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Verizon Associate Long-Term Care Plan (LTC) Benefits - MetLife
Summary Plan Description

New York and New England Associates

Effective January 1, 2018

V-B-AA-N-LTC –943-1/18

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Introduction to your long-term care (LTC) coverage

The Verizon Associate Long-Term Care Plan (the Plan) offers financial protection if you need extended care as the result of an illness or accident, or due to the loss of functional ability brought on by aging. The Plan includes:

- Eligibility from your date of hire. At the time of enrollment, you were able to enroll your spouse, your parents and/or your parents-in-law in coverage. Coverage is only available if you and/or your eligible dependents enrolled prior to January 1, 2012.
- Coverage for expenses related to care you need when you are unable to perform certain basic activities of daily living.
- The choice of two types of coverage.
- Reimbursement to your estate of a portion of the premiums you paid, less any benefits that you received for covered charges, if you die at or before age 70.

About this SPD

This document is the summary plan description (SPD) for the Verizon Associate Long-Term Care Plan, including the Other Plan Provisions of Verizon Plans Covering New York and New England Associates. with respect to participants who enrolled with MetLife. The Plan is subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. This document meets ERISA's requirements for an SPD and reflects Plan provisions effective through the date hereof. It updates and replaces all previous SPDs and other descriptions of the benefits provided by the Plan. This SPD is a summary of the Plan.

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

This SPD is divided into the following major sections:

- **Participating in the Plan.** This section explains your eligibility at the time of enrollment, for you and your dependents and when eligibility ends.
- **Your coverage.** This section describes the long-term care insurance coverage available to you. Refer to it when you need information about your coverage and benefits.
- **What is not covered.** This section lists services and supplies not covered under the Plan.
- **How to file a claim.** This section provides information on when you need to file a claim to receive benefits.
- **Additional information.** This section provides additional details about the administrative provisions of the Plan and your legal rights.
- **Terms to know.** This section defines certain terms used in this SPD.

NOTE:

The LTC insurance being provided through MetLife was closed to new entrants effective January 1, 2012. MetLife continues to administer the MetLife LTC insurance covering participants who enrolled prior to January 1, 2012.

If you enrolled in LTC coverage on or after January 1, 2012, please refer to the SPD titled, "Verizon Associate Long-Term Care Plan (LTC) Benefits - Prudential" as the eligibility and benefits described in this SPD does not apply to you.

Additionally, while the MetLife policy did not allow new enrollees on or after January 1, 2012, effective July 1, 2013, no new LTC policies will be issued to Participants under the terms of the Plan, including Prudential. A Participant who is enrolled in LTC coverage through the Plan as of midnight, in the Eastern Time zone, on June 30, 2013, will be permitted to continue coverage under the Plans as long as such Participant remains continuously eligible and enrolled according to the terms of the Plan.

References to “you” or “your” refer to the covered employee and covered family members.

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

LTC plan contacts

	Contact	Reasons to access
LTC plan	MetLife **Member Services** 800.438.6388 **Mailing address:** MetLife LTC P.O. Box 990028 Hartford, CT 06199-0028	• Obtain information on how LTC coverage works. • Request coverage information. • Request changes to your LTC coverage at any time. • Submit claims. • Check the status of a claim. • Ask billing questions. • Request a copy of your Certificate of Insurance.
Other sources for information		
BenefitsConnection	Via the Internet at: verizon.com/benefitsconnection (User ID and password required) Via About You on the VzWeb	• Request a free printed copy of an SPD.
Verizon Benefits Center	855.4vz.bens (855.489.2367)	

Accessing your benefits information

This SPD is available online on BenefitsConnection. Generally, the SPD on BenefitsConnection is the most up to date. Once you have logged onto BenefitsConnection, select the Library link from the home page to view "Summary Plan Descriptions."

For free printed copies of your SPD, contact the Verizon Benefits Center.

Changes to the Plan

Verizon reserves the right to amend, modify, suspend or terminate the Plan at any time, at its discretion, with or without advance notice to participants, subject to any duty to bargain collectively. Verizon also reserves the right to change the amount of required participant contributions for coverage under the Plan at any time, with or without advance notice to participants, subject to any duty to bargain collectively.

The Plan may be amended by publication of any SPD, summary of material modification, enrollment materials or other communication relating to the Plan, as approved by Verizon.

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.

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Participating in the Plan

Effective January 1, 2012, the LTC insurance through MetLife was closed to new entrants. Accordingly, MetLife will no longer issue any new LTC insurance certificates to Verizon employees or retirees, but will continue to administer LTC benefit claims for participants who were enrolled prior to January 1, 2012 and remain eligible and enrolled in the LTC benefit through MetLife under the Plan.

You were eligible for MetLife LTC coverage under the Plan if...

You have been *continuously* enrolled in LTC coverage under the Plan with MetLife as of midnight, in the Eastern Time zone, on December 31, 2011, and continue to pay premiums on time, and:

- Are an active full-time, part-time or eligible temporary associate employed by a participating company and your employment is covered by a collective bargaining agreement that provides for participating in the Plan; or
- Are retired and received a pension under the Verizon Pension Plan for New York and New England Associates.

“Associate” as used throughout this summary plan description (SPD) includes any non-management employee.

