Contents

Your Health Care Benefits

Verizon medical coverage is designed to protect you and your family from the financial burden of large medical bills while giving you the flexibility to choose an option that meets your needs to manage your share of expenses. This book describes your medical options under the Verizon Medical Expense Plan for New York and New England Associates (the Medical Plan) and the Health Maintenance Organizations (HMOs) available through the Verizon Alternate Choice Plan for New York and New England Associates (the Alternate Choice Plan). The Plans include:

- 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 that vary by option
- Comprehensive coverage of medically necessary services and supplies, such as doctor's office visits, surgery, hospitalization, emergency care and outpatient services
- Prescription drug coverage
- Coverage for mental health and substance abuse treatment.

About This SPD

This book is the summary plan description (SPD) for the Verizon Medical Expense Plan for New York and New England Associates, as well as the Verizon Alternate Choice Plan for New York and New England Associates. The Plans are subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. This book meets ERISA's requirements for an SPD and is based on Plan provisions effective January 1, 2004. It updates and replaces all previous SPDs and other descriptions of the medical plan benefits provided by the Plans.

Important Note

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

This SPD is divided into the following major sections:

- **Participating in the Plans.** This section explains your eligibility, which of your dependents are eligible to be covered and when eligibility ends.

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

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

- **The Empire MEP Indemnity and Aetna MEP Preferred Provider Organization (PPO) Options.** This section provides details of how the Empire MEP Indemnity and Aetna MEP PPO options work.

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

- **Health Maintenance Organization (HMO).** This section provides some details on HMOs available through the Alternate Choice Plan.

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

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

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

- **Additional Information.** This section provides additional details about the administrative provisions of the Plans and your legal rights.

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

Verizon Benefits Center

The Verizon Benefits Center offers a Web site called *Your Benefits Resources*™ where you'll find tools to help you manage your benefits. The Web site makes finding information fast and easy as it guides you through your benefits transactions. In addition to enrolling on the site, you can:

- Create and print personalized provider listings and maps to physicians' offices for most plans.
- Hotlink to HMOs and other provider sites.
- Review details about your health care, insurance and pension plans.
- Verify your Verizon elections that are on file at the Verizon Benefits Center.
- Select and update your beneficiary designations.
- Change the *Your Benefits Resources* password.
- Give yourself a helpful "hint" in case you forget your password.
- Calculate how much to contribute to your Flexible Reimbursement Plan health care and dependent care accounts.
- Model future pension benefits.

From time to time, additional tools will be added to *Your Benefits Resources* Web site to help you better manage your benefits.

The Verizon Benefits Center also offers an interactive voice response (IVR) system for benefits information. Benefits representatives are available should you have questions about your benefits. To reach the Verizon Benefits Center, see your Important Benefits Contacts insert for the telephone number. Via this toll-free telephone number, you can connect with the Verizon Benefits Center and other Verizon benefit providers.

Getting More Information

If you have questions about your benefits or need additional information after reading this SPD, you have the following resources:

- **For general information about the Plans,** access the Verizon Benefits Center Web site, *Your Benefits Resources* (see your Important Benefits Contacts insert for the address). *Your Benefits Resources* Web site is available 24 hours a day, Monday through Saturday and from 1:00 p.m. to midnight, Eastern time on Sunday. You also can call the Verizon Benefits Center (see your Important Benefits Contacts insert for the telephone number). The Verizon Benefits Center IVR system is available 24 hours a day, Monday through Saturday and from 1:00 p.m. to midnight, Eastern time on Sunday. Benefits representatives are available to answer your questions from 8:00 a.m. to 6:00 p.m., Eastern time Monday through Friday (excluding holidays).

- **For specific details about your option's coverage provisions,** access the Benefits Manual available on *Your Benefits Resources* Web site. In addition, you can access the Verizon Benefits Center by calling 1-877-Ask-VzHR (1-877-275-8947). By calling this number, you can transfer to your health Plans' Member Services.

Every effort has been made to ensure the accuracy of the information included in this SPD, which is based on the Plan documents, which is effective January 1, 2004, including bargaining changes as signed August 3, 2003. Copies of Plan documents are available by contacting the Plan administrator in writing at the address provided on page 131 in the "Additional Information" section.

Changes to the Plans

While Verizon expects to continue the Plans indefinitely, the Verizon Employee Benefits Committee (VEBC) 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 the chairperson of the VEBC or an individual in a Director level position or above in the employee benefit design or delivery or the communication branch of the Company's Human Resources organization. The Company also reserves the right to change the amount of required participant contributions for coverage under the Plans at any time, with or without advance notice to participants, subject to any duty to bargain collectively.

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

Participating in the Plans

Eligibility

You are eligible for the Plans after you have completed three months of net credited service if you are employed by a Verizon participating company (see page 137) and are a regular full-time, part-time, eligible temporary or job-sharing New York or New England associate.

"Associate," as used throughout this summary plan description (SPD), includes any non-management employee. "Net credited service" is based on provisions of the Verizon Pension Plan for New York and New England Associates. Also, if you have less than three months of net credited service, you may choose to start coverage earlier by paying the full premium cost.

You are not eligible to participate in the Plans if one of the following applies:

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

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

Eligible Dependents

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 page 6), including your:

- Class I Dependents
- Class II Dependents
- Sponsored Children.

Dependent Eligibility Requirements		
Dependent Class	**Who They Are**	**Relationship**
Class I Dependents	• Your legal spouse (whether or not legally separated)	• Spouse
	• Your unmarried children until the end of the calendar year in which they reach age 19. Children means children by birth, as well as legally adopted children (or children placed for adoption), stepchildren who live in your home, and children who live in your home and for whom you or your spouse is the legal guardian	• Child
	• Your unmarried children (as defined above) from age 19 through the end of the calendar year in which they reach age 25 and are full-time students at an accredited educational institution. Coverage lasts until the end of the month they no longer qualify as full-time students or, if earlier, the end of the calendar year in which they reach age 25	• Full-Time Student
	• Your unmarried children (as defined above) of any age who are dependent on you for support due to physical or mental disability (if the disability began before age 19 or before age 25 while a full-time student and they were covered continuously)	• Disabled Child
	• Your same-sex domestic partner and his or her children who meet the Plan requirements for a same-sex domestic partner (and children of a same-sex domestic partner) are eligible for coverage under the Health Care Network (HCN), an HMO (if they meet the HMO's eligibility requirements) or, if no HCN or HMO is available, the Empire MEP Indemnity option (if currently enrolled) or Aetna MEP Preferred Provider Organization (PPO) option (if enrolling for the first time). For more information on eligibility requirements and tax implications, access *Your Benefits Resources* Web site or call the Verizon Benefits Center and speak with a representative	• Domestic Partner • Domestic Partner's Child
	• Your unmarried children (as defined above and including any age requirements) who are alternate recipients under an approved qualified medical child support order (QMCSO)	• Child
Class II Dependents[1]	• Your unmarried children who do not qualify as Class I Dependents	• Class II Child
	• Your unmarried grandchildren	• Class II Grandchild
	• Your unmarried brothers and sisters	• Class II Sibling
	• Your parents and grandparents and your spouse's (or same-sex domestic partner's) parents and grandparents	• Class II Parent/ Grandparent
	Each Class II Dependent **must** meet **all** of the following eligibility requirements: • Live in your home or in one you provide near 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	
Sponsored Children[1,2]	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

[1] Class II Dependents and Sponsored Children (and surviving spouses and partners as well as their dependents) are not eligible for coverage for substance abuse treatment.

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

Qualified Medical Child Support Order

A qualified medical child support order (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. The order is served on Verizon or its agent for service of legal process and reviewed by the Verizon Benefits Center. You may obtain a copy of the QMCSO's administrative procedures, free of charge, from the Plan administrator (via the Verizon Benefits Center). In any case, if subject to an order, you and each child will be notified about further procedures.

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 employee or the other, but not by both.

- You can be covered as an employee or retiree or as a dependent under a Verizon associate medical plan, but not as more than one of these. To be covered as a dependent under another Verizon associate plan, you must be eligible for and 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 an associate under the Medical Plan or Alternate Choice Plan and as a dependent under a Verizon management plan and do not need to waive coverage. If you are an eligible full-time or part-time employee treated as full time under the Plans or a job-sharing employee treated as full time under the Plans, you may receive a $500 annual waiver credit ($700 for New England IBEW-represented employees) prorated for the number of pay cycles remaining in the year if you waive coverage as an eligible employee in the Medical Plan and the Alternate Choice Plan. (If you are a part-time employee as defined by the Plans, this waiver credit will be prorated according to the schedule in the applicable collective bargaining agreement.) However, you will not receive the $500 (or $700) waiver credit if you waive coverage as an employee to be covered as a dependent under your spouse's Verizon-sponsored Medical Plan.

- Your spouse or same-sex domestic partner can be covered as an employee or retiree or can be covered as a dependent under a Verizon associate medical plan, but cannot be covered as more than one of these. 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. If he or she is not eligible to choose the no coverage option under his or her plan, your spouse or same-sex domestic partner cannot be covered under your plan. If your spouse or same-sex domestic partner is a Verizon management employee or retiree who elects no coverage under his or her management plan and you elect to cover him or her under your associate plan, your spouse/same-sex domestic partner may receive a waiver credit (if eligible) under the management plan; however, you will still be required to pay the working spouse/same-sex domestic partner surcharge under your associate plan (see page 16).

Enrolling in the Plans

Initial Enrollment by Newly Hired Associates

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

- **Medical Option.** You will have to choose whether to be covered under the Plans and, if you want coverage, under which option. (See the Dependent Eligibility Requirements chart on page 6 for information on options when covering a same-sex domestic partner and his or her children.) In most instances, these are your options:

  — HCN if your home ZIP code is in the HCN service area, or you may choose to "opt-in" even if you live outside the service area

  — Empire MEP Indemnity option or Aetna MEP PPO

  — An HMO (available through the Alternate Choice Plan) if your home ZIP code is in one of the Company-sponsored HMO service areas, or you may be able to "opt-in" even if you live outside the HMO's service area

  — No coverage.

Important: If You Enroll in an HMO

The eligibility requirements described in this section are the general eligibility requirements for the Medical Plan. Under the alternative to the Medical Plan, the Alternate Choice Plan, you instead may choose to enroll in an HMO. The eligibility requirements for HMOs available to you may differ from the general eligibility requirements for the Medical Plan. **If so, the HMO's eligibility rules will override the rules described in this eligibility section.** Because of this, you should check with an HMO before enrolling to make sure its eligibility requirements suit your needs. Information on an HMO's eligibility rules can be obtained by contacting the HMO directly at the telephone number shown on the Health Plan Comparison Charts you receive during your benefits renewal period.

- **Coverage Level.** You also will need to choose a coverage level. You have three options:

  — Yourself only

  — Yourself plus one dependent

  — Yourself plus two or more dependents.

Note: You and any eligible dependent you choose to enroll must be covered under the same option, unless you and your dependents are covered as Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) qualified beneficiaries. (When COBRA is first elected, all qualified beneficiaries must choose the option they were covered under on the date of the qualifying event. However, during any benefits renewal period occurring during the COBRA period, each qualified beneficiary can make his or her own coverage election and does not have to be in the same plan option as the employee.)

You will have the option to enroll yourself and your eligible dependents at any time prior to your attainment of three months of service by contacting the Verizon Benefits Center. You pay the full premium cost during this interim period before the Company starts contributing toward the cost of coverage. You can stop your medical coverage at any time during your first three months of service by contacting the Verizon Benefits Center. Your coverage will end effective the first day of the month following your request to cancel. If you stop coverage, you will not be able to re-enroll in coverage until your three-month enrollment opportunity, unless you have a change in status.

Before you attain three months of service, in preparation for your upcoming enrollment opportunity, the Verizon Benefits Center will send you enrollment materials with your medical options listed. You will need to choose your coverage option and, if applicable, your coverage category, and authorize any payroll deductions before your enrollment deadline. If you enroll by the deadline, your elections are effective the first day of the month in which you attain three months of net credited service; otherwise, you will be assigned the HCN option if your home ZIP code is in the HCN service area or the Aetna MEP PPO option if your home ZIP code is outside the service area, or if you elected interim coverage or are a part-time associate scheduled to work less than 25 hours per week and have not been employed continuously by the Company since December 31, 1980, the applicable option described on pages 22 and 23.

Also, the following special rules apply:

- If you are changing from a management position to a full-time associate position or part-time associate position in which you are scheduled to work 25 or more hours per week, your coverage begins the first day of the month following the date your payroll changes for the change in position. If you are changing to a part-time position in which you are scheduled to work less than 25 hours per week, you must enroll to have coverage.

- If you terminate your employment and later are re-employed by a participating company, your net credited service for purposes of eligibility is defined under the Verizon Pension Plan for New York and New England Associates. If you terminate your employment and are rehired in the same plan year, your coverage elections in effect when your employment terminated automatically will be reinstated and you will not be permitted to change your coverage elections upon return to work except as otherwise permitted under applicable Plan provisions. If immediately prior to your re-employment you were a retired participant, you will be eligible for coverage starting the first day of the month after your re-employment on the same basis as an associate who has met the waiting period.

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

If You Do Not Enroll

Interim Three-Month Period

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

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

- If you are a full-time associate, a job-sharing employee (who regularly is scheduled to work at least 40 percent of a regular full-time employee's hours) or a part-time associate who has been employed continuously by the Company since December 31, 1980, you will have coverage for yourself only under the HCN option if your home ZIP code is in the HCN service area or under the Aetna MEP PPO option if your home ZIP code is outside the service area.

- If you are a part-time associate scheduled to work less than 25 hours per week and have not been employed continuously by the Company since December 31, 1980, you will be assigned the no coverage option.

Enrollment As a Surviving Spouse or Dependent

Class I and Class II Dependents are eligible for 24 months of coverage under the Medical Plan or the Alternate Choice Plan that's fully paid for by the Company after an employee's death, provided the employee dies after August 6, 2000. (Note that same-sex domestic partners are treated the same as spouses for the purposes of survivor benefits.) After the end of the 24-month period, coverage for Class I Dependents can be continued as a surviving dependent under the Plan, subject to the same coverage rules that apply to retired participants. Class I Dependents pay the full cost for this continued coverage. Class II Dependents' coverage ends at the end of the 24-month period of Company-paid coverage. Class II Dependent Children then can continue coverage under COBRA (see pages 108 through 111).

Coverage for Sponsored Children ends on the last day of the month in which the associate dies. Sponsored Children then can continue coverage under COBRA (see pages 108 through 111).

Changing Your Elections

Benefits Renewal

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

Status Changes

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

You Gain a New Dependent

If you gain a new, eligible dependent through marriage, acquisition of a same-sex domestic partner, birth, adoption or placement for adoption, that person 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 them.

Note: If you disenroll a same-sex domestic partner, you must wait 60 days before you can enroll a new same-sex domestic partner.

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

If you gain a new, eligible dependent as the result of an event other than those listed above—for example, a dependent child age 23 starts attending school full time after a period of ineligibility due to age—you can enroll that dependent in the Plans by calling the Verizon Benefits Center. Your election will take effect the first day of the month following your election.

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

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

Note: You may choose to continue coverage for a legally separated spouse.

A Dependent Loses Eligibility

If a dependent loses eligibility or ceases to be a dependent for 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. An exception occurs if the dependent is a child who loses eligibility because he or she reaches an age limit for coverage. In this case, the child's coverage will continue until December 31 of the year in which the age limit is reached. However, if a child reaches the age 25 limit and is a full-time student who graduates prior to December 31 of his or her 25th year or no longer maintains his or her full-time student status, his or her coverage will terminate at the end of the month in which he or she loses full-time student status. If you are enrolled in an HMO, check with your HMO regarding eligibility rules since HMO rules may be different.

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

If you do not notify Verizon, any claims incurred by your ineligible dependent will become your financial responsibility and 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 coverage under COBRA.

A Dependent Changes Eligibility Class

If a dependent loses eligibility as a Class I Dependent but would be eligible for coverage as a Class II or Sponsored Child, you must notify Verizon by calling the Verizon Benefits Center within 90 days of the change in eligibility to ensure your dependent's coverage will continue without interruption. Likewise, if a child's eligibility class changes from a Sponsored Child to a Class I Dependent due to enrollment as a full-time student, you must call the Verizon Benefits Center and certify the child's full-time student status. If you do not notify the Verizon Benefits Center of the change within 90 days, the dependent's coverage will cease until notification is received. When notification is received, coverage will be reinstated on the first day of the month following notification.

You Move

If you move, you must notify your department of your address change. After payroll registers your move, you automatically will receive a move package from the Verizon Benefits Center if you move to a location outside of your current option's service area and you will have the opportunity to choose a new option. If you call the Verizon Benefits Center and make your election within 90 days of the creation of your move package, your election will be effective on the date of your move. If you do not call within 90 days of the creation of your move package, your election will be effective on the first day of the month following the date on which the election is made.

