non-PPO Providers (Benefits Are Based on the MAA)
Inpatient Substance Abuse Treatment	90% after deductible	70% after deductible
Outpatient Substance Abuse Treatment	100% after $20 copay ($10 copay if Medicare-eligible)	70% after deductible
Other Services		
Durable Medical Equipment	80% after deductible; pre-certification required for items over $5,000	70% after deductible; pre-certification required for items over $5,000
Ambulance Services	• 90% of the submitted amount after deductible if an emergency • 70% of the NNF (in-network) or 70% of the MAA (out-of-network), in each case, after deductible if a nonemergency	
Prosthetic Devices	80% after deductible; pre-certification required for items over $5,000	70% after deductible; pre-certification required for items over $5,000
Urgent Care Facility	100% after $20 copay ($10 copay if Medicare-eligible)	
Emergency Room Care	100% after $75 copay ($25 copay if Medicare-eligible); this copay is waived if you are admitted to the hospital	
Infertility – coverage includes advanced reproductive technology such as GIFT, ZIFT, and artificial insemination	$20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 90% after deductible; pre-certification required	$20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 70% after deductible; pre-certification required

More Information About the MEP-HCP Option

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

Mental Health and Substance Abuse Treatment

Mental health and substance abuse treatment coverage for MEP-HCP option participants is administered by Anthem, which gives you the option to seek in-network or out-of-network care. Benefit levels are higher if you receive your care in-network.

Eligibility

All participants in the MEP-HCP option, including your dependents, are eligible for mental health and substance abuse treatment benefits.

Although not required for in-network, it is a good idea to first contact Anthem when you need care to ensure you are matched to the treatment that best meets your needs.

In-Network Benefits

Your care is considered in-network if it is delivered by a provider who belongs to Anthem's network.

- Inpatient mental health care and substance abuse treatment will be covered on an in-network basis at 90 percent of the NNF, after your deductible is met.

- Outpatient mental health care and substance abuse treatment will be covered on an in-network basis with a $20 copay ($10 copay if Medicare-eligible).

- Coverage is 90 percent of the MAA after the deductible for up to 30 days of a single confinement in an alternate care facility (pre-certification required) or any other facility if there is no approved Anthem facility within 40 miles of your home.

- Coverage is 70 percent of the MAA after the deductible for up to 30 days for a single confinement for care in any other facility not mentioned above, pre-certification required. Inpatient mental health admissions separated by less than 180 days will be considered a single confinement.

For emergency admissions to a non-Anthem facility for covered mental health care, the Plan will pay 90 percent of MAA for the first five days of the confinement. After five days, the Plan will pay benefits the same as for any other confinement for mental health care.

Out-of-Network Benefits

Your care is considered out-of-network if it is received from a provider who does not belong to Anthem's network.

- Inpatient mental health care and substance abuse treatment will be covered on an out-of-network basis at 70 percent of the MAA after your deductible is met. Pre-certification is required for inpatient mental health care on an out-of-network basis.

- Outpatient mental health care and substance abuse treatment will be covered on an out-of-network basis 70 percent of the MAA after your deductible is met.

Pre-Certification Requirements

If you receive in-network care, your provider will handle all pre-certification for you. If you receive out-of-network care, you'll need to call the claims administrator prior to receiving certain medical care services in order to receive full benefits. Otherwise, the coverage you normally would receive under the MEP-HCP option out-of-network will be suspended, or your claim may be denied.

If you and your physician decide that you need hospitalization, you should call the claims administrator to begin the pre-certification process. The claims administrator will then contact your doctor for the additional medical information necessary to determine if hospitalization will be covered as medically necessary.

The following services must be pre-certified:

- **Nonemergency hospital stays.** You must call your claims administrator for pre-certification at least 48 hours in advance of any nonemergency hospital admission.

- **Emergency hospital admissions.** If you are admitted to the hospital in an emergency, you or your representative must call your administrator within five days of such admission (note that all emergency admissions automatically will be approved for five days, unless the claims administrator approves a longer stay).

- **Extended maternity admissions.** Maternity admissions do not need to be authorized if they are no longer than 48 hours for a vaginal birth or 96 hours for a cesarean section. If a maternity admission lasts longer than this, you must call for certification within five days of the admission.

If you're admitted to the hospital on a Friday or Saturday, the Plan will not cover Saturday and Sunday room and board charges, unless the claims administrator has pre-approved the admission or your check-in is due to the following:

- An emergency.

- Maternity.

- Surgery being scheduled for the next day.

Pre-certification is not required:

- When Medicare or another plan is primary.

- For services provided while traveling outside the continental United States.

- For maternity admissions to a hospital or birthing center that are no longer than 48 hours for a vaginal birth or 96 hours for a cesarean section.

- For substance abuse rehabilitation.

Concurrent Review
Concurrent review while hospitalized is the review by the claims administrator of the covered person's condition to determine whether the inpatient confinement will continue to be covered as medically necessary. During an inpatient confinement, the claims administrator will periodically review the covered person's case and may modify the number of days of confinement initially authorized. If a covered person is hospitalized in an in-network hospital, no further action is required on that person's part. If the covered person is hospitalized in an out-of-network facility and the covered person's physician believes additional days of confinement are required beyond the number of days initially authorized, the physician, the covered person or a family member must contact the claims administrator to determine how the MEP-HCP option will provide coverage for the extension.

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

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

If a covered person remains in the hospital despite the recommendation to be discharged to an alternate setting and hospitalization is determined by the claims administrator to be medically necessary, then benefits for hospital and physician services will be reduced, as described below Also, if the claims administrator determines that further care is not covered whether in a hospital or alternate care setting, the Plan will pay no further benefits for the hospital confinement.

Reimbursement Rules With Pre-Certification
If you obtain pre-certification for hospitalization through an out-of-network facility and the claims administrator determines that your services are medically necessary, the MEP-HCP option will pay regular Medical Plan benefits up to the number of days certified by the claims administrator. If the services, supplies or treatment are not determined to be medically necessary, no benefits will be paid. Pre-certification for medically necessary inpatient care for hospitalization at an in-network facility will be handled by your doctor.

Reimbursement Rules Without Pre-Certification
If you fail to receive proper pre-certification for a service that requires pre-certification, your claim(s) will be suspended to request medical records. If the medical records are not received within 21 days, your claim will be denied and your care will not be covered by the Medical Plan. However, once the medical record information is received, your claim can be re-opened and only medically necessary services will be paid.

In the case of an emergency or maternity admission (other than an admission to a birthing center), you must notify the claims administrator of the admission within two days; otherwise, hospital and physician benefits for the unapproved days will be suspended, as described above. The suspension in benefits will not apply, however, to a maternity admission for charges incurred during the first 48 hours of a stay resulting from a vaginal delivery or 96 hours for a cesarean section.

Outpatient Surgery

Outpatient surgical procedures as well as diagnostic X-ray, laboratory and other associated services are covered after the applicable deductible at 90 percent of the NNF for in-network providers and 70 percent of the MAA for out-of-network providers. A $20 copay ($10 copay if you are Medicare-eligible) will apply for outpatient surgery performed in a physician's office on an in-network basis.

Special Rules for Surgery Coverage

The following rules apply to surgery coverage:

- Cosmetic surgery is covered only if required to correct an accidental injury or illness that occurs while covered by the Medical Plan, or to correct a child's congenital defect if the child is born while his or her parent is covered by the Medical Plan. Reconstructive surgery after a mastectomy also is covered (as described below).

- Mastectomy, reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and services and supplies to treat physical complications during all stages of mastectomy are covered.

- Dental surgery is covered only as a result of accidental injury to sound natural teeth while the individual is covered by the Plan. Hospitalization for other dental surgery is covered only if a physician other than a dentist certifies that hospitalization is necessary to safeguard the individual's life or health due to another physical condition. In all cases, inpatient hospitalization must be pre-certified under the regular Plan provisions.

- For surgery involving multiple surgical procedures, the following rules apply. Note that multiple surgical procedure reimbursement rules for in-network procedures are governed by contract arrangements between Anthem and their network participating providers. The following rules do not apply to in-network procedures:

  — If two or more surgical procedures are performed through the same incision or through two incisions in the same operative field, benefits will be paid only for the major procedure. However, this does not apply to bilateral surgical procedures described below. (A surgical procedure is bilateral if it involves both of two symmetrical organs and unilateral if it involves one of two symmetrical organs.)

  — If two or more surgical procedures are performed through more than one incision and in separate operative fields, regular option benefits will be paid for the major procedure. The secondary procedures will be paid at 50 percent of the regular option benefit. Total benefits will not exceed the actual charges for all procedures, multiplied by the applicable payment percentage.

  — If bilateral procedures are performed during the same operative session through more than one incision, regular benefits will be payable for both procedures, up to 150 percent of the regular option benefit for a unilateral surgical procedure of the same types. Total benefits will not exceed the actual charges for all procedures, multiplied by the applicable payment percentage.

- Human organ and tissue transplants will be considered covered services or supplies under the MEP-HCP option subject to the following:

  — When the recipient and donor are both covered persons under the Medical Plan, benefits will be provided to both parties.

  — When the recipient is a covered person under the Plan, but the donor is not, benefits will be provided to both to the extent that benefits are not provided to the donor under any other plan.

  — When the donor is a covered person under the Plan, but the recipient is not covered under a plan that provides benefits for donor expenses, benefits will be provided to the donor for his or her expenses only. No benefits will be provided to the recipient. Benefits will be payable to the donor except as specified by the claims administrator.

  — When diagnostic evaluation and procurement of human organs or tissue for transplant is needed, the Plan will pay benefits. No benefits will be paid for the purchase of any human organ or tissue for transplant.

Second Surgical Opinions

Because there are risks involved with any surgical procedure, it's important to get a second opinion when surgery is recommended. A second surgical opinion, after a current recommendation for covered surgery, will be considered a covered service or supply under the MEP-HCP option. Benefits are paid on an in-network basis after a $20 copay ($10 copay if Medicare-eligible). Benefits are paid on an out-of-network basis at 70 percent of the MAA after the deductible is met. When the second surgical opinion is nonconcurring, the MEP-HCP option will cover a third surgical opinion and associated diagnostic tests on the same basis as a second surgical opinion. If you receive a second or third surgical opinion, contact your MEP-HCP's Member Services for more information on filing claims.

Predetermination of Benefits

If you want to know in advance if your medical procedure will be covered by the MEP-HCP option, contact the claims administrator. If the MEP-HCP option is your primary insurance, the Medical Plan provides a procedure for predetermination of benefits. Under this provision, based on information supplied by the retiree and/or his or her medical provider, the retiree will receive information on whether the proposed procedure is covered. It is understood, however, that the actual benefit only can be determined after the actual claim is received because circumstances may require differences between the proposed procedure and the procedure as actually performed. This estimate would not indicate how much the MEP-HCP option would actually pay the retiree. The amount paid to the retiree would have to take into account other factors, such as applicable deductibles and coinsurance.

Note: This is not a guarantee or pre-approval for non-medically necessary services. If the procedure is not medically necessary, it will not be approved.

Preventive Care Services

The MEP-HCP option covers a wide array of preventive care items and services with no copay, coinsurance or deductible on an in-network or out-of-network basis. In each case, coverage is subject to frequency, age and other limitations under the Affordable Care Act. Under the Affordable Care Act, preventive care services include routine physicals, screening tests, immunizations, mammograms, colonoscopies and other items and services that are designed to detect and treat medical conditions to prevent avoidable illness and premature death. Preventive care services also include certain services for women: well-woman visits, screening for gestational diabetes, testing for the human papilloma virus, counseling for sexually transmitted diseases, counseling and screening for human immune-deficiency virus, FDA-approved contraceptive methods and counseling as prescribed for women, breastfeeding support, supplies and counseling, and screening and counseling for interpersonal and domestic violence, as defined in guidelines from the U.S. Department of Health and Human Services, Health Resources and Services Administration. When preventive and non-preventive care is provided at the same office visit, special rules apply regarding whether or not cost sharing for preventive care services will be imposed.

You should contact the claims administrator to confirm services are covered preventive care services and are not subject to cost sharing.

Maternity and Newborn Care

Benefits for maternity care will be provided to covered persons regardless of when the pregnancy began. Benefits will not be provided for services rendered after coverage has ended, even if the pregnancy began before coverage ended.

Care given to the newborn child during the mother's stay and in the infant's nursery will be covered if the child is a Class I Dependent.

The MEP-HCP option will cover a hospital stay for a mother and her eligible newborn for 48 hours for a vaginal delivery and for 96 hours for a cesarean section. However, with the consent of the mother, a physician may discharge the mother and newborn sooner than this. Longer stays will be covered if considered medically necessary by the claims administrator, subject to pre-certification requirements. The following newborn care services are covered under the MEP-HCP option:

- One pediatric examination of the eligible newborn while the mother is hospitalized; and

- Circumcision of the eligible newborn (including pre- and post-operative services) regardless of where the circumcision is performed, when performed by a physician.

Reproductive and Fertility Treatments

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

You must contact the claims administrator for authorization to receive any benefits for this care. Advanced reproductive technologies and fertility treatment are covered after the deductible in-network at 90 percent of the NNF and out-of-network at 70 percent of the MAA, and are limited to a lifetime family maximum of $20,000 (prescription drugs associated with this provision will count toward the lifetime family maximum).

The following procedures are excluded from coverage:

- Procedures when you and/or your spouse or same-sex domestic partner has had a previous sterilization procedure, with or without surgical reversal;
- Charges incurred by your spouse or same-sex domestic partner who is not covered by the MEP-HCP option; and
- Charges for a surrogate parent.

Covered Hospital Services and Supplies

The hospital services and supplies covered under the MEP-HCP option are listed below:

- Hospital room and board charges are covered as described earlier in the MEP-HCP option summary table.
- Special diets.
- General nursing care (excluding care by private duty nurses).
- Routine nursery care of an eligible newborn child while the mother is hospitalized for maternity care.
- Use of operating, cystoscopic delivery, recovery, and treatment rooms and equipment.
- Drugs and medicines for use in a hospital, which, at the time of admission to the hospital, are listed in the U.S. Pharmacopoeia or National Formulary or are commercially available for purchase and readily obtainable by the hospital.
- Dressings, ordinary splints and casts.
- X-ray examinations.
- X-ray therapy, chemotherapy, radiation therapy and electroshock therapy.
- Laboratory services.
- Oxygen and oxygen therapy.
- Electrocardiograms (EKGs) and electroencephalograms (EEGs).
- Physical therapy, occupational therapy and hydrotherapy.

- Anesthesia and its administration.

- Plasma processing and administration of blood and blood plasma, but not the supply of blood or blood plasma.

- Dialysis treatment.

- Sera, vaccines, biologicals, intravenous preparations and visualizing dyes.

- Services of physicians and technicians employed by or under contract to the hospital.

- Diagnostic laboratory and X-ray examinations performed under a program of pre-admission testing.

Excluded Hospital Services and Supplies

The following are not considered covered services and supplies under the MEP-HCP option:

- Hospital inpatient care if the confinement is for dental treatment or services, except in the cases of:

  — Dental care when a physician other than a dentist certifies that hospitalization is medically necessary.

  — Dental surgery for accidental injury to the natural, healthy teeth while the individual is covered by the Plan.

- Hospitalization that is primarily for diagnostic tests, X-rays, laboratory exams, EKGs, EEGs or physical therapy.