"Service" means net credited service as defined by the Verizon Pension Plan for Associates (to the extent that it covers New York and New England Associates).

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 Plan.

Eligible family members

At the time of enrollment, which must have occurred before January 1, 2012, the following family members, if they were under age 80, were eligible to apply for coverage under the Plan/Policy:

- Your spouse.
- Your parent(s) or parent(s)-in-law. Both you and your spouse were able to enroll one male and one female parent each. Your designation of a parent may not be changed after you applied for coverage.

Your spouse, parents and parents-in-law were eligible to apply for coverage even if you declined coverage under the Plan/Policy.

NOTE: Ex-spouses and dependent children were not eligible for coverage under the Plan.

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

States sometimes pass laws that require employee benefit plans to provide benefits and/or coverage to individuals who otherwise are not eligible.

It is Verizon's position that the federal law known as ERISA supersedes state law. As a result, the company only covers the individuals outlined in this SPD.

However, when benefits are fully insured, such as the LTC plan, the insurer (MetLife in this case) may be required to comply with state laws. It is MetLife's responsibility to make this determination.

To the extent that a domestic partner was eligible for coverage due to Verizon's agreement with a municipality or state under an Equal Benefits Ordinance, you were notified.

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Paying for coverage

Your or your family member's cost for coverage (the "premium") is based on the following factors:

- Age on the effective date of coverage.
- The coverage selected.

Premiums for you and/or your spouse, parents and parents-in-law will be deducted from your paycheck on an after-tax basis. MetLife bills you, if you are a retiree, and your other eligible family members directly.

NOTE: Following your enrollment before midnight, Eastern time zone, on January 1, 2012, your cost will not increase due to age, changing health or benefit claims.

If you increase your benefit level at some later date, the premium for the increased benefit amount is based only on your age on the effective date of the increase, and does not affect the premium cost for your original coverage.

Enrollment materials included cost information.

Your cost may increase after the end of the rate guarantee period on December 31, 2015.

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Changing or canceling coverage

You may change or cancel your LTC coverage at any time. If you change your benefit coverage, your cost of coverage is subject to change. You cannot change coverage if nonforfeiture coverage is in effect. See the “Special Plan features” section for nonforfeiture coverage information.

Increasing or decreasing your benefit

You can request an increase or decrease in your daily benefit amount (DBA). Your DBA is the maximum amount you can be reimbursed for LTC services received in a single day.

You will need to provide evidence of insurability before an increase request is approved. Increase and decrease amounts are subject to DBA amounts available at the time of your request. See the “LTC plan benefits” section for additional information.

All other benefits (including the total lifetime benefit) that are computed as a multiple of the DBA also increase or decrease at the same rate as your DBA increases or decreases. If you have received any benefits, only the remaining portion of the total lifetime benefit and transition expense benefit will increase or decrease by that same percentage rate. See the “LTC plan benefits” section for additional information regarding the total lifetime benefit and the transition expense benefit.

Your coverage change is effective on the first day of the month following MetLife’s approval of the change.

Canceling your coverage

You may cancel your LTC coverage at any time. You will not be eligible to enroll again.

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LTC plan benefits

Here is a brief summary of the LTC coverage options. All options offer comprehensive coverage that assists with the costs of LTC services received at home, in a nursing home or assisted living facility, or in the community. The LTC plan option does not have any pre-existing condition exclusions.

Coverage at a glance

The LTC plan benefit provides both pre-packaged and customized plan benefits:

Pre-packaged benefit plans	**Plan A**	**Plan B**	**Plan C**
Daily benefit amount (DBA)	$100	$200	$300
Benefit period	5 years	5 years	5 years
Total lifetime benefit	$182,500	$365,000	$547,500
Nursing home/respite care/assisted living facility/inpatient hospice coverage	100% of DBA	100% of DBA	100% of DBA
Home care/adult day care/at-home hospice services coverage	75% of DBA	75% of DBA	75% of DBA
Informal care services	25% of DBA (up to 30 days per calendar year)	25% of DBA (up to 30 days per calendar year)	25% of DBA (up to 30 days per calendar year)

Customized benefit plans: You can choose to customize your DBA amount and/or add the nonforfeiture coverage feature.					
Daily benefit amount (DBA) options	$100	$150	$200	$300	$400
Nonforfeiture coverage	With nonforfeiture coverage, you maintain a reduced lifetime benefit coverage amount if you have paid premiums for at least 3 years, but elect to stop making payments. The reduced total lifetime benefit is at least 30 times the daily benefit amount or the total premiums paid to date, whichever is greater.				

LTC coverage may vary from state to state. See your certificate of coverage for specific coverage information.

Transition expense benefit

The Plan may pay for certain expenses incurred during the waiting period; however, these expenses are not paid until you complete the waiting period. Examples include:

- A personal emergency response system.
- Durable medical equipment.

The benefit maximum for the transition expense benefit is 10 times the DBA.

Proof of payment for the expenses must be submitted to MetLife (see the “LTC plan contacts” section for contact information).

Payment of this benefit does not count toward your total lifetime benefit. The transition expense benefit is not available if you are receiving nonforfeiture coverage.

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What is covered

Coverage is provided for these services:

- Skilled, intermediate and custodial care in a licensed nursing home or Alzheimer's facility. Custodial care means services provided on an extended basis to a chronically ill person.