Special Enrollment Rules

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

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

If you enroll yourself or your dependents in the 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, placement for adoption or acquisition of a same-sex domestic partner, you will be able to enroll yourself and your dependents. If you enroll:

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

Cost of Coverage

Each year, Verizon makes a contribution toward your Company-sponsored benefits. Through December 31, 2008, for eligible associates with at least three months of net credited service, the Company contribution covers the full cost of medical coverage for you and, if applicable, your enrolled Class I and Class II Dependents. Note that if your spouse or same-sex domestic partner is employed and you cover him/her under your Plan, you may be required to pay the working spouse/domestic partner surcharge (see page 16). You're an eligible associate if you have at least three months of net credited service and are as follows:

- An active associate working at least 25 hours per week or a job-sharing associate working at least 40 percent of a full-time employee's schedule

- An active part-time associate hired before January 1, 1981 and employed continuously by the Company since that date.

If you are a regular part-time associate who has not been employed continuously since December 31, 1980 and are working at least 17 but less than 25 hours per week (and you are not a job-sharing associate that qualifies as a full-time employee), Verizon will contribute 50 percent of the amount it contributes for regular full-time associates.

If you are a regular part-time associate who has not been employed continuously since December 31, 1980 and you work less than 17 hours per week (and you are not a job-sharing associate that qualifies as a full-time employee), you can enroll for coverage if you call the Verizon Benefits Center and agree to pay the full cost.

You pay the full cost of medical coverage for any Sponsored Children whom you choose to cover.

If you cover a same-sex domestic partner and his or her dependents whom you do not claim as a dependent for federal tax purposes, Verizon is required by tax law to impute income to you based on the fair market value of the coverage provided to your same-sex domestic partner and his or her dependents.

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

Working Spouse/Same-Sex Domestic Partner Surcharge

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

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

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

- Your spouse or same-sex domestic partner elects individual medical coverage under his or her employer's medical plan,
- Your spouse's or same-sex domestic partner's gross base wage rate on an annualized basis as of the previous July 1 is $25,000 or less, or
- Your spouse or same-sex domestic partner is required to contribute $900 or more per year for individual medical coverage.

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

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

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

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

Certification of a Spouse/Same-Sex Domestic Partner

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

If your spouse/same-sex domestic partner experiences a change in employment status where the surcharge should be applied, you are responsible for notifying the Verizon Benefits Center within 31 days. The change will be effective the first day of the month following notification. During 2004, failure to notify the Verizon Benefits Center within 31 days will result in having the surcharge applied retroactively for past due amounts.

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

When Participation Ends

This section explains when participation in the Medical Plan and Alternate Choice Plan ends for you, your dependents and your survivors.

Associate Coverage

An associate's coverage will end on the earliest date described below. You may be able to continue coverage under COBRA. See pages 108 through 111 for more information.

Leaves of Absence

In general, if you go on a leave of absence, your coverage continues in accordance with Company guidelines and as collectively bargained:

- **Leaves Under the Family and Medical Leave Act.** The Company complies with the Family and Medical Leave Act of 1993 (FMLA). All leaves of absence qualifying under the FMLA will be administered in accordance with the terms of the FMLA. Coverage may be continued during approved leaves, as provided in Company policy and as collectively bargained. Call the Verizon Benefits Center for details.

- **Leaves of Absence Under the Uniformed Services Employment and Reemployment Rights Act.** All military leaves of absence qualifying under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) will be administered in accordance with the terms of USERRA.

- **Union Leaves of Absence.** Under a Union Leave of Absence, coverage can be continued according to your collective bargaining agreement.

- **Anticipated Disability Leaves of Absence, Care for Newborn Children (CNC) Leaves of Absence, Family Care Leaves of Absence and Enhanced Educational Leaves of Absence.** Under an Anticipated Disability Leave of Absence, CNC Leave of Absence, Family Care Leave of Absence or an Enhanced Educational Leave of Absence, Verizon will pay the amount it normally does for your coverage. If you contribute to the cost of your medical coverage, however, you must continue making contributions during your leave. The Company will bill you monthly for these charges.

Change in Employment Status

If your employment status changes from associate to management status, coverage under the Medical Plan and the Alternate Choice Plan will end on the last day of the month in which you become a manager of Verizon or an affiliate of Verizon. You will have an opportunity to make an election into another plan.

Long-Term Disability (LTD)

Coverage under the Plans will end on the last day of the month in which you begin to receive benefits under the Verizon Long-Term Disability Plan for New York and New England Employees. On the first day of the month that you begin to receive LTD benefits, you are covered under the health plan coverage rules that apply to retiree participants. **Note:** LTD participants cannot add new dependents or cover sponsored dependents. Dependents of LTD participants are not eligible for substance abuse treatment.

Cancellation of Coverage

If you cancel coverage due to a change in status, 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.

Force Adjustment Plan (or a Successor to That Plan)

If your employment ends due to the lay off portion of the Force Adjustment Plan (or a successor to that plan) and you have:

- Five or more years of net credited service, your coverage will end on the last day of the sixth month following the last day of the month in which your employment ends
- At least one, but less than five years of net credited service, your coverage will end on the last day of the third month following the last day of the month in which your employment ends
- Less than one year of net credited service, your coverage will end on the last day of the month in which your employment ends.

Other End of Employment

If your employment ends for any reason not specified on the previous page, coverage under the Medical Plan and the Alternate Choice Plan will end on the last day of the month in which your employment ends.

Dependent Coverage

A dependent's coverage will end on the earliest date described in the following section. Your dependent may be able to continue coverage under COBRA. See pages 108 through 111 for more information.

Associate's Coverage Ends

If the associate's coverage ends for any reason except when the associate dies, coverage for all dependents also will end at the same time.

Associate Dies

If an employee dies on or after August 6, 2000, coverage for his or her Class I and Class II Dependents who are enrolled on the date of the associate's death will continue until the last day of the 24-month period following the month in which the associate dies. Coverage also will continue for the newborn child of a deceased employee who is born subsequent to the associate's death. After the end of the 24-month period, coverage for Class I Dependents can be continued as a surviving dependent under the plan, subject to the same coverage rules that apply to retired participants. Coverage for the associate's Sponsored Children will end on the last day of the month in which the associate dies.

Continuing Coverage When a Dependent Is Ineligible

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. Furthermore, if you do not disenroll your dependents within 60 days of when they become ineligible, they 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 survivors will lose their eligibility for the Plans, effective as of the date determined by the Medical Plan or Alternate Choice Plan's administrator.

Dependent Ceases to Meet the Eligibility Requirements

A dependent's coverage will end on the earlier of the date the dependent is covered as an associate or retiree under any Company-sponsored plan and the last day of the month in which the 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 date 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. Under the Alternate Choice Plan, coverage for an ex-spouse under an HMO option will end when you or your ex-spouse remarries, except as otherwise required by state mandate or as determined by the claims administrator. Check with your HMO regarding eligibility rules for ex-spouse coverage.

- Coverage for a same-sex domestic partner ends on the date in which he or she fails to meet the definition of a same-sex domestic partner.

- Coverage for a child ends on the last day of the calendar year in which he or she reaches age 19 (if not a full-time student), or the last day of the month in which the child is married, if earlier.

- Coverage for a stepchild ends on the last day of the month in which he or she no longer lives with you, or the date the stepchild otherwise becomes an ineligible dependent, if earlier.

- Coverage for a full-time student ends on the earlier of the last day of the calendar year (plan year) in which the student reaches age 25 or the last day of the month in which he or she no longer qualifies as a full-time student because he or she reduces his or her course load to a level below full time as defined by the educational institution, graduates or otherwise leaves school for reasons other than his or her illness or injury.

- Coverage for a disabled child ends on the last day of the month in which he or she no longer meets the definition of a disabled child.

- Coverage for a child under a QMCSO ends on the date the employee no longer is required to provide coverage for this child or, if earlier, the date the child no longer would be eligible for coverage, as defined on page 6.

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

- Coverage for a child of a same-sex domestic partner ends on the last day of the calendar year (plan year) in which the child reaches age 19 or age 25 (if a full-time student), as applicable, or the last day of the month in which the child otherwise fails to meet the definition of a child of a same-sex domestic partner (or the same-sex domestic partner no longer meets the definition of a same-sex domestic partner), as defined on page 6.

Extended Benefits

If You or Your Dependents Are Hospitalized: Coverage for a covered person's hospital room and board and related hospital facility services will continue (until 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 COBRA and its subsequent amendments. Continuation of coverage under COBRA is described on pages 108 through 111 of this SPD.

Certificate of Creditable Coverage

When any person's coverage under the Medical Plan and the Alternate Choice Plan ends for any reason, including the end of COBRA continuation coverage, Verizon will send that person a Certificate of Creditable Coverage, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This certificate may help the person receive coverage under another plan. Additional certificates may be requested by the former employee or dependent at any time within 24 months of the date on which the person's coverage ended. To request a certificate, access *Your Benefits Resources* Web site or call the Verizon Benefits Center.

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 on page 6 for information on options when covering a same-sex domestic partner and his or her children):

- The Health Care Network (HCN) option. This option is offered through the Medical Plan to associates whose home ZIP code is in the service area covered by the HCN. With the HCN, you can seek in-network care through a primary care physician (PCP) or out-of-network care. When your PCP coordinates 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.

- Empire MEP Indemnity option administered by Empire BlueCross BlueShield (Empire MEP Indemnity option). This option is a traditional medical plan, where you can use any licensed doctor or hospital you choose, and there is no requirement to coordinate care through a PCP. After you meet your annual deductible, the Empire MEP Indemnity option pays a percentage of your covered reasonable and customary (R&C) charges. If you are a New York IBEW or New York CWA-represented associate, in addition to your regular Empire MEP Indemnity option coverage, the option includes an Indemnity Participating Network (IPN) component as part of your coverage. The IPN consists of a network of providers in selected counties of New York State that have agreed to charge a negotiated discounted fee for certain services. Your financial payment for medical care, if any, is then based on the discounted fee rather than R&C charges; however, your benefit structure remains the same. (See page 59 for additional information about the Empire MEP Indemnity option and the IPN.)

Opting-In

If you live outside the service area of either the HCN or an HMO, you may be able to opt-in to the HCN or HMO. That is, you may decide that you are willing to travel farther to have access to a participating doctor in order to have HCN or HMO coverage. Call the Verizon Benefits Center for details since not all HMOs will allow members to opt-in.

- Aetna MEP Preferred Provider Organization (PPO) option administered by Aetna, Inc (Aetna MEP PPO). The Aetna MEP PPO 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 PPO. When you use PPO providers, you receive a higher level of benefit coverage and because charges are based on the NNF rather than R&C charges, your out-of-pocket medical costs are lower. Your financial payment for medical care, if any, is based on the discounted fee, and may consist of a fixed copayment rather than deductible and variable coinsurance, depending on the type of service provided. The Aetna MEP PPO option also offers out-of-network benefits that are the same benefits as the Empire MEP Indemnity option. (See pages 68 through 74 for additional information about the Aetna MEP PPO option.)

- Under the Alternate Choice Plan, a Health Maintenance Organization (HMO). In most parts of the country, you also will have the opportunity to join an HMO. If you join an HMO, you'll usually need to choose one of the HMO's doctors to be your PCP. Your PCP then will coordinate all your medical care. If you join an HMO, your care usually will be covered only if it is received through your PCP and other providers affiliated with the HMO. **You typically do not receive coverage for care not coordinated through your PCP.**

- No coverage. As an eligible associate, you have the option to elect no medical coverage for you and your dependents.

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 HCN. If you seek medically necessary care in-network through your PCP, you'll pay only a small copayment for office visits, with most other medically necessary in-network care covered in full. 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.
- If you want even more flexibility, think about selecting the Empire MEP Indemnity option or Aetna MEP PPO option, where there is no requirement to coordinate care through a PCP and you can choose to use any doctor or hospital. After you meet your deductible (if applicable), the option pays a percentage of your covered expenses. Some services require only a copayment at the time of service. With the Aetna MEP PPO option, whenever you need medical care, you can receive your care in-network from providers/facilities that participate in the Aetna MEP PPO network and you receive a higher level of benefit coverage and charges are based on the NNF. If you receive your care out-of-network under the PPO (or if you are in the Empire MEP Indemnity option), coverage is based on R&C charges.
- If you select an HMO, in most cases, you pay a copayment of no more than $10 for each office visit to your doctor (and no more than $50 for each emergency room visit). Most other medically necessary services are covered at 100 percent by the HMO.
- If you're thinking about opting-in to the HCN or selecting 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 not at all (HMOs) (unless you have a true emergency). Therefore, you'll want to be sure that the doctors and hospitals in the network are right for you.
- Also, when choosing an option, closely look at the option's coverage provisions—including coverage for preventive care, prescription drugs, physical therapy and mental health care. Certain options may offer better coverage for the types of care you are most likely to use.

Comparing Your Medical Options

Coverage Feature	HCN		Empire MEP (Indemnity Option)	Aetna MEP PPO Option		HMO
	In-Network	Out-of-Network		In-Network	Out-of-Network	
You have a PCP who directs your care	Yes	No	No	No	No	Yes, for most HMOs
You need referrals from your PCP before you receive care	Yes	No	No	No	No	Yes, for most services and in most HMOs
You can receive covered care anywhere in the United States	Yes, if an emergency as defined by the claims administrator	Yes	Yes	Yes	Yes	No
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	Yes or no, depending on the service	Yes	No
You pay a small per-visit copay for most care	Yes	No	No	Yes or no, depending on the service	No	Yes
You pay a percentage of your covered care in coinsurance for certain services	No	Yes	Yes	Yes	Yes	No; most services are covered at 100% after the copay
You may have to pay bills and submit claims for reimbursement	No	Yes	Yes, unless you live in the NY Empire BlueCross BlueShield operating area and are a New York IBEW- or New York CWA-represented associate who uses an IPN participating provider or BlueCard provider or if your doctor has already submitted the bill directly to the insurance company on your behalf	No	Yes	No
The Plan has an annual out-of-pocket maximum	Not applicable	Yes	Yes	Yes	Yes	Generally not applicable

For additional information pertaining to your HCN and Empire MEP Indemnity option and Aetna MEP PPO option, please refer to the specific coverage summary charts on pages 35 through 40 and 68 through 74.

The Health Care Network Option

With the Health Care Network (HCN), after you have selected a primary care physician (PCP), 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 on pages 35 through 40. When your PCP coordinates 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. In-network care provides coverage for preventive care, as described on page 37.

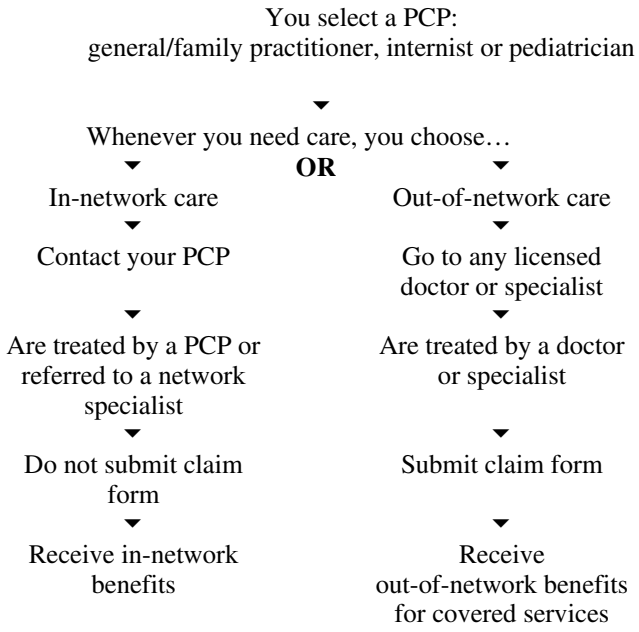
If your PCP leaves the HCN network, you cannot change your medical option for that reason. However, you must select a new PCP in order to receive in-network benefits.

See pages 35 through 40 for information on covered services and page 133 for a list of HCN administrators. For more information about covered services and your HCN benefits, contact the claims administrator at the telephone number listed on your Important Benefits Contacts insert or on your HCN ID card.

How the HCN Works

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

The chart below describes how the HCN works.



Your PCP

When you join the HCN, you will be asked to select a PCP for yourself and each of your covered dependents. You can choose the same PCP for all family members, or each covered family member can have a different PCP.

A list of PCPs available to you and your family can be obtained by contacting your claims administrator via the telephone number shown on your Important Benefits Contacts insert or on your HCN ID card. Most of the HCN claims administrators also have an Internet site where you can get information about PCPs online.

Your PCP needs to be a general practitioner, an internist, a pediatrician or family practice provider. Your PCP will coordinate all of your in-network care and is responsible for:

- Providing your in-network health care
- Referring you to in-network specialists
- Arranging in-network hospitalization, testing and other services for you

- Handling in-network pre-certification, if needed

- Handling claims for in-network care, so there's little or no paperwork for you when you receive in-network care.