- Hospitalization that is for convalescent care, custodial or sanitarium care, or rest cures.

- Hospitalization charges incurred when you are not covered by the Plan; e.g., hospitalization that begins after coverage has ended.

- Saturday and Sunday room and board charges for admissions on Friday and Saturday that are not emergency or maternity admissions, or admission for surgery scheduled on the day immediately following admission, unless pre-certified by the claims administrator.

- Hospitalization when the stay primarily becomes rehabilitative in nature, provided that hospital charges for rehabilitation in a facility which is part of a hospital or acute physical rehabilitation facility are covered when the physician’s diagnosis is such that rehabilitation cannot be provided on an outpatient basis, such as in the case of stroke or spinal injury.

Medical Expenses Not Covered by the MEP Health Care PPO (MEP-HCP) Option

The following are some of the expenses that the MEP-HCP option does not cover. Additional expenses may not be covered. If you have any questions about whether an expense is covered, call the claims administrator.

- Services or supplies that are not medically necessary, as determined by the claims administrator.
- Care in a nursing home, home for the aged, convalescent home or rehabilitative facility. However, the Plan does cover care in a skilled nursing facility, hospice or facility for inpatient substance abuse treatment.
- Hospitalization for convalescent care, custodial or sanitarium care, or rest cures.
- Cosmetic surgery (or drugs for cosmetic purposes), unless required to correct an accidental injury or illness that occurs while the individual is covered by the Plans, or to correct a child's congenital defect if the child is born while his or her parent is covered by the Plans. Reconstructive surgery after a mastectomy is covered, as described in the "Special Rules for Surgery Coverage" section.
- Care provided before coverage begins or after coverage ends.
- Charges or services the individual is entitled to obtain without cost, in accordance with any government laws or regulations except Medicare.
- Charges for services or supplies provided for any condition covered by Workers' Compensation laws or for any other occupational condition, ailment, injury or illness occurring on the job if:
  - The covered person's employer furnishes, pays for or provides reimbursement for such charges.
  - The covered person's employer makes a settlement for such charges.
  - The covered person waives or fails to assert his or her rights respecting such charges.
- Services relating to testing, treatment or training for learning disabilities or developmental delays.
- Education or job training.
- Services or supplies provided as a result of injury or illness due to an act of war that occurs after the individual becomes covered by the Medical Plan or the Alternate Choice Plan.
- Personal services, such as barber services, guest meals, radio and television rentals, telephone, etc.
- Charges which the participant has no legal obligation to pay.
- Charges during a continuous hospital confinement that began before the person's coverage began.

- Charges in excess of the MAA or in excess of any applicable maximum, as determined by the claims administrator.

- Any medical observation or diagnostic study when no illness or injury is revealed, unless the covered person had a definite symptomatic condition of illness or injury other than hypochondria and the medical observation and diagnostic studies were not undertaken as a matter of routine physical examination or health checkup. This exclusion does not apply to in-network preventive care and to Pap tests or mammograms.

- Any service or supply for experimental purposes, including drugs or other care. However, effective as of January 1, 2014, because the medical options offered under the Plan are not grandfathered, you will be eligible for coverage of routine costs for items and services furnished in connection with your participation in an approved clinical trial. The clinical trial must relate to the treatment of cancer or another life-threatening disease or condition. Contact your claims administrator for details.

- Eyeglasses or hearing aids (or related exams), except when initially required because of surgery or injury.

- Eye surgery to correct refractive errors.

- Services rendered by a member of the covered person's immediate family.

- Services or supplies that do not meet currently accepted standards of medical practice and are not approved for general use by one of the following:

  — The U.S. Food and Drug Administration (FDA).

  — The Agency for Health Care Research and Quality (AHRQ) guidelines.

  — The Centers for Medicare & Medicaid Services, a division of the Social Security Administration.

  — Evidence-based guidelines from recognized medical specialty societies (for example, the American College of Physicians, the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians/American Society of Internal Medicine).

  — The U.S. Preventive Services Task Force.

  — Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

  — The National Cancer Institute.

  — The Council of Medical Specialty Societies (CMSS).

  — The U.S. Surgeon General.

  — The U.S. Department of Public Health.

- The National Institute of Health.

- The Office of Technology Assessment.

- Any surgery, treatment or diagnostic procedure that is considered experimental or investigational by the claims administrator.

- Admitting fees and deposits.

- Vitamins and minerals, except as provided by the prescription drug program.

- Telephone consultations, missed appointments and completion of claim forms.

- Artificial means of conception, except as otherwise covered by the Plan as described under "Reproductive and Fertility Treatments" earlier in this section.

- Charges for any care, treatment, service or supply (except charges related to elective or therapeutic abortions or sterilizations) other than one that is being required for a necessary treatment of the covered individual's injury or illness and certified by a physician or professional provider who is attending the covered individual.

- Services or supplies for which the covered person recovers the cost by legal action, insurance proceeds or settlement from a third party or from the insurer of a third party.

- Services or supplies related to treatment of obesity, except for:

  - Medically necessary nutritional counseling prescribed by a doctor and furnished by a licensed dietitian or nutritionist up to $500 a year; or

  - Medically necessary surgical procedures as determined by the Plan administrator, when the patient has a diagnosis of morbid obesity. Morbid obesity is defined as having a body mass index (BMI) which exceeds 40, or a BMI which exceeds 35 in conjunction with a severe co-morbidity.

- Treatment of sexual dysfunction that does not have a physiological or organic basis.

- Gender reassignment surgery for treatment of transsexualism or treatment for gender identity disorders.

- Treatment of temporomandibular joint (TMJ) dysfunction syndrome, except for expenses related to surgical treatment of TMJ are covered. No other charges will be covered. Any inpatient hospitalization should be pre-certified.

- Reversal of sterilization.

- Acupuncture, unless performed by a physician in relation to covered surgery.

- Marriage, family, child, career, social, adjustment, pastoral or financial counseling.

- Speech therapy, except as a result of loss of speech from an injury or illness.
- Charges for maintaining an environment suitable for preventing the worsening of a medical condition.
- Primal therapy, Rolfing, psychodrama, megavitamin therapy, bioenergentic therapy, vision perception training or carbon dioxide therapy.
- Dental treatment, except as a result of an accidental injury to sound, natural teeth that occurs while the individual is covered by the MEP-HCP option.
- Convenience items.
- Custodial nursing care.
- Athletic club dues, exercise equipment.
- Routine foot care, unless medically necessary as defined by the claims administrator.
- Non-prescription drugs.
- Wigs, except for patients receiving chemotherapy and radiation therapy.
- Nutritional formulas or food supplements (however, exempt infant formula may be considered a covered drug under the prescription drug program).

BlueCare Consultant Program

Under the HCN and MEP-HCP options administered by Anthem, the BlueCare Consultant program encourages an efficient system of care for you and your covered dependents by identifying and addressing possible unmet covered health care needs. This program is only available if you are not eligible for Medicare.

A BlueCare Consultant nurse may provide the following services:

- Inpatient care advocacy – If you are hospitalized, a BlueCare Consultant works with your physician to make sure you are getting the care you need and that your physician's treatment plan is being carried out effectively.

- Readmission management – This program serves as a bridge between the hospital and your home if you are at high risk of being readmitted.

- Risk management – If you have certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information and coordination of equipment and supplies.

A BlueCare Consultant also reviews your medical information (for example, medical and pharmacy claims) and may reach out to you to offer educational information, tips, advice or suggestions on a health-related issue based on your health profile. If you do not receive a call from a BlueCare Consultant, but feel you could benefit from the program, you can call in at any time.

You, your representative or your doctor must call your BlueCare Consultant through Member Services regarding the services outlined below and within the time frames specified below. If you do not call your BlueCare Consultant when required, your claim may be denied as not covered.

- Hospitalization – when possible, at least five days before a regular inpatient admission.

- Emergency care – within two business days or as soon as practicable following situations that require inpatient admissions.

- All organ or tissue transplants – when possible, at least 15 days before the scheduled date of an evaluation, donor search, organ procurement/tissue harvest or transplant.

- Skilled nursing facility/home health care/hospice care/private duty nursing/rehabilitation facility admissions/home infusion therapy – before any admission to a skilled nursing facility or before receiving any home health care or hospice services.

- Pregnancy – if the mother's hospital stay needs to be extended beyond 48 hours for a normal birth or 96 hours for a cesarean section, call within the 48- or 96-hour period, respectively.

- High-risk pregnancy – if there is a high risk of premature delivery, or a condition that would be harmful to the mother or the fetus, notify your BlueCare Consultant so that special attention can be provided. Additionally, contact your BlueCare Consultant if a high-risk condition develops at any time during the pregnancy.

- Newborn stay beyond the mother's stay – if the newborn needs to stay in the hospital longer than the mother.

- Orthognathic surgery (surgery to correct facial skeleton abnormalities) – when possible, at least 15 days before the procedure is performed.

- Durable medical equipment – when possible, at least 15 days before purchasing or renting durable medical equipment when the cost is more than $5,000.

- Bariatric procedures (surgeries to correct morbid obesity) performed in an inpatient and outpatient setting – when possible, at least 15 days before the procedure is performed.

- Plastic/reconstructive surgeries including but not limited to blepharoplasty, rhinoplasty, panniculectomy and lipectomy/diastasis recti repair, insertion/injection of prosthetic material collagen implants and chin implant/mentoplasty/osteoplasty mandible – when possible, at least 15 days before the procedure is performed.

- Uvulopalatopharyngoplasty (UPPP) surgery.

- Inpatient behavioral health and substance abuse treatment and electroconvulsive therapy.

- Air ambulance or nonemergency ambulance transport.

Pre-Certification

To receive benefits, you, a family member or your physician must contact your BlueCare Consultant to pre-certify the following:

- Bariatric procedures.

- Elective admissions.

- Emergency admissions (no later than two days after the admission).

- OB-related admissions (complications, excludes childbirth).

- Use of a freestanding birthing center.

- Newborn hospital stays beyond the stay of the mother.

- Inpatient hospitalization.

- Rehabilitation admissions.

- Confinement in a skilled nursing facility.

- Home health care.

- Hospice care.

- Private duty nursing.
- Certain outpatient procedures, services and tests, as determined by Anthem BCBS.
- All inpatient mental health and substance abuse treatment.
- Outpatient ECT, psychological testing, neuropsychological testing, amytal interview and hypnosis.
- Elective, rehabilitation and long-term acute care facility admissions.
- All organ and bone marrow/stem cell transplants.
- Nonemergency ambulance or ambulette transport.
- Lumbar spinal injuries.
- Durable medical equipment (DME)/prosthetics/orthotics over $5,000.

Your BlueCare Consultant will notify you and your physician of Anthem's decision. If you or your physician disagrees with Anthem's decision, you can appeal the decision.

You must certify emergency hospital admissions no more than 48 hours after admission or the next business day, whichever is later.

Outpatient Procedures Requiring Pre-Certification

The following require pre-certification before the procedure or treatment is performed. Even though these procedures or treatments are most often done on an outpatient basis, pre-certification is required whether the procedure or treatment will be performed on an inpatient or outpatient basis:

- Plastic/reconstructive surgeries.
- Bariatric procedures.
- Bone marrow and stem cell transplants.
- Private duty nursing (home).
- Uvulopalatopharyngoplasty (UPPP) surgery.
- Home infusion therapy.
- Hospice care.

Penalty for Not Calling

If you do not call your BlueCare Consultant when required, your claim will be denied as not covered if medical records have not been received within 21 days. The claim may be re-opened if additional medical information is received at a later date. Any services deemed not medically necessary will be denied.

Prescription Drug Program for the HCN and MEP-HCP Options

Your prescription coverage includes:

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

For the MEP-HCP option, there is an out-of-pocket expense maximum for mail-order pharmacy prescriptions under the prescription drug program. The limit varies by year ($600 in 2013; $700 in 2014). In 2015 and each calendar year thereafter, the annual out-of-pocket maximum will increase by 6 percent when compared to the annual out-of-pocket maximum for the prior calendar year in 2015. If you are a pre-Medicare retiree, any expenses you incur as a result of paying the difference between the cost of a brand-name and a generic drug when a generic equivalent is available will not count toward the out-of-pocket maximum.

The retail and mail-order prescription benefit is administered by Express Scripts. Express Scripts works with Arriva Medical and Liberty Medical to dispense Medicare Part B prescriptions by mail. (Orders are assigned to Arriva and Liberty after being placed with Express Scripts.)

Prescription Drug Program Overview

The following chart provides an overview of the benefits payable under the prescription drug program:

Prescription Drugs	**Using a Participating Pharmacy**	**Using a Non-Participating Pharmacy**
Retail Pharmacy (supply appropriate for up to 30 days of therapy) ***If you are a Medicare-eligible retiree who is enrolled in a Verizon-sponsored Medicare Part D plan**, you will be eligible for three 30-day supplies of covered medication per visit at retail. The 3x retail copay applies.*		
Annual Deductible	No deductible required.	If you are not Medicare-eligible, $50 combined for generic and brand-name drugs. This annual deductible provision does not apply to Medicare-eligible retirees.

Prescription Drugs	Using a Participating Pharmacy	Using a Non-Participating Pharmacy
Cost Sharing		
Generic Drugs, If **NOT** Medicare-Eligible	• You pay the discounted network price (DNP) but no more than an $8 copay in 2013 and 2014 and $9 copay in 2015 per prescription. • Once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP. Fixed dollar maximum copays will not apply.	After the deductible is met, you pay 100% of the cost difference between the DNP and retail cost. In addition: • You pay 30% of the DNP cost for the original prescription and each refill. • Once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP.
Generic Drugs, If Medicare-Eligible	• You pay the discounted network price (DNP) but no more than an $8 copay in 2013 and 2014 and $9 copay in 2015 per prescription. • If you are enrolled in the Verizon-sponsored Medicare Part D plan, before 8/13/2013, once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail order pharmacy or you will pay 47.5% of the DNP and fixed dollar maximum copays will not apply. Effective 8/13/2013, this provision no longer applies.[1]	After the deductible is met, you pay 100% of the cost difference between the DNP and retail cost. In addition: • You pay 30% of the DNP cost for the original prescription and each refill. • If you are enrolled in the Verizon-sponsored Medicare Part D plan, before 8/13/2013, once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail order pharmacy or you will pay 47.5% of the DNP. Effective 8/13/2013, this provision no longer applies.[1]
Single-Source Brand-Name Drugs (No Generic Available), if **NOT** Medicare-eligible	• You pay 30% of the DNP but no more than a $25 copay per prescription for each of 2013 and 2014.[2] • Once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP and fixed dollar maximum copays will not apply.	After the deductible is met, you pay 100% of the cost difference between the DNP and the retail cost. In addition: • You pay 40% of the DNP for the original prescription and each refill. • Once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP.