Custodial care services are for maintaining a person's health and/or preventing deterioration in that person's functional status.

Custodial care does not include any transportation services or other services that are primarily for personal convenience or companionship.

- Inpatient hospice care.
- Care in an assisted living facility.
- Voluntary initial care advisory visit. An initial care advisory visit means the service that a care advisor provides to:
  - Assess your need for LTC services.
  - Develop or work with others to develop options for your LTC.
  - Discuss the LTC options with you, your family or your representative.
- Home care, including:
  - Services from a licensed home care agency by registered nurses (RNs), licensed practical nurses (LPNs), licensed visiting nurses (LVNs), social workers and home health aides; homemaker services; and physical, respiratory, occupational and speech therapy.
  - Care by an RN, LPN, LVN or a licensed therapist who is not affiliated with a licensed home care agency.
  - Adult day care.
  - At-home hospice care.
  - Ongoing advisory services.
- Informal care services for up to 30 days per calendar year. This is defined as custodial care not provided by a nurse or therapist or through a home care agency and includes care provided by immediate family members.
- Respite services for up to 21 days per calendar year in a home, nursing home or an assisted living facility. This is defined as care provided by an alternative caregiver to temporarily relieve the primary caregiver.
- Alternate plan of service.
  - A MetLife case manager can authorize benefits for LTC services not specifically listed if the services are both of these:
    - Meet the needs of the covered person.
    - Are a cost-effective alternative to covered services.

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Benefit amounts

Benefits for covered services are paid as follows:

- Up to 100% of the daily benefit for nursing home, inpatient hospice, respite or assisted living facility care.
- Up to 75% of the daily benefit for home care, adult day care and at-home hospice services.
- Up to 25% of the daily benefit, up to 30 days per calendar year, for informal care services.

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What is not covered

This Plan does not provide benefits for:

- Care in a facility that provides services primarily for detoxification of or rehabilitation for alcoholism or drug addiction (chemical dependency), except drug addiction sustained at the hands of, or while being treated by, a physician for an injury or sickness.
- Any service or supply received outside the United States or its territories. See “International benefit” in the “Special plan features” section for more information.
- Illness, treatment or a medical condition arising out of:
  - War or act of war.
  - Participation in a felony, riot or insurrection.
  - Service in the armed forces or auxiliary units of any country.
  - Attempted suicide (while sane or insane) or intentionally self-inflicted injury.
- Treatment in a government facility, unless otherwise required by law.
- Any care provided while in a hospital, except for confinement in a distinct part of a hospital that is licensed as a nursing home or hospice.
- Any service or supply to the extent that such expenses are reimbursable under Medicare, or would be reimbursable except for the application of a deductible or coinsurance or copayment amount. This exclusion does not apply in those instances where Medicare is determined to be the secondary payer under applicable law.
- Any service provided by your immediate family, unless provided by an informal care provider.
- Services for which no charge normally is made in the absence of insurance.

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Special plan features

Nonforfeiture coverage

This feature, which is available for an additional cost, enables you to elect a reduced lifetime benefit coverage amount if you have paid premiums for at least three years but choose to stop making payments.

The reduced total lifetime benefit is at least 30 times the daily benefit amount or the total premiums paid to date, whichever is greater. See the “LTC plan benefits” section for daily benefit amount and total lifetime benefit information.

Return of premium upon death

Provisions for a return of premiums paid upon your death depends on your age at the time of death:

- **If you die before age 65:** All premiums paid less any benefits paid to you or on your behalf under the Plan.
- **If you die on or after age 65 but before age 75:** All premiums due and paid up to your 65th birthday - reduced by 1/120 of that amount for each full month you were covered after your 65th birthday - less any benefits paid to you or on your behalf under the Plan.

  MetLife will not refund any premiums that were due and paid after your 65th birthday.
- **If you die on or after age 75**: No premiums will be returned.

However, MetLife will not refund premiums if nonforfeiture coverage was being provided as described above under "Nonforfeiture coverage" on the date of your death.

The time limit for submitting proof of claim to MetLife for a refund of premiums is 90 days after the date of the covered person's death.

Also, if your coverage ends because of your death, any additional premiums paid for any period beyond the date of Your death will be refunded to your estate.

Inflation adjustment provision

The LTC plan offers a choice of inflation adjustment provisions:

- **Automatic inflation protection**
  Your daily benefit amount and the remaining portion of your total lifetime benefit automatically increase by 5%, compounded annually, on January 1 each year. Although the initial premium is higher with this option, your premiums do not increase as your coverage increases. However, it is important that you be aware that, as explained in the Guaranteed Renewability statement in your certificate, and subject to any applicable regulatory approval, MetLife reserves the right to increase rates in the future. See the “LTC plan benefits” section for daily benefit amount and total lifetime benefit information.

  You can add **automatic inflation protection** to your coverage at any time; however, evidence of insurability is required, and there is additional premium associated with adding this feature.
- **Optional inflation feature**

You have the option to increase your daily benefit amount and remaining portion of your total lifetime benefit by at least 5%, compounded annually, once every three years. You are eligible to request this **optional inflation increase** without providing evidence of insurability as long as you have accepted this option at least once during the last two consecutive times this offer was made to you.

