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# Health Care and Dependent Day Care Spending Accounts and Dependent Care Reimbursement Fund

# Summary Plan Description for New York and New England Associates

# Published January 1, 2023

V-B-AA-N-R-68933-1/23

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## Your Health Care and Dependent Day Care Spending Accounts and the Dependent Care Reimbursement Fund

You can use the Health Care Spending Account (HCSA) and Dependent Day Care Spending Account (DCSA) to receive tax-free reimbursement for your eligible health care and dependent care expenses. You can use one or both accounts. In addition, if you are eligible, the Dependent Care Reimbursement Fund provides you with Company-paid reimbursement for eligible dependent care expenses.

### About this SPD

This document is the summary plan description (SPD) for the Verizon Welfare Benefit Plan for New York and New England Associates (the Plan). 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 is based on Plan provisions and bargained-for changes in effect as of January 1, 2023. In addition, this document describes the Dependent Care Reimbursement Fund, a program that is not subject to ERISA but which may affect your contribution decision for the DCSA. This SPD updates and replaces all previous SPDs and other descriptions of the Plan, as well as all previous descriptions of the Dependent Care Reimbursement Fund. 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 "Additional information" section.

This SPD is divided into the following major sections:

- **Health Care Spending Account (HCSA).** This section explains how the HCSA works, defines eligible health care expenses, and how to file claims.
- **Dependent Day Care Spending Account (DCSA).** This section describes the DCSA, eligible dependents for whom you can claim expenses, how the account works, defines eligible dependent care expenses, and how to file claims.
- **Dependent Care Reimbursement Fund.** This section describes the Dependent Care Reimbursement Fund, which provides Company funding for reimbursement of eligible dependent care expenses to employees who qualify under certain earned income guidelines.
- **Additional information.** This section provides additional details about provisions of the Plan and your legal rights.
- **Administrative information.** This section includes administrative provisions of the Plan.
- **Terms to know.** Certain terms used in this SPD are defined in the "Terms to know" section.

### Important Note:

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

**Flexible Spending Account (FSA) contacts**

| Plan | Contact | Reason to contact |
|---|---|---|
| **Flexible Spending Accounts (FSA)** | **BenefitsConnection:**<br>From Inside Verizon or<br>verizon.com/benefitsconnection<br>(User ID and password required)<br>> Spending Accounts<br><br>**Member Services**<br>855.4vz.bens (855.489.2367)<br>Fax: 855.785.3471<br><br>**Mailing Address:**<br>Verizon Benefits Center<br>PO Box 8999<br>Norfolk, VA 23501-8999 | • Verify your HCSA and/or DCSA balance<br>• Ask about covered expenses<br>• Submit claims<br>• Check the status of a claim<br>• Order additional HCSA debit cards for eligible family members<br>• View a list of eligible providers that accept the spending account debit card |
| **General Benefits Information** | | |
| **BenefitsConnection**<br><br>**Verizon Benefits Center** | From Inside Verizon or<br>verizon.com/benefitsconnection<br><br>855.4vz.bens (855.489.2367) | • Enroll for coverage<br>• Verify overall eligibility and coverage<br>• Review personal benefits information<br>• Make changes to your coverage due to a Qualified Life Event<br>• Update dependent information<br>• Verify eligibility for COBRA coverage<br>• Enroll for COBRA coverage<br>• Update COBRA coverage due to a qualifying life event |
| **Internal Revenue Service Forms & Publications** | irs.gov | • Review IRS forms |

**Verizon Benefits Center**

The Verizon Benefits Center offers a website called BenefitsConnection where you will find tools to help you manage your benefits. You can access BenefitsConnection from Inside Verizon or verizon.com/benefitsconnection (user ID and password required).

The website makes finding information fast and easy as it guides you through your benefits transactions, including Annual Enrollment and Qualified Life Events (e.g., birth, marriage, divorce). In addition, you can:

- Link to other Verizon benefit provider sites
- Review details about your health care and insurance plans

- Select and update your beneficiary designations
- Change your BenefitsConnection password
- Give yourself a helpful “hint” in case you forget your password

Verizon Benefits Center representatives are available at 855.4vz.bens (855.489.2367) should you have questions about your benefits. Using this toll-free telephone number, you also can connect with other Verizon benefit providers.