You can change your PCP at any time, for any reason, by calling your HCN Member Services. Member Services will tell you when your change will become effective. If your PCP leaves the HCN network, you will have to select a new one within the network. You cannot change your medical option for this reason.

In-Network Benefits

Generally, when your PCP provides your care or refers you to another in-network doctor, you will pay a copayment for each office visit, including surgical procedures performed in the doctor's office. The HCN typically then pays 100 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 or coinsurance charges and no balance billing.

Special in-Network Preventive Care

When you receive in-network care, the HCN provides coverage for certain preventive care based on an age and frequency schedule. See the coverage summary on page 37 for coverage provisions.

Most preventive care is not covered when you use an out-of-network provider.

In-Network Copayments

A copayment is a flat dollar amount you pay for covered expenses. When you seek in-network care under the HCN, you pay a copayment for each office visit to a PCP, each office visit to any other provider referred by your PCP, and visits for outpatient surgery when performed in the PCP's office or in the office of another provider when coordinated by your PCP.

HCN Office Visit Copayment

The current HCN office visit copayment is $10. It will increase to $15 on January 1, 2005.

Care Not Coordinated Through Your PCP

To receive in-network benefits, most—but not all—of your care must be coordinated through your PCP. For example:

- If you need emergency care, go to the nearest emergency facility. There is no need to contact your PCP first, but you or a family member should call your PCP within 48 hours of receiving emergency medical treatment.
- Women may see a network obstetrician/gynecologist (OB/GYN) for an annual routine exam and certain OB/GYN services without a PCP's referral. Specific provisions vary by state—with Blue Cross Blue Shield of Massachusetts, women may self-refer to an OB/GYN for all services except surgical and maternity. They must receive a PCP's referral for these two procedures.
- You may use a network chiropractor for medically necessary services without a PCP referral (maintenance chiropractic services are not covered).
- You may use a network oral surgeon without a PCP referral.
- An enrolled dependent who is attending college can receive urgent care or emergency care in a college infirmary without a PCP referral. However, follow-up care is subject to regular coverage rules and must be coordinated through the dependent's PCP.
- For covered ambulance services, you will receive in-network coverage if the service is determined by the claims administrator to be medically necessary or if you obtain prior pre-certification.
- Covered bereavement counseling will be covered on an in-network basis, subject to limits set by the claims administrator.
- To have a prescription filled, use the prescription drug program. (See pages 95 through 102.)
- For mental health and substance abuse treatment, call your claims administrator via the telephone number listed on your Important Benefits Contacts insert.

Note: The HCN will pay out-of-network benefits if you receive a referral by a doctor who is not your PCP at the time of your referral.

Out-of-Network Benefits

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

Also, most preventive care is not covered when you use out-of-network providers (with the exception of Pap tests and mammograms, subject to scheduled limits). Please contact Member Services for additional information on the preventive care guidelines.

Out-of-Network Deductible

Each calendar year, you must meet a $250 annual deductible per person before the HCN 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 on an out-of-network basis in a year. The following expenses do not apply to the deductible:

- Amounts paid for in-network care
- Amounts paid by the employee or eligible dependent when he or she fails to follow the pre-certification procedures
- Expenses for mental health care or substance abuse treatment, as described on pages 41 through 44
- Expenses for prescription drugs, as described on pages 95 through 102
- Amounts paid for non-covered services and supplies by the Medical Plan
- Amounts in excess of R&C
- Expenses for LASIK services.

Out-of-Network Coinsurance

After you pay the $250 deductible, the HCN typically pays 70 percent of R&C charges for most covered expenses, including:

- Physician's office visits
- Laboratory/X ray
- Hospital charges
- Surgery.

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

- The HCN will pay 100 percent for covered emergency care in the event of an emergency as defined by the claims administrator, and if you notify your PCP within 48 hours of receiving treatment.
- The HCN will pay 100 percent of R&C 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 for covered bereavement counseling. Contact your HCN claims administrator for details on Plan reimbursement.

When you use an out-of-network provider or use a provider without your PCP's referral (see exceptions on page 29), it is your responsibility to contact HCN Member Services to pre-certify all inpatient hospital stays (including inpatient mental health care and substance abuse treatment). In addition, you also must pre-certify selected outpatient procedures, home health care, hospice care, private duty nursing and stays in a skilled nursing facility. (See pages 44 and 45 for more information on pre-certification.)

Annual Out-of-Pocket Maximum

There is financial protection if you have large out-of-network expenses. If an individual's share of covered out-of-network expenses reaches $1,500 in a calendar year (including the $250 deductible), the HCN will pay 100 percent of R&C for most additional covered out-of-network expenses for that individual for the rest of the calendar year.

Charges for covered out-of-network services or supplies under the HCN will be applied to the out-of-pocket maximum. Copayments and coinsurance amounts for mental health care and prescription drugs also will be applied to the out-of-pocket maximum.

The following expenses cannot be used to satisfy the out-of-pocket maximum:

- Charges that exceed R&C or NNF or other Medical Plan limits
- Charges for services and supplies that are not covered by the Medical Plan
- Copayments for office visits to a PCP and each office visit to any other provider when the visit is coordinated by the PCP (including visits for outpatient surgery when performed in the PCP's office or in the office of another provider when coordinated by the PCP), hospital expenses, surgery, outpatient laboratory tests and outpatient X rays
- Additional amounts you pay if you do not follow pre-certification program procedures (see pages 44 and 45)
- Amounts you or your covered dependents pay for LASIK services.

Special Transition Rules

These special transition rules apply if you are a new enrollee who elects the HCN option during your initial three-month waiting period or during benefits renewal.

If You Are Pregnant

- ***If you are not a new associate employee:*** 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, 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.
- ***If you are a new associate employee:*** If you (or a covered dependent) are pregnant when you enroll in the HCN and your doctor is not in the HCN, 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 date of hire 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.

To receive in-network benefits for your newborn's medical care, you must call the HCN's Member Services to designate a PCP for him or her.

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 network 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 your current option's Member Services to request this extension of benefits.

If You Are Being Treated for a Serious Condition

If your doctor is not in the network and you (or a covered dependent) are being treated for a serious, acute medical condition immediately before your coverage effective date, you must contact the HCN's Member Services to apply for transition benefits. If approved by the network administrator, benefits for this treatment will be paid at the network level for up to three months—or longer if the treatment is for a terminal illness. All other conditions and treatments will be covered subject to regular HCN rules, and you will have to go through your PCP to receive in-network benefits.

If You Currently Are Receiving Mental Health or Substance Abuse Treatment

- ***Outpatient care:*** If you (or a covered dependent) are receiving outpatient mental health or substance abuse treatment from a provider who is not in the United Behavioral Health (UBH) network, continuing treatment may be covered at in-network levels for up to three months. You must contact UBH to request these transition benefits. See your Important Benefits Contacts insert for the telephone number. If approved, these transition benefits will begin at the time of your initial enrollment, or on January 1 (and continuing until no later than March 31) of the new plan year if you enroll at benefits renewal.

- ***Inpatient care (or an alternative to inpatient care):*** Coverage will continue on the same basis as the current coverage in effect when HCN coverage begins and will continue until discharged. You must contact your current option's administrator to apply for this transition benefit.

If Your Dependent Attends School in a Non-Network Area

If your covered child or other covered dependent resides in a location outside the network area, he or she should select a network PCP and receive routine care while at home. (Call the HCN's Member Services to see if network coverage is available at the school location. In certain areas, a covered child may be able to select a PCP close to his or her school.) If your child gets sick while away at school, your child's PCP may be able to authorize care at the in-network benefit level; however, you may have to file a claim form. College infirmary charges are paid on an in-network basis. However, follow-up care needs to be coordinated with the dependent's PCP. Eligible emergency care is covered at the in-network level, provided the child's PCP is notified within 48 hours.

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 HCN 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 your claims administrator appears on your HCN ID card and your Important Benefits Contacts insert.)

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

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 Important Benefits Contacts insert or your HCN ID card.

HCN 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. (See pages 28 through 34 for an explanation of in-network and out-of-network coverage rules.)

Keep in mind, if you utilize out-of-network providers or do not coordinate care through your PCP, charges in excess of the R&C amounts will not be covered by the Plan. If a charge for a covered service exceeds the R&C, the Medical Plan will apply its reimbursement percentage only to the amount within the R&C limit, and you may be responsible in full for the difference between the billed charges and the R&C amount. Certain other restrictions may apply—for additional information, see the "Additional Information" section, beginning on page 116.

HCN Feature	Benefits	
	In-Network[1]	**Out-of-Network**
Deductible Requirements	None	$250 per person, per calendar year; no family limit
Annual Out-of-Pocket Maximum (per person, per calendar year) excludes charges that you pay to the extent they exceed R&C or NNF or other HCN limits, charges for services and supplies that are not covered by the Plan, copays for office visits to a PCP and each office visit to any other provider when the visit is coordinated by the PCP (including surgical procedures performed in the PCP's office or in the office of any other provider when coordinated by the PCP), copays for hospital expenses, surgery, outpatient lab tests and outpatient X rays, additional amounts you pay if you do not follow pre-certification program procedures and amounts you or your covered dependents pay for LASIK services	None	$1,500 per person, per calendar year (includes deductible); no family limit
Lifetime Maximum Benefit	None for active associates	None for active associates

(See page 40 for footnotes.)

HCN Feature	Benefits	
	In-Network[1]	**Out-of-Network**
When Benefits Are Paid	For care provided, pre-certified or approved by the PCP or claims administrator when specified, benefits are based on the NNF and the HCN pays:	For covered nonemergency care provided on an out-of-network basis, benefits are based on the R&C and the HCN pays:
Inpatient Hospital Services		
Room and Board (in a semi-private room of a hospital or in an intensive care unit)[2]	100%	70% after deductible, if pre-certified
In-Hospital Physician's Visits (limited to 1 visit per day; visits for customary pre- and post-operative care are not covered; visits also subject to claims administrator's established limits)	100%	70% after deductible
X rays and Lab Tests	100%	70% after deductible, if pre-certified
Maternity Care	100%	70% after deductible
Newborn Baby Care (initial pediatric exam while mother is hospitalized)	100%	70% after deductible, if pre-certified
Skilled Nursing Facilities	100% if medically necessary and pre-certified (no stay limits)	70% after deductible, if medically necessary and pre-certified
Birthing Centers (note that not all New England states have birthing centers)	100%	70% after deductible, if pre-certified
Hospice Care (excluding bereavement counseling, which is subject to different payment rules—contact your claims administrator for more information)	100%	70% after deductible, if medically necessary and pre-certified
Surgery[3] and Anesthesia		
Second Opinions (and third opinion, if second is nonconcurring)	100%	70% after deductible
Inpatient Surgery	100%	70% after deductible, if pre-certified **Note:** Blue Cross Blue Shield of Massachusetts does not require pre-certification for out-of-network surgery
Outpatient Surgery	100% (you pay $10 copay if office visit is billed; $15 after January 1, 2005)	70% after deductible (with pre-certification for certain procedures as determined by the claims administrator) **Note:** Blue Cross Blue Shield of Massachusetts does not require pre-certification for out-of-network surgery

(See page 40 for footnotes.)

HCN Feature	Benefits	
	In-Network[1]	**Out-of-Network**
Outpatient Treatments		
Doctors' Office Visits	100% after you pay $10 per office visit copay ($15 after January 1, 2005)	70% after deductible
Doctors' Home Visits	100% after you pay $10 per visit copay ($15 after January 1, 2005)	70% after deductible
X rays and Lab Tests	100% if done in the physician's office (you pay $10 copay if done in the physician's office if office visit is billed; $15 after January 1, 2005)	70% after deductible (with pre-certification for certain procedures as determined by the claims administrator)
Radiation therapy, chemotherapy, electroshock therapy, hemodialysis	100% after you pay $10 per office visit copay ($15 after January 1, 2005)	70% after deductible
Physical, Occupational and Speech therapy (duration must be prescribed by your doctor and approved by the claims administrator)	100% if done in the physician's office (you pay $10 office visit copay if done in the physician's office if office visit is billed; $15 after January 1, 2005)	70% after deductible
Licensed Chiropractor	100% of medically necessary charges	70% of medically necessary approved charges after deductible; limited to $1,500 per calendar year
Private Duty Nursing (when prescribed by your doctor)	100%	70% after deductible, if medically necessary and pre-certified
Preventive Care Services		
Well-Baby/Child Exams	100% after $10 copay ($15 after January 1, 2005) *Age 0-2 years as prescribed* *Age over 2-25:1 exam every year; includes immunizations*	Not covered
Adult Physical Exams	100% after $10 copay ($15 after January 1, 2005) *Age over 25-50: 1 exam every 2 years* *Age 50 and over: 1 exam every year*	Not covered
Immunizations and Flu Shot	100% *1 complete regimen of immunizations and 1 flu vaccine annually for children and adults*	Not covered

(See page 40 for footnotes.)

HCN Feature	Benefits	
	In-Network[1]	**Out-of-Network**
Fecal Occult Test	100% *Age 18-39: 1 every 2 years* *Age 40 and over: 1 every year*	Not covered
Colonoscopy or Sigmoidoscopy	100% *Age 50 and over: 1 every 3 years*	Not covered
Routine Mammogram	100% *1 annual routine mammogram for women regardless of age*	70% after deductible
Well-Woman Exam	100% after $10 copay ($15 after January 1, 2005) *1 well-woman exam, every year, regardless of age and with or without a Pap test, including the blood count and urinalysis*	70% after deductible
Prostate Specific Antigen Test	100% *Age 18-49: 1 every 2 years* *Age 50 and over: 1 every year*	Not covered
Hearing Aids	100% up to $1,000 for hearing aid (and related exam and fitting) every 24 calendar months[4]	
Home Health Care	100%	70% after deductible, if medically necessary and pre-certified

(See page 40 for footnotes.)

Prescription Drugs	Using a Participating Pharmacy	Using a Non-Participating Pharmacy
Retail Pharmacy (supply appropriate for up to 30 days of therapy)		
Annual Deductible	No deductible required	$50 combined for generic and brand name
Coinsurance		
• Generic	You pay 15% of the discounted network price (DNP) but no more than $25 per prescription	You pay 15% of the retail cost but no more than $25 per prescription
• Brand drugs when generic is not available, or if a generic is available but the doctor has ordered the prescription to be "dispensed as written" (DAW)	You pay 20% of the DNP but no more than $40 per prescription	You pay 20% of the retail cost but no more than $40 per prescription
• Brand drugs when generic is available and the doctor does not order the prescription to be DAW	You pay 30% of the DNP but no more than $50 per prescription	You pay 30% of the retail cost but no more than $50 per prescription
Medco Health Home Delivery Pharmacy Service (supply appropriate for up to 90 days of therapy)		
• Generic	You pay $8 copay or the DNP, whichever is less	
• Brand drugs when generic is not available, or if a generic is available but the doctor has ordered the prescription to be DAW	You pay $12 copay or the DNP, whichever is less	
• Brand drugs when generic is available and the doctor does not order the prescription to be DAW	You pay $20 copay or the DNP, whichever is less	

(See page 40 for footnotes.)

HCN Feature	Benefits	
	In-Network[1]	**Out-of-Network**
Mental Health/Substance Abuse		
Inpatient Mental Health Care	100%, if pre-certified by UBH	70%, if pre-certified by UBH
Outpatient Mental Health Care	You pay $10 per visit ($15 after January 1, 2005) if pre-certified by UBH; maximum charge of $10 per week ($15 after January 1, 2005)	50% up to 52 visits per calendar year
Inpatient Substance Abuse Treatment[5]	100%, if pre-certified by UBH	70%, if pre-certified by UBH, up to $250 benefit per day[6]
Outpatient Substance Abuse Treatment[5]	You pay $10 per visit ($15 after January 1, 2005) if pre-certified by UBH; maximum charge of $10 per week ($15 after January 1, 2005)	50% up to 52 visits per calendar year
Halfway House	100%, if pre-certified by UBH	Not covered
Emergency Room Care	100%, if you call UBH within 48 hours of receiving the care and your care is approved; if UBH is not contacted within 48 hours or if treatment is not a true emergency, benefits will be reduced	70%
Other Services		
Medical Equipment	100%	70% after deductible
Ambulance Services	100% provided the ambulance is used to transport the covered person to or from a local hospital (or nearest hospital at which the necessary treatment is available) and only if the service is determined to be medically necessary or with prior pre-certification. Otherwise, 70% after deductible for covered ambulance services. Transport from an out-of-network hospital to a network hospital following the covered person's stabilization may be covered as determined by the claims administrator	
Prosthetic Devices	100%	70% after deductible
Emergency Room Care	100%, if you notify the PCP within 48 hours and the claims administrator determines your condition was an emergency; otherwise, HCN pays 70% of NNF after the deductible for an in-network facility or 70% of the actual charge after deductible if you visit a non-network hospital or emergency facility	

[1]In the event a service or supply is covered under the Empire MEP Indemnity option or Aetna MEP Preferred Provider Organization (PPO) option but is not available under the HCN on an in-network basis, Plan benefits for the service or supply will be payable on an in-network basis.
[2]Confinement in a private room may be covered in certain limited situations, as determined by the claims administrator.
[3]Multiple surgical procedures are an exception to the rules described here. (See pages 47 and 48 for more information.)
[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 more information.
[5]Class II Dependents, Sponsored Children and surviving spouses (or surviving same-sex domestic partners) and their dependents are not eligible for coverage for substance abuse treatment.
[6]Benefits limited to 30 days per stay and two stays per lifetime.