The premium for increased coverage is based on your age at the time the increase is effective.

Restoration of benefits

If you receive LTC benefits, and then do not receive LTC benefits for two years, your total lifetime benefit is restored if you meet all of the following:

- Did not exhaust the total lifetime benefit.
- Have not been authorized for benefits for the prior two years.
- Provide proof to MetLife that you have not been chronically ill during this two-year period (see the "LTC plan contacts" section for MetLife contact information).
- Have made premium payments during the continuous two-year period since the last time you were authorized for benefits.

Bed reservation

The Plan provides a nursing home, inpatient hospice or assisted living facility bed reservation benefit up to 21 days per calendar year if, while confined in such a facility, you are transferred to a hospital for acute care.

This means that if you are in a nursing home, an inpatient hospice or assisted living facility and you develop an illness that necessitates your admission to a hospital for acute care, the Plan continues to pay for your nursing home, inpatient hospice or assisted living facility bed while you are confined in that hospital. This benefit protects you from losing your bed reservation at a nursing home, an inpatient hospice or assisted living facility if you leave for an admission to a hospital.

Coverage reinstatement

If you stop paying premiums for coverage, you can apply for reinstatement - at the same premium rate in effect when you stopped paying - within 12 months.

Coverage is reinstated if you meet both of these conditions:

- Pay all back premiums.
- Provide evidence of insurability (EOI). (However, if you prove within five months after payments stop that you could not pay because of a loss of functional capacity or cognitive impairment, coverage is reinstated without EOI. After the fifth month of nonpayment of your premiums and up to 12 months of nonpayment of premiums, you must provide EOI.)

If you reapply for coverage more than 12 months from the time your coverage ended due to nonpayment of your premium, you will need to provide EOI and MetLife will need to approve you as a new participant. Premium rates will be based on your age on the effective date of this new coverage.
NOTE: MetLife LTC coverage was closed to new entrants effective January 1, 2012.

International benefit

If you are outside of the United States and are approved for benefits, the Plan does not pay for LTC services, but instead pays a per diem benefit amount after you complete the waiting period. The per

diem benefit amount is 50% of the home care daily benefit. See the “LTC plan benefits” section for home care information.

This benefit is paid in U.S. dollars.

Special rules apply for:

- **New York residents.** If you provide proof satisfactory to MetLife that you are confined in a nursing home outside the United States, the daily benefit amount will be not less than $50 per day. For all other covered services, the daily benefit amount will be not less than $25 per day. This daily benefit amount is paid for a maximum of six years while outside the United States.
- **Residents of all other states.** The daily benefit amount is paid for a maximum of 10 years while outside the United States.

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Filing an LTC claim

You or your covered family members are eligible for benefits after a licensed health care practitioner provides proof, satisfactory to MetLife, that you are chronically ill.

The certification process

Call a case manager at MetLife if you or a covered family member needs LTC services. (See the "LTC plan contacts" section for contact information.) Case managers:

- Certify your need for LTC.
- Assist in locating sources of care in your community.
- Can recommend the type of facility and level of care that is appropriate for your needs.

You do not have to follow the recommendations of your case manager, but you must call the case manager to begin the certification process to qualify for benefits. You, your doctor and your family make the final decisions concerning the type of care you should receive.

Within 10 business days of receipt of necessary information relating to your request for LTC benefits, the case manager will notify you or your covered family member regarding the approval or denial of your LTC benefit eligibility. If you are eligible for LTC benefits, then your notification will contain claim forms for you to submit proof of a claim for LTC benefits. If your request for eligibility for LTC benefits is denied, then you may file an appeal. See the "If a claim is denied" section for additional information on filing eligibility claims, benefit claims and appeals.

You must submit your claim within 90 days after the end of the calendar year in which the expenses were incurred.

When benefits are paid

After you satisfy the waiting period, the Plan pays benefits for covered services, as long as you remain certified as chronically ill, up to the selected total lifetime benefit.

Your provider is paid directly if you assign benefits to him or her. Otherwise, MetLife sends payment directly to the insured.

Premium waiver

Premium payments are waived beginning on the first day of the month on or after the date you satisfy the waiting period. Premium payments resume on the first day of the month after you no longer are certified as chronically ill.

Coordination of benefits*

Your LTC benefits are reduced by the dollar amount payable by any of the following, to the extent that the combination of the benefit and amounts payable, or which would be payable by any of the following, exceed 100% of the actual charge for the covered LTC expenses:

- Any federal, state or other governmental health care plan or law (except Medicaid or Medicare).
- Any state or federal Workers' Compensation law.
- Any employer's liability or occupational disease law.
- Any other plan that the employer contributes to or sponsors.
- Any mandatory motor vehicle no-fault law.

*These provisions may vary by state.