**Changes to the plan**

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

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

## Health Care Spending Account (HCSA)

### Eligibility

You are eligible to participate in the HCSA on the first day of your employment if you meet all of the following requirements:

- Are employed by a Verizon participating company (see the "Administrative information" section)
- Are a regular full-time, part-time, or eligible temporary New York or New England associate

A temporary employee's eligibility is governed by the applicable collective bargaining agreements. "Associate," as used throughout this SPD includes any non-management employee who is a member of a union that has negotiated participation in the Plan.

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

- You are paid by a temporary staffing or placement agency, or another 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 Plan.

**IMPORTANT:**

Plan the amount of your contribution carefully. IRS rules require that you forfeit any amount you contribute that you cannot claim for reimbursement at the end of the Plan Year (calendar year). However, you have until May 31 of the following year to file claims. If you are enrolled in the Plan as of December 31 of the current Plan Year, you will also have an additional 2 ½ month Grace Period to incur Eligible Expenses. This means if you are enrolled in the Plan on December 31 of the current Plan Year, you may incur Eligible Expenses through March 15 of the following Plan Year and apply these expenses towards your prior year account balance. This Grace Period is designed to help you avoid forfeiting money remaining in your account at the end of the Plan Year.

With careful planning, you can avoid forfeiting any balance in your HCSA. Forfeited amounts are applied toward the administrative costs of providing the HCSA.

### Enrolling in the HCSA

#### Initial enrollment by newly hired associates

If you are a new associate, you can begin making contributions as soon as you become eligible to participate. You automatically will receive enrollment information. You must enroll via BenefitsConnection or by calling the Verizon Benefits Center by the deadline included in your enrollment materials. Indicate the amount you want to deposit in your account on a before-tax basis;

otherwise, you will not be eligible to contribute to the account until the next election Annual Enrollment period, unless you have a Qualified Life Event during the year (see “Changing your elections”).

You can contribute as little as $100 or as much as $3,050 (subject to annual cost-of-living adjustments) per calendar year to your account depending on your marital status, tax filing status, and income level(s). However, when you join in the middle of the year, your contribution is prorated for the portion of the year you will be contributing. Your contributions will begin as soon as administratively possible after you enroll and will be deducted on a before-tax basis from your paychecks over the course of the year.

If you are changing from a management position to an associate position, your participation in the HCSA will continue without interruption. Your contributions, account and claims activity will be transferred to the account for associates if you contributed to the account as a manager.

**NOTE:**

Expenses that are eligible for reimbursement must be incurred by you or your family members whom you claim as dependents for income tax purposes.

**If you are rehired**

If you leave the Company and are rehired within 30 days, your HCSA election in place at the time of your termination will be reinstated, but you cannot make changes unless you experience a Qualified Life Event.

If you leave the Company and are rehired by the Company after 30 days, you may re-enroll in the Plan effective the date you are rehired.

**Changing your elections**

**Annual Enrollment**

After your initial enrollment opportunity, you will make a decision each year during the Annual Enrollment period about whether you want to participate for the following calendar year. Elections made during the Annual Enrollment period take effect on the following January 1, and remain in effect through December 31 of that year as long as you are eligible, unless you change the election during the year due to a Qualified Life Event (or another permissible event described here). If you do not make changes, your current elections remain in effect for the next calendar year as long as you are eligible.

**Declining enrollment**

If you do not enroll, or decline to participate in the HCSA, you will not be able to participate until the next Annual Enrollment period unless you have a Qualified Life Event that permits you to make a mid-year election change. Examples would be marriage, birth of a child, loss of coverage because of divorce, or termination of employment. You must request enrollment within 90 days after your Qualified Life Event.

**Qualified Life Events**

Between Annual Enrollment periods, you will be able to change your contribution amount or stop or start contributing, provided that you have a Qualified Life Event that affects eligibility for using the

account, and the election change you make is consistent with the Qualified Life Event. If you elect to reduce your election amount, your election will be limited to the amount you had contributed year to date or the amount that you had been reimbursed, whichever is greater. If you elected to enroll in the HCSA or DCSA or increase your spending account election, the new amount will be taken ratably over the remaining paychecks in the year.

For example, you can start contributing if you have or adopt a baby, or you can stop or decrease your contributions in the event of your dependent's death.

Any change will remain in effect until December 31 of the calendar year in which the change is made or, if sooner, until you experience another Qualified Life Event and change your election. Your new election will take effect as soon as administratively possible after you call the Verizon Benefits Center, and deductions from your pay will be adjusted accordingly.

Elections made due to Qualified Life Events must be made within 90 days of the life event; otherwise, a change will not be allowed with respect to that Qualified Life Event.