More Information About the HCN

The following section provides information about special coverage rules for:

- Mental health and substance abuse treatment
- Pre-certification requirements
- Emergency care
- Surgery coverage
- Maternity and newborn care
- Covered hospital services and supplies
- Covered medical services and supplies.

Prescription drug coverage is described on page 95.

If you have questions about coverage, call Member Services (see your Important Benefits Contacts insert for the telephone number).

Mental Health and Substance Abuse Treatment

Mental health and substance abuse coverage for HCN participants is offered through a separate program administered by UBH. The UBH program 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

Generally, all participants in the HCN are covered for mental health benefits. However, benefits for substance abuse treatment are not available to the following:

- Class II Dependents and Sponsored Children
- Any dependents of an associate who dies.

Mental Health and Substance Abuse Treatment

In-Network Benefits

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

When you call UBH, you will speak to 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 UBH counselor arranges your care and provides pre-certification, you will be covered at in-network rates for inpatient and outpatient care. When you receive pre-certification of inpatient mental health or substance abuse treatment and receive care from a therapist or hospital in the UBH network, it's covered at 100 percent with no annual maximum. Plus, you pay no more than $10 per week for outpatient treatment, when pre-certified.

Counselors are available 24 hours a day, 365 days a year. You can call UBH via the telephone number shown on your Important Benefits Contacts insert.

Out-of-Network Benefits

Your care is considered out-of-network if it is not arranged through UBH's individual assessment program or if it is received from a provider who does not belong to UBH's network.

When you receive pre-certification for inpatient mental health treatment and substance abuse detoxification or rehabilitation, coverage is at 70 percent of R&C charges. If inpatient mental health treatment is not pre-certified, but the claims administrator determines it is medically necessary, benefits will be payable at 70 percent of the benefit that otherwise would be payable under the Plan. 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.

Inpatient substance abuse treatment is limited to a $250 per day benefit maximum and two 30-day stays per lifetime. Outpatient treatment for mental health and substance abuse is paid at 50 percent of R&C, with each subject to separate limits of 52 visits per calendar year.

Note: The HCN covers emergency detoxification as an inpatient treatment. Confinement in an in-network halfway house is covered by the HCN; out-of-network care is not covered. For inpatient detoxification to be covered by the HCN, it must be followed by an approved and completed rehabilitation program.

Emergency Mental Health Care and Substance Abuse Treatment

If you or a covered dependent needs emergency mental health care 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 UBH first. However, within 48 hours of admission (or the next business day, if sooner), you or your representative must contact UBH 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 UBH for certification for your care to be covered.

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

- If UBH 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
- If UBH 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

- Travel, whether or not recommended or prescribed as part of treatment.

Pre-Certification Requirements

To receive benefits under the HCN, 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 Important Benefits Contacts insert:

- Inpatient hospitalization

- Use of a birthing center (note that not all New England states have birthing centers)

- Confinement in a skilled nursing facility

- Home health care or hospice care

- Private duty nursing

- Certain outpatient procedures, services and tests, as determined by the respective claims administrator. **Note:** Blue Cross Blue Shield of Massachusetts does not require pre-certification for out-of-network outpatient procedures.

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

- 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. (If your PCP provides your care or refers you to a network specialist, the PCP or network specialist automatically will 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. 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 pages 116 through 126.)

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 will pay the regular level of benefits up to the number of days for inpatient treatment certified by the claims administrator. If the service or supply is determined not to be medically necessary, no benefits will be paid. Outpatient services and supplies will be paid if medically necessary. Otherwise, benefits will not be paid.

Reimbursement Rules Without Pre-Certification

If you fail to receive proper pre-certification for a service that requires pre-certification and if services and supplies are determined not to be medically necessary by the claims administrator, your care will not be covered by the Medical Plan.

Individual Case Management (ICM) Program

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

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

- Spinal cord injury
- High-risk neonates
- Acute psychiatric illness
- Long-term infections

- Cancer
- Stroke
- Severe head trauma.

The ICM Program provides the following services:

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

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

Emergency Care

If you need emergency care, go to the nearest emergency facility. There's no need to contact your PCP first, but you or a family member should call your PCP within 48 hours of receiving emergency medical treatment. Your expenses for emergency treatment will be covered at 100 percent whether or not you use a network hospital, provided the event meets the definition of emergency.

The emergency room should be used only for true medical emergencies. If your illness or injury does not require immediate hospital attention, your first step should be to call your PCP. **(Your network PCP or an associated practitioner is required to be available 24 hours a day.)**

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 and/or if you go to an emergency room and the condition is determined not to be an emergency, the HCN will pay 70 percent of NNF (70 percent of actual charges if you visit a non-network hospital or emergency facility), subject to medical necessity (as determined by the claims administrator), and you'll have to satisfy the out-of-network annual deductible of $250.

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 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 is covered.

- Dental surgery is covered only as a result of accidental injury to sound natural teeth while the individual is covered by the Plans. 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, subject to the following:

  — When the recipient and donor both are covered persons under the 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 HCN. When the second surgical opinion is nonconcurring, the HCN will cover a third surgical opinion and associated diagnostic tests on the same basis as a second surgical opinion. To be covered, the second and third opinions must be provided by a doctor who is a network provider.

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 or if the child has been enrolled as a Class II Dependent. Because of this, the newborn child of an unmarried dependent must be enrolled as a Class II Dependent to be covered.

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:

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

- 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 (in-network only), you or your covered spouse (or same-sex domestic partner) is 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 HCN physician and which are pre-authorized by the claims administrator as being medically appropriate for individuals in similar circumstances. ART procedures are covered under the HCN only if you or your spouse or same-sex domestic partner have 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
- Charges for a surrogate parent.

Covered Hospital Services and Supplies

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

- Room and board in a semi-private 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 or Class II 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 commercially are 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:

- 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 and healthy teeth while the individual is covered by the Plan.

- Hospitalization that primarily is for diagnostic tests, X rays, laboratory exams, electrocardiograms, electroencephalograms or physical therapy

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

- Hospitalization that began after coverage had 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 (maximum out-of-network benefit is $1,500 per calendar year). Also, if your HCN coverage is administered by Blue Cross Blue Shield of Massachusetts, diagnostic X rays and laboratory tests performed in connection with chiropractic care also are covered as part of chiropractic services.

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

- Diabetic kits (available by home delivery pharmacy through the Medco Health prescription drug program).

- Diagnostic services.

- Durable medical equipment.

- Obesity treatment (covered in-network only), including surgery, for medically necessary treatment of clinical obesity and prescription appetite suppressants when pre-authorized by your PCP. 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.

- 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

  — 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.

- 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.

- 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.

Medical Expenses Not Covered by the HCN

The following are some of the expenses that the HCN 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.

- 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 on page 47.

- 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 means, 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 R&C amount 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.

- 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 Health Care Policy and Research (AHCPR) 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 Advisory Committee on Immunization Practices

  — The National Cancer Institute

  — The Agency for Health Care Research and Quality

  — The Council of Medical Specialty Societies (DMSS)

  — 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 HCN.
- 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.
- Routine foot care, unless medically necessary, as defined by the claims administrator.
- Non-prescription drugs.

The Empire MEP Indemnity and Aetna MEP PPO Options

You have a choice of the Empire MEP Indemnity option or the Aetna MEP Preferred Provider Organization (PPO) option. The Empire MEP Indemnity option is a traditional medical plan and is administered by Empire BlueCross BlueShield. The Aetna MEP PPO option offers the same traditional medical plan, but also includes a PPO. This option is administered by Aetna, Inc.

Note

For more information about covered services, contact the appropriate claims administrator. See page 117 for a list of administrators. You can reach your claims administrator via the telephone number shown on your Important Benefits Contacts insert.

Empire MEP Indemnity Option

The Empire MEP Indemnity option allows the use of any doctor or hospital you choose. The Empire MEP Indemnity option pays benefits as a percentage of reasonable and customary (R&C) charges or the negotiated discounted fee (if you use an Indemnity Participating Network (IPN) provider in some areas of New York—see below for information), after you meet the deductible.

For New York IBEW and New York CWA-represented associates, the Empire MEP Indemnity option includes an IPN feature, which provides benefits based on a negotiated discounted fee when you use participating providers. The IPN consists of a network of providers in selected counties of New York State. The IPN can include an ancillary provider network with cost discounts for laboratories, radiology, anesthesiology, durable medical equipment and home health care services. The IPN provider files claims on your behalf so there is little or no paperwork to fill out. The Empire MEP Indemnity option reimburses your IPN costs based on the same rules as the regular Empire MEP Indemnity option. However, because IPN reimbursement is based on the discounted rate (which generally is lower than the R&C), your out-of-pocket costs typically are less.

Aetna MEP PPO Option

A PPO is a network of doctors, hospitals and other providers who agree to meet strict quality standards for treatment and utilization and provide services according to a network negotiated fee (NNF) schedule. The PPO offers the flexibility of going in or out of the PPO network for care. The out-of-network benefits under the Aetna MEP PPO option are the same as the Empire MEP Indemnity option benefits.

Plan Details

Annual Deductible

Each calendar year before the Empire MEP Indemnity option or the Aetna MEP PPO option pays benefits for medical expenses (not including prescription drugs and mental health and substance abuse treatment) that are subject to the deductible (those classified as Other Covered Charges—see page 64), a covered individual must meet the individual annual deductible in effect for the plan year ($150 in 2004). However, if expenses applied toward the deductible for covered family members (you, your Class I and Class II Dependents) total the family deductible (2-1/2 times the individual deductible), then no further individual deductibles apply for the remainder of the calendar year.

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.

The following expenses do not apply toward meeting the deductible:

- Charges other than coinsurance amounts for the services and supplies described on pages 68 through 74
- Charges that are not covered by the Empire MEP Indemnity option or the Aetna MEP PPO option
- Amounts in excess of R&C
- Any charges for failing to pre-certify health care when pre-certification is required
- Copayments for in-network office visits
- Charges for prescription drugs
- LASIK services.

Note: There is a separate annual deductible of $50 for prescription drugs when a non-participating pharmacy is used. See page 72 for information.

Common Accident Provision

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

Annual Deductible

Effective January 1, 2004, the annual deductible is $150. The deductible will increase under the Empire MEP Indemnity option and the Aetna MEP PPO option to $200 on January 1, 2006 and to $250 on January 1, 2008.

However, if you enroll in the Empire MEP Indemnity option or the Aetna MEP PPO option, reside outside the PPO service area and are not eligible to participate in the HCN, the future increases to the deductible will not apply.

Year-End Carryover

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

Coinsurance and Copayments

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

The amount you are required to pay and the amount the Empire MEP Indemnity option or the Aetna MEP PPO option pays for your covered expenses will depend on the type of service you receive. See the chart on pages 68 through 74 for the amount the Medical Plan pays for covered services.

Office Visit Copayment

If you are enrolled in the Aetna MEP PPO option, effective January 1, 2004, the in-network office visit copayment is $10. It will increase to $15 on January 1, 2005.

Plan Benefits

In-Network Aetna MEP PPO Option

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

When you receive your care in-network, the same services and supplies as for the Empire MEP Indemnity option are covered, but with enhanced in-network benefits:

- For inpatient hospital admissions and ancillary services and supplies in a semi-private room (for confinement other than for mental health care or substance abuse treatment), as well as for the covered services described in the section below (for the Empire MEP Indemnity option and out-of-network Aetna MEP PPO option), the in-network Aetna MEP PPO option pays 100 percent of the NNF, with no deductible required

- Many of the charges identified as Other Covered Charges on pages 64 and 65 are covered at 100 percent with no deductible.

See the chart on pages 68 through 74 for specific provision information.

Empire MEP Indemnity Option and Out-of-Network Aetna MEP PPO Option

The following describes coverage provided for certain expenses covered under both the Empire MEP Indemnity option and the out-of-network Aetna MEP PPO option. Additional expenses may be covered. If you have any questions about whether an expense is covered, call the health plan's Member Services.

- The Empire MEP Indemnity option and the out-of-network Aetna MEP PPO option will pay 100 percent of the R&C (or the negotiated discounted fee if applicable to Empire MEP Indemnity option charges) for the following:

  — Inpatient hospital admissions and ancillary services and supplies in a semi-private room up to 120 days per confinement (for confinement other than for mental health care or substance abuse treatment). In the case of confinement in a hospital with only private rooms, the Empire MEP Indemnity option and the out-of-network Aetna MEP PPO option will pay 90 percent of the most prevalent private room rate of that hospital.

  — Emergency room charges when provided within 72 hours of an accidental injury or the onset of a sudden, serious, life-threatening illness.

  — Certain outpatient surgery (described on page 70).

  — Second (and third) surgical opinions, if pre-certified, and associated X rays and pathology.

  — Ambulance service (other than air ambulance) if for a medical emergency or if necessary for transportation from one hospital to another.

  — Use of an ambulatory surgical facility or birthing center (and applicable ancillary charges).

  — Diagnostic X ray (excluding dental services) and laboratory tests, except as otherwise specified.

  — Home health care services, if pre-certified.

  — Radiation therapy, chemotherapy and hemodialysis (except home dialysis).

  — Electroshock therapy and related anesthesia.

— Care in a skilled nursing facility, if pre-certified.

— Hospice care (except bereavement counseling), if pre-certified.

— Anesthesia or sedation and its administration when in conjunction with outpatient endoscopic procedures.

- The Empire MEP Indemnity option and the out-of-network Aetna MEP PPO option coverage will pay 95 percent of R&C (or the negotiated discounted fee if applicable to Empire MEP Indemnity option charges) for:

  — Most covered inpatient surgery, except as described on page 84

  — Outpatient surgery, except as provided on page 70.

- The covered person's coinsurance amount will be considered Other Covered Charges. The Empire MEP Indemnity option and the out-of-network Aetna MEP PPO option coverage will pay 90 percent of R&C (or the negotiated discounted fee if applicable to Empire MEP Indemnity option charges) for:

  — Anesthesia (except when provided with respect to electroshock therapy or along with outpatient surgery)

  — In-hospital physician's visits and consultations up to the 30-day or 120-day limit, whichever applies to the covered person's confinement

  — Newborn care, as described on page 86

  — Emergency care in a physician's office.

- The covered person's coinsurance amount will be considered Other Covered Charges.

- The Empire MEP Indemnity option and the out-of-network Aetna MEP PPO option coverage will pay 50 percent of R&C (or the negotiated discounted fee if applicable to Empire MEP Indemnity option charges) for:

  — Bereavement counseling, if provided within six months following the covered person's death and subject to limits established by the claims administrator.

The covered person's coinsurance amount will be considered Other Covered Charges.

Other Covered Charges

The following describes services and supplies that are considered "Other Covered Charges." Other Covered Charges are generally covered at 80 percent of the R&C charge or the negotiated discounted fee (if applicable) after you've met your deductible (if applicable) and your coinsurance is the remaining 20 percent. Other Covered Charges include:

- Air ambulance when medically necessary.
- 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). Please contact your claims administrator for further details.
- Chiropractic care.
- Dental services rendered as a result of an accidental injury to sound natural teeth that occurs while covered by the Plans.
- Durable medical equipment.
- Home dialysis treatment.
- Outpatient mental health care and substance abuse treatment (including treatment in a halfway house).
- Physical, speech and occupational therapies.
- Physicians' home and office visits (except as otherwise specified in the Plan).
- Podiatric services when the services performed are covered services common to medicine and podiatry, as determined by the claims administrator (routine foot care is not covered).
- Private duty nursing, but only to the extent the nursing is determined to be medically necessary by the claims administrator.

- Prostheses, including eyeglasses or contact lenses following intraocular surgery or intraocular injury, including exams for prescribing and fitting such eyewear; 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; 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. Replacement of a prosthesis is covered only when a replacement is necessary due to the normal growth of a child. Replacements also are covered if necessary due to illness or injury. Dental appliances are excluded under the Plan, except when required as part of treatment for accidental injury of sound natural teeth for which benefits are payable under the Plan. Replacement of cataract lenses also are excluded, unless needed because of a lens prescription change.

- Coinsurance amounts you pay for covered services identified in the Plan Benefits section (that begins on page 61) for which it is stated that the covered person's coinsurance amount will be considered Other Covered Charges.

- Inpatient mental health care received after 30 days of a single confinement (confinements separated by less than 180 days will be considered a single confinement).

- Inpatient hospitalization (other than for mental health care or substance abuse treatment) received after 120 days of a single confinement (confinements separated by less than 90 days are considered a single confinement).