Prescription Drugs	Using a Participating Pharmacy	Using a Non-Participating Pharmacy
Single Source Brand-Name Drugs (No Generic Available), If Medicare-Eligible	• You pay 30% of the DNP but no more than a $25 copay per prescription for each of 2013 and 2014. [2] • If you are enrolled in the Verizon-sponsored Medicare Part D plan, before 8/13/2013, once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail order pharmacy or you will pay 47.5% of the DNP and fixed dollar maximum copays will not apply. Effective 8/13/2013, this provision no longer applies. [1]	After the deductible is met, you pay 100% of the cost difference between the DNP and the retail cost. In addition: • You pay 40% of the DNP for the original prescription and each refill • If you are enrolled in the Verizon-sponsored Medicare Part D plan, before 8/13/2013, once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail order pharmacy or you will pay 47.5% of the DNP. Effective 8/13/2013, this provision no longer applies. [1]
Multi-Source Brand-Name Drugs (When Generic Is Available), If **NOT** Medicare-Eligible	• If you purchase a brand-name drug when a generic equivalent is available, you pay the generic equivalent DNP but no more than an $8 copay per prescription in 2013 and 2014 and $9 in 2015, **plus** 100% of the cost difference between the brand-name and generic drug (fixed dollar maximum copay does not apply). [3] • Once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP and fixed dollar maximum copays will not apply.	After the deductible is met, you pay 100% of the cost difference between the DNP and the retail cost. In addition: • If you purchase a brand-name drug when a generic equivalent is available, you will pay 30% of the generic equivalent DNP plus 100% of the cost difference between the brand-name and generic drug. [3] • Once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP.

Prescription Drugs	Using a Participating Pharmacy	Using a Non-Participating Pharmacy
Multi-Source Brand-Name Drugs (When Generic Is Available), If Medicare-Eligible	• If you purchase a brand-name drug when a generic is available, you pay 40% of the DNP but no more than $30 copay. • If you are enrolled in the Verizon-sponsored Medicare Part D plan, before 8/13/2013, once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 47.5% of the DNP and fixed dollar maximum copays will not apply. Effective 8/13/2013, this provision no longer applies.[1]	After the deductible is met, you pay 100% of the cost difference between the DNP and the retail cost. In addition: • You pay 50% of the DNP for the original prescription and each refill. • If you are enrolled in the Verizon-sponsored Medicare Part D plan, before 8/13/2013, once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 47.5% of the DNP. Effective 8/13/2013, this provision no longer applies.[1]
Mail Service Pharmacy (supply appropriate for up to 90 days of therapy)		
Generic Drugs	You pay the DNP per prescription, but no more than a $16 copay in 2013 and 2014 and $18 copay in 2015.	N/A
Single-Source Drugs (No Generic Available)	You pay 30% of the DNP, but no more than a $50 copay per prescription in 2013 and 2014.[2]	N/A
Multi-Source Brand-Name Drugs (When Generic Is Available), If **NOT** Medicare-Eligible	You pay the DNP per prescription, but no more than a $16 copay in 2013 and 2014 and $18 copay in 2015, plus 100% of the cost difference between the brand-name and generic drug (fixed dollar maximum copay does not apply).[3]	N/A
Multi-Source Brand-Name Drugs (When Generic Is Available), If Medicare-Eligible	You pay 40% of the DNP, but no more than $60 per prescription.	N/A

[1] If you are Medicare-eligible but not enrolled in the Verizon-sponsored Medicare Part D plan, before 8/13/2013, once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail order pharmacy or you will pay 47.5% of the DNP. Fixed dollar maximum copays will not apply. Effective 8/13/2013, this provision no longer applies.

[2] For 2015 and each calendar year thereafter, the maximum per prescription copay will increase by 6% when compared with the maximum copay for the prior plan year.

[3] Does not apply for brand-name drugs where there is a generic equivalent and the claims administrator approves your doctor's certification that you are medically unable to take the generic version of the medication. If the claims administrator approves your request, the cost sharing that applies to brand-name drugs with no generic available will apply.

Retail Prescription Benefit

You can get up to a 30-day supply of medication at a retail pharmacy. If you are Medicare-eligible, you can get up to three 30-day supplies of a covered medication per visit at a retail pharmacy; however, 3 times the retail copay would apply. It is your decision to use either a participating or non-participating pharmacy each time you need short-term medications.

Using a Participating Pharmacy

When you use a participating pharmacy, you pay:

- **For a generic drug (regardless of your Medicare eligibility status)**, you'll pay the discounted network price (DNP) for each prescription drug, but no more than $8 copay in 2013 and 2014 and $9 copay in 2015.

- **If You Are a Pre-Medicare Retiree**:

  — ***For single-source and multi-source brand-name drugs***, you'll pay 30 percent of the DNP (but not more than a $25 copay) per prescription in 2013 and 2014. The maximum copay will increase by 6 percent per year, when compared with the maximum copay for the prior plan year, for the years 2015 and beyond.

  — ***If you choose a brand-name drug when a generic equivalent is available***, you'll pay an amount equal to the generic equivalent DNP, up to a maximum copay of $8 per prescription in 2013 and 2014, and $9 in 2015, plus 100 percent of the cost difference between the brand-name and generic drug; the fixed dollar maximum copays do not apply. You will not have to pay the cost difference between the brand-name and the generic drug if your doctor certifies that you are medically unable to take the generic version of the medication and such exception is approved by Express Scripts' procedures for approval of treatment or services and instead, you will pay 30 percent of the brand-name DNP, subject to the maximum copay.

    Example: You select a brand-name drug with a DNP of $20. This particular brand-name drug also has a generic equivalent DNP of $10. In this example, in 2013, you would pay an **$8** copay **plus** the cost difference between the brand-name and generic drug ($20 minus $10 which is equal to **$10**). Your total cost would be **$18**.

  Once you obtain three fills of a prescription for a maintenance medication from a participating pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you'll pay 50 percent of the DNP; the fixed dollar maximum copays will not apply. This requirement applies regardless of whether you are purchasing a generic, single-source or multi-source brand-name drug.

- **If You Are a Medicare-Eligible Retiree**:

  — ***For single-source brand-name drugs***, you'll pay 30 percent of the DNP (but no more than a $25 copay) for each prescription in 2013 and 2014. The $25 maximum copay will increase by 6 percent per year, when compared with the maximum copay for the prior plan year, for the years 2015 and beyond.

  — ***For multi-source brand-name drugs***, you'll pay 40 percent of the DNP (but no more than $30) for each prescription.

If you are enrolled in the Verizon-sponsored Medicare part D plan before August 13, 2013, once you obtain three fills of a prescription for a maintenance medication from a participating pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you'll pay 47.5 percent of the DNP; the fixed dollar maximum copays will not apply. This requirement applies regardless of whether you are purchasing a generic, single-source or multi-source brand-name drug. This provision no longer applies as of August 13, 2013.

If you are Medicare-eligible but not enrolled in the Verizon-sponsored Medicare Part D plan before August 13, 2013, once you obtain three fills of a prescription for a maintenance medication from a participating pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 47.5% of the DNP; the fixed dollar maximum copays will not apply. This provision no longer applies as of August 13, 2013.

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

If you are Medicare-eligible and enrolled in a Verizon-sponsored Medicare Part D plan, you can get up to three 30-day supplies of a covered medication per visit at a retail pharmacy; however, three times the retail copay would apply.

Note: If you are not Medicare-eligible or Medicare-eligible and not enrolled in a Verizon-sponsored Medicare Part D plan, and your doctor prescribes more than a 30-day supply, the maximums do not apply and you are responsible for the cost of the additional supply.

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

Using a Retail Non-Participating Pharmacy

If you are not Medicare-eligible, when you use a non-participating pharmacy, you pay an annual $50 per person prescription deductible combined for generic and brand-name drugs. This annual deductible does not apply if you are Medicare-eligible. After the annual deductible is met (if applicable), you also pay:

- **For generic drug expenses (regardless of your Medicare eligibility status)**, you'll pay 30 percent of the DNP for each prescription. In addition, you pay 100 percent of the cost difference between the DNP and retail cost.

- **If You Are a Pre-Medicare Retiree**:

  — ***When you purchase a single-source or multi-source brand-name drug***, you'll pay 40 percent of the DNP for each prescription drug. In addition, you'll pay 100 percent of the cost difference between the DNP and retail cost.

  — ***If you choose a brand-name drug when a generic equivalent is available***, you'll pay 30 percent of the generic equivalent DNP for each prescription plus 100 percent of the cost difference between the brand-name retail cost and generic drug DNP. You will not have to pay the cost difference between the brand-name and generic drug (and the single-source and multi-source brand-name drug coverage will apply) if your doctor certifies that you are medically unable to take the generic version of the medication, and this exception is approved by Express Scripts' procedures for approval of treatment or services and instead, you will pay 40 percent of the brand-name DNP, subject to the maximum copay.

Example: You select a brand-name drug with a DNP cost of $50. This brand-name drug has a retail cost of $75. This particular brand-name drug also has a generic equivalent with a DNP cost of $20 and a retail cost of $35. In this example, in 2013, you would pay **$6** (30 percent of the generic equivalent DNP of $20) **plus** the cost difference between the brand-name retail cost and generic drug DNP ($75 minus $20 which is equal to $55). Your total cost would be **$61** (in addition to all or any portion of the annual $50 deductible that applies).

Once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you'll pay 50 percent of the DNP. This requirement applies regardless of whether you are purchasing a generic, single-source, or multi-source brand-name drug.

- **If You Are a Medicare-Eligible Retiree**:

  — ***For single-source brand-name drugs,*** you'll pay 40 percent of the DNP.

  — ***For multi-source brand-name drugs***, you'll pay 50 percent of the DNP.

  If you are enrolled in the Verizon-sponsored Medicare Part D plan before August 13, 2013, once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you'll pay 47.5 percent of the DNP. This requirement applies regardless of whether you are purchasing a generic, single-source or multi-source brand-name drug. This provision no longer applies as of August 13, 2013.

  If you are Medicare-eligible but not enrolled in the Verizon-sponsored Medicare Part D plan before August 13, 2014, once you obtain three fills of a prescription for a maintenance medication from a retail pharmacy (i.e., the initial prescription plus two refills), then you must use the mail order pharmacy or you will pay 47.5% of the DNP. This provision no longer applies as of August 13, 2014.

  Your costs could be much higher based on the retail cost of the drug.

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

Mail-Order Prescription Benefit

You can obtain up to a 90-day supply of medication delivered to your home by mail. When you do:

- **For a generic drug (regardless of your Medicare eligibility status)**, you'll pay the DNP for each prescription drug, but no more than a $16 copay in 2013 and 2014, and an $18 copay in 2015.

- **If You Are a Pre-Medicare Retiree**:

  — ***For a single-source or multi-source brand-name drug***, you'll pay 30 percent of the DNP for each prescription drug, but no more than a $50 copay in 2013 and 2014. The $50 maximum copay will increase by 6 percent per year, when compared with the maximum copay for the prior plan year, for the years 2015 and beyond.

— ***If you choose a brand-name drug when a generic equivalent is available***, you'll pay an amount equal to the generic DNP, up to a maximum of $16 in 2013 and 2014, and $18 in 2015, plus 100 percent of the cost difference between the brand-name and generic drug; the fixed dollar maximum copays do not apply. You will not have to pay the cost difference between the brand-name and generic drug (and the single-source and multi-source brand-name drug coverage will apply) if your doctor certifies that you are medically unable to take the generic version of the medication, and this exception is approved by Express Scripts' procedures for approval of treatment or services.

- **If You Are a Medicare-Eligible Retiree**:

— ***For single-source brand-name drugs***, you'll pay 30 percent of the DNP for each prescription drug, but no more than a $50 copay in 2013 and 2014. The $50 maximum copay will increase 6 percent per year in 2015 and beyond.

— ***For multi-source brand-name drugs***, you'll pay 40 percent of the DNP for each prescription drug, but no more than a $60 copay in 2013, 2014 and 2015.

There is no deductible for mail-order prescriptions.

Initial Orders

There are three ways to order a prescription by mail:

- Access Express Scripts' website (www.express-scripts.com/verizon) and follow the instructions to order a new prescription. Your prescription will be filled by Express Scripts, Liberty Medical or Arriva Medical, as appropriate.

- Send your original prescription and your payment to Express Scripts using a mail-order form.

- Have your doctor call 1-888-EASYRX1 (1-888-327-9791) for instructions on faxing the prescription.

  For the fastest service, ask your doctor to send the prescription directly to Express Scripts by e-prescribing.

Your prescription will be sent to your home by United States Postal Service mail or UPS within 14 days of the date that Express Scripts receives your order.

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

Note: Medications cannot be mailed outside the United States.

Refills

There are three ways to order refills:

- Access Express Scripts' website (www.express-scripts.com/verizon) and follow the instructions for refilling prescriptions.

- Call Express Scripts at the number listed on your ID card.

- Mail your refill slip to Express Scripts using a mail-order form.

Verizon-Sponsored Medicare Part D Plan (PDP Administered by Express Scripts

If you or a covered family member is or becomes eligible for Medicare, you and your dependents will generally receive your prescription drug coverage through a Verizon-sponsored group Medicare Part D plan with a supplemental "wrap around" benefit (often referred to as an employer group waiver plan plus wrap or EGWP). Verizon designed this supplemental "wrap-around" plan to preserve a comprehensive level of prescription drug benefits. The Medicare Part D plan sponsored by Verizon is called "Express Scripts Medicare (PDP) for Verizon" and is administered by Express Scripts. If you or your family members become eligible for Medicare, you will receive information about the Verizon-sponsored Medicare Part D plan from Express Scripts prior to his or her coverage effective date. If you have moved to this Verizon-sponsored Medicare Part D plan with a supplemental wrap-around benefit, you will receive additional information about this program each year.

Under Medicare Part D, including the Verizon-sponsored Medicare Part D plan, you may be eligible to receive help with premiums and copays if you have limited income and resources. In addition, if you have yearly income that exceeds a certain threshold, you may need to pay an extra Medicare Part D premium amount to the federal government. (The specified threshold amounts are $85,000 or above in 2014 for an individual filing an individual tax return [or married individual filing separately] or $170,000 or above in 2014 for married couples filing a joint tax return.) If you are impacted, the Social Security Administration will send you a letter outlining the extra amount and you must contact the Verizon Benefits Center for assistance.

In addition:

- You can get up to three 30-day supplies of a covered medication per visit at a retail pharmacy; however, three times the retail copay would apply.

- You can request an Explanation of Benefits for each month prescriptions have been filled which will detail your prescription drug costs and will help you to understand your total out-of-pocket costs (total out-of-pocket costs are what you and others pay on your behalf, including manufacturer discounts but excluding plan premiums or payments made by the Medicare prescription drug plan).

What Is Covered

The prescription program covers the following items. If you have questions about covered charges, you should contact Express Scripts. See your ID card for contact information.

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

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

- Biologicals, immunization agents and vaccines.

- Allergy sera, at a retail pharmacy.

- Diabetes therapy.

  — Insulin needles and syringes.

  — Diabetic kits (insulin, apparatus and supplies), available through Express Scripts. You pay a single payment when the order is placed as one prescription on the same day with insulin or other oral agents. If you request the medication and supplies be refilled, but part of the request is made too soon, then the prescriptions will not be dispensed together.

  — Over-the-counter insulin and diabetic supplies ordered separately (not as a kit). If you are Medicare-eligible, diabetic supplies are covered by Medicare, not by the prescription program.

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

  — Premenstrual conditions.

  — Asthma.

  — Erectile dysfunction.

  — Acne (only under the HCN option).[1]

  — Flu prevention and treatment.

  — Contraceptives.

  — Cancer.

  — Hormone replacement.[1]

  — Irritable bowel syndrome.[1]

  — Medications as required by the Affordable Care Act.

- Exempt infant formula when it is medically necessary for infants who have been diagnosed with medical or dietary problems.

Special Purchase Requirements for Certain Medications

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

- Before dispensing medications with the potential of drug interaction with other drugs, the prescription program will alert the pharmacist who will determine if the doctor should be contacted.