**You gain a new dependent**

If you gain a new, eligible dependent through marriage, birth, adoption, or placement for adoption, you can start or increase contributions to the HCSA. To make a change, you must notify the Verizon Benefits Center of your Qualified Life Event within 90 days gaining the new dependent.

**You lose a dependent**

If you lose a dependent through death or divorce, you may start, stop, increase, or decrease your contributions to the HCSA by notifying the Verizon Benefits Center within 90 days of the date you lose a dependent. Note that your change must be consistent with your Qualified Life Event.

**Change in employment for you, your Spouse or a dependent**

If you, your Spouse, or a dependent has a change in employment status that affects your eligibility to use the account, you can make a contribution change within 90 days of the employment change that is consistent with the event. Eligible events include the end or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, changes in worksite or any other change in an individual's employment status.

**Change in dependent's eligibility for medical plan coverage**

If your dependent either gains or loses eligibility for coverage under the medical plan options for New York and New England Associates (for example, when coverage ends due to age requirements) you may be eligible to change your account contribution amount. You are eligible to make a change within 90 days of the event if your dependent's change in eligibility affects your eligibility to use the account, and your change is consistent with the event.

**You or a dependent becomes eligible or loses eligibility for Medicare or Medicaid**

If you or a dependent becomes eligible for Medicare or Medicaid during the year, you may elect to reduce or stop your contributions to the HCSA by notifying the Verizon Benefits Center.

If you or a dependent loses eligibility for Medicare or Medicaid during the year, you may elect to start or increase your contributions to the HCSA by notifying the Verizon Benefits Center.

**NOTE:**

Changes are not permitted if Medicare coverage consists only of the Social Security program for distribution of pediatric vaccinations.

**When participation ends**

Your participation in the HCSA will end on the earliest date described below.

| Event | Effect on Participation |
|---|---|
| **Leaves of Absence** | In general, if you go on a leave of absence, your participation continues in accordance with Company guidelines and as collectively bargained. |
| **Leaves Under the Family and Medical Leave Act** | Verizon 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. Your payroll deductions stop when your leave begins. However, depending on your type of leave, you may either be direct billed for your contributions, or you may elect to continue your participation in the HCSA through COBRA . If you return within 30 days of your leave, your original balance is reinstated. Your payroll deductions will then be increased to account for the missed payroll deductions and contributions. If you return after 30 days from your leave, then you will need to re-enroll. Call the Verizon Benefits Center for details.<br><br>For information on non-FMLA Leaves of Absence, go to Inside Verizon > Leaves of Absence. |
| **Leaves 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. Call the Verizon Benefits Center for details. |
| **Change in Employment Status** | If your employment status changes from an associate to management status, your participation in the HCSA will continue without interruption. Any contributions, account and claims activity will also be transferred to the account for management employees. |
| **Disability** | If you become disabled, your HCSA participation will continue as long as you are receiving short-term disability (STD) benefits; however, your DCSA participation will end. If your employment with Verizon ends after your STD benefits end or if your employment ends as a result of a long-term disability, you may be able to continue your HCSA participation through COBRA. |
| **Cancellation of Coverage** | If you stop contributions due to a Qualified Life Event, your participation will end on the date you elect to stop contributing. |
| **You Die** | If you die while you are participating in the HCSA, your dependents can file claims on any remaining amounts in your account for Eligible Expenses incurred up to the date of your death. Your dependents can file claims on these amounts until May 31 of the following year. |

| Event | Effect on Participation |
|---|---|
| **End of Employment** | Participation in the Plan will end on the day in which your employment ends. You can claim reimbursement for Eligible Expenses incurred up to the date your participation ends. |
| **Plan Termination** | Although Verizon does not intend to terminate the Plan, were the Plan to be terminated, all contributions would end on the date of termination. |

**Continuation of coverage under COBRA**

In some instances, a person whose eligibility for participation in this Plan ends still may be able to continue making contributions on an after-tax basis and receive reimbursement for eligible claims in accordance with a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments. See the "Continuation of coverage under COBRA" section for more information.