- In hospital physician's visits after the 30- or 120-day limit, as applicable.

Note: Other Covered Charges do **not** include:

- Services and supplies not covered by the Plan

- Amounts you pay toward multiple surgical procedures, as described on page 84

- Any additional amounts you pay as a result of failure to follow pre-certification procedures, as described on pages 77 through 80

- Amounts you pay for prescription drugs, as described on pages 95 through 102.

Annual Out-of-Pocket Maximum

Whether you are covered by the Empire MEP Indemnity option or the Aetna MEP PPO option and receive your care in- or out-of-network, there are separate out-of-pocket expense maximums for medical, prescription drug and mental health and substance abuse benefits. The separate out-of-pocket maximums for 2004 and 2005 are:

- Medical: $600 per person, per calendar year
- Prescription drug program: $200 per person, per calendar year
- Mental health care and substance abuse treatment: $200 per person, per calendar year.

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

- Charges that are not considered "Other Covered Charges" under the Empire MEP Indemnity option and the Aetna PPO option
- Amounts paid to satisfy the deductible
- Copayments for doctor's visits
- Charges that are not covered by the Medical Plan
- Charges in excess of the R&C charge or charges in excess of any applicable Empire MEP Indemnity or Aetna MEP PPO option maximums
- Amounts you pay if you fail to pre-certify medical services
- Amounts you pay for outpatient mental health care provided by a non-United Behavioral Health (UBH) provider, when there is an approved UBH provider within 40 miles of your home
- Amounts you or your covered dependents pay for LASIK services
- Charges in excess of obesity and fertility treatment maximums.

Out-of-Pocket Maximum

The annual out-of-pocket maximums under the Empire MEP Indemnity option and Aetna MEP PPO option will increase in future years as follows:

- Medical:
  $650 on January 1, 2006;
  $700 on January 1, 2008
- Prescription drug program:
  $250 on January 1, 2006;
  $300 on January 1, 2008

However, if you enroll in the Empire MEP Indemnity option or the Aetna MEP PPO option, reside outside the PPO service area and are not eligible to participate in the HCN, increases to the out-of-pocket maximum will not apply.

Paying for Care and Filing Claims

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

If you participate in the Empire MEP Indemnity option or Aetna MEP PPO 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 the claims administrator.

After the claims administrator has received the bill for your care, it will determine your benefits and, if appropriate, reimbursement will be made. It also will send you an Explanation of Benefits (EOB) statement. The EOB shows how much of the bill the Plan paid and how much (if any) remains for you to pay. After you receive the EOB, you should receive a new bill from your medical provider for any remaining amount not covered by the Plan.

Requesting a Claim Form

If you need to file a claim for benefits, you should contact the appropriate administrator for a claim form.

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.

Empire MEP Indemnity and Aetna MEP PPO Option Coverage Summary

The table in this section provides an overview of the benefits payable for covered services and supplies provided by the Empire MEP Indemnity option and the Aetna MEP PPO option. Charges in excess of R&C amounts will not be covered by the Medical Plan. If a charge for a covered service exceeds the R&C, the Empire MEP option's Indemnity and the Aetna MEP PPO option's reimbursement percentage will be applied to the R&C amount, and you may be responsible in full for the difference between the billed charges and the R&C amount. You must pre-certify medical care, as specified on pages 77 through 80. Certain other restrictions may apply—for additional information, see the "Additional Information" section beginning on page 116. (See pages 90 through 94 for a list of expenses that are not covered.)

Empire MEP Indemnity Option and Aetna MEP PPO Option	Plan Feature
Annual Deductible Requirements Applies only to "Other Covered Charges" on a calendar-year basis	*Individual:* $150 ($200 on January 1, 2006; $250 on January 1, 2008)[1] *Family Deductible:* 2–1/2 times individual deductible
Annual Out-of-Pocket Maximum Applies on a calendar-year basis. Does not apply to: charges that are not considered "Other Covered Charges" under the Medical Plan, amounts paid to satisfy the deductible, charges that are not covered by the Medical Plan, charges in excess of the R&C charge or charges in excess of any applicable Medical Plan maximums, amounts you pay if you fail to pre-certify medical services, copays for office visits, amounts you pay for outpatient mental health care provided by a non-UBH provider when there is an approved UBH provider within 40 miles of your home, amounts you or your covered dependents pay for LASIK services and charges in excess of obesity and fertility maximum	Maximums apply to both the Empire MEP Indemnity and the Aetna MEP PPO options; under the Aetna MEP PPO option, in-network and out-of-network benefits are combined in applying these maximums: • Medical: $600 per person, per calendar year; increasing to $650 on January 1, 2006; $700 on January 1, 2008[1] • Prescription drug program: $200 per person, per calendar year; increasing to $250 on January 1, 2006 and $300 on January 1, 2008[1] Mental health care and substance abuse treatment: $200 per person, per calendar year
Lifetime Maximum Benefit	None for active associates

(See page 74 for footnotes.)

	Aetna MEP PPO Option In-Network	Empire MEP Indemnity Option and Aetna MEP PPO Option Out-of-Network
When Benefits Are Paid	Unless otherwise noted, for care that is medically necessary, benefits are based on the network negotiated fee (NNF)	Unless otherwise noted, for care that is medically necessary, benefits are based on the R&C charge or if applicable for the Empire MEP Indemnity option, the negotiated discounted fee
Inpatient Hospital Services		
Room, Board and Ancillary Services in a semi-private room of a hospital or in an intensive care unit, including maternity care stays (excludes stays for mental health or substance abuse treatment)	100% (no deductible)	For the first 120 days of a single stay, 100% (no deductible), if pre-certified After the first 120 days of the same stay, 80% after deductible, if pre-certified
In-Hospital Physician's Visits. Does **not** include visits for customary pre- and post-operative care or for eye exams or the fitting of eyeglasses and subject to other limits set by the claims administrator	100% (no deductible)	For the first 120 days (30 days for confinement for mental health or substance abuse treatment) of a single stay; up to 1 visit per day, 90% (no deductible); Medical Plan also pays 80% of your remaining 10% coinsurance, after deductible For visits after the first 120 days (30 days for confinement for mental health or substance abuse treatment) of the same stay, 80% of after deductible
Maternity Care (including associated in-hospital physician's services and surgery)	100% (no deductible)	95% (no deductible); Medical Plan also pays 80% of your remaining 5% coinsurance, after deductible
Newborn Baby Care (initial pediatric exam while mother is hospitalized); limited to Class I Dependents and newborns of Class II Dependents, if newborn is enrolled as a Class II Dependent	100% (no deductible)	90%; Medical Plan also pays 80% of your remaining 10% coinsurance, after deductible
Skilled Nursing Facilities	100% (no deductible), if pre-certified	100% (no deductible), if pre-certified
Birthing Centers	100% (no deductible), if pre-certified	100% (no deductible), if pre-certified
Hospice Care	100% (no deductible), if pre-certified (excluding bereavement counseling, which is covered at 50% during the 6 months after the individual's death)	100% (no deductible), if pre-certified (excluding bereavement counseling, which is covered at 50% during the 6 months after the individual's death)

(See page 74 for footnotes.)

	Aetna MEP PPO Option In-Network	Empire MEP Indemnity Option and Aetna MEP PPO Option Out-of-Network
Surgery and Anesthesia		
Inpatient Surgery	100% (no deductible)	95% (no deductible); Plan also pays 80% of your remaining 5% coinsurance, after deductible
Outpatient Surgery	100% (no deductible)	100% (no deductible) for surgeon, anesthesiologist and facility when part of the outpatient surgical program and for a procedure covered by the outpatient surgical program If procedure is not covered by the outpatient surgical program, 95% (no deductible); Plan also pays 80% of your remaining 5% coinsurance, after deductible
Anesthesia	100% (no deductible)	90% (no deductible); Plan also pays 80% of your remaining 10% coinsurance, after deductible; 100% when rendered on an outpatient basis for a procedure included in the outpatient surgical program or when administered in a physician's office for an endoscopic procedure
Outpatient Treatments		
Doctors' Office Visits	100% after $10 copay ($15 after January 1, 2005)	80% after deductible (excludes preventive care visits, unless for an annual Pap test)
Doctors' Home Visits	100% after $10 copay ($15 after January 1, 2005)	80% after deductible (excludes preventive care visits, unless for an annual Pap test)
X rays and Lab Tests	100% (no deductible), including allergy tests and mammograms	100% (no deductible), including allergy tests and mammograms
Radiation therapy, chemotherapy, electroshock therapy, hemodialysis	100% (no deductible)	100% (no deductible)
Physical, Occupational and Speech Therapy (duration must be prescribed by your doctor)	80%[2] after deductible	80% after deductible
Licensed Chiropractor	80%[2] after deductible	80% after deductible
Private Duty Nursing	80% after deductible, if medically necessary	80% after deductible, if medically necessary

(See page 74 for footnotes.)

	Aetna MEP PPO Option In-Network	Empire MEP Indemnity Option and Aetna MEP PPO Option Out-of-Network
Well-Baby/Child Exams	100% *Age 0-2 years as prescribed* *Age over 2-25: 1 exam every year; includes immunizations*	Not covered
Adult Physical Exams	100% *Age over 25-50: 1 exam every 2 years* *Age 50 and over: 1 exam every year*	Not covered
Immunizations and Flu Shot	100% *1 complete regimen of immunizations and 1 flu vaccine annually for children and adults*	Not covered
Fecal Occult Test	100% *Age 18-39: 1 every 2 years* *Age 40 and over: 1 every year*	Not covered
Colonoscopy or Sigmoidoscopy (and related anesthesia)	100% *Age 50 and over: 1 every 3 years*	Not covered
Routine Mammogram	100% *1 annual routine mammogram for women regardless of age*	100% (no deductible), subject to age and frequency schedule
Well-Woman Exam	100% after $10 copay ($15 after January 1, 2005) *1 well-woman exam, every year, regardless of age and with or without a Pap test, including the blood count and urinalysis*	100% (no deductible) for Pap test, 80% after deductible for related office visit
Prostate-Specific Antigen Test	100% *For men age 18-49: 1 every 2 years* *For men age 50 and over: 1 every year*	Not covered
Allergy Testing	100% (no deductible)	100% (no deductible)
Home Health Care	100% (no deductible), if pre-certified	100% (no deductible), if pre-certified

(See page 74 for footnotes.)

Prescription Drugs	Aetna MEP PPO Option and Empire MEP Indemnity Option: Using Participating Pharmacy	Aetna MEP PPO Option and Empire MEP Indemnity Option: Using Non-Participating Pharmacy
Retail Pharmacy (supply appropriate for up to 30 days of therapy)		
Annual Deductible	No deductible required	$50 combined for generic and brand name
Annual out-of-pocket maximum	$200 per covered individual; no family limit	$200 per covered individual; no family limit
Coinsurance • Generic	You pay 15% of the discounted network price (DNP) but no more than $25 per prescription	You pay 15% of the retail cost but no more than $25 per prescription
• Brand-name drugs when generic is not available, or if a generic is available but physician has ordered the prescription to be "dispensed as written" (DAW)	You pay 20% of the DNP but no more than $40 per prescription	You pay 20% of the retail cost but no more than $40 per prescription
• Brand-name drugs when generic is available and the doctor does not order the prescription to be DAW	You pay 30% of the DNP but no more than $50 per prescription	You pay 30% of the retail cost but no more than $50 per prescription
Medco Health Home Delivery Pharmacy Service (supply appropriate for up to 90 days of therapy)		
• Generic	You pay $8 copay or the DNP, whichever is less	
• Brand-name drugs when generic is not available, or if a generic is available but physician has ordered the prescription to be DAW	You pay $12 copay or the DNP, whichever is less	
• Brand-name drugs when generic is available and the doctor does not order the prescription to be DAW	You pay $20 copay or the DNP, whichever is less	

(See page 74 for footnotes.)

Mental Health/Substance Abuse	
Mental Health/Substance Abuse These benefits are the same for the Empire MEP Indemnity option and the Aetna MEP PPO option. These benefits are administered by UBH, which provides a network for participating providers at discounted rates. See pages 75 and 76 for details.	
Inpatient mental health care	For the first 30 days of a single confinement, the following rules apply: • If care is received through a UBH provider, the Plan pays 100% of the NNF, if pre-certified • If care is received through a non-UBH provider, the Plan pays 80% of R&C, if pre-certified • If care is received through a non-UBH provider and there is no UBH provider within 40 miles of the member's home, the Plan pays 100% of R&C, if pre-certified • After the first 30 days for a single confinement, the Plan will pay 80% of R&C
Outpatient mental health care	• If care is received through a UBH provider, the Plan pays 80% of NNF • If care is received through a non- UBH provider, the Plan pays 80% of R&C; limited to $80 per visit, 1 visit per day ($85 per visit, 1 visit per day for psychiatrists), up to a maximum of 52 visits per plan year • If care is received through a non-UBH provider and if there is no UBH provider within 40 miles of the member's home, the Plan pays 80% of R&C; however, benefits shall be limited to $90 per visit, 1 visit per day ($110 per visit, 1 visit per day after the out-of-pocket expense maximum has been reached)
Inpatient substance abuse treatment[3]	100% of R&C charges up to 30 days per confinement in an approved facility. In a non-approved facility the benefit is $250 per day up to 30 days per confinement[4]
Detoxification[3]	100% of R&C up to 30 days per confinement; after 30 days, 80%, if pre-certified
Outpatient substance abuse treatment[3]	80%; limited to a maximum of 52 visits per covered person, per year if an approved facility is not used[5]; counseling services that are not part of a day service program or an outpatient program are limited to 2 visits per week, up to 52 visits per calendar year

(See page 74 for footnotes.)

	Aetna MEP PPO Option In-Network	Empire MEP Indemnity Option and Aetna MEP PPO Option Out-of-Network
Other Services		
Durable Medical Equipment	80%[2] after deductible	80% after deductible
Ambulance Services	100% (no deductible)	100% after deductible
Prosthetic Devices	80%[2] after deductible	80% after deductible
Emergency Room Care (within 72 hours of injury or onset of illness and only in the case of an emergency)	100% (no deductible)	100% (no deductible)

[1]Increases do not apply for participants who enroll in the Empire MEP Indemnity option or Aetna MEP PPO option, reside outside the PPO service area and are not eligible to participate in the HCN.
[2]Coinsurance is applied to the NNF or the actual price, if less than the NNF.
[3]Class II Dependents and Sponsored Children are not eligible for coverage for substance abuse treatment.
[4]There is a two-stay per lifetime limit for rehab only.
[5]For confinement in an approved halfway house, the Medical Plan pays 80% of R&C, for up to 30 days of confinement, but limited to two 30-day stays per lifetime.

The following section provides information about special coverage rules for:

- Mental health and substance abuse
- Pre-certification rules
- The Individual Case Management (ICM) Program
- Recommended outpatient surgical procedures
- Surgery coverage
- Maternity and newborn care
- BlueCard program (for Empire MEP Indemnity option only)
- Covered hospital services and supplies.

Prescription drug coverage is described on page 95.

Mental Health Care and Substance Abuse Treatment

Mental health care and substance abuse treatment coverage for Empire MEP Indemnity option and Aetna MEP PPO option participants is administered by UBH, giving you access to a large network of providers and trained counselors that offer you an individualized approach to mental health care and substance abuse treatment. Generally, all participants in the Empire MEP Indemnity option and Aetna MEP PPO option, including your dependents, are eligible for mental health care benefits. However, benefits for substance abuse treatment are not available to Class II Dependents and Sponsored Children or surviving dependents, including dependents of a deceased associate who receive 24 months of Company-paid coverage.

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

Inpatient Mental Health Benefits

For inpatient mental health care in an approved UBH facility, the Plan will pay 100 percent of NNF for up to 30 days of a single confinement, if pre-certified. In addition, the Plan will pay:

- 100 percent of R&C for up to 30 days of a single confinement in an alternate care facility (if pre-certified) or any other facility if there is no approved UBH facility within 40 miles of your home

- 80 percent of R&C for up to 30 days for a single confinement for care in any other facility not mentioned above, if pre-certified. Regardless of where you receive your care, after the first 30 days of a single confinement, inpatient mental health care is covered as Other Covered Charges. Inpatient mental health admissions separated by less than 180 days will be considered a single confinement.

For emergency admissions to a non-UBH facility for covered mental health care, the Plan will pay 100 percent of R&C 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.

Outpatient Mental Health Care Benefits

For outpatient mental health care provided by an approved UBH provider, the Plan will pay 80 percent of the NNF. In addition, the Plan will pay:

- 80 percent of R&C if you choose to receive your care from a non-UBH provider but there is an approved UBH provider within 40 miles of your home. However, benefits will be limited to $80 per visit, one visit per day ($85 per visit, one visit per day for psychiatrists), up to a maximum of 52 visits per year. The out-of-pocket maximum does not apply.

- 80 percent of R&C for care provided by a non-UBH provider if there is no approved UBH provider within 40 miles of your home. However, benefits will be limited to $90 per visit, one visit per day ($110 per visit after the out-of-pocket expense maximum has been reached).