[1] If you are Medicare-eligible, the medications/category limitations or considerations do not apply.

- After clinical reviews are performed, patients who potentially may be overusing highly addictive narcotics may be limited to purchasing their medications at one participating retail pharmacy of their choice and through mail order.

Generic Medications

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

Compound Medications

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

Special rules apply for submitting claims for compound medications. See the "Filing Prescription Claims" section for more information.

Prescription Drug Program Provisions If You're Covered Under the HCN Option

Medications That Require a Coverage Review

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

If you have a prescription that needs this review, the pharmacist will coordinate with the prescribing doctor. If you have a question about whether a medication will require a coverage review, call Express Scripts. For faster approval or if you or your doctor has a question, you or your doctor can contact the Express Scripts coverage review unit (see your ID card for contact information). Usually, approval takes two to three business days to process a request for review.

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

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

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

- Acne therapy.[1]
- Alzheimer's therapy.[1]
- Antidepressants (Prozac Weekly).
- Anticonvulsants (seizure medication).
- Appetite suppressants and other weight loss medications.
- Cancer medications (Lupron).
- Diabetes medications (Glucophage XR).
- Erectile dysfunction medications.
- Erythroid stimulants (correct anemia in patients with dialysis, HIV, etc.).
- Hepatitis C therapy.[1]
- Hereditary angioedema.[1]
- Human growth hormones.
- Interferons (used to treat immune disorders and infections).
- Miscellaneous dermatologicals.[1]
- Myeloid stimulants (used to fight infection and treat low white-blood cell counts).
- Platelet proliferation stimulants.

Quantity Dispensing Limits

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

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

[1] If you are Medicare-eligible, coverage review in this category does not apply.

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

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

Medicare Part B Medications and Supplies

Certain prescriptions are eligible for coverage by both Medicare Part B and your Verizon prescription benefit. The following provisions apply if you or your dependent is Medicare-eligible and Medicare pays primary (first) under the Medicare secondary payer rules. Medicare generally pays primary if you are a retired employee or the dependent of a retired employee.

If you are eligible for Medicare and Medicare is primary, **Verizon will coordinate as if you are enrolled in Medicare Part B, even if you are not. Accordingly, if you are eligible for Medicare and Medicare pays primary, you may lose important benefits if you haven't enrolled in Medicare Part B**. Please see "Coordination with Medicare" section of your medical SPD for more details.

Retail Prescription Coverage

You need to show your Medicare ID card when you use a retail pharmacy. If your prescription is eligible for Medicare Part B coverage, after you meet the Medicare Part B deductible, the retail pharmacy will bill Medicare and submit any costs not paid by Medicare to Express Scripts for coverage under your Verizon prescription benefit. You will not need to take any additional action other than show your Medicare ID card. **Your out-of-pocket cost will not be any more than it would have been without this coordination.**

Mail-Order Prescription Coverage

You will continue to order your initial prescriptions in the same way you do today. If your prescription is eligible for Medicare Part B coverage, after you meet the Medicare Part B deductible, Express Scripts will transfer your prescription request to Arriva Medical, Liberty Medical or Accredo, mail-order pharmacies that specialize in Medicare Part B. Arriva Medical, Liberty Medical or Accredo will provide you with instructions on how to order refills if you need them. **Your out-of-pocket cost will not be any more than it would have been without this coordination.**

What Is Not Covered Under the HCN Option

Under the HCN option, the prescription drug program does **not** cover:

- Medications not approved by the U.S. Food and Drug Administration (FDA).
- Medications that states restrict for sale or distribution.
- Medications that are not medically necessary or that do not treat an accidental injury, illness or pregnancy, except those identified under "What Is Covered."

- Appetite suppressants and other weight loss drugs, unless for treating morbid obesity and taken in conjunction with a patient support program.

- Therapeutic devices, bandages, heat lamps, braces or artificial appliances. However, the Plan may cover insulin needles and syringes, over-the-counter diabetic supplies (unless covered by Medicare), and diaphragms and IUDs that require a prescription.

- Health and beauty aids and medications for cosmetic purposes, such as Renova, Retin-A or Solage for age spots or as a wrinkle cream, and Propecia or Rogaine for hair loss.

- Charges for the administration or injection of any drug.

- Medications for experimental use.

- Medication covered by Workers' Compensation laws or similar government programs, or for which no charge is made.

- Charges covered by Medicare, including both Medicare Part A and Part B – regardless of whether or not you have enrolled in or received Medicare Part A and Part B benefits.

- Blood or blood plasma.[1]

- Medication you receive in a hospital or outpatient surgical center.[1, 2]

- Medication you receive while you are a patient in a skilled nursing facility or similar institution when medications provided by those institutions are covered by a medical plan, including Medicare.[1, 2]

- Prescriptions refilled in excess of the number of times the doctor specified or any refill dispensed after one year from the doctor's original order.

- Mifeprex, for termination of intrauterine pregnancy.

- Over-the-counter (OTC) medications and their equivalents available by prescription (except for insulin, diabetic supplies and products included in the Affordable Care Act).

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

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

Prescription Drug Program Provisions If You're Covered Under the MEP-HCP Option

Medications That Require a Coverage Review

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

If you have a prescription that needs this review, the pharmacist will coordinate with the prescribing doctor. If you have a question about whether a medication will require a coverage review, call Express Scripts. For faster approval or if you or your doctor has a question, you or your doctor can contact the Express Scripts coverage review unit (see your ID card for contact information). Usually, approval takes two to three business days to process a request for review.

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

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

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

- Acne therapy.[1]
- Anticonvulsants (seizure medication).
- Erectile dysfunction medications.
- Erythroid stimulants (correct anemia in patients with dialysis, HIV, etc.).
- Hepatitis C therapy.[1]
- Hereditary angioedema.
- Human growth hormones.

[1] If you are Medicare-eligible, coverage review in this category does not apply.

Quantity Dispensing Limits

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

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

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

- Cholesterol medications (Crestor).
- Erectile dysfunction agents.
- Hereditary angioedema agents.
- Migraine medications.

Medicare Part B Medications and Supplies

Certain prescriptions are eligible for coverage by both Medicare Part B and your Verizon prescription benefit. The following provisions apply if you or your dependent is Medicare-eligible and Medicare pays primary (first) under the Medicare secondary payer rules. Medicare generally pays primary if you are a retired employee or the dependent of a retired employee.

If you are eligible for Medicare and Medicare is primary, Verizon will coordinate as if you are enrolled in Medicare part B, even if you are not. Accordingly, if you are eligible for Medicare and Medicare pays primary, you may lose important benefits if you haven't enrolled in Medicare part B. Please see "Coordination with Medicare" section of your medical SPD for more details.

Retail Prescription Coverage

You need to show your Medicare ID card when you use a retail pharmacy. If your prescription is eligible for Medicare Part B coverage, after you meet the Medicare Part B deductible, the retail pharmacy will bill Medicare and submit any costs not paid by Medicare to Express Scripts for coverage under your Verizon prescription benefit. You will not need to take any additional action other than show your Medicare ID card. **Your out-of-pocket cost will not be any more than it would have been without this coordination.**

Mail-Order Prescription Coverage

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

What Is Not Covered Under the MEP-HCP Option

Under the MEP-HCP option, the prescription drug program does **not** cover:

- Medications not approved by the U.S. Food and Drug Administration (FDA).
- Medications that states restrict for sale or distribution.
- Medications that are not medically necessary or that do not treat an accidental injury, illness or pregnancy, except those identified under "What Is Covered."
- Therapeutic devices, bandages, heat lamps, braces or artificial appliances. However, the Plan may cover insulin needles and syringes, over-the-counter diabetic supplies (unless covered by Medicare), and diaphragms and IUDs that require a prescription.
- Health and beauty aids and medications for cosmetic purposes, such as Renova, Retin-A or Solage for age spots or as a wrinkle cream, and Propecia or Rogaine for hair loss.
- Charges for the administration or injection of any drug.
- Medications for experimental use.
- Medication covered by Workers' Compensation laws or similar government programs, or for which no charge is made.
- Charges covered by Medicare, including both Medicare Part A and Part B – regardless of whether or not you have enrolled in or received Medicare Part A and Part B benefits.
- Blood or blood plasma.[1]
- Medication you receive in a hospital or outpatient surgical center.[1, 2]
- Medication you receive while you are a patient in a skilled nursing facility or similar institution when medications provided by those institutions are covered by a medical plan, including Medicare.[1, 2]
- Prescriptions refilled in excess of the number of times the doctor specified or any refill dispensed after one year from the doctor's original order.
- Mifeprex, for termination of intrauterine pregnancy.
- Over-the-counter (OTC) medications and their equivalents available by prescription (except for insulin, diabetic supplies and products included in the Affordable Care Act).

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

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

Filing Prescription Claims

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

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

If your claim is denied, you have a right to appeal. See the "If a Benefit Is Denied" section for information on filing an appeal.

Claims for Compound Medications

There are two ways to submit claims for compound medications:

- Take the prescription to a participating retail pharmacy, and ask the pharmacist to submit the claim directly to Express Scripts so that you only need to make your copay at the time of service. (**Note**: Effective January 1, 2014, Express Scripts will not dispense compound prescriptions through mail order.)

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

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

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

If your claim is denied, you have a right to appeal. See the "If a Benefit Is Denied" section for information on filing an appeal.

No Coverage Option

You can elect to waive coverage by electing the “No Coverage” option under the Medical Plan or Alternate Choice Plan at the time you are first eligible or during any subsequent “Anytime Enrollment.” You are not required to have other medical coverage in order to elect no medical coverage with Verizon. If you elect no coverage for a calendar year, you and your eligible dependents will not have medical coverage under the Plans for that calendar year, unless you later decide to enroll under “Anytime Enrollment.” If you are an under age 65, non-Medicare-eligible New York IBEW- or New York or New England CWA-represented associate retiree, you will receive a $500 annual waiver credit. If you are an under age 65, non-Medicare-eligible New England IBEW-represented associate retiree, you will receive a $700 annual waiver credit. The waiver credit is prorated and paid quarterly.

Note: You are not eligible for the waiver credit if you are covered as a dependent of an associate (or retiree) under another Verizon-sponsored medical plan.

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

Health Maintenance Organizations (HMOs) and Medicare Advantage Plans

HMOs

As an alternative to the HCN or MEP-HCP options under the Medical Plan, you may continue coverage in your Health Maintenance Organization (HMO) provided through the Verizon Alternate Choice Plan for New York and New England Associates (the Alternate Choice Plan), if:

- You are eligible for the HMO;
- You remain continuously enrolled in the HMO in which you were enrolled as a covered associate (as long as the HMO is offered to covered retirees); and
- You are not eligible for Medicare.

If you were not enrolled in an HMO as a covered associate when you retired, you cannot enroll in an HMO as a covered retiree.

The HMOs available to you will vary depending on where you live. Some HMOs offer programs for people eligible for Medicare; others do not. See "Medicare Advantage Plans (Medicare Advantage HMOs)" later in this section for information on Medicare HMOs. Your enrollment materials will explain which HMOs (if any) are offered to covered retirees.

How HMOs Typically Work

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

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

Every HMO has its own coverage provisions. If you are thinking of continuing your enrollment in an HMO, you should access the BenefitsConnection website or contact the HMO directly to get full information about the HMO's coverage provisions. Upon request, and free of charge, you will receive written materials describing the services provided by the HMO, the conditions for eligibility to receive those services, the circumstances under which services may be denied, the procedures to be followed in obtaining covered services, and the procedures for review of claims for services that are denied in whole or in part.

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

Be Sure Your Dependents Are Eligible for HMO Coverage

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

Choosing a Primary Care Physician (PCP)

When you join an HMO, you'll typically need to choose a PCP from the HMO's network of doctors. Your PCP will be your primary doctor – the physician who coordinates all your care and guides you through the HMO's services and network. You may also contact the HMO to obtain a list of the network of doctors. The HMO may refer you to a website, but you also have a right to receive a paper copy, free of charge.

Procedures for Receiving Care

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

Patient Protections Disclosure

HMOs generally require the designation of a PCP. You have the right to designate any PCP who participates in the HMO network and who is available to accept you or your family members. Until you make this designation, it is possible that your HMO may designate one for you. For information on how to select a PCP, and for a list of the participating PCPs, please contact the HMO directly. You may obtain contact information for your HMO by calling the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

For children, you may designate a pediatrician as the PCP.

You do not need prior authorization from the HMO or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the HMO network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your HMO.

Emergencies

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

Your Costs

Generally, all you pay for in an HMO is a copay of $20 copay per visit for your PCP and $25 for a specialist (no more than a $75 copay for an emergency room visit) each time you receive care. Most other services, such as hospitalization and surgery, are covered at 100 percent by the HMO. Typically, you will not receive any bills for care, and all claims will be handled directly by the HMO.

Prescription Drug Coverage for HMOs

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

The Health Plan Comparison charts available on the BenefitsConnection website at the time you choose your health plan will clarify whether or not Express Scripts is your prescription drug provider. If your retail and home mail service pharmacy is carved out to Express Scripts, your prescription drug benefits will be the same as described in the "Prescription Drug Program for the HCN and MEP-HCP Options" section. Regardless of the administrator, see your Health Plan Comparison charts available on the BenefitsConnection website and contact the HMO or Express Scripts (whichever is your prescription drug provider) for more information on your prescription drug program.

Medicare Advantage Plans (Medicare Advantage HMOs)

Medicare Advantage plans or Medicare Advantage HMOs offer Medicare-eligible individuals cost-effective alternatives to original Medicare. To enroll in a Medicare Advantage HMO, you must be enrolled in both Medicare Part A (hospital coverage) and Part B (physician coverage). You must continue to pay premiums for Medicare Part B if you enroll in a Medicare Advantage HMO. You should contact the Medicare Advantage HMO directly for a detailed schedule of benefits, free of charge.

If you enroll in a Medicare Advantage HMO, you generally must use your PCP in order to receive benefits. Medicare Advantage HMOs provide the same types of services as non-Medicare HMOs, but with a focus on the special needs of Medicare-eligible members. Generally, you only pay a small copay or have no cost sharing for covered services. You have a right to receive a network provider listing, free of charge, from the Medicare Advantage HMO.

This type of option will be offered to you only if you live in a Medicare Advantage plan service area. A Medicare Advantage HMO is approved by the Centers for Medicare & Medicaid Services, a division of the Social Security Administration, and **replaces** your original Medicare coverage. The Medicare Advantage HMO is responsible for coordinating all your health care needs and providing all the services covered by original Medicare.

A Medicare Advantage HMO may or may not offer Medicare Part D; it depends on the particular Medicare Advantage plan. You should ask the insurer/administrator whether the Medicare Advantage plan offers Medicare Part D, another type of prescription drug coverage or no prescription drug coverage.

Keep Your Medicare Card

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

Enrolling in a Medicare Advantage HMO

To enroll in a Medicare Advantage HMO through Verizon, you or your dependent must be:

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

How to Enroll
When enrolling in a Medicare Advantage HMO, you may enroll via the BenefitsConnection website or by calling the Verizon Benefits Center and speaking with a representative.

You can enroll in a Medicare Advantage HMO (or possibly change Medicare Advantage HMOs) at any time. You also have the option to leave the Medicare HMO and re-enroll in the Verizon Medical Expense Plan for New York and New England Associates and ordinary Medicare.