**HCSA highlights**

Key features of the HCSA are highlighted below.

| Account feature | How it works |
|---|---|
| **Before-Tax Contribution You Can Deposit Each Year** | Minimum: $100 per year<br>Maximum: $3,050 for 2023 Plan Year |
| **Using Your Account** | You can use the HCSA debit card to pay for many eligible health care expenses. See the "The Spending Account Debit Card Program" section for more information. Otherwise, you can submit a claim for reimbursement with supporting documentation whenever you have paid an eligible expense for you or an eligible dependent[1]. The money will be taken out of your account up to the amount you have elected to deposit for the year, less any prior reimbursements, and you will receive reimbursement according to your preference of direct deposit or check. |
| **Some Eligible Expenses**<br>To verify what is an eligible expense, go to: BenefitsConnection > Library > Spending Accounts > Eligible Expenses | • Copayments<br>• Deductibles<br>• Coinsurance<br>• Amounts you pay above health care plan limits.<br>• Unreimbursed dental expenses, including amounts above a plan's benefit limit (for example, orthodontic expenses)<br>• Unreimbursed vision and hearing care expenses<br>• Over-the-counter medications |

[1] Expenses for non-tax-qualified dependents are not eligible for reimbursement under the HCSA. See definition of IRS Tax Dependent in the "Terms to know section" of the SPD for details regarding whose expenses are eligible for reimbursement under the HCSA.

| Account feature | How it works |
|---|---|
| **Some Expenses That Are Not Eligible** | • Health insurance premiums<br>• Cosmetic surgery or procedures that are not medically necessary |

**For more information**

For a complete listing of eligible/Ineligible Expenses, go to BenefitsConnection. From the Home Page, select Library > Spending Accounts > Eligible Expenses.

**How the account works**

With the account, you make contributions on a before-tax basis through payroll deductions. This reduces your taxable income, which means you pay less taxes. When you have an eligible health care expense during the year, you file a claim for reimbursement from the account, and you do not pay any taxes on this money when you are reimbursed. You can also use your spending account debit card to pay for eligible health care expenses. (See “The Spending Account Debit Card Program” for more information about how the spending account debit card works.)

To use the account:

- **Step 1:** During your initial enrollment and each Annual Enrollment period, you decide if you want to participate, and elect the amount you want to contribute by enrolling via BenefitsConnection or by calling the Verizon Benefits Center. This contribution should be based on a careful estimate of the eligible out-of-pocket health care expenses you and your family members expect to incur during the upcoming calendar year.
- **Step 2:** During the year, your contribution will be deducted from your paychecks in installments— before federal income and Social Security taxes are figured. In most cases, you also will avoid state and local taxes on your contributions.
- **Step 3:** When you have eligible health care expenses, you can file a claim for reimbursement— there is no minimum required to file a claim. (See “Eligible health care expenses” for a list.) You can also use your spending account debit card to pay for eligible health care expenses.
- **Step 4:** You cannot carry over your unused HCSA contributions from one Plan Year to the next. However, the Plan does have a Grace Period. If you are enrolled in the Plan as of December 31 of the current Plan Year, any amounts remaining in your account through March 15 of the next calendar year can be used to reimburse Eligible Expenses that you incur through March 15. If you do not incur enough Eligible Expenses by March 15 to claim all of your contributions for the previous calendar year, the law requires you to forfeit the remaining unused amount. You have until May 31 of the following calendar year to file all claims incurred through March 15 of the next calendar year.

**Example of tax savings**

The table below shows the tax savings you may receive when you use the FSAs assuming you are filing as single. Remember that you can contribute up to $3,050 into your HCSA during the 2023 Plan Year.

**Examples of potential tax savings based on income**

The amounts shown are estimates only and are based on 2023 federal income and Social Security (FICA) taxes. You also may save on state and local income taxes. Your actual savings will depend on your income and tax filing status.

| **Estimated federal tax savings using the spending accounts (FSAs)** | |
|---|---|
| If you contribute: | 22% federal income tax plus 7.65% FICA tax (e.g., annual income of $60,000, if single) |
| $250 | $74 |
| $500 | $148 |
| $750 | $222 |
| $1,000 | $297 |
| $1,500 | $445 |
| $2,500 | $741 |

The 7.65% FICA tax is comprised of a 6.2% Social Security tax (up to the Social Security wage base of $160,200 for 2023) plus a 1.45% Medicare tax. Therefore, there is no Social Security tax savings above the Social Security wage base of $160,200 for 2023.

The advantages of participating in a flexible spending account on a before-tax basis - or claiming the tax deduction/credit on an after-tax basis - depend on the amount of your expenses and your financial situation. You should consult a tax advisor for specific information about the tax implications of participating in an FSA.

Estimates are based on the 2023 federal income tax rates. Your actual tax savings depends on a number of factors, including your filing status, your Deductible expenses, your exemptions, and your total household income. Consult your tax advisor to determine tax savings for your particular situation.