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When coverage ends

Your coverage ends on the earliest of:

- The date your employment with Verizon terminates unless you continue your coverage by direct premium payment to MetLife. See the “Continuing coverage” section for additional information.
- Last day of the month in which you notify MetLife that you wish to cancel coverage.
- 35 days after MetLife sends you a written notice of termination of your coverage.
- Day you no longer meet the eligibility requirements unless you continue your coverage by direct premium payment to MetLife. See the “Who is eligible to participate” and “Continuing coverage” sections for additional information.
- Day you receive benefits equal to your total lifetime benefit. See the “LTC plan benefits” section for additional information.
- Last day for which you paid for coverage if you stop making required payments. However, the “reinstatement provision” may apply. See the “Coverage reinstatement” section for additional information.
- Day your eligibility ended if you misrepresent your eligibility status.
- Day you die. Depending on your age when you die, the “return of premium upon death” provision may apply. See the “Return of premium upon death” section for additional information.
- Day the LTC plan ends or the official plan document is amended to eliminate coverage for all participants or a group of participants that includes you, unless you continue your coverage. See the “Plan documents” section for additional information.

Your family members’ coverage ends on the :

- Last day of the month in which your family member notifies MetLife that he or she wishes to cancel coverage.
- The date the dependent is covered as an employee or retired participant under any company-sponsored long-term care insurance plan.
- The last day of the month in which the dependent no longer qualifies as a dependent under the Plan.
- 35 days after MetLife sends a written notice of termination of your coverage as stated in the "Grace period" definition in the "Terms to know" section.
- Day your family member receives benefits equal to his or her total lifetime benefit. See the “LTC plan benefits” section for additional information.
- Last day for which your family member paid for coverage if he or she stopped making required payments. However, the “reinstatement provision” may apply. See the “Coverage reinstatement” section for additional information.
- Day your covered family member’s eligibility ended if you or he or she misrepresents the family member’s eligibility status.
- Day your family member dies. Depending on your family member’s age when he or she dies, the “return of premium upon death” provision may apply. See the “Return of premium upon death” section for additional information.

- Day the LTC plan ends or the official plan document is amended to eliminate coverage for all participants or a group of participants that includes your family members, unless the family member chooses to continue his or her coverage. See the “Plan documents” section for additional information.

Extension of benefits

If you are certified as chronically ill, and are in a nursing home, hospice facility or assisted living facility as of the date your coverage ends, MetLife will extend your LTC benefits. Subject to the waiting period and all other requirements of this group policy, your benefits will be extended only until the earliest of the date:

- You no longer are certified as chronically ill.
- You no longer are confined in a nursing home, hospice facility or assisted living facility.
- The total lifetime benefit has been paid.

Continuing coverage

You have the right to continue coverage if your coverage ends. This is called “continuation coverage.” To continue your LTC coverage, you pay premiums directly to MetLife.

MetLife automatically provides continuation coverage if you or your family members are eligible. If you do not want continuation coverage, you need to notify MetLife.

Continuation coverage generally is not available if:

- You stop making any required payments.
- You notified MetLife that you wished to cancel coverage.
- You receive benefits equal to your total lifetime benefit.
- The group policy terminates and coverage is replaced within 31 days by other group coverage that:
  - Is effective on the day following coverage termination.
  - Provides benefits that are identical to, substantially equivalent to or exceed those provided by the group policy.
  - Calculates your premium based on your age at the beginning of coverage under the group policy.

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Administrative information

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

Plan name/identification

Long-term care coverage is provided through the Verizon Associate Long-Term Care Plan. It is a welfare plan, listed with the Department of Labor under two numbers: The Employer Identification Number (EIN) is 23-2259884 and the Plan Number is (PN) 585.

Plan documents

The Plan documents consist of:

- This SPD.
- Applicable summaries of material modifications (SMMs) and other general communications identified as being part of the Plan.
- Certificates of Insurance.
- Any trust agreements formally adopted under the Plan.
- The pertinent contracts between Verizon and the claims administrator and other firms that provide services under the Plan. See the “Additional plan information” section for contact information.

Collective bargaining agreements

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

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Additional plan information

Plan sponsor/employer	Verizon Communications Inc. One Verizon Way Basking Ridge, NJ 07920
Plan administrator	The Verizon Employee Benefits Committee (VEBC) and/or the Chairperson of the VEBC c/o Verizon Benefits Center P.O. Box 8998 Norfolk, VA 23501-8998 855.4vz.bens (855.489.2367)
Claims administrator	**Enrollment and eligibility claims and appeals:** Verizon Claims Review Committee (VCRC) c/o Verizon Claims Review Unit P.O. Box 8998 Norfolk, VA 23501-8998 855.4vz.bens (855.489.2367) **Benefit claims and appeals:** MetLife LTC Claims P.O. Box 14407 Lexington, KY 40512-4633
Participating company	Since benefits were frozen as of January 1, 2012, the participating companies were the companies that participated in the Plan as of January 1, 2012 and were communicated in the SPD at that time. If you need information on whether a particular company was a participating company, please contact the Verizon Benefits Center.
Agent for service of legal process	MetLife LTC P.O. Box 14407 Lexington, KY 40512-4633 In addition, to the Plan administrator at the address listed above, a copy of the legal process involving this LTC plan should be delivered to: Verizon Legal Dept. Employee Benefits Group Verizon Communications Inc. One Verizon Way Basking Ridge, NJ 07920
Plan year	January 1 - December 31

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Funding and type of administration

The LTC plan is fully insured by MetLife.

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 SPD, there are two claims and appeals administrators for the Plan.

There are two types of claims: **eligibility** claims and **benefit** claims. See below for more information.