If you are enrolling yourself or your dependent in a Medicare Advantage HMO for the first time, an HMO enrollment form must be completed for yourself and each Medicare-eligible dependent. If you (or a dependent) are disenrolling from a Medicare Advantage HMO, an HMO disenrollment form must be completed for yourself and each Medicare-eligible dependent. Your election will not be effective immediately, but will be effective as soon as administratively possible once your enrollment or disenrollment form is approved. Until your election form is effective, you will continue to be covered under your previously elected medical plan option.

Under federal rules, no one is eligible for Medicare Advantage HMO coverage if he or she doesn't meet the guidelines above, is undergoing renal dialysis treatment, or has had a kidney transplant within the last 36 months.

If You Travel for Part of the Year
Some Medicare Advantage HMOs have made provisions for retirees who live away from their permanent residence for more than 90 consecutive days each year. These plans allow you to receive coverage at both your permanent and temporary residences. You should call the HMO to check if the HMO has these provisions.

Coverage for Dependents
If you or a dependent is Medicare-eligible, the following rules apply:

- Your Medicare-eligible family members must all select the same option; and

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

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

Changes to Medicare Advantage HMO Options
The Medicare Advantage HMO benefits design, administrators and service areas may change from time to time. However, any changes will be made in correspondence with the annual enrollment period. Review the information you receive during annual enrollment for any Plan changes. For details regarding your Medicare Advantage HMO benefits and cost sharing, contact the Verizon Benefits Center or your Medicare Advantage HMO directly and request a certificate of coverage/insurance. This document will be provided to you free of charge upon request.

If a Medicare Advantage HMO option is terminated and you are enrolled in such HMO and you fail to elect another available medical option within the time and manner specified by Verizon, you will be defaulted into the MEP-HCP option with the coverage level you elected before the Medicare Advantage HMO option was terminated.

National EPO NYNE Option

With the EPO option, when you receive in-network care from participating providers, you pay no deductible; your cost for in-network medical care consists of a fixed copay, depending on the type of service provided. On the other hand, generally, if you receive care from out-of-network providers, your expenses are not covered.

Additional Eligibility Provisions

You cannot enroll in the EPO option after October 19, 2012. If you are enrolled in the EPO option on October 19, 2012, you can continue to be covered under the EPO provided that you remain continuously eligible for the Plans and remain enrolled in the EPO option, and are not Medicare-eligible. If you change to another medical option at any time after October 19, 2012 and are no longer enrolled in the EPO option, you will no longer be eligible to re-enroll in the EPO option.

If you are enrolled in the EPO option at retirement and you are eligible for retiree medical coverage under the Plans, then you and your eligible dependents may remain continuously enrolled in the EPO option if:

- You and your eligible dependents remain continuously eligible for the Plans;
- You are enrolled in the EPO option; and
- You are not Medicare-eligible.

For details regarding the benefits provided, including cost sharing, contact the Verizon Benefits Center for a copy of the EPO summary of coverage. In addition, you should know that the following copay amounts will apply for in-network care:

- Copay for an office visit to a primary care provider (including an OB-GYN) will be no greater than $20.
- Copay for a specialist office visit will be no greater than $25.
- Copay for an emergency room visit will be no more than $75.
- Copay for inpatient hospital admissions will be no more than $150.

Additional Details About Your Benefits

For details regarding your EPO benefits and cost sharing, contact the Verizon Benefits Center or your EPO directly and request a summary of coverage/insurance. This document will be provided to you free of charge upon request.

Other Benefits

Reimbursement of Medicare Premiums

Medicare Part B reimbursement is available to retired associates (and enrolled spouses if the retired associate retired prior to January 1, 1990). To qualify for reimbursement, Medicare must be your primary plan, as defined under “Medicare Advantage Plans (Medicare Advantage HMOs)” in the “Health Maintenance Organizations (HMOs) and Medicare Advantage Plans” section. For example, Medicare is primary for those with end-stage renal disease after the first 30 months of Medicare coverage. Contact the Verizon Benefits Center for more information.

You are not eligible for reimbursement if you were hired by Verizon or an affiliated company on or after the “return to work” dates applicable to the 1989 work stoppage.

Laser Vision Correction (LASIK) Discount

Davis Vision provides you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at discounts of up to 25% off a participating provider’s normal charges, or 5% off any advertised special (please note that some providers have flat fees equivalent to these discounts). Please check the discount available to you with the participating provider. For more information, please call Davis Vision at 1-877-999-7006 or online at www.davisvision.com.

Continuing Coverage If Eligibility Ends

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

Important Note
If you have questions about the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or wish to enroll, contact the Verizon Benefits Center. You can access COBRA information via the BenefitsConnection website.

Continuation of Coverage Under COBRA

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

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

Coverage continuation is available in the following situations:

- **If you, your covered spouse (or same-sex domestic partner) or dependent child loses coverage** under the Plan, **or there is a substantial reduction in coverage** under the Plan, because of Verizon's bankruptcy, special rules may allow coverage to be continued for a certain period.

- **If your covered spouse (or same-sex domestic partner) or dependent child becomes ineligible for coverage** under the Plan because you become legally separated or divorced, your same-sex domestic partner relationship ends or you die, your spouse (or same-sex domestic partner) or children will have the opportunity to continue coverage for up to **36 months from the date coverage would otherwise have ended**.

- **If your dependent child becomes ineligible for coverage** under the Plan because of that child's age or you die, your dependent child can continue Verizon coverage for up to **36 months from the date coverage would otherwise have ended**.

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

Note: If the Company's health care coverage changes during the period that your spouse or your dependents are continuing coverage, the changes apply to their COBRA coverage as well.

Notification Requirements

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

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

Paying for Continued Coverage

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

How Continued Coverage Could End

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

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

If You Have Questions

If you have questions about COBRA or wish to enroll, contact the Verizon Benefits Center. You can access COBRA information via the BenefitsConnection website. You can also call your COBRA administrator via the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

When You Become Eligible for Medicare

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

General Information About Medicare

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

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

- **Part A** covers hospitalization and similar services. If you are receiving Social Security benefits when you turn age 65, you are automatically enrolled in Part A. If you are age 65 or close to age 65 and have not begun receiving Social Security benefits, you must apply for Part A. (If you're not applying for Social Security benefits, you can enroll separately in Medicare benefits.)

- **Part B** covers outpatient and doctors' visits, as well as many other services. You pay a small monthly premium for Medicare Part B, which will be deducted from your social security check.

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

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

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

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

Reimbursement of Medicare Part B Premiums

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

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

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

Medicare-Eligible Participants and Prescription Drug Coverage

The primary prescription drug coverage offered to Medicare-eligible retirees and dependents is a Verizon-sponsored Medicare Part D plan. If you enroll in either Medicare Part D, including Verizon-sponsored Medicare Part D coverage, or creditable prescription drug coverage and maintain such coverage as long as you are Medicare Part D eligible, you will not be subject to a late enrollment penalty if you later enroll in a Medicare Part D plan that is not sponsored by Verizon. To avoid or reduce a Medicare Part D late enrollment penalty, you should consider enrolling in the Verizon-sponsored Medicare Part D plan or a creditable prescription drug coverage option. (A prescription drug coverage option is "creditable," if, on average for all plan participants, it is expected to pay out as much as standard Medicare prescription drug coverage pays.)

Starting with the end of the last month that you are first eligible to join a Medicare Part D drug plan but do not join (i.e., generally once you are eligible for Medicare Part A and/or Part B), if you go 63 continuous days or longer without Medicare Part D coverage or other prescription drug coverage that's creditable, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D or creditable prescription drug coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium if you later enroll in Medicare Part D. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage.

If you enroll in a prescription drug option through a Medicare Advantage HMO, you should confirm at the time of enrollment whether the prescription drug coverage is Part D or is creditable coverage. A notice is not required to be issued if the coverage is Part D and confirming the creditable status of the Medicare Advantage HMO will help you avoid a late enrollment penalty if you later enroll in Medicare Part D.

Medicare and the Coordination of Benefits

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

- A covered person who is eligible for or entitled to Medicare because of end-stage renal disease. In this case, Medicare will be the secondary plan and the Verizon-sponsored medical plan will be primary for the first 30 months of Medicare eligibility or entitlement. After the first 30 months of Medicare eligibility or entitlement because of end-stage renal disease, Medicare will become the primary plan and the Verizon-sponsored medical plan will become secondary.

- For all other persons entitled to Medicare, Medicare is primary and the Verizon-sponsored medical plan is the secondary plan. Benefits are coordinated as follows:

  — The Verizon-sponsored medical plan determines the benefit amount it would pay if there were no other coverage, and then subtracts any benefits payable under Medicare.

  — The Verizon-sponsored medical plan takes into account the benefits you are or would be eligible to receive from both Medicare Parts A and B.

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

A note about Medicare Parts C and D:

- **Medicare Part C** allows for Medicare Advantage plans, which are alternative systems of health care that combine delivery of care and payment to promote cost-effective health care. Verizon may offer a Medicare Advantage plan from time to time. A monthly premium may apply.

- **Medicare Part D** provides prescription drug coverage. Verizon offers you an employer-sponsored Medicare Part D plan, sometimes referred to as an employer group waiver plan (EGWP) plus supplemental wrap. If you decide to enroll in Part D through the individual market, you will be disenrolled from Verizon-sponsored Part D coverage (and your Verizon-sponsored medical coverage) – you cannot be enrolled in Part D through Verizon and through another Part D plan in the individual market.

For more information about Medicare, contact the Social Security Administration.

Coordination of Benefits

How Coordination Works

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

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

When the Medical Plan or the Alternate Choice Plan is primary, it pays benefits up to the limits described in this SPD. When the Medical Plan or the Alternate Choice Plan is secondary, the claims administrator for this Plan subtracts the primary plan's payment from the actual amount charged. The Plan's secondary payment and the primary plan's payment, added together, will never exceed the amount of actual charges (100 percent). (Under the HCN or MEP-HCP options, benefits for covered services or supplies received on an in-network basis or from a PPO provider will not exceed the applicable NNF.) The Verizon claims administrator pays the lesser of what would have been paid if the Verizon plan was primary, or the difference between the actual charge and amount paid by the primary plan. If you have coverage through a Health Maintenance Organization (HMO), the reasonable cash value of each service provided under the Alternate Choice Plan will be deemed the benefit paid for purposes of the COB provisions of the Alternate Choice Plan.

Priority of Payment

Under the Medical Plan's or the Alternate Choice Plan's COB provisions, the order of payment is as follows:

- A plan that covers a patient as an active, inactive or former associate pays before a plan that covers the patient as a dependent.

- For a dependent child, Verizon uses the "birthday rule." This means that if a child is covered by both parents' group medical coverage, the parent whose birthday falls first during the calendar year pays benefits first. So, if the mother's birthday is April 27 and the father's birthday is October 23, the mother's plan pays benefits first. The parents' age has no effect on whose plan pays benefits first. If, however, the plan covering the parent who is not a plan participant does not use the birthday rule, then that plan (not the Verizon plan) pays benefits first.

- In the case of a divorce or separation, the plan of the parent with court-ordered financial responsibility for the dependent child pays benefits for the child first. If there is no court order establishing financial responsibility or if both parents have joint legal custody, the plan of the parent with physical custody of the child pays first. If the court order provides they have joint physical custody, the birthday rule applies.

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

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

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

See “Medicare and the Coordination of Benefits” in the “When You Become Eligible for Medicare” section for information for those eligible for Medicare.

Subrogation and Third-Party Reimbursement

If you recover any charges for covered expenses from a third party (for example, as a result of a lawsuit from an automobile accident), the Medical Plan’s and Alternate Choice Plan’s provision for subrogation and reimbursement takes effect.

Under these procedures, the claims administrator’s subrogation vendor tries to recover money that has been paid (or should be paid) on behalf of a third party (the other driver, in this example) whose negligence or wrongful actions caused illness or injury to a Plan participant.

In this example of a car accident, should the Plans provide benefits because of your accident, the Plans have the right to recover the amount of these benefits from the negligent person or by obtaining a reimbursement from that person’s insurance company – or from you if settlement amounts have been paid to you by the negligent person or his or her insurer.

If you are a covered person under a self-insured plan option, you can contact the subrogation vendor directly with questions. If you are a covered person under an insured plan option, you can contact the claims administrator with questions.

The subrogation and reimbursement provisions also mean that if you make a liability claim against a third party after you have received benefits from the Medical Plan or the Alternate Choice Plan, you must include the amount of those benefits as part of the damages you claim. If the claim proceeds to a settlement or judgment in your favor, you must reimburse the Plan for the benefits you received. You and your dependents must grant a lien to the Medical Plan or the Alternate Choice Plan, and you and your dependents must assign to the Plan any benefits received under any insurance policies or other coverages.

As a condition of eligibility for benefits, you and your dependents must agree to cooperate with the claims administrator’s subrogation vendor in carrying out the Medical Plan’s or the Alternate Choice Plan’s subrogation and reimbursement rights. Cooperation means you must respond promptly and fully with inquiries from the claims administrator’s subrogation vendor and take what action the claims administrator’s subrogation vendor requests to help recover the value of benefits provided under the Plan. If you don’t, any amounts which could have been recovered through subrogation may be deducted from future Medical Plan or Alternate Choice Plan payments.

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

The Medical Plan or the Alternate Choice Plan is not responsible for your legal costs.

Right of Recovery

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

Additional Information

Claims and Appeals Procedures

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

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

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

Claims Regarding Eligibility to Participate in the Plans

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

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

Verizon Claims Review Unit
P.O. Box 8998
Norfolk, VA 23501-8998

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

Verizon Benefits Center
Attn: Verizon Claims Review
P.O. Box 8998
Norfolk, VA 23501-8998

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

Claims Regarding Scope/Amount of Benefits Under the Plans

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

Coverage	Claims and Appeals Administrators
Health Care Network (HCN) Option (For hospital, surgical, medical and mental health care/substance abuse treatment benefits)	Anthem Blue Cross and Blue Shield
MEP Health Care PPO (MEP-HCP) Option (For hospital, surgical, medical and mental health care/substance abuse treatment benefits)	Anthem Blue Cross and Blue Shield
Prescription Drug Program	Express Scripts

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

The addresses of the claims and appeals administrators for the Medical Plan are listed under "Benefits Administrators" in the "Administrative Information" section. If you have a claim or appeal, you should contact the appropriate claims and appeals administrator for the type of claim or appeal you have.

The claims and appeals administrators have discretionary authority to:

- Interpret the Plans based on their provisions and applicable law and make factual determinations about claims arising under the Plans.
- Determine whether a claimant is eligible for benefits.
- Decide the amount, form and timing of benefits.
- Resolve any other matter under the Plans that is raised by a participant or a beneficiary, or that is identified by either the claims or appeals administrator.

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

If a Benefit Is Denied

The claims and appeals procedure applicable to medical, including prescription drug, benefits is explained here under this "If a Benefit Is Denied" section of this SPD. If you enroll in a non-grandfathered, medical option such as the HCN or MEP-HCP, the Affordable Care Act offers you an independent, external review for certain 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 15 months of the receipt of service or onset of illness or injury, whichever is later, or your claim will be denied.

The claims and appeals procedures are 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.[1] It typically will include your initial request for benefits.

Note: If you are enrolled in a fully-insured medical option, such as an HMO, the procedures may vary slightly from this summary. Upon request, the insurer will notify you of its specific process.

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 additional treatments that have been approved.