**Additional tax considerations**

When you receive reimbursement from the HCSA for these expenses, you cannot take a tax deduction on your federal income tax return for the same expenses. You have to choose whether you want to take the tax deduction or receive reimbursement through the HCSA.

Visit the Internal Revenue Service (IRS) website at irs.gov for specific information about the tax deduction or consult a tax advisor for guidance on your specific situation.

**Eligible health care expenses**

In general, you can use the HCSA for any health care expense not paid in full by your health care coverage, as long as it is considered medically necessary or an eligible preventive care measure.

Expenses for “medical care” that are incurred during the Plan Year but not covered by a health care plan are eligible for reimbursement. Generally, an expense for medical care means that it must diagnose, cure, mitigate, treat, or prevent disease or affect a structure or function of the body.

Effective January 1, 2020, the definition of eligible health care expenses includes over the counter (OTC) medications and supplies obtained without a prescription, and feminine care products. For a complete listing of Eligible Expenses, visit BenefitsConnection. From the Home Page, select Library > Spending Accounts > Eligible Expenses.

Examples of expenses eligible for reimbursement through the HCSA include, but are not limited to:

- Copayments, Deductibles and Coinsurance that you pay under any health care plan.
- Alcohol and/or drug dependency treatment center costs
- Cardiac rehabilitation classes
- Childbirth classes
- Eyeglasses
- Hearing aids and batteries
- Laboratory tests
- Over-the-counter medications
- Prescription birth control devices
- Routine hearing exams
- Routine physical exams
- Smoking cessation programs and prescription drugs used to treat nicotine withdrawal.
- Transportation expenses if transportation is primarily for and essential to medical care.
- Weight-loss programs (for example, the cost of participation in a weight-loss program and fees for periodic meetings) for treatment of a specific disease or ailment, diagnosed by a doctor (such as obesity, hypertension, or heart disease). This does not include the purchase of related food items.
- X-rays

**Ineligible health care expenses**

Here are examples of expenses that are not eligible for reimbursement under the HCSA:

- Cosmetics
- Cosmetic surgery unless it is for the treatment of a disfiguring illness or injury.
- Cosmetic dental procedures, such as bleaching and teeth whitening.
- Dietary supplements
- Expenses incurred before your participation in the HCSA begins or after your participation ends in each calendar year.
- Expenses incurred for individuals who are not eligible dependents under the HCSA.
- Health care expenses that are reimbursable under any other health plan or insurance
- Health club or gym fees (unless recommended by a physician for a medical condition and accompanied by a Letter of Medical Necessity)
- Household help expenses, even if your doctor recommends you have help because you physically are unable to do housework.
- Illegal surgical procedure and drug charges
- Living expenses
- Long-term care
- Premium payments for disability insurance, life insurance and group health coverage, including payments for COBRA coverage

- Weight-loss treatments, unless prescribed by a physician to cure a specific illness, and fees for diet food or beverages associated with weight loss (even if associated with a weight loss program that is diagnosed by a physician)

Keep in mind that you can only be reimbursed for Eligible Expenses that were incurred while contributing to the HCSA.

**For more information**

For a complete listing of eligible/Ineligible Expenses, go to BenefitsConnection. From the Home Page, select Library > Spending Accounts > Eligible Expenses.

**The Spending Account Debit Card Program**

You can use the HCSA debit card to pay for eligible health care expenses. As you use your spending account debit card, eligible health care expenses will be deducted automatically from your HCSA.

**How the Spending Account Debit Card Program works**

You will receive a package containing one debit card issued in your name, instructions on how to create a PIN, a Cardholder Agreement, Additional Disclosures, and information explaining approved use of the card. You may request additional cards for your eligible dependents under the Plan through BenefitsConnection. From the Home Page, select Spending Accounts > My Debit Cards.

The spending account debit card remains active for up to four years as long as your HCSA is in good status, you continue to participate in the HCSA, and you remain actively employed. Your card will be cancelled upon termination of employment or termination of participation in the Plan – inactive participants may not use the spending account debit card. If you elect to continue the HCSA under COBRA, your spending account debit card will be reactivated upon your first payment (and you must continue to make monthly payments in order for your card to remain active).

By signing and using the card, you certify that:

- You will only use the card for your own eligible health care expenses and those of your eligible dependents under the Plan
- Incurred expenses were for health care services or supplies purchased on or after the date your HCSA took effect
- Your expenses do not include any amounts that are otherwise payable by plans for which you or your dependents are eligible
- Any expense paid with the card has not been, or will not be, reimbursed by another source

You can present your spending account debit card for eligible health care expenses at select