Claims regarding eligibility to participate in the Plan

At this time, for eligibility-related claims, the claims and appeals administrator is the VCRC. Eligibility claims should be directed to the Verizon Claims Review Unit at:

Verizon Claims Review Committee
P.O. Box 8998
Norfolk, VA 23501-8998

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 8998.

Claims regarding scope/amount of benefits under the Plan

At this time, for benefit related claims, the VCRC has delegated its authority to finally determine claims to MetLife, which has discretionary authority to determine claims and appeals for your Long-Term Care Insurance Plan benefits.

The addresses of the claims and appeals administrators for the Plan are listed under the “Additional plan information” section. If you have a claim or appeal, you should contact the appropriate claims and appeals administrator for the type of claim or appeal you have.

The claims and appeals administrators have discretionary authority to:

- Interpret the Plan based on its provisions and applicable law and make factual determinations about claims arising under the Plan.
- Determine whether a claimant is eligible for benefits.
- Decide the amount, form and timing of benefits.
- Resolve any other matter under the Plan that is raised by a participant or a beneficiary, or that is identified by either the claims or appeals administrator.

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

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Filing an ERISA claim or appeal

Disagreements about benefit eligibility or benefit amounts can arise. If the Verizon Benefits Center is unable to resolve the disagreement, Verizon has formal appeal procedures in place for Employee Retirement Income Security Act of 1974 (ERISA) covered plans.

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

An **eligibility** claim is a claim to participate in a plan or plan option or to change an election to participate during the year.

A **benefit** claim is a claim for a particular benefit under a plan. It typically will include your initial request for benefits.

	***Eligibility* claims procedure**	***Benefit* claims procedure**
Benefit Claims Procedure - Step 1:		
How to file a claim	To file an **eligibility** claim, request a Claim Initiation Form from the Verizon Benefits Center at 855.4vz.bens. You (or your authorized representative) must return the form to the Verizon Claims Review Unit at the address on the form. You must include: • A description of the benefits for which you are applying. • The reason(s) for the request. • Relevant documentation. See the "LTC plan contacts" section for contact information.	To file a **benefit** claim, you (or your authorized representative) should complete the appeal claim form sent with your decision letter or you may write to MetLife to obtain an appeal claim form. See the "LTC plan contacts" section for contact information.
When you will be notified of the claims decision	You will be notified of the decision within 90 days of the Claims Review Unit's receipt of your Claim Initiation Form (180 days, when special circumstances apply).	You will be notified of the decision within 90 days of MetLife's receipt of your written claim (180 days, when special circumstances apply).
Failure to provide sufficient information	The Claims Review Unit will notify you of the deadline to submit additional information, if applicable.	MetLife will notify you of the deadline to submit additional information, if applicable.

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	***Eligibility* claims procedure**	***Benefit* claims procedure**
How you will be notified of the claim decision	If your claim is **approved** the Claims Review Unit will notify you in writing. If your claim is **denied**, in whole or in part, your written denial notice will contain: • The specific reason(s) for the denial. • The plan provisions on which the denial was based. • Any additional material or information you may need to submit to complete the claim. • The Plan's appeal procedures.	If your claim is **approved**, MetLife will notify you in writing. If your claim is **denied**, in whole or in part, your written denial notice will contain: • The specific reason(s) for the denial. • The plan provisions on which the denial was based. • Any additional material or information you may need to submit to complete the claim. • The Plan's appeal procedures.
Appeals - Step 2:		
About appeals and the claims fiduciary	Before you can bring any action at law or in equity to recover plan benefits, you **must** exhaust this process. Specifically, you must file an appeal as explained in this Step 2 and the appeal must be finally decided by the Claims Review Committee, the claims fiduciary. As such, the Claims Review Committee is authorized to finally determine eligibility appeals and interpret the terms of the Plan in its sole discretion. All decisions by the Claims Review Committee are final and binding on all parties.	Before you can bring any action at law or in equity to recover plan benefits, you **must** exhaust this process. Specifically, you must file an appeal as explained in this Step 2 and the appeal must be finally decided by MetLife. The Claims Review Committee has delegated its authority to finally determine claims to MetLife. As such, MetLife is the claims fiduciary and is authorized to finally determine benefit appeals and interpret the terms of the Plan in its sole discretion. All decisions by MetLife are final and binding on all parties.
How to file an appeal	If your claim is denied and you want to appeal it, you must file your appeal within 60 days from the date you receive written notice of your denied claim. You may request access, free of charge, to all documents relating to your appeal. To file your appeal, write to the address specified on your claim denial notice.	If your claim is denied and you want to appeal it, you must file your appeal within 60 days from the date you receive written notice of your denied claim. You may request access, free of charge, to all documents relating to your appeal. To file your appeal, write to MetLife and include:

	***Eligibility* claims procedure**	***Benefit* claims procedure**
	You should include: • A copy of your claim denial notice. • The reason(s) for the appeal. • Relevant documentation.	• A copy of your claim denial notice. • The reason(s) for the appeal. • Relevant documentation.
When you will be notified of the appeal decision	You will be notified of the decision within 60 days of the Claims Review Committee's receipt of your appeal (120 days, when special circumstances apply). If your appeal is **approved**, the Claims Review Committee will notify you in writing. If your appeal is **denied**, in whole or in part, your written denial notice will contain: • The specific reason(s) for the denial. • A statement regarding the documents that you are entitled to that are available upon request and free of charge. • The plan provisions on which the denial was based. • Your right to bring a civil action under Section 502(a) of ERISA.	You will be notified of the decision within 60 days of MetLife's receipt of your appeal (120 days, when special circumstances apply). If your appeal is **approved**, MetLife will notify you in writing. If your appeal is **denied**, in whole or in part, your written denial notice will contain: • The specific reason(s) for the denial. • A statement regarding the documents that you are entitled to. • The plan provisions on which the denial was based. • Your right to bring a civil action under Section 502(a) of ERISA.
Step 3:		
How to proceed if necessary	The decision on your appeal is final. As a result, Verizon will not review your matter again, unless new facts are presented. You have a right to bring a civil action.	The decision on your appeal is final. As a result, MetLife will not review your matter again, unless new facts are presented. You have a right to bring a civil action.

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Your rights under ERISA

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

Receive information about your plan and benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent actions by plan fiduciaries

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

Enforce your rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

Assistance with your questions

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

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

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

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

HIPAA privacy rights

The Notice of Privacy Practices for the Verizon Health Plans is included in its entirety in your medical SPD. Because the LTC benefit is fully-insured, you should contact MetLife for a copy of its Notice of Privacy Practices.

Nondiscrimination and accessibility requirements

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements with respect to Verizon's Group Health Plans that are "Covered Entities"

Discrimination is against the law.

Verizon's group health plans that are "covered entities" (referred to in this notice as "Verizon's group health plans") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

Verizon's group health plans[1]:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Verizon Benefits Center at 855.4Vz.Bens (855.489.2367).

[1] With respect to the nondiscrimination rules explained in this notice, the following Verizon group health plans are "covered entities:" The Plan for Group Insurance, The Verizon Retiree Group Health Plan for Management & Non-Union Hourly Employees, The Verizon Retiree Group Health Plan for West Associates, Verizon Plan 550, Verizon's Mid-Atlantic Group Health Plan for Retired Associates (Pre-1990), Verizon New York and New England Retiree Health (Post-1992 Retirees) and Group Life Insurance Plan for Active and Retired Associates, and Verizon Post-1995 Collectively Bargained Retiree Health Plan (Pre-1993 Retirees).

If you believe that Verizon's group health plans have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Verizon Benefits Center
Attn: Civil Rights Coordinator
P.O. Box 8998
Norfolk VA 23501-8998
Phone: 908.559.3342
TTY: 711
Fax: 908.630.2639
E-mail: lucy.romeo@verizon.com

You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, Lucy Romeo, Executive Assistant, Verizon's Civil Rights Coordinator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame 855.489.2367 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855. 489. 2367.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855.489.2367.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 855.489.2367.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 855.489.2367 (ATS: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855.489.2367 번으로 전화해 주십시오.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 855.489.2367.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 7632.984.558 (رقم هاتف الصم والبكم:
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ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855.489.2367.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 855.489.2367.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 855.489.2367.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 855.489.2367.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 855.489.2367.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。855.489.2367 まで、お電話にてご連絡ください。.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 855.489.2367 تماس بگیرید.

Verizon's rights

Verizon's right of recovery

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

Verizon's right to use your Social Security Number for administration of benefits

Verizon retains the right to use your Social Security Number for benefit administration purposes, including tax reporting. If a state law restricts the use of Social Security Numbers for benefit administration purposes, Verizon generally takes the position that ERISA preempts such state laws.

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Disclaimer

Your eligibility for benefits is determined by this SPD. The company has full discretionary authority to interpret the terms of the Plan summarized in this document and determine your eligibility for benefits under the Plan's terms. In some cases, Verizon has delegated this authority.

If this SPD conflicts with the provisions of Internal Revenue Code section 7702B, Verizon reserves the right to address the matter with MetLife and modify the Plan to comply with Internal Revenue Code section 7702B. It is Verizon's intent that this Plan comply with the provisions of Internal Revenue Code section 7702B and related guidance.

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

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

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

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

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

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Terms to know

Assisted living facility

An assisted living facility is a facility that:

- Maintains all appropriate licensing required under the laws of the jurisdiction in which it is located to provide maintenance or personal care.
- Provides 24-hour-a-day care and services sufficient to assist residents with needs that result from the inability to perform activities of daily living or severe cognitive impairment.
- Has a minimum of six residents.
- Uses aides trained or certified to provide maintenance or personal care in accordance with any laws applicable to the provision of such care.
- Provides 24-hour supervision of residents by a trained and awake staff.
- Has formal arrangements for emergency medical care.
- Maintains written records of services provided to each resident.
- Provides residents with three meals a day.
- Has appropriate methods and procedures to assist in administering prescribed drugs where allowed by law.

The term “assisted living facility” includes any such facility that specializes in the care of persons with Alzheimer’s disease and other dementias.

The term “assisted living facility” does not include any facility used primarily as a hotel, motel, place for rest, place for treatment of drug addiction or alcoholism, retirement home, congregate living facility, senior housing facility, facility primarily intended to provide residential services (but not maintenance or personal care) or facility primarily providing care for residents who are related to the owner or manager of the facility. If a facility has multiple licenses or purposes, only that section of the facility specifically meeting the definition of Assisted Living Facility will qualify as such.