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

[1] A benefit claim includes a rescission (e.g., retroactive termination) of coverage.

Under the Affordable Care Act, medical benefit claims (not eligibility claims[2]) offered under a non-grandfathered health plan and first filed on or after January 1, 2013 are eligible for an external review (Step 3 of the claims and appeals process) by an independent review organization (IRO). To be eligible for the external review, the medical benefit claim must involve medical judgment[3] excluding claims that involve only contractual or legal interpretation without any use of medical judgment as determined by the external reviewer. You will be provided with information regarding this new external review if you receive a final internal adverse benefit determination (i.e., your claim is denied after completing Step 2 of the claims and appeals process). You cannot request an external review unless you have exhausted the internal claims and appeals process and receive a final adverse benefit determination.

Following is a summary of the claims and appeals procedure that generally applies to all Verizon non-grandfathered medical plan options. The claims administrator will be able to provide you with more details regarding this process specific to your medical or prescription drug plan option. The claims fiduciary must comply with this process or you may be entitled to argue that the process has been exhausted. If you believe that the claims fiduciary has violated this process, you may write to the Verizon Claims Unit or the claims administrator, and they must respond with an appropriate explanation within 10 days.

References to "you" refer to the claimant, including his or her authorized representative.

[2] An eligibility claim is a claim to participate in a plan or plan option or to change an election to participate during the year. The only eligibility-type claim eligible for the IRO is a rescission.

[3] An adverse benefit determination is eligible for the external review if it involves medical judgment (i.e. the Plan's requirements for medical necessity, health care setting, level of care, or effectiveness of a covered benefit or involves a determination that a treatment is experimental or investigational. It also includes rescissions (a retroactive termination of coverage).

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
Internal Claims (Internal Benefit Determination) – Step 1:				
How to file a claim To file an **eligibility claim**, request a Claim Initiation Form from the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367). You (or your authorized representative) must return the form to the address on the form. To file a **benefit claim**, you (or your authorized representative, including your provider) should write to the medical or prescription drug Plan administrator (e.g., Anthem or Express Scripts) (the "claims administrator"). Refer to the "Claims and Appeals Administrators" section for claims administrator contact information. 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 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 Claims Unit's or the claims administrator's receipt of your Claim Initiation Form or the health plan's receipt of your claim letter. If your claim is denied, it is referred to by ERISA as an adverse benefit determination.	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

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
Failure to provide sufficient information procedure If you fail to provide sufficient information, the claim may be decided based on the information provided. If the Verizon Claims Unit or the claims administrator decides to request additional information before deciding the claim, you will be notified 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 involved urgent care; see urgent care time frame.	24 hours
If the administrator does not deny the claim based on lack of sufficient information, you will have **(see columns to the right)** from receipt of the notice 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 Verizon Claims Unit or claims administrator 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 (benefit determination) is approved**, the Verizon Claims Unit or the claims administrator will notify you in writing. For benefit claims, if this notification is provided in writing, it is commonly referred to as an explanation of benefits or EOB. **If your claim is denied (adverse benefit determination),** in whole or in part, the Verizon Claims Unit or the claims administrator will notify you in writing, except for urgent care. Your denial notice will contain: • The specific reason(s) for the denial. • The Plan provisions on which the denial was based. • Information sufficient to identify the claim involved (date of service, the health care provider, claim amount [if applicable], and upon request, the availability of the diagnosis and treatment codes and their corresponding meanings). • 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. • The availability of and contact information for any office of health insurance consumer assistance or ombudsman available to assist with the appeals process. Your notice will be written in a culturally and linguistically appropriate manner. Depending on where you live, you may be able to receive the denial notice in Spanish, Tagalog, Chinese or Navajo. In addition: • If the Verizon Benefits Center or the claims administrator relies on new evidence to deny your claim, you will be notified in advance, free of charge, with the rationale so that you can respond in advance of the final internal adverse benefit determination. • You have a right to review your claim file.				If your claim is denied, the Verizon Claims Unit or claims administrator will notify you by telephone. Within 3 days of the 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.

Internal Appeals (Benefit Determinations on Review) -- 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 VCRC has delegated its authority to finally determine claims to the claims administrators for Benefit claims. The vast majority of claims administrators have accepted the responsibility of being the claims fiduciary. If the claims administrator has not, you will be notified in your claim denial notice, which will ask you to appeal with the VCRC.

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 (adverse benefit determination). You may request access, free of charge, to all documents relating to your appeal. You should write to the party identified in your claim denial notice (adverse benefit determination) and include: • A copy of your claim denial notice. • The reason(s) for the appeal. • Relevant documentation.	180 days	180 days	180 days	180 days You may orally file your appeal with the Verizon Claims Unit for eligibility-related claims or with the claims administrator (e.g., the claims and appeals fiduciary) for benefit-related claims. At the time your claim is denied, the Verizon Claims Unit or claims administrator, as applicable, will give you instructions about how to file your appeal. You must identify that you are appealing an urgent care claim.
The individual/committee (and any medical expert) reviewing your appeal will be independent from the individual/committee who reviewed your initial claim. In addition, if your appeal involves a medical judgment, the claims administrator will consult with a health care professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request.				

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 VCRC's or claims administrator's receipt of your appeal.	**Eligibility appeals:** 60 days **Benefit appeals**: • 60 days if VCRC / claims administrator provides 1 level of mandatory appeal. • 30 days, if claims administrator provides 2 levels of mandatory appeal.	**Eligibility appeals**: 30 days **Benefit appeals**: • 30 days, if VCRC / claims administrator provides 1 level of mandatory appeal. • 15 days, if claims administrator provides 2 levels of mandatory appeal.	**Eligibility and benefit appeals:** Before a reduction or termination of benefits would occur (the claims administrator may respond within 72 hours). If the concurrent care claim involves urgent care, 72 hours.[4]	**Eligibility and benefit appeals:** 72 hours[4]

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

If your appeal is **denied (final internal adverse benefit determination)**, in whole or in part, your denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.
- Information sufficient to identify the claim involved (date of service, the health care provider, claim amount [if applicable], and upon request, the availability of the diagnosis and treatment codes and their corresponding meanings).
- A statement regarding the documents to which you are entitled, upon request and free of charge.
- 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).
- Information pertaining to your right to an external review (and if applicable, any second level internal appeal).
- The availability of and contact information for any office of health insurance consumer assistance or ombudsman available to assist with the appeals process.
- A statement of your right to bring a civil action under Section 502(a) of ERISA.

Your notice will be written in a culturally and linguistically appropriate manner. Depending on where you live, you may be able to receive the denial notice in Spanish, Tagalog, Chinese or Navajo.

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

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
External Review -- Step 3:				

If you receive a final internal adverse benefit determination with respect to your medical benefit claim/appeal, you have the right to file an external review. **Only** medical benefit claims/appeals are eligible for an external review, including rescissions as explained above.

Your claim will be reviewed de novo (afresh or anew) by an IRO, if it's eligible for the external review. The IRO is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Standard external review
You may request a Standard External Review within four months after the date of receipt of notice of an adverse benefit determination or final internal adverse benefit determination.

Expedited external review
You may make a request for an expedited external review at the time you receive:

- **An internal adverse benefit determination** if the determination involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A **final internal adverse benefit determination**, if (1) you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function; or (2) the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
Preliminary review Within **(see columns to the right)** following receipt of the request, the claims administrator must complete a preliminary review of the request to determine whether: • You were covered under the Plan at the time the medical care, item, or service was requested; • The adverse benefit determination does not relate to your failure to meet the eligibility requirements under the terms of the Plan, except for a rescission (again, external review generally does not apply to eligibility-type requests or claims); • You have exhausted the Plan's internal appeal process; and • You have provided all the information and forms required to process the external review.	5 business days	5 business days	5 business days Immediately if the concurrent care claim involves urgent care.	Immediately

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
Issue written notice to claimant The claims administrator is required to issue a written notice and explain its preliminary review determination within **(see columns to the right)**: • If the request is eligible for external review, the claims administrator on behalf of the Plan must assign the review an IRO. • If the request is incomplete, the notice must state what is needed to complete the request for external review. • If the request is complete but not eligible for external review, the notice must state the reasons for ineligibility and provide EBSA's contact information (1-866-444-EBSA [3272]).	1 business day ***If a request is incomplete, claimant*** must provide required information within the 4-month filing period or 48 hours following notice, whichever is later.	1 business day ***If a request is incomplete, claimant*** must provide required information within the 4-month filing period or 48 hours following notice, whichever is later.	1 business day Immediately if the concurrent care claim involves urgent care.	Immediately
Provide IRO with all documentation The claims administrator must provide the IRO any documents and information considered in making the adverse benefit determination within **(see columns to the right)** after the date of assignment.	5 business days	5 business days	5 business days If the concurrent care claim involves urgent care, refer to "Expedited external review."	Refer to "Expedited external review."

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
Provide claimant with written notice of acceptance of external review request The IRO must provide you written notice of acceptance of external review request within **(see columns to the right)** and include a statement that you may submit additional information in writing within 10 business days to be considered by the IRO. Upon receipt of additional information, the IRO has 1 business day to forward the information to the claims administrator.	Timely	Timely	Timely If the concurrent care claim involves urgent care, refer to "Expedited external review."	N/A
Reconsider adverse benefit determination Upon the IRO's receipt of any information submitted by you, the IRO must forward the information to the claims administrator. The claims administrator may then **reconsider its adverse benefit determination**, but will not delay the external review. If the claims administrator **reverses** its decision, they must notify you and the IRO within **(see columns to the right) following the decision** and the IRO must terminate the external review. The amount of time that it takes to review and reverse a decision may vary by claims administrator. For Express Scripts Inc., it is 72 hours.	1 business day following decision	1 business day following decision	1 business day following decision If the concurrent care claim involves urgent care, refer to "Expedited external review."	Refer to "Expedited external review."

General procedure	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
When you will be notified of the external appeal decision The IRO must provide (oral or written) notice of the final external review decision to you and the claims administrator within **(see columns to the right)** after the IRO receives the request for external review.	**Written notice:** 45 days	**Written notice:** 45 days	**Written notice:** 45 days **Oral notice:** 72 hours, if the concurrent care claim involves urgent care. If the initial notice is not in writing, the IRO must provide written confirmation of decision to the claimant and the claims administrator within 48 hours.	**Oral notice:** 72 hours If the initial notice is not in writing, the IRO must provide written confirmation of decision to the claimant and the claims administrator within 48 hours.
IRO external review decision notice The decision notice must include: • General description of the reason for the request for external review, including sufficient information to identify the claim (i.e., date[s] of service, health care provider, claim amount (if applicable), diagnosis, and treatment codes and their meaning, and the reason for the previous denial); • Date IRO received the assignment to conduct the external review and the date of the IRO's decision; • References to evidence or documentation, including specific coverage provisions and evidence-based standards considered; • Discussion of the principal reason(s) for its decision, including rationale and any evidence-based standards relied upon; • Statement that the determination is binding except to the extent other remedies may be available under state or federal law to either the Plan or to the claimant; • Statement that judicial review may be available to the claimant; and • Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.				
If IRO reverses claims administrator's decision The claims administrator must provide coverage or payment for the claim within **(see columns to the right)**	Immediately	Immediately	Immediately	Immediately

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plans, 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 Plans, 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 Plans' annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue group health care coverage for yourself, your spouse or your 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 your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions 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, 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. (See the "When Participation Ends" section for more information.)

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare 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 them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits which 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 medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plans, 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.

Your Maternity Rights (Newborns' and Mothers' Health Protection Act)

Verizon complies with the Newborns' and Mothers' Health Protection Act. The following notice legally applies to you:

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.

Summary Health Information Required by the Patient Protection and Affordable Care Act

As required by the Affordable Care Act, Summaries of Benefits and Coverage (SBCs) are available on the BenefitsConnection website at: www.verizon.com/benefitsconnection. If you would like a paper copy of the SBCs (free of charge), you may contact the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

Verizon is required to make SBCs, which summarize important information about health benefit plan options in a standard format, available to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family in the case of illness or injury, and choosing a health benefit option is an important decision. SBCs are available in addition to other Plan information on BenefitsConnection. Click on See My Medical Plan Provisions and select My Medical Plan Options.

Consumer Protections Under the Affordable Care Act

Preventive Care

The Verizon medical options available to you are not grandfathered and accordingly, these medical options must offer certain preventive care benefits to you in-network without cost-sharing. Under the Affordable Care Act, the medical plans generally may use reasonable medical management techniques to determine frequency, method, treatment, or setting for a recommended preventive care service.

The preventive care items and services that must be provided under the Affordable Care Act to you with no cost sharing if provided in-network can be found at:
http://www.hhs.gov/healthcare/prevention/index.html

For 2015, an additional update has been made to the preventive care benefits that must be offered without cost sharing. Specifically, if you are a woman who is at increased risk for breast cancer and at low risk for adverse medication effects, you may be eligible to receive risk reducing medications, such as tamoxifen or raloxifene, in-network without cost sharing under the Verizon medical/ prescription drug plan options. If your physician prescribes this type of medication to reduce your risk of breast cancer, contact Express Scripts (or your medical/prescription drug plan administrator) to ensure that you satisfy the administrative requirements necessary to receive this important benefit. You may be required to meet requirements beyond just submitting the prescription – for example, you and/or your physician may need to demonstrate that you are at an increased risk for breast cancer. Again, contact the Verizon medical plan option or prescription drug plan administrator, such as Express Scripts, for more details.

In-Network Out-of-Pocket Maximum

Effective as of January 1, 2014, the Affordable Care Act requires that Verizon ensure that your in-network out-of-pocket maximum meet specific requirements. In 2014, your total in-network out-of-pocket costs (including medical plan copays, but not prescription drugs) under the medical plan options available to you will not exceed $6,350 for individual coverage and $12,700 for family coverage. In 2015, your total in-network out-of-pocket costs under the medical plan options available to you will not exceed $6,600 for individual coverage and $13,200 for family coverage.

The maximum imposed by the Affordable Care Act does not change your bargained for out-of-pocket maximum, but creates a separate legally required limit on in-network out-of pocket costs, which requires that additional costs (such as copays and in 2015, prescription drug expenses[1]) count toward these limits even if they do not apply toward your bargained for out-of-pocket maximum. Costs that apply toward your total in-network out-of-pocket maximum include, for example, deductibles, copays, coinsurance, and in 2015, eligible prescription drug expenses.[1] Out-of-pocket expenses that do not apply toward your in-network out-of-pocket maximums include, for example, premium contributions, spending for non-covered items and services, out-of-network items and services, and the additional cost if you purchase a brand name prescription drug in a situation where a generic drug was available and medically appropriate as determined by your physician. Please refer to your Health Plan Comparison Charts on the BenefitsConnection website for more details.

If you are a Medicare-eligible retiree who participates in the Verizon-sponsored Medicare Part D Plan (PDP), prescription drug expenses will **not** apply towards this extra layer of out-of-pocket cost protection under the Affordable Care Act.

Provider Nondiscrimination

Effective as of January 1, 2014, the Plan will not discriminate against an eligible health care provider based on his or her license or certification to the extent the provider is acting within the scope of his or her license or certification under state law. This rule is subject to certain limitations and does not require the Plan to accept all types of providers into a network.

The U.S. Department of Labor is contemplating the application of these consumer protections (also known as group market reforms) to employer-sponsored Medicare Part D plans, such as Verizon's. If you are Medicare-eligible and have questions regarding the application, of these consumer protections on the Verizon-sponsored Medicare Part D Plan, contact Express Scripts.