Inpatient Substance Abuse Treatment

For inpatient substance abuse treatment in an approved facility, the Plan pays 100 percent of R&C for up to 30 days per confinement. For treatment in a non-approved facility, the Plan will pay up to $250 per day for up to 30 days per confinement. In addition, inpatient substance abuse treatment, including stays in an approved facility, is limited to two 30-day stays per lifetime.

For emergency detoxification, the Plan pays 100 percent of R&C up to 30 days per single confinement. After 30 days, the Plan pays 80 percent if pre-certified.

Confinements separated by less than 180 days will be considered a single confinement.

Outpatient Substance Abuse Treatment

For outpatient substance abuse, the Plan pays 80 percent of R&C charges. Coverage is limited to 52 visits per calendar year if a non-approved facility is used. Also, halfway houses are covered at 80 percent for up to 30 days per confinement, but limited to two 30-day stays per lifetime.

Pre-Certification Requirements

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

If you and your physician decide that you need hospitalization, you should call the appropriate administrator—Empire or Aetna—to begin the pre-certification process. The health care administrator then will 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 under the Empire MEP Indemnity option or out-of-network Aetna MEP PPO option:

- **Nonemergency hospital stays.** You must call your 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 health care 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 periodically will review the covered person's case and may modify the number of days of confinement initially authorized. If a covered person enrolled in the Aetna MEP PPO option is hospitalized in an in-network hospital, no further action is required on that person's part. If a covered person is hospitalized under the Empire MEP Indemnity option, or is hospitalized in an out-of-network facility under the Aetna MEP PPO option 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 Empire MEP Indemnity option or Aetna MEP PPO 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 by the Empire MEP Indemnity option or Aetna MEP PPO option, the covered person or his or her physician may appeal the claims administrator's decision by providing additional information supporting the necessity of the additional days of hospitalization. (See pages 120 through 126 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 under "Reimbursement Rules Without Pre-Certification." 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 either the Empire MEP Indemnity option or for an out-of-network facility under the Aetna MEP PPO option, and the claims administrator determines that your services are medically necessary, the Empire MEP Indemnity option or Aetna MEP PPO option will pay regular Medical Plan benefits up to the number of days certified by the claims administrator. If services, supplies or treatment are determined not to be medically necessary, no benefits will be paid. Pre-certification for medically necessary inpatient care for hospitalization at an in-network facility under the MEP PPO option will be handled by your doctor.

Reimbursement Rules Without Pre-Certification

Under the Empire MEP Indemnity option or out-of-network under the Aetna MEP PPO option, if you do not obtain pre-certification within the required time or if your hospitalization is not certified, your benefits may be reduced to 80 percent of the amount the Empire MEP Indemnity or Aetna MEP PPO option would have paid for each day of hospitalization per hospital stay had certification been received. The most your benefits will be reduced, however, is the lesser of $1,000 or 2.5 percent of your annual pay. Benefits won't be reduced if your stay is equal to or shorter than what would have been certified by the administrator.

In the case of an emergency or maternity admission (other than an admission to a birthing center) under the Empire MEP Indemnity option or out-of-network under the Aetna MEP PPO option, you must notify the claims administrator of the admission within five days; otherwise, hospital and physician benefits for the unapproved days beyond five days will be reduced, as described above. The reduction in benefits will not apply, however, to a maternity admission if the covered individual is enrolled and participates in the Healthy Pregnancy Program during the first trimester of her pregnancy or for charges incurred during the first 48 hours of a stay resulting from a vaginal delivery or 96 hours for a cesarean section.

Any penalties you pay for uncertified hospital stays will not count toward satisfying the deductible or toward your annual out-of-pocket maximum.

Individual Case Management (ICM) Program

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

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

- Spinal cord injury
- High-risk neonates
- Acute psychiatric illness

- Long-term infections
- Cancer
- Stroke
- Severe head trauma.

The ICM Program provides the following services:

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

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

Outpatient Surgery

In-network Aetna MEP PPO option

If you receive your care in-network under the Aetna MEP PPO option, all outpatient surgical procedures as well as diagnostic x-ray, laboratory and other associated services are covered at 100 percent, with no deductible applied.

Empire MEP Indemnity option and out-of-network Aetna MEP PPO option

If you are in the Empire MEP Indemnity option or receive your care out-of-network under the Aetna MEP PPO option, your benefits vary depending on whether or not the surgical procedure is covered by the outpatient surgical program:

- When the following eligible surgical procedures are performed on an outpatient basis, the Empire MEP Indemnity option or Aetna MEP PPO option will pay 100 percent of the R&C amount or negotiated discounted fee for that surgery (when determined by the claims administrator to be medically necessary):

  — Knee surgery

  — Biopsy of breast and/or lymph nodes

  — Foot surgery (including bunionectomy and hammertoe repair)

  — Removal of cysts, tumors and lipomas

  — Incision and/or repair of tendons or tendon sheath

  — Surgery on enlarged or varicose veins

  — Surgery on nerves and nerve tissue

  — Removal of mastoid process

  — Hernia repair

  — Partial excision or nasal septum

  — Removal of hemorrhoids

  — Dilation and curettage (D&C)

— Surgery to correct eye muscle imbalance

— Colonoscopy, cystocopy, bronchostopy, other scope procedures and related anesthesia or sedation

— Pelvic examination under anesthesia (as an independent procedure)

— Blepharoplasty (repair of drooping upper eyelids)

— Myringotomy (draining of ear drum)

— Gastroscopy (inspection of the inner surface of the stomach).

In addition, the Empire MEP Indemnity option or Aetna MEP PPO option also will pay 100 percent of R&C or negotiated discounted fee for diagnostic x-ray, laboratory and other associated services with no deductible applied.

- If you receive an outpatient surgical procedure not listed above, the Empire MEP Indemnity option or Aetna MEP PPO option out-of-network will pay 95 percent of the R&C amount or the negotiated discounted fee, with no deductible applied. (The Empire MEP Indemnity option or Aetna MEP PPO option out-of-network also will pay 80 percent of your remaining 5 percent coinsurance after the deductible.)

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 is covered.

- Dental surgery is covered only as a result of accidental injury to sound natural teeth while the individual is covered by the Plans. 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 under the Aetna MEP PPO option are governed by contract arrangements between Aetna, Inc. and their network participating providers. The following rules do not apply to in-network procedures provided under the Aetna MEP PPO option:

  — 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 Empire MEP Indemnity option or out-of-network Aetna MEP PPO option benefits will be paid for the major procedure. The secondary procedures will be paid at 50 percent of the regular Empire MEP Indemnity option or Aetna MEP PPO 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 Empire MEP Indemnity option or out-of-network Aetna MEP PPO 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 Empire MEP Indemnity option or Aetna MEP PPO option, subject to the following:

  — When the recipient and donor both are 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 Empire MEP Indemnity Plan option or Aetna MEP PPO option. When the second surgical opinion is nonconcurring, the Empire MEP Indemnity option or Aetna MEP PPO option will cover a third surgical opinion and associated diagnostic tests on the same basis as a second surgical opinion. If you receive a second or third surgical opinion, contact your health Plan's Member Services for more information on filing claims.

Pre-Determination of Benefits

If you want to know in advance how much of your surgical costs will be covered by the Empire MEP Indemnity option or Aetna MEP PPO option, contact the claims administrator. The Medical Plan provides a procedure for pre-determination of Empire MEP Indemnity option or Aetna MEP PPO option surgical benefits. Under this procedure, based on information supplied by the employee and/or his or her medical provider, the employee will receive information on whether the proposed surgery is covered, as well as an estimate of what benefits the Plan would allow for the proposed surgical procedure. It is understood, however, that the actual allowed benefits only can be determined after the actual claim is received because circumstances may require differences between the proposed surgical procedure and the surgery as actually performed. This estimate would not indicate how much the Empire MEP Indemnity option or Aetna MEP PPO option actually would pay the employee. The amount paid to the employee 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.

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 or if the child has been enrolled as a Class II Dependent. Because of this, the newborn child of an unmarried dependent must be enrolled as a Class II Dependent to be covered.

The Empire MEP Indemnity option or Aetna MEP PPO 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 Indemnity option or Aetna MEP PPO option:

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

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

BlueCard Program (for Empire MEP Indemnity Option Only)

The BlueCard Program provides you with access to care when outside of the Empire MEP Indemnity option claims administrator's service area. By presenting your ID card to a Blue Cross and/or Blue Shield participating hospital, physician or other provider outside of the Empire MEP Indemnity option claims administrator's service area (but within the U.S.), you may receive covered services or supplies and may benefit from any discounts that participating providers have agreed to extend to their local Blue Cross and/or Blue Shield plan.

Reproductive and Fertility Treatments (for Aetna MEP PPO Option Only)

Whether you receive your care in- or out-of-network under the Aetna MEP PPO 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. ART procedures are covered under the Aetna MEP PPO option only if you or your spouse or same-sex domestic partner have 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 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 Aetna MEP PPO option

- Charges for a surrogate parent.

Covered Hospital Services and Supplies

The hospital services and supplies covered under the Empire MEP Indemnity option and Aetna MEP PPO option are listed below:

- Hospital room and board for the first 120 days of a single confinement are covered as non-Other Covered Charges.
- Hospital room and board charges for stays beyond 120 days are considered Other Covered Charges. Confinements for the same or related medical conditions separated by less than 90 days are considered a single confinement.
- 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 commercially are 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 Empire MEP Indemnity option or Aetna MEP PPO 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 and healthy teeth while the individual is covered by the Plan.

- Hospitalization that primarily is 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 that began after coverage had 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 Empire MEP Indemnity Option or Aetna MEP PPO Option

The following are some of the expenses that the Empire MEP Indemnity option or Aetna MEP PPO 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 on page 83.

- 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 means, 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 R&C amount, 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 provided under the Aetna MEP PPO option and to Pap tests or mammograms under the Empire MEP Indemnity option or out-of-network under the Aetna MEP PPO option.

- Any service or supply for experimental purposes, including drugs or other care.

- 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 Policy and Research (AHCPR) 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 Advisory Committee on Immunization Practices

— The National Cancer Institute

— The Agency for Health Care Research and Quality

— The Council of Medical Specialty Societies (DMSS)

— 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, such as in vitro fertilization, artificial insemination and such other procedures, except as otherwise covered by the Plan as described on pages 49 and 87.

- 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 dietician 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.

- 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.

- Dental treatment, except as a result of an accidental injury to sound natural teeth that occurs while the individual is covered by the Empire MEP Indemnity option or Aetna MEP PPO option.

- Convenience items.

- Out-of-network well-baby/well-child care.

- 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, food supplements.

Prescription Drug Program

Whether you are in the Health Care Network (HCN), Empire MEP Indemnity option or the Aetna MEP Preferred Provider Organization (PPO) option, you have a prescription benefit through Medco Health Solutions, as described below.

Prescription Drug Program

You have three ways to get prescription drug coverage:

- By presenting your prescription drug ID card at a participating retail pharmacy. For the retail program, you can receive benefits for prescriptions written for a supply appropriate for up to 30 days of therapy, and for each refill.

- Using a retail pharmacy outside the network.

- Using the Medco Health Home Delivery Pharmacy Service, referred to as the "home delivery pharmacy," for a supply appropriate for up to 90 days of therapy (also referred to as maintenance drugs).

With the Empire MEP Indemnity option and Aetna MEP PPO option, regardless of where you purchase your prescriptions, you are protected from large out-of-pocket prescription drug expenses by the prescription drug out-of-pocket maximum. The prescription drug out-of-pocket maximum is $200 per person, per calendar year (increasing to $250 on January 1, 2006 and to $300 on January 1, 2008) and is completely separate from your medical out-of-pocket maximum. **Note:** This prescription drug out-of-pocket maximum does not apply to the HCN.

In-Network Benefits Using Your Prescription ID Card

Through the retail program, you will receive an ID card to use at participating pharmacies. When you use your ID card at an in-network pharmacy, you will receive in-network benefits for a supply appropriate for up to 30 days of therapy as follows:

- For a generic drug, you'll pay 15 percent (but no more than $25) of the discounted network price (DNP) for your prescription drugs.
- For a brand-name drug when a generic is not available, or if a generic is available but the physician has requested the prescription be "dispensed as written (DAW)," you'll pay 20 percent of the DNP (but no more than $40).
- If a generic is available and the physician has not requested DAW and you choose the brand-name drug, you'll pay 30 percent of the DNP (but no more than $50).

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.)

You generally do not have to file your own claim forms for prescriptions filled at an in-network pharmacy when you present your prescription drug ID card.

For information on participating pharmacies, call the toll-free telephone number that appears on your prescription program ID card.

Out-of-Network Benefits

You can use pharmacies outside the network. If you do, you first will have to pay a $50 per person annual deductible. You then will be reimbursed at the same percentages as in-network prescriptions, but based on the retail cost of the drug, so your costs usually will be much higher. At an out-of-network pharmacy, you will have to pay the full retail cost up front and file a claim to receive reimbursement.

Home Delivery Pharmacy

For maintenance drugs (for a supply appropriate for up to 90 days of therapy), you can use the home delivery pharmacy:

- For a generic drug, you'll pay $8 or the DNP, whichever is less.
- For a brand-name drug when a generic is not available, or if a generic is available but the physician has ordered the prescription to be DAW, you'll pay $12 or the DNP, whichever is less.
- If a generic is available and the physician has not requested DAW and you choose the brand-name drug, you'll pay $20 or the DNP, whichever is less.

Diabetic kits (consisting of, for example, insulin, apparatus and supplies) are available by the home delivery pharmacy when the order is placed as a single prescription order on the same day with insulin or other oral agents. A single payment applies.

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

If your prescription can be refilled, you'll receive a refill notice and pre-addressed envelope with your medication. To receive your refill, return the refill notice in the envelope provided. You also can order your refill online (see your Important Benefits Contacts insert for the Web site address). Be sure to request your refill about two to three weeks before you will need the refill.

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

Additional order forms and envelopes are available by calling Medco Health. (See your Important Benefits Contacts insert for the telephone number.) Order forms also can be obtained online. (See your Important Benefits Contacts insert for the Web site address.)

Note: For the retail program and home delivery pharmacy, a supply of medication (30-day supply, 90-day supply, etc.) refers to the amount of medication prescribed or typically consumed in a certain period of time. For example, a 30-day supply of a pill taken once a week equals four pills. If a drug is prescribed to be taken as needed, there may be limits on the amount of medicine covered by the Plan in a certain period of time.

Covered Drugs and Supplies

Drugs covered by the program must meet the general standards that apply to any medical claim. Drugs must be medically necessary to diagnose or treat an individual's illness or injury and must be safe, appropriate, effective and essential in treating the individual's condition and must meet accepted standards of medical practice. Contact Medco Health if you have a question as to whether a particular drug is covered for your condition.

Under the prescription program, oral, implanted or injected contraceptive drugs and diaphragms, cervical caps and IUD contraceptive devices that require a prescription are considered covered medications. Coverage for prescription contraceptive medications and devices is based on medical necessity as well as personal preference, and is subject to all other applicable requirements for coverage.

Medications That Require a Double Check (for the HCN Only)

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

Medications are selected for coverage review or some other forms of Double Check before dispensing for a variety or reasons. Typically, the drugs selected:

- Often are associated with complications
- Have a high potential for adverse reactions, abuse or misuse
- Require more information to determine whether the drug meets the Plan's coverage criteria
- Treat complex conditions
- Only are effective with other therapies.

If your prescription is on the list, your case will be reviewed to ensure you receive the most effective medical care and that the Plan is being administered in accordance with its terms. Examples of drugs subject to coverage review are listed on pages 99 through 102. The list changes from time to time as new drugs come to market, new clinical guidelines for appropriate use are developed or concerns are identified. Call Medco Health via the telephone number listed on your Important Benefits Contacts insert for more information about medications that require coverage review.

Examples of medications that require coverage review include:

- **Acne Therapy** (if age 35 or older):
  - — Retin-A, Avita and Atlinac (tretinoin cream/gel)
  - — Accutane (isotretinoin, amnesteem)
  - — Tazorac cream/gel (tazarotene).
- **Alzheimer's Therapy**:
  - — Aricept (donzepezil)
  - — Cognex (tacrine)
  - — Exelon (rivastigmine)
  - — Reminyl (galantamine).

- **Antidiabetic Therapy**:

  — Glucophage XR (metformin).

- **Appetite Suppressants and Other Obesity Drugs**:

  — Didrex (benzphetamine)

  — Bontril and phendimetrazine

  — Tenuate, Tenuate Dospan and diethylpropion

  — Ionamin and phentermine

  — Meridia (sibutramine)

  — Xenical (orlistat).

- **Depression**:

  — Prozac Weekly (fluoxetine hydrochloride).

- **Erythroid Stimulants** (correct anemia in dialysis, HIV, etc. patients):

  — Epogen, Procrit (erythropoietin)

  — Aranesp (darbepoetin).