Benefit period

The length of time your coverage will last if you receive care every day at a cost equal to your daily benefit amount. If your care costs less than your daily benefit amount, your coverage will last longer than your benefit period.

Chronically ill

A licensed health care practitioner needs to provide proof, satisfactory to MetLife, that you or a family member is chronically ill.

Chronically ill means:

- Being unable to perform, without substantial assistance from another person, at least two of the following six activities of daily living for a period expected to last at least 90 days due to a loss of functional capacity:
  - Bathing.
  - Toileting.
  - Eating.
  - Dressing.

- Continence.
- Transferring.

Or

- Having a severe cognitive impairment requiring substantial supervision to protect you from threats to health and safety.

Daily benefit amount (DBA)

The maximum amount you can be reimbursed for long-term care services received in a single day.

Doctor or physician

The definition of doctor or physician includes a doctor of chiropody (D.P.M. or D.S.C.), doctor of chiropractic (D.C.), doctor of dental medicine (D.M.D.), doctor of dental surgery (D.D.S.), doctor of medicine (M.D.), doctor of osteopathy (D.O.) and doctor of podiatry (D.P.M.) acting within the scope of his or her license.

Evidence of insurability (EOI)

Submitting EOI means providing information on your medical history when you apply for reinstatement or a coverage increase to long-term care (LTC) coverage. You must complete a form that includes specific medical information questions. MetLife reviews your form and must approve before the reinstatement or coverage change becomes effective. Generally your effective date is the first of the month following acceptance.

NOTE: Effective January 1, 2012, The LTC insurance being provided through MetLife was closed to new entrants. Accordingly, MetLife will no longer issue any new LTC insurance certificates to Verizon employees and retirees.

Full-time associate

A full-time associate is an active employee who is regularly scheduled to work 25 or more hours per week. In addition, the definition of a full-time associate includes job-sharing employees who are regularly scheduled to work at least 40 percent of a regular full-time employee's hours.

Grace period

There is a 31 day grace period for payment of your contribution. This means MetLife must receive your contribution, by the 31st day after the date it is due. If MetLife does not receive your contribution by the end of this grace period, MetLife will send a written notice of termination of your coverage to you (and to any person you have designated to receive such notice) by first class U.S. mail, postage prepaid.

You have the right to designate an individual to receive notice of termination concurrently with any such notice we will send you. The individual you designate will not be responsible for payment of the contribution. It is your responsibility to notify MetLife of any change in your designation.

Home care coverage

The benefits you can receive for covered in-home services.

Hospital

A hospital is a facility that is licensed as a hospital and provides:

- A broad range of 24-hour-a-day medical and surgical services for sick and injured persons by, or under the supervision of, a staff of physicians.
- Nursing care 24 hours a day.

Informal care services

This is defined as custodial care not provided by a nurse or therapist or through a home care agency and includes care provided by immediate family members.

Licensed health care practitioner

A licensed health care practitioner is defined as a physician, a registered nurse, a licensed social worker, or another professional individual who meets the requirements prescribed by the United States Secretary of the Treasury.

Nursing home

A nursing home is a facility that is licensed as a nursing facility under the laws of the jurisdiction in which it is located, or a MetLife-approved facility that satisfies all of the following:

- Maintains all appropriate licensing required under the laws of the jurisdiction in which it is located to provide maintenance or personal care.
- Provides 24-hour-a-day nursing care.
- Provides 24-hour-a-day maintenance or personal care by a trained/certified and awake staff supervised by a nurse.
- Has formal arrangements for emergency medical care.
- Maintains written records of services provided to each resident.
- Provides residential services including, but not limited to, food, shelter and laundry.

The term “nursing home” includes any such facility that specializes in the care of persons with Alzheimer’s disease and other dementias.

The term “nursing home” does not include any facility used primarily as a hospital (except a distinct part of a hospital that is a nursing facility), residential facility, hotel, motel, place for rest, home for the aged, sheltered living accommodation, facility for the treatment of mental illness, continuing care retirement community or similar entity, place for treatment of drug addiction or alcoholism or facility primarily providing care for residents who are related to the owner or manager of the facility.

Parent or parent-in-law

You or your spouse's natural parent or legal adoptive parent, or any other person who was at one time married to you or your spouse's natural or legal adoptive parent.

Participating company

Verizon or any corporation or partnership that is an affiliate of Verizon that has elected to participate in the Verizon Associate Long-Term Care Plan.

Part-time associate

A part-time associate is an active employee who is regularly scheduled to work fewer than 25 hours per week, other than an employee who has been continuously employed since December 31, 1980 and other than a job-sharing employee who is considered a full-time associate.

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Spouse

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

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

Total lifetime benefit

The total dollar amount of benefits that your coverage could pay for covered services. This is calculated by multiplying your daily benefit amount by the benefit period of five years.

Waiting period

The Plan does not pay benefits until you satisfy a waiting period. The waiting period begins on the date you are certified as chronically ill, and you must remain certified during that time. The waiting period is 90 calendar days, or 10 calendar days for inpatient and outpatient hospice care.

- You do not have to receive covered services during the waiting period.
- Waiting period days do not have to be consecutive, as long as they are not separated by more than 180 days.

Once you have satisfied the waiting period, it does not need to be satisfied again.