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.

[1] Eligible prescription drug expenses do not apply towards this legally required out-of-pocket maximum for participants enrolled in the Verizon-sponsored Medicare Part D Plan.

- Prostheses.

- Treatment of physical complications at all states 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 option.

For more information on mastectomy coverage, call the Verizon Benefits Center or the Member Services Department of your HMO, PPO or EPO.

HIPAA Privacy Rights

The information provided in the notice that follows is required under the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA Privacy Notice

NOTICE OF PRIVACY PRACTICES FOR THE VERIZON COMMUNICATIONS INC. HEALTH PLANS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

I. Background Information and Effective Date

The Department of Health and Human Services published a final regulation addressing the privacy of Protected Health Information (as defined in section III below) in August of 2002 (the "Privacy Rule"). As a result, the Verizon Communications Inc. ("Verizon") health plans listed in section II below will have to comply with the Privacy Rule, effective April 14, 2003 (the "Effective Date"). This Notice, which is required by the Privacy Rule, is effective on the Effective Date.

II. Plans on Behalf of Which this Notice is Being Provided

For purposes of this Notice, the term "Verizon Health Plans" has special meaning. This Notice applies to the following Verizon plans, which collectively are referred to in this Notice as the "Verizon Health Plans:"

- Verizon Dental Expense Plan for New York and New England Associates (EIN: 23-2259884, PIN: 505)
- Verizon Medical Expense Plan for New York and New England Associates (EIN: 23-2259884, PIN: 556)
- Verizon Vision Care Plan for New York and New England Associates (including VDT Eyecare Program) (EIN: 23-2259884, PIN: 570)
- Verizon Post-1995 Collectively Bargained Retiree Health Plan (Pre-1993 Retirees) (EIN: 23-2259884, PIN: 567)

- Verizon Post-1995 Collectively Bargained Retiree Health Plan (Post-1992 Retirees) (EIN: 23-2259884, PIN: 576)

In addition, in the event you are covered by an insured health plan, your insurer will be providing you with a separate notice that describes the insurer's use and disclosure of your Protected Health Information.

III. Health Information to Which this Notice Applies

This Notice 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 health care 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 health care to you;
  - Your past, present, or future physical or mental condition; or
  - The past, present, or future payment for your health care.

This includes any of the following documentation, if the documentation reveals your identity and your health status or payment issues: medical records (such as hospital charts or doctor's notes); medical bills (such as bills for hospital or doctor's services); claims data (such as data on claims payments made by one of the Verizon Health Plans on your behalf); and insurance payment information (such as an Explanation of Benefits).

IV. Uses and Disclosures of Protected Health Information by the Verizon Health Plans

The Verizon Health Plans may use or disclose your Protected Health Information for purposes of making or obtaining payment for your health care, for purposes of conducting health care operations, or for certain other specified purposes. The Verizon Health Plans have established a policy to guard against unnecessary uses and disclosures of your Protected Health Information.

The purposes for which your Protected Health Information may be used and disclosed by the Verizon Health Plans may be summarized as follows:

A. To Make or Obtain Payment for Health Care

The Verizon Health Plans may use or disclose your Protected Health Information to make payment for, or to obtain or facilitate payment of, your health care claims. Payment for health care includes such activities as: making eligibility or coverage determinations; claims management or adjudication; claims appeals determinations; coordination of benefits with another health plan; medical necessity determinations; concurrent or retrospective review of services; utilization review of services; pre-certification or pre-authorization of services; subrogation of claims; billing; determination of cost sharing amounts; risk adjusting based on enrollee health status and demographics; disclosure to consumer reporting agencies; obtaining payment under a contract of reinsurance; and collection activities.

For example, a Verizon Health Plan may provide Protected Health Information regarding your coverage or treatment to other health plans to coordinate the payment of benefits between or among the other plans and the Verizon Health Plan.

B. To Conduct Health Care Operations

The Verizon Health Plans may use or disclose your Protected Health Information to facilitate the administration and operation of the Verizon Health Plans. Health care operations include such activities as: case management and care coordination; conducting or arranging for medical review, auditing, or legal services; population-based activities to improve health or reduce health care costs; contacting providers or patients with information regarding treatment alternatives; clinical guideline and protocol development; reviewing the competence or qualifications of health care professionals and evaluating health plan performance; underwriting and premium rating; fraud and abuse detection; and activities relating to the creation, renewal, or replacement of a health care contract. Pursuant to the provisions of the Genetic Information Nondiscrimination Act of 2008, the Verizon Health Plans do not use or disclose Protected Health Information that is "genetic information" for underwriting purposes as defined under such Act.

For example, a Verizon Health Plan may use Protected Health Information regarding your coverage or treatment for case management to help ensure that appropriate treatment is being provided for your condition.

C. For Treatment Alternatives or Distribution of Health-Related Benefits and Services

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.

D. To Assist Verizon as Plan Sponsor

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.

E. When Legally Required

The Verizon Health Plans may disclose your Protected Health Information when required to do so by any federal, state, or local law.

F. In Connection With Judicial and Administrative Proceedings

The Verizon Health Plans may disclose your Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by the order. The Verizon Health Plans also may disclose your Protected Health Information in the course of any judicial or administrative proceeding in response to a subpoena, discovery request, or other lawful process, but only when the Verizon Health Plan involved receives satisfactory assurance from the party seeking the Protected Health Information that that party made reasonable efforts to either notify you about the request or to obtain an order protecting your Protected Health Information.

G. For Law Enforcement Purposes

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.

H. For Health Oversight Activities

The Verizon Health Plans may disclose your Protected Health Information to a health oversight agency for health oversight activities authorized by law, including: audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of the health care system, certain government benefit programs, certain entities subject to government regulatory programs, or certain entities subject to civil rights laws. The Verizon Health Plans may not disclose your Protected Health Information if you are the subject of an investigation and the investigation does not arise out of and is not directly related to your receipt of health care or public benefits.

I. In the Event of a Serious Threat to Health or Safety

Under certain circumstances, the Verizon Health Plans may, consistent with applicable law and standards of ethical conduct, use or disclose your Protected Health Information if the Verizon Health Plans, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or to the health or safety of the public.

J. For Specified Government Functions

Under certain circumstances, the Verizon Health Plans may use or disclose your Protected Health Information to facilitate specified government functions related to: the military and veterans; national security and intelligence activities; protective services for the President of the United States and others; or correctional institutions and inmates.

K. For Public Health Activities

The Verizon Health Plans may disclose your Protected Health Information for public health activities, such as to assist public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other public health activities as specified in the Privacy Rule.

L. For Disaster Relief Purposes

Under certain circumstances, the Verizon Health Plans may use or disclose your Protected Health Information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

M. In Connection with Decedents

The Verizon Health Plans may disclose your Protected Health Information to funeral directors or coroners to enable them to carry out their lawful duties.

N. For Workers' Compensation Purposes

The Verizon Health Plans may disclose your Protected Health Information to the extent necessary to comply with laws related to Workers' Compensation or similar programs established by law that provide benefits for work-related injuries or illnesses without regard to fault.

O. For Involvement In, and Notification Of, Your Care

The Verizon Health Plans may use or disclose your Protected Health Information to your relatives or other persons you identify who are involved in your care or payment for your care, or to notify family members or others responsible for your care of your condition or location. In these situations, when you are present and not incapacitated, the Verizon Health Plans will either: (1) provide you with an opportunity to disagree to the use or disclosure and, if you do not disagree, your Protected Health Information may be used or disclosed; or (2) obtain your agreement to the use or disclosure.

P. To Assist Victims of Abuse, Neglect, or Domestic Violence

The Verizon Health Plans may, under certain circumstances, disclose Protected Health Information about individuals who are reasonably believed to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive such reports.

Q. For Cadaveric Organ, Eye, or Tissue Donation

The Verizon Health Plans may use or disclose Protected Health Information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye, or tissue donation and transplantation.

R. For Certain Government-Approved Research Activities

The Verizon Health Plans may use or disclose Protected Health Information about you for research as provided under the Privacy Rule.

S. To Other Covered Entities

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

T. With an Authorization

Other than as stated above, 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 will no longer 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 has already made prior to the date the Verizon Health Plan receives notice of the revocation.

V. Your Rights Regarding Your Protected Health Information

You have the following rights regarding the Protected Health Information retained by a Verizon Health Plan:

A. Right to Request Restrictions

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 health care operations.
- Certain uses and disclosures for disaster relief and other notification purposes and for involvement in your care.

If you make a request to a Verizon Health Plan for a restriction as described above, the Verizon Health Plan is not required to agree to such a restriction in certain situations.

However, the Verizon Health Plan must comply with your requested restriction if: (1) except as otherwise required by law, you request a restriction on the disclosure to a health plan of your Protected Health Information for payment or health care operations; and (2) the Protected Health Information relates solely to a health care item or service for which a health care provider has been paid out of pocket in full.

If you wish to make a request for a restriction, please make a request in writing to the privacy contact identified in paragraph IX below. Your request should include the following: (1) what uses and/or disclosures you want to limit; and (2) to whom you want the restriction to apply (for example, disclosures to your spouse).

B. Right to Receive Confidential Communications

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. For example, you may ask that a Verizon Health Plan only communicate with you at a certain telephone number. If you wish to receive confidential communications, please make your request in writing to the privacy contact identified in paragraph IX below. Your request must be reasonable and should include the following: (1) an alternative address or other means of contacting you; and (2) a statement that the disclosure of all or part of the Protected Health Information to which the request pertains could endanger you. The Verizon Health Plan(s) will attempt to accommodate these requests for confidential communications.

C. Right to Inspect and Copy

In general, you have the right to inspect and obtain a copy of your Protected Health Information. If a Verizon Health Plan uses or maintains an electronic health record with respect to your Protected Health Information, you have the right to request and obtain a copy of this information in an electronic format. A request to inspect or obtain a copy of your Protected Health Information must be made in writing to the privacy contact identified in paragraph IX below and must include: (1) the desired form or format of access; (2) a description of the Protected Health Information to which the request applies; and (3) appropriate contact information. If you request a copy of your Protected Health Information, you may be charged a reasonable fee for the costs of copying, postage, and other supplies associated with your request. Under very limited circumstances, your request to inspect or obtain a copy of your Protected Health Information may be denied. In most cases, if your request is denied, you may request a review of the denial in accordance with the privacy complaint procedure, a copy of which can be obtained from the privacy officer in care of the Verizon HIPAA Unit at the address in paragraph IX below.

D. Right to Amend

If you believe that Protected Health Information a Verizon Health Plan has about you is inaccurate or incomplete, you may ask that Verizon Health Plan to amend that Protected Health Information. You have the right to request an amendment for as long as the Protected Health Information is kept by the Verizon Health Plan.

A request to amend your Protected Health Information must be made in writing to the privacy contact identified in paragraph IX below. The request to amend must include the name of the Verizon Health Plan(s) to which the request applies, a description of the amendment requested, and a reason to support the request.

Your request for an amendment may be denied if you request an amendment of Protected Health Information that the Verizon Health Plan determines: (1) was not created by the Verizon Health Plan, unless the originator of the Protected Health Information is no longer available to make the amendment; (2) is not part of the Verizon Health Plan's records; (3) is not Protected Health Information that you would be permitted to inspect or copy; or (4) is accurate and complete.

If your request is denied, you may request a review of the denial in accordance with the privacy complaint procedure, a copy of which can be obtained from the privacy officer in care of the Verizon HIPAA Unit at the address in paragraph IX below.

E. Right to an Accounting of Disclosures

You have a right to request a list of the disclosures made by a Verizon Health Plan of your Protected Health Information. The list will not include the following types of disclosures: (1) disclosures to you of your own Protected Health Information; (2) disclosures for purposes of payment and health care operations; (3) disclosures you authorize; (4) disclosures to persons involved in your care or for disaster relief or other notification purposes; (5) disclosures for national security, intelligence, or law enforcement purposes; (6) disclosures that are part of a limited data set, as defined in the Privacy Rule; or (7) disclosures that are incident to a use or disclosure otherwise permitted or required by the Privacy Rule.

A request for an accounting must be made in writing to the privacy contact identified in paragraph IX below. The request must specify the name of the Verizon Health Plan(s) to which the request applies, as well as the time period for which you are requesting the accounting. The time period for which you request an accounting may not start earlier than the April 14, 2003 Effective Date of the Privacy Rule and may not be for a period of time going back more than six years. The first accounting you request within a 12-month period will be free of charge. For additional accountings within that same 12-month period, you may be charged a reasonable fee for the costs of providing the accounting. You will be notified in advance of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

F. Right to Receive a Paper Copy of this Notice

You have the right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously or agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

VI. Other Obligations of the Verizon Health Plans

In addition to the other obligations set forth in this Notice, the Verizon Health Plans are required to:

- Maintain the privacy of your Protected Health Information in a manner consistent with the Privacy Rule.
- Provide you with this Notice of their legal duties and privacy practices with respect to your Protected Health Information.
- Abide by the terms of this Notice.

When and as required, the Verizon Health Plans will notify you in the event of an impermissible or unauthorized acquisition, access, use, or disclosure of your Protected Health Information, that compromises the security or privacy of such Protected Health Information, under the Privacy Rule.

VII. Changes to this Notice

The Verizon Health Plans reserve the right to change this Notice and to make the revised or changed Notice effective for Protected Health Information the Verizon Health Plans already have about you, as well as for any such information received in the future. If the Verizon Health Plans change any of their privacy policies and procedures, the Verizon Health Plans will revise the Notice as appropriate and will provide a copy of the revised Notice to you within 60 days of the material change. You may also obtain a paper copy of this Notice from the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

VIII. Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the privacy officer in care of the Verizon HIPAA Unit identified in paragraph IX below or with the Secretary of the United States Department of Health and Human Services. All complaints must be submitted in writing. You will not be retaliated against in any way for filing a complaint.

IX. Contact Information

In some cases, your Protected Health Information may be held internally at Verizon by members of the Verizon workforce who perform functions on behalf of the Verizon Health Plans. In most cases, however, your Protected Health Information will be held by privacy contacts, such as the health insurers or health plan option administrators, who pay claims on behalf of one or more of the Verizon Health Plans.

Contact your health insurer or health plan option administrator:

If you have a question, concern, complaint, or request regarding Protected Health Information held by a **health insurer or health plan option administrator**, contact your health insurer or health plan option administrator directly. Contact information for your health insurer or health plan option administrator can be found in your summary plan description, your insurance cards, on the BenefitsConnection website at www.verizon.com/benefitsconnection or by calling the Verizon Benefits Center toll free at 1-855-4VzBens (1-855-489-2367).

Contact the Privacy Officer for the Verizon Health Plans:

If you have a question, concern, complaint, or request regarding Protected Health Information held internally at Verizon, contact the privacy officer for the Verizon Health Plans as follows:

HIPAA Privacy Officer
c/o Verizon HIPAA Unit
P.O. Box 1483
Lincolnshire, IL 60069-1483
(908) 559-3628

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT THE PRIVACY OFFICER DESIGNATED IN PARAGRAPH IX ABOVE.