- **Human Growth Hormones**:

  — Genotropin, Humatrope, Norditropin, Nutropin, Serostim, Saizen (somatropin)

  — Protropin (somatrem)

  — Geref (sermorelin).

- **Interferons** (treat immune disorders and infections in patients with chronic granulomatous disease):

  — Infergen (interferon alphacon 1)

  — Roferon A (interferon alpha 2a)

  — Alferon N (interferon alpha n3)

  — Intron A (interferon alpha 2b)

— Rebetron (Inron [interferon alpha 2b] and Rebetol [ribavirin])

— PEG-Intron (peginterferon alpha 2b)

— Pegasys (Peginterferon alpha-2a)

— Actimmune (interferon gamma 1b).

- **Miscellaneous Dermatologicals**:

  — Panretin Gel (alitretinoin).

- **Multiple Sclerosis**:

  — Avonex and Rebif (interferon beta 1a)

  — Betaseron (interferon beta 1b)

  — Copaxone (glatiramer).

- **Myeloid Stimulants** (fight infection and treat low white blood cell counts):

  — Neupogen (filgrastim)

  — Leukine (sargramostim)

  — Neulasta (pegfilgrastim)

  — Neumega (oprelvekin).

Other drugs may not need the same level of review before claims are paid, but the amount of medication covered for a specific period may be limited based on typical use in a specific period of time. The coverage allowances are based on U.S. Food and Drug Administration (FDA)-approved guidelines, manufacturer labeling and accepted medical practice. If your medication is prescribed in doses or quantities outside of these guidelines, coverage may be limited. While you or your pharmacist may initiate a review, having your doctor initiate the process is highly recommended. Your doctor can initiate the review process by calling the telephone number listed on your Important Benefits Contacts insert. Again the list changes from time to time. Examples include:

- **Anti-Influenza**:

  — Relenza (zanamivir)

  — Tamiflu (oseltamivir phosphate).

- **Antiviral** (anti-hepatitis C):

  — Copegus (ribavirin)

  — Rebetol (ribavirin).

- **Erectile Dysfunction**:

  — Viagra (dildenafil)

  — Caverject (alprostadil powder)

  — Muse (alprostadil)

  — Edex (alprostadil)

  — Levitra (vardenafil)

  — Cialis (tadalafil).

- **Miscellaneous Dermatologicals**:

  — Regranex Gel (becaplermin).

The No Coverage Option

You can elect no coverage under the Medical Plan and the Alternate Choice Plan at the time you first are eligible or during any subsequent benefits renewal period. You are not required to have other medical coverage in order to elect no coverage with Verizon. If you elect no coverage for a calendar year, you and your eligible dependents will not have medical coverage under 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 for that calendar year, unless you have a change in status (see pages 11 through 14) that allows you to make a change. You will receive a $500 annual waiver credit ($700 for New England IBEW-represented Associates) if you are an eligible full-time employee or part-time employee treated as full-time under the Plan (prorated for the number of pay cycles remaining in the year).

The waiver credit is prorated for employees considered part-time as defined by the Plan according to the schedule in the applicable collective bargaining agreement.

Note, however, you are not eligible for the waiver credit if either of the following apply:

- You are covered as a dependent of an employee (or former employee) under another Verizon-sponsored Medical Plan

- You are on a leave of absence during which you are not entitled to Verizon-sponsored benefit coverage.

Health Maintenance Organization

As an alternative to the Health Care Network (HCN) or Empire MEP Indemnity or Aetna MEP Preferred Provider Organization (PPO) options under the Medical Plan, an eligible associate may elect to join a Health Maintenance Organization (HMO) provided through the Verizon Alternate Choice Plan for New York and New England Associates (the Alternate Choice Plan). The HMOs available to you will vary depending on where you live. Some HMOs offer programs for people eligible for Medicare. Others do not. Your enrollment materials will explain which HMOs (if any) are open to you.

How HMOs Typically Work

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

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

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

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

Choosing a PCP

When you join an HMO, you'll typically need to choose a primary care physician (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.

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 Verizon Medical Expense Plan for New York and New England Associates. **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.

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.

Emergencies

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

Supplemental Behavioral Health Benefits

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

Contacting MHN

You can contact MHN by calling 1-800-777-7991.

Your Costs

Generally, all you pay for care in an HMO is a copayment of no more than $10 for an office visit to a provider (no more than $50 for 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 HMOs may have a retail and home delivery pharmacy "carved out" to the Verizon prescription drug program administered by Medco Health instead of through the HMOs. The Health Plan Comparison Charts you receive at the time you choose your health plan will clarify whether or not Medco Health is your prescription drug provider. If your retail and prescription drug program is carved out to Medco Health, your prescription drug benefits will be the same as described on pages 95 through 102 (however, no prescription drug out-of-pocket maximum will apply). Regardless of the administrator, see your Health Plan Comparison Charts and contact the HMO or Medco Health (whichever is your prescription drug provider) for more information on your prescription drug program.

Changes to HMO Options

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

Other Benefits

Reimbursement of Medicare Premiums

Medicare Part B reimbursement is available to employees or eligible dependents with end-stage renal disease after the first 30 months of Medicare coverage. Contact the Verizon Benefits Center for more information.

Laser Vision Correction (LASIK) Discount

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

Continuing Coverage

Generally, your coverage or a dependent's coverage will end when your eligibility or a dependent's eligibility for the Medical Plan and the Alternate Choice Plan ends. In some circumstances, however, coverage can be continued after eligibility ends.

Continuation of Coverage Under COBRA

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

Eligible dependents include your spouse or same-sex domestic partner and children covered at the time coverage otherwise would end. Note that same-sex domestic partners are not included under COBRA rules, but Verizon has chosen to extend COBRA-like coverage to same-sex domestic partners and children of same-sex domestic partners in the same manner as an eligible covered spouse and children. Class II Dependents who are not your children are not eligible for continuation of coverage. Also, if you have or adopt a child or if a child is placed with you for adoption during the continuation period, you can add coverage for that child who then will become a qualified beneficiary. During the continuation period, you or your dependent must pay the full cost of the coverage on an after-tax basis, plus a two percent administrative charge, or 150 percent of the Company's cost during the 11-month period for which you have coverage because you or your eligible dependent is disabled.

Important Note

If you have questions about COBRA or wish to enroll, contact the COBRA administrator.

- Before October 1, 2004, ADP COBRA Services. ADP can be reached at the following address:
  2575 Westside Parkway
  Suite 500
  Alpharetta, GA 30004
- On or after October 1, 2004, the Verizon Benefits Center. You can access COBRA information via *Your Benefits Resources* Web site.

You also can call ADP COBRA Services via the telephone number shown on your Important Benefits Contacts insert.

Coverage continuation is available in the following situations:

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

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

  These 18- and 36-month periods will run concurrent with (not in addition to) any period of continuation coverage provided through USERRA, and coverage under "Force Adjustment Plan (or a Successor to That Plan)" (see page 19).

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

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

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

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

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

Note: If the Company's health care coverage changes during the period that you, your spouse or same-sex domestic partner or your dependents are continuing coverage, the changes apply to your COBRA coverage and are applicable under your medical option.

Notification Requirements

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

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

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

How Continued Coverage Could End

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

- The period of continued coverage expires.
- The Medical Plan or the Alternate Choice Plan is terminated by the Company.
- You do not make the required monthly payments on a timely basis.
- You or a dependent becomes eligible for coverage under another group medical plan (for example, a new employer) after electing COBRA, unless the new plan has a pre-existing condition limitation or exclusion that applies to you or your dependent. If a pre-existing condition or exclusion applies, the Medical Plan or the Alternate Choice Plan will be primary as to the excluded condition only and will be the secondary Plan for all other covered services and supplies.
- You or a dependent becomes entitled to Medicare after electing COBRA.
- You or a dependent ceases to be disabled during the special 11-month extension for a disabled individual.

Conversion to an Individual Policy

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

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 will pay second (the secondary plan) and so on. The coordination rules described in this section do not apply to the Medco prescription drug program (retail pharmacy and home delivery pharmacy services).

When the Medical Plan or the Alternate Choice Plan is primary, it pays benefits up to the limits described in this summary plan description (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 allowable expense. The Medical Plan or the Alternate Choice Plan will pay the difference as a secondary payment but not more than it would have paid as the primary plan. As a result, the total amount you receive from both plans never will exceed the amount of the allowable expense. If you have coverage through a Health Maintenance Organization (HMO) or other discount network plan, 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 employee pays before a plan that covers the patient as a dependent.

- For a dependent child, Verizon uses the "birthday rule." This means that if a child is covered by both parents' group medical coverage, the parent whose birthday falls first during the calendar year pays benefits first. So, if the mother's birthday is April 27 and the father's birthday is October 23, the mother's plan pays benefits first. The parent's age has no effect on whose plan pays benefits first. If, however, the plan covering the parent who is not a Plan participant does not use the birthday rule, 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 previous rules do not establish an order of benefit determination, the plan that covers the person as an active employee is the primary plan and the plan that covers the person as an inactive or former employee is the secondary plan. If this rule does not establish an order of benefit determination, the plan that has covered the person for the longer period of time is the primary plan and the plan that has covered the person for the shorter period of time is the secondary plan.

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

For Those Eligible for Medicare

For covered persons eligible for or entitled to Medicare, the Medical Plan or the Alternate Choice Plan automatically is considered the primary plan and Medicare is secondary with respect to the following persons entitled to Medicare:

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

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

- For Medicare entitlement due to disability for employees with coverage under a Verizon-sponsored Medical Plan due to current employment status and their family members.

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—whether or not you are enrolled in Part B. So, it is important to enroll in Part B when you first become eligible.

Subrogation and Third-Party Reimbursement

If you recover any charges for covered expenses from a third party (for example, as a result of a lawsuit from an automobile accident), the 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.

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 Employee Benefits Committee (VEBC) and the Verizon Claims Review Committee (VCRC), and to the individuals who chair each of these committees. At the time of publication of this summary plan description (SPD), there are several claims and appeals administrators for the Plans. The VEBC or the VCRC may change these designations at any time.

Claims Regarding Eligibility to Participate in the Plans

At this time, for eligibility related claims, the claims and appeals administrator is the VCRC which can be reached at the following address:

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

Claims should be directed to the Verizon Claims Review Unit, whereas appeals should be directed to the Verizon Claims Review Committee c/o the Verizon Claims Review Unit. In either case, the P.O. Box is 1438.

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 benefits (not including Health Maintenance Organizations [HMOs]):

Health Care Network (HCN)	Benefits Administrators
For hospital, surgical and medical benefits (based on your ZIP code): Metropolitan New York, Central New York, Pennsylvania and Washington D.C.	Aetna, Inc.
Northeastern New York and Vermont	MVP Select Care, Inc. or Blue Cross Blue Shield of Massachusetts
Western New York	Univera Healthcare
Massachusetts, New Hampshire, Rhode Island and Maine	Blue Cross Blue Shield of Massachusetts
Mental Health Care/Substance Abuse Treatment Benefits	United Behavioral Health
Prescription Drug Program	Medco Health

Empire MEP Indemnity Option and Aetna MEP Preferred Provider Organization (PPO) Option	Benefits Administrators
Hospital, surgical and medical benefits for Empire MEP Indemnity	Empire BlueCross BlueShield
Hospital, surgical and medical benefits for Aetna MEP PPO	Aetna, Inc.
Mental Health Care/Substance Abuse Treatment	United Behavioral Health
Prescription Drug Program	Medco Health

If you choose an HMO, your HMO will handle medical claims and appeals related to benefits provided through the HMO. If your HMO prescription drug program is carved out to Medco Health, Medco Health 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 appeal 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 on pages 133 and 134. 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 its 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 or appeals administrators' decision was an abuse of administrator discretion.

If a Benefit Is Denied

Disagreements about benefit eligibility or benefit amounts can arise. If the Verizon Benefits Center is unable to resolve the disagreement, Verizon has formal appeal procedures in place for the Medical Plan or Alternate Choice Plan.

The following information applies for "group health" or "health" claims initially filed on or after January 1, 2003. "Group health" or "health" refers to medical options including mental health and substance abuse care, prescription drugs, and vision care and dental options. The steps that you or your authorized representative is required to take to file a group health claim or appeal are outlined in the following chart. The steps vary slightly depending on the type of claim involved.

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

- ***Post-service***
  A claim for reimbursement of medical services already received. This is the most common type of claim.
- ***Pre-service***
  A claim for a benefit for which coverage review is required by the Plan.

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

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

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

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

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
Step 1				
How to file a claim To file an **eligibility** claim, request a Claim Initiation Form from the Verizon Benefits Center at 1-877-Ask-VzHR (1-877-275-8947). You (or your authorized representative) must return the form to the Verizon Claims Review Unit at the address on the form To file a **benefit** claim, you (or your authorized representative) should write to your group health Plan administrator. To obtain contact information for your Plan, you should refer to the telephone number and/or Web site shown on the back of your ID card or the Health Plan Comparison Charts available on *Your Benefits Resources* Web site You must include: • A description of the benefits for which you're applying • The reason(s) for the request and • Relevant documentation				To file an urgent care claim, you should call the Verizon Benefits Center at 1-877-Ask-VzHR (1-877-275-8947) or your health Plan. In addition, you must state that you are filing an urgent care claim
What happens if you don't follow procedure If you misdirect your claim, but provide sufficient information to an individual who is responsible for Verizon benefits administration, you will be notified of the proper procedure within **(see columns to the right)** of receipt of the claim	Not applicable. Response time frame does not begin until claim is properly filed	5 days	Not applicable. Response time frame does not begin until claim is properly filed. If claim involves urgent care, 24 hours	24 hours

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

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
How you will be notified of the claim decision If your claim is approved, the Verizon Claims Review Unit or health Plan generally will notify you by telephone If your claim is denied, in whole or in part, the Claims Review Unit or the health Plan will notify you in writing, except for urgent care. Your denial notice will contain: • The specific reason(s) for the denial • The Plan provisions on which the denial was based • Any additional material or information you may need to submit to complete the claim and • Any internal procedures or clinical information on which the denial was based and • The Plan's appeal procedures				If your claim is denied, the health Plan will notify you via telephone. Within 3 days of this oral denial, you will receive a written denial notice, as explained under the general procedure. The denial notice also will explain the expedited review process

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
Step 2				
About appeals and the claims fiduciary Before you can bring **any** action at law or at equity to recover Plan benefits, you **must** exhaust this process. Specifically, you must file an appeal or appeals, as explained in this Step 2, and the appeal(s) must be finally decided by the claims fiduciary The Claims Review Committee is the claims fiduciary for all eligibility claims. The Claims Review Committee has delegated its authority to finally determine claims to the health Plans for benefit claims. The vast majority of health Plans have accepted the responsibility of being the claims fiduciary. If your health Plan has not accepted this responsibility, you will be notified in your claim denial notice, which will indicate that you should appeal to the Claims Review Committee The claims fiduciary is authorized to finally determine appeals and interpret the terms of the Plan in its sole discretion. All decisions by the claims fiduciary are final and binding on all parties				

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
How to file an appeal If your claim is denied and you want to appeal it, you must file your appeal within **(see columns to the right)** from the date you receive notice of your denied claim. You may request access to all documents relating to your appeal. If you have an appeal for **eligibility** (i.e., you wrote to the Verizon Claims Review Unit at Step 1), write to the address specified on your claim denial notice If you have an appeal for **benefits** (i.e., you wrote to your health Plan as explained at Step 1), write to the contact identified by your health Plan administrator in your claim denial notice You should include: • A copy of your claim denial notice • The reason(s) for the appeal and • Relevant documentation The individual/committee (and any medical expert) reviewing your appeal will be independent from the individual/committee who reviewed your claim. In addition, if your appeal involves a medical judgment, the Claims Review Committee or the health Plan administrator will consult with a health care professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request	180 days	180 days	Within a reasonable period of time, considering the time period scheduled for reduction or termination of benefits	180 days You may orally file your appeal with the Verizon Claims Review Unit or the contact identified by your health Plan administrator. At the time your claim is denied, the Verizon Claims Review Unit or your health Plan administrator will give you instructions about how to file your appeal. You must identify that you are appealing an urgent care claim

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
When you will be notified of the appeal decision You will be notified of the decision within **(see columns to the right)** of the Claims Review Committee's or the health Plan's receipt of your appeal	Eligibility appeals: 60 days Benefit appeals:[1] 60 days, if health Plan provides 1 level of mandatory appeal 30 days, if health Plan provides 2 levels of mandatory appeal	Eligibility appeals: 30 days Benefit appeals:[1] 30 days, if health Plan provides 1 level of mandatory appeal 15 days, if health Plan provides 2 levels of mandatory appeal	Eligibility and benefit appeals: Before a reduction or termination of benefits would occur If the concurrent claim involves urgent care, 72 hours[2]	Eligibility and benefit appeals: 72 hours[2]
How you will be notified of the appeal decision If your appeal is approved, the Claims Review Committee or the health Plan will notify you in writing If your appeal is **denied**, in whole or in part, the Claims Review Committee or the health Plan will notify you in writing. Your denial notice will contain: • The specific reason(s) for the denial • A statement regarding the documents to which you are entitled • An explanation of the voluntary appeal procedures, if any • Any internal procedures or clinical information on which the denial was based • The Plan provisions on which the denial was based and • The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."				