The Notice of Privacy Practices for the Verizon Communications Inc. Health Plans is available on the BenefitsConnection website at www.verizon.com/benefitsconnection. Generally, the Notice of Privacy Practices for the Verizon Communications Inc. Health Plans available on BenefitsConnection is the most up to date. Once you have logged on to BenefitsConnection, select the Library link from the home page and click on the Benefit Forms tab in order to view the Notice. You may view the Notice on the website and/or print a paper copy from the website. You may also request a paper copy of the Notice at any time by calling the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

Administrative Information

Administrative information about the Plans is provided in this section.

Important Telephone Numbers

You can connect to the Verizon Benefits Center and other Verizon benefit providers by calling the toll-free number 1-855-4VzBens (1-855-489-2367). If you prefer, you can call the benefit providers directly via the telephone numbers shown on your ID card.

Plan Sponsor/Employer

The Plan sponsor/employer is:

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

Plan Administrator

The Plan administrator is:

Chairperson of the VEBC
c/o Verizon Benefits Center
P.O. Box 8998
Norfolk, VA 23501-8998

Telephone number: 1-855-4VzBens (1-855-489-2367) and follow the instructions to reach the Verizon Benefits Center.

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

The Plan administrator (or a person designated by the administrator) has the full and final discretionary authority to publish the Plan document and benefit Plan communications, to prepare reports and make filings for the Plans, and to otherwise oversee the administration of the Plans. However, most of your day-to-day questions can be answered by the Plans' benefits administrator or a Verizon Benefits Center Representative. Do not send any benefit claims to the Plan administrator or to the Verizon legal department. Instead, submit them to the claims administrator for the Plan (see the "Additional Information" section for more information).

Benefits Administrators

The benefits administrators listed below have the authority and responsibility to perform daily administration of benefits under the Plans. You can call the benefits administrators via the telephone number shown on your ID card. See below for the addresses.

If you need a list of participating providers, please contact your benefits administrator. They may direct you to a website, but also will provide you with a list free of charge, upon request.

- Anthem Blue Cross and Blue Shield.

- Express Scripts.

Claims and Appeals Administrators

There are several claims and appeals administrators for the Plans.

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

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

Verizon Claims Review Committee (VCRC)

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

Verizon Claims Review Committee
c/o Verizon Benefits Center
P.O. Box 8998
Norfolk, VA 23501-8998

You can call the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

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

Coverage	Benefits Administrators
Health Care Network (HCN) Option	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 1-855-869-8139
MEP Health Care PPO (MEP-HCP) Option	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 1-855-869-8139
Prescription Drug Program Express Scripts is the claims and appeals administrator for the retail program and the home mail service pharmacy. Express Scripts is responsible for authorizing benefit payments, considering appeals, resolving questions, maintaining records, filing reports and distributing information to Plan participants.	Express Scripts P.O. Box 631850 Irving, TX 75063 Attn: Appeals 1-877-877-1878
Disease Management Program	Anthem Blue Cross Blue Shield P.O. Box 105187 Atlanta, GA 30348 1-866-832-1229
Subrogation vendor	Healthcare Recoveries Attention: Verizon Subrogation Unit P.O. Box 32200 Louisville, KY 40232 1-800-395-5568

HMOs

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

Qualified Medical Child Support Orders (QMCSOs)

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

Verizon Benefits Center
P.O. Box 8998
Norfolk, VA 23501-8998

You can call the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

Plan Funding

Except for certain HMO benefits, an insurance company does not finance the Medical Plan and the Alternate Choice Plan, nor are Plan benefits guaranteed under a contract of insurance. The claims and appeals administrators listed under the “Additional Information” section do not insure or guarantee Plan benefits.

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

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

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

Plan Identification

Medical coverage is provided through the Verizon Medical Expense Plan for New York and New England Associates and the Verizon Alternate Choice Plan for New York and New England Associates, including the Other Plan Provisions of Verizon Covering New York and New England Associates. The Verizon Medical Expense Plan for New York and New England Associates is a welfare plan, which is a group health plan, listed with the Department of Labor under two numbers: the employer identification number (EIN) for the Verizon Medical Expense Plan for New York and New England Associates is 23-2259884 and the plan number (PN) is 556. The Verizon Alternate Choice Plan for New York and New England Associates forms part of the Verizon Medical Expense Plan for New York and New England Associates. The Verizon Medical Expense Plan for New York and New England Associates and the Verizon Alternate Choice Plan for New York and New England Associates are component plans of the Verizon Post-1995 Collectively Bargained Retiree Health Plan (Pre-1993 Retirees) and the Verizon Post-1995 Collectively Bargained Retiree Health Plan (Post-1992 Retirees). The EIN for the Verizon Post-1995 Collectively Bargained Retiree Health Plan (Pre-1993 Retirees) is 23-2259884 and the PN is 567, and the EIN for the Verizon Post-1995 Collectively Bargained Retiree Health Plan (Post-1992 Retirees) is 23-2259884 and the PN is 576.

Plan Year

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

Agent for Service of Legal Process

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

In addition, a copy of the legal process involving the Medical Plan or the Alternate Choice Plan should be delivered to:

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

Legal process also may be served on the trustee.

Official Plan Document

This SPD is a summary of the official Plan documents.

Collective Bargaining Agreements

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

Participating Companies

The following is a list of participating companies as of January 1, 2013. The list may change from time to time.

- Empire City Subway Company (Limited)
- Verizon Advanced Data Inc.
- Verizon Avenue Corp.
- Verizon Corporate Services Corp.
- Verizon New England Inc.
- Verizon New York Inc.
- Verizon Services Corp.

Glossary

A

Accidental Injury
An injury caused by a chance event or unknown causes.

Affordable Care Act
In March of 2010, Congress passed the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act. These new laws are commonly referred to as “Health Care Reform.” For purposes of this SPD, they are collectively referred to as the “Affordable Care Act.”

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

Associated Practitioner
A medical professional whom your PCP has designated to provide patient care in his or her absence.

Attending Physician
The physician who is directing the covered person’s care.

B

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

C

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

Clinically Necessary
To be clinically necessary, services or supplies must meet the following requirements:

- They must be consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or chemical dependency;
- They must be consistent with standards of good clinical practice;
- They must treat the symptoms (i.e., the treatment should not be for the covered person’s convenience or preference or that of the providers); and

- The care must provide the desired results at an adequate level (i.e., the treatment must be the least restrictive and least intrusive level of service that can be safely provided to the covered person).

The claims administrator may consult with professional clinical consultants, peer review committees, or other appropriate sources for recommendations regarding whether particular services, supplies or accommodations provided or to be provided to a covered person are clinically necessary. Services and supplies may not be considered clinically necessary even if a health care provider prescribes them.

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

Coinsurance
The cost sharing percentage that applies for certain services and supplies based on the network negotiated fee (NNF) for in-network care and the maximum allowed amount (MAA) for out-of-network care if you are enrolled in the HCN option or MEP-HCP option.

Copay
A fixed dollar amount you pay for certain services or supplies.

Covered Person
Any retiree and his or her dependents enrolled in the Verizon Medical Expense Plan for New York and New England Associates or the Verizon Alternate Choice Plan for New York and New England Associates, or any eligible individual who has elected coverage under COBRA.

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

Creditable Prescription Drug Coverage
A prescription drug coverage option is "creditable" if on average for all plan participants, it is expected to pay out as much as standard Medicare prescription drug coverage pays.

D

Deductible
The amount of covered expenses you pay before certain options pay benefits for specific care.

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

E

Emergency

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

Experimental/Investigational

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

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

A drug, device, procedure or treatment is determined to be experimental or investigational if:

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

However, effective as of January 1, 2014, because the medical options offered under the Plan are not grandfathered, you will be eligible for coverage of routine costs for items and services furnished in connection with your participation in an approved clinical trial. The clinical trial must relate to the treatment of cancer or another life-threatening disease or condition. Contact your benefits administrators for details.

G

Generic Drug

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

H

HMO
A Health Maintenance Organization (HMO) that has entered into a written contract with Verizon with the purpose of being included as a coverage option under the Alternate Choice Plan.

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

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

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

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

I

Illness
A nonoccupational bodily disorder.

Imputed Income
Most dependents are considered Internal Revenue Service (IRS) tax dependents. You are not taxed on imputed income for IRS tax dependents.

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

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

Injury
A nonoccupational bodily injury.

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

IRS Tax Dependent

An IRS tax dependent for Medical Plan purposes changed under the Health Care and Education Reconciliation Act. While Verizon always recommends that you consult with a tax adviser, the definition provided here is a summary of these complex rules for **federal** tax purposes. State tax rules may differ.

General Rule

Your spouse (including your same-sex spouse) is an IRS tax dependent. In addition, your child who has not attained the age of 27 as of the end of the taxable year is an IRS tax dependent. This rule is more generous than the eligibility rule that applies to covering a child under the Plan. To meet this general rule, the child must be your (the retiree's) son, daughter, stepson, stepdaughter or eligible foster child[1]. A son or daughter includes your legally adopted child or a child who is lawfully placed with you for adoption. This exclusion does **not** apply to the child of your domestic partner.

Other Categories

If you are covering an individual who is not an IRS tax dependent under the general rule, he or she may still be an IRS tax dependent if he or she is a U.S. citizen or resident who is a "qualifying child" or a "qualifying relative."

A "qualifying child" generally is a person who meets **all** of these requirements:

- Is younger than the retiree 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.
- 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 meets **all** of these requirements:

- 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."

[1] An "eligible foster child" is an individual who is placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

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

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

L

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

M

Maximum Allowed Amount (MAA)
For covered services you receive from an out-of-network provider under the HCN or MEP-HCP, the maximum allowed amount is 315 percent of the national Medicare schedule.

Medically Necessary
Benefits are payable under the Plan only when the care, treatment, services or supplies are required for the necessary treatment of an injury, illness or pregnancy, as distinct from those which are unnecessary or experimental/investigational. The respective claims administrator will apply this standard, as described here and has the discretion to apply this standard, based upon the facts and circumstances of each individual case. These applications are applied solely for the purpose of determining medical plan benefits and not for determining what type of medical care should be provided; all decisions related to the type of medical care to be provided shall be made independently by the covered person and the covered person’s physician.

N

Network Negotiated Fee (NNF)
The NNF is the fee the provider has agreed with the benefits administrator to accept as payment in full for covered services or supplies provided on an in-network basis under the HCN or MEP-HCP network, as applicable.

O

Out-of-Pocket Maximum
The maximum amount you will have to pay in a calendar year for covered out-of-network expenses under the HCN option, and for certain services and supplies under the MEP-HCP option.

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

P

Participating Company
Verizon or any corporation or partnership that is an affiliate of Verizon that has elected to participate in the Verizon Medical Expense Plan for New York and New England Associates.

Participating Retail Pharmacy
A retail pharmacy that belongs to the Express Scripts Select National Network.

Physician or Doctor
A person who is licensed to practice medicine, prescribe and administer drugs, or perform surgery.

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

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

S

Same-Sex Domestic Partner
To qualify as a Class I Dependent, your same-sex domestic partner must meet all of the following criteria:

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

In addition, if you disenroll your same-sex domestic partner, you cannot re-enroll him or her, and you cannot add a new same-sex domestic partner. However, if you are same-sex married (i.e., your domestic partner is your spouse or becomes your spouse), he or she can be enrolled or re-enrolled.[1]

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

Skilled Nursing Facility

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

Spouse

Before February 15, 2013 for CWA Plant (Verizon New York, VSC, ECS, VZA, VZAD, VCSC), CWA District 1 (VSC), CWA Local 1104 (Downstate Accounting) (Verizon New York, VCSC), CWA Local 1105 (Downstate Commercial) (Verizon New York, VCSC, VSC), CWA Local 1108 (Downstate Traffic)(Verizon New York, VCSC, VSC), CWA Local 1104 (Upstate Traffic) (formerly Local 1112) (Verizon New York), CWA Local 1113 (Upstate Accounting) (Verizon New York, VCSC, VSC), CWA Local 1302 (Central Order Bureau) (Verizon New England), CWA Local 1395 (VSC), CWA Local 1400 (New England Service Centers) (Verizon New England, VCSC, VSC); **before November 8, 2013** for IBEW Plant (Verizon New England Inc., VADI, Verizon Avenue, VCSC, and VSC), IBEW Traffic (Verizon New England Inc. and VSC), IBEW Accounting (Verizon New England Inc., VCSC, and VSC), and IBEW Sales (Verizon New England Inc., VADI, VCSC and VSC); **and before November 25, 2013** for Verizon New York (Upstate Commercial) (Verizon New York, VCSC, VSC), Spouse is defined under the Plan as follows:

Your spouse is a person of the opposite sex who is a husband or wife, pursuant to a legal union, under the laws of the state in which you live. The definition of spouse specified in this document is consistent with the definition under the federal Defense of Marriage Act. The Plan uses this definition, even if state or local laws define spouse differently.

[1] The ability to add a same-sex spouse after retirement is effective as of: February 15, 2013 for CWA Plant (Verizon New York, VSC, ECS, VZA, VZAD, VCSC), CWA District 1 (VSC), CWA Local 1104 (Downstate Accounting) (Verizon New York, VCSC), CWA Local 1105 (Downstate Commercial) (Verizon New York, VCSC, VSC), CWA Local 1108 (Downstate Traffic)(Verizon New York, VCSC, VSC), CWA Local 1104 (Upstate Traffic) (formerly Local 1112) (Verizon New York), CWA Local 1113 (Upstate Accounting) (Verizon New York, VCSC, VSC), CWA Local 1302 (Central Order Bureau) (Verizon New England), CWA Local 1395 (VSC), CWA Local 1400 (New England Service Centers) (Verizon New England, VCSC, VSC); November 8, 2013 for IBEW Plant (Verizon New England Inc., VADI, Verizon Avenue, VCSC, and VSC), IBEW Traffic (Verizon New England Inc. and VSC), IBEW Accounting (Verizon New England Inc., VCSC, and VSC), and IBEW Sales (Verizon New England Inc., VADI, VCSC and VSC) and November 25, 2013 for Verizon New York (Upstate Commercial) (Verizon New York, VCSC, VSC).

On and after February 15, 2013 for CWA Plant (Verizon New York, VSC, ECS, VZA, VZAD, VCSC), CWA District 1 (VSC), CWA Local 1104 (Downstate Accounting) (Verizon New York, VCSC), CWA Local 1105 (Downstate Commercial) (Verizon New York, VCSC, VSC), CWA Local 1108 (Downstate Traffic)(Verizon New York, VCSC, VSC), CWA Local 1104 (Upstate Traffic) (formerly Local 1112)(Verizon New York), CWA Local 1113 (Upstate Accounting) (Verizon New York, VCSC, VSC), CWA Local 1302 (Central Order Bureau) (Verizon New England), CWA Local 1395 (VSC), CWA Local 1400 (New England Service Centers) (Verizon New England, VCSC, VSC**); on and after November 8, 2013** for IBEW Plant (Verizon New England Inc., VADI, Verizon Avenue, VCSC, and VSC), IBEW Traffic (Verizon New England Inc. and VSC), IBEW Accounting (Verizon New England Inc., VCSC, and VSC), and IBEW Sales (Verizon New England Inc., VADI, VCSC and VSC); **and on and after November 25, 2013** for Verizon New York (Upstate Commercial) (Verizon New York, VCSC, VSC), Spouse is defined under the Plan as follows:

Your spouse is a person who is a husband or wife, pursuant to a legal union, under the laws of the state in which you live. The term spouse includes a person of the same sex to whom you are married under state law. “State” means any domestic or foreign jurisdiction having the legal authority to sanction marriage.

Sudden, Serious and Life-Threatening Illness

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