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

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

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
Step 3				
How to proceed if necessary If you had an **eligibility** appeal that was denied by the Claims Review Committee, Verizon will not review your matter again, unless new facts are presented. You have a right to bring a civil action If you had a **benefit** appeal that was denied by a group health Plan administrator that offers 1 mandatory level of appeal, the group health Plan administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action If you had a **benefit** appeal that was denied by a group health Plan administrator that offers 2 mandatory levels of appeal, you may appeal to the health Plan a second time. You must submit your second appeal within 180 days from the date that you received the denial of your first appeal. In addition, your health Plan will provide you with an independent medical review, upon request, in conjunction with this second and final appeal				
The following provision applies if the health Plan provides 2 levels of mandatory appeal:				
When you will be notified of the second and final appeal decision You will receive a response within **(see columns to the right)** of the health Plan administrator's receipt of your second and final appeal. If this appeal is denied, the health Plan administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action	30 days	15 days	Time period remaining from your first appeal. Of course, the clock stops while you are preparing your second appeal	Time period remaining from your first appeal. Of course, the clock stops while you are preparing your second appeal

Rights of Participants and Beneficiaries 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) and its subsequent amendments. ERISA provides that all Plan participants are entitled to:

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

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

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

- Continue group health coverage if there is a loss of coverage under the Plan as a result of a status change (see pages 11 through 14).

- Obtain a Certificate of Creditable Coverage (see page 21).

In addition to establishing rights for Plan participants, ERISA imposes certain duties upon the persons who are responsible for the operation of the Plans. The people who operate your Plans, called "fiduciaries" of the Plans, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim to be frivolous).

Assistance With Your Questions

If you have any questions about the ERISA-covered 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 publication hotline of the Employee Benefits Security Administration.

Privacy Rights

The Federal Government's Privacy Rule applies to "Protected Health Information," which is defined as any written, oral or electronic health information that meets the following three requirements:

- The information is created or received by a 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.

The Notice of Privacy Practices for the Verizon Health Plans contains a complete explanation of your rights under the Privacy Rule. The following is a summary of those rights:

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

- 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.

- Other than as permitted or required by law, the Verizon Health Plans will not use or disclose your Protected Health Information without your written authorization. If you authorize a Verizon Health Plan to use or disclose your Protected Health Information, you may revoke that authorization in writing at any time. If you revoke the authorization, the Verizon Health Plan 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.

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

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

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

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

- If you believe that Protected Health Information a Verizon Health Plan has about you is inaccurate or incomplete, you have the right to request a correction.

- You have a right to request a list of disclosures made by a Verizon Health Plan of your Protected Health Information, other than those for which an accounting is not required.

For more information regarding these rights and the privacy policies of the Verizon Health Plans, please review the Verizon Health Plans' Notice of Privacy Practices.

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 benefit providers directly via the telephone numbers shown on your Important Benefits Contacts insert.

Plan Sponsor/Employer

The Plan sponsor/employer is:

Verizon Communications Inc.
4 West Red Oak Lane
White Plains, NY 10604

Plan Administrator

The Plan administrator is:

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

Telephone number: 1-877-Ask-VzHR (1-877-275-8947) and follow the instructions to reach the Verizon Benefits Center

You may communicate to the Plan administrator in writing at the address above. But, for questions about Plan benefits, you should contact the Verizon Benefits Center. The Verizon Benefits Center administers enrollment and handles participant questions, requests and certain benefit claims, but is not the Plan administrator. Claims relating to the scope and amount of benefits under the Plans are administered by the administrators listed on page 117.

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 legal department. Instead, submit them to the claims administrator for the Plan (see page 116).

Benefits Administrators

The benefits administrators have authority and responsibility to perform daily administration of benefits under the Medical Plan. You can call the benefits administrators via the telephone numbers shown on your Important Benefits Contacts insert. See pages 133 and 134 for the addresses.

- Aetna, Inc.
- Blue Cross Blue Shield of Massachusetts
- Empire BlueCross BlueShield
- Medco Health
- MVP Select Care, Inc.
- United Behavioral Health
- Univera Healthcare.

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
100 Half Day Road
P.O. Box 1438
Lincolnshire, IL 60069-1438

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 Important Benefits Contacts insert for the telephone numbers.

Health Care Network (HCN)	Claims and Appeals Administrators
Metropolitan New York, Central New York, Pennsylvania and Washington D.C.	Aetna, Inc. P.O. Box 981106 El Paso, TX 79998-1106
Northeastern New York and Vermont	If you have elected the MVP plan: MVP Select Care, Inc. Appeals Unit P.O. Box 1434 Schenectady, NY 12301-1434 If you have elected the Blue Cross Blue Shield of Massachusetts plan: For appeals: Blue Cross Blue Shield of Massachusetts Landmark Center 401 Park Drive Boston, MA 02215 For claims: Blue Cross Blue Shield of Massachusetts P.O. Box 9206 North Quincy, MA 02171
Western New York	Univera Healthcare Claims P.O. Box 350 Buffalo, NY 14221
Massachusetts, New Hampshire, Maine and Rhode Island	For appeals: Blue Cross Blue Shield of Massachusetts Landmark Center 401 Park Drive Boston, MA 02215 For claims: Blue Cross Blue Shield of Massachusetts P.O. Box 9206 North Quincy, MA 02171
Mental Health Care	For appeals: United Behavioral Health Employer Division Appeals & Complaint Unit P.O. Box 32040 Oakland, CA 94604 For claims: United Behavioral Health P.O. Box 30755 Salt Lake City UT, 84130-0755

Health Care Network (HCN)	Claims and Appeals Administrators
Prescription Drug Program Medco Health is the claims and appeals administrator for the retail program and the home delivery pharmacy. Medco Health is responsible for authorizing benefit payments, considering appeals, resolving questions, maintaining records, filing reports and distributing information to participants.	Medco Health Solutions 8111 Royal Ridge Parkway Irving, TX 75063

Empire MEP Indemnity Option and Aetna MEP PPO Option	Claims and Appeals Administrators
Empire MEP Indemnity Option	Empire BlueCross BlueShield P.O. Box 5047 Middletown, NY 10940-9047
Aetna MEP PPO Option	Aetna, Inc. P.O. Box 981106 El Paso, TX 79998-1106
Mental Health Care/Substance Abuse Treatment	For appeals: United Behavioral Health Employer Division Appeals & Complaint Unit P.O. Box 32040 Oakland, CA 94604 For claims: United Behavioral Health P.O. Box 30755 Salt Lake City UT, 84130-0755
Prescription Drug Program Medco Health is the claims and appeals administrator for the retail program and the home delivery pharmacy. Medco Health is responsible for authorizing benefit payments, considering appeals, resolving questions, maintaining records, filing reports and distributing information to participants.	Medco Health Solutions 8111 Royal Ridge Parkway Irving, TX 75063

HMOs

Under an HMO option, your ***HMO*** is the benefits administrator responsible for exercising the discretion to determine benefit payments, and also is the claims administrator for claims regarding the scope or amount of benefits under this option. You should check the literature you receive from your HMO for their address and telephone number. If your HMO prescription drug program is carved out to Medco Health, Medco Health will be 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 note, 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

The firm responsible for the administration of qualified medical child support orders (QMCSOs) is Hewitt Management Company LLC. Hewitt Management Company LLC can be reached at the following address:

Hewitt Management Company LLC
c/o Verizon Benefits Center
100 Half Day Road
P.O. Box 1457
Lincolnshire, IL 60069-1457

You also can call Hewitt via the Verizon Benefits Center at 1-877-Ask-VzHR (1-877-275-8947).

Plan Funding

Except for certain HMO benefits, the Medical Plan and the Alternate Choice Plan are not financed by an insurance company, nor are Plan benefits guaranteed under a contract of insurance. The claims and appeals administrators listed on pages 116 and 117 do not insure or guarantee Plan benefits.

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

The trustee is:

Mellon Bank
One Mellon Bank Center – Room 1315
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. The Verizon Medical Expense Plan for New York and New England Associates is a welfare plan that 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.

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 on page 131.

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.
37th Floor
1095 Avenue of the Americas
New York, NY 10036

Legal process also may be served on the trustee.

Participating Companies

The following is a list of participating companies as of January 1, 2004. The list may change from time to time.

- Empire City Subway Company (Limited)
- Telesector Resources Group Inc.
- Verizon New England Inc.
- Verizon New York Inc.
- Verizon Yellow Pages Company.

Glossary

A

Accidental Injury
An injury caused by a chance event or unknown causes.

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

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).

- 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 eligibility because of certain changes in status.

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

Copayment
A fixed dollar amount you pay for certain services and supplies under the Health Care Network (HCN), Empire MEP Indemnity option or Aetna MEP Preferred Provider Organization (PPO) option or Health Maintenance Organization (HMO).

Covered Person
Any associate and his or her dependents enrolled in the Verizon Medical Expense Plan or Alternate Choice Plan, or any eligible individual who has elected coverage under COBRA.

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

D

Deductible
The amount of covered expenses you pay before certain options pay benefits for specific care.

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

Under the HCN:

- ***Aetna, Inc.*** considers "experimental/investigational" to mean 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.

Blue Cross Blue Shield of Massachusetts considers "experimental/investigational" to mean services or supplies received for or related to care that does not meet the claims administrator's medical technology assessment guidelines. The fact that a treatment is offered as a last resort does not mean that coverage will be provided for it. There are two exceptions to this exclusion. As required by law, coverage is provided for:

- One or more bone marrow transplants for a covered person who has been diagnosed with breast cancer that has spread. The covered person must meet the eligibility standards that have been set by the Massachusetts Department of Public Health.

- Certain drugs used on an off-label basis, including drugs used to treat cancer and HIV/AIDS.

MVP Select Care, Inc. considers "experimental/investigational" to mean services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonable substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered. The claims administrator will make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The claims administrator will be guided by a reasonable interpretation of Plan provisions. The claims administrator's decision will be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the claims administrator will be final and binding. The claims administrator will be guided by the following principles:

- If the drug or device cannot lawfully be marketed without the approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished

- If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's IRB or other body serving a similar function, or if federal law requires such review or approval

- If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical studies, or otherwise is under the study to determine its maximum tolerated dose, its toxicity, its safety or its efficacy, as compared with a standard means of treatment or diagnosis

- If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety or its efficacy, as compared with a standard means of treatment or diagnosis.

Drugs are considered experimental if they are not commercially available for purchase or they were not approved by the FDA for general use.

Univera Healthcare considers "experimental/investigational" to mean medical or surgical procedures and associated services which:

- Have not been proven to be beneficial in prolonging life, curing disease, illness or malfunction of a body part, or improving quality of life more than to a de minimis degree when used as a therapy for the illness, disease or disability with which the covered person has been diagnosed

- Are not reproducible in accordance with accepted scientific method

- Have not been subjected to peer review

- Have not been endorsed by the established medical community.

In making the foregoing determination, the claims administrator will rely on the medical and scientific evidence demonstrating the safety and efficacy, or lack thereof, of a health service. Scientific evidence must be based on published studies in peer-reviewed literature reporting the results of well-conducted, randomized clinical and controlled clinical trials. Cost differences may be considered only in relation to different treatment options that offer substantially similar results. A drug or medical device's status with FDA also is taken into account, with the claims administrator providing coverage only for those drugs or devices that have received FDA approval.

Under the Empire MEP Indemnity option:

Empire BlueCross BlueShield considers "experimental/investigational" to mean services or supplies which are not of proven benefit for the diagnosis or treatment of the covered person's condition, or generally are not recognized by the medical community as effective or appropriate for that condition, as determined by the claims administrator.

Under the Aetna MEP PPO option:

Aetna, Inc. considers "experimental/investigational" to mean 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.

G

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

H

HMO
A Health Maintenance Organization (HMO) that has entered into a written contract with Verizon with the purpose of being included as a coverage option under the 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 primarily is a place for rest, a place for the aged or a nursing home.

I

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

L

Legally Separated
An employee 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 employee or his or her spouse intends to live separately.

M

Medically Necessary

Benefits are payable under the Plan only where the care, treatment, services or supplies are required of 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 purpose of determining Medical Plan benefits and not for determining that 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.

Aetna, Inc.: "Medically necessity" or "medically necessary" means a service or supply provided by a hospital physician or other provider of health care services to diagnose or treat an illness or injury, which service or supply is consistent with the covered person's condition and which meets all of the following tests, as determined by the claims administrator:

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

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

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

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

- It is furnished for the medical care of a diagnosed illness (including a congenital defect or birth abnormality) or injury and meets all of the foregoing tests or

- It is furnished to newborns immediately after the child's birth and is one of the following:

  — Hospital room and board

  — Other supplies and non-professional services furnished by the hospital for medical care in that hospital.

Blue Cross Blue Shield of Massachusetts: "Medical necessity" or "medically necessary" means care that is required to diagnose or treat a covered person's illness, injury, symptom or complain, as determined by the claims administrator, and is:

- Consistent with the diagnosis and treatment of the covered person's condition and in accordance with the Medical Plan and the claims administrator's medical technology assessment guidelines

- Essential to improve the covered person's net health outcome and as beneficial as any established alternatives covered under the Medical Plan

- As cost-effective as any established alternatives and consistent with the level of skilled services that are furnished

- Furnished in the least intensive type of medical care setting required by the covered person's medical condition.

It is not care that: is furnished solely for the covered person's convenience or religious preference or the convenience of the covered person's family or plan provider; promotes athletic achievements or a desired lifestyle; or increases or enhances the covered person's environmental or personal comfort. The claims administrator determines if a treatment, service, supply or drug is medically necessary for Medical Plan purposes.

Univera Healthcare: "Medical necessity" or "medically necessary" means a service or supply that is determined by the claims administrator to be in accordance with well-established professional medical standards and:

- Consistent with and essential for diagnosis and treatment of the covered person's condition, illness, ailment or injury

- The most appropriate supply or level of service which can be provided safely

- Provided for the diagnosis or the direct care and treatment of the covered person's condition, illness, ailment or injury

- When applied to hospitalization, means further that the covered person required acute care as an inpatient due to the nature of the services rendered or the covered person's condition.

In making the foregoing determination, the claims administrator shall rely on medical and scientific evidence demonstrating the safety and efficacy, or lack thereof, of a health service. Scientific evidence must be based on published studies in peer-reviewed literature reporting the results of well-conducted, randomized clinical and controlled clinical trials. Cost differences may be considered only in relation to different treatment options that offer substantially similar results. A drug or medical device's status with the FDA also is taken into account, with the claims administrator providing coverage only for those drugs or devices that have received FDA approval.

MVP Select Care, Inc.: "Medical necessity" or "medically necessary" means care and treatment is recommended or approved by a physician; is consistent with the patient's condition and accepted standards or good medical practice; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services that can be safely provided to the patient and is medically proven to be effective treatment of the condition. All of these criteria must be met; merely because a physician recommends or approves certain care does not mean that it is medically necessary. The Plan administrator has the discretionary authority to decide whether care or treatment is medically necessary.

Empire BlueCross BlueShield: "Medical necessity" or "medically necessary" means care which, according to the claims administrator's criteria and in the claims administrator's judgment, is:

- Consistent with the symptoms or diagnosis and treatment of the covered person's condition, illness, ailment or injury
- In accordance with standards of good medical practice
- Not solely for the covered person's convenience or that of the covered person's physician or other provider
- Not primarily custodial
- The most appropriate supply or level of service which can safely be provided to the covered person.

N

Network Negotiated Fee

The network negotiated fee (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, the in-network Aetna MEP PPO option or the United Behavioral Health (UBH) 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 and for certain services and supplies under the Empire MEP Indemnity option or Aetna MEP PPO 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 Medco Health Select National Network.

Physician or Doctor
A person who is licensed to practice medicine, prescribe and administer drugs or perform surgery.

Primary Care Physician
With coverage in the HCN or an HMO, you generally must choose a primary care physician (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.

R

Reasonable and Customary Charge
The reasonable and customary charge (R&C) is the lesser of the actual charge or the maximum fee allowance for a covered service or supply. The benefits administrator determines the R&C charge.

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

- The fee most commonly charged by a majority of providers in a given geographic area where those providers have similar training in the performance of the procedures

- The fee normally charged by that provider for a similar service or supply

- The amount charged for unusual circumstances or complications requiring additional time, skill and experience in connection with that particular medical service, supply or procedure.

S

Same-Sex Domestic Partner

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

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

In addition, if you disenroll your partner, you must wait 60 days before enrolling a new partner.

The employee must agree to notify the Verizon Benefits Center if he or she 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.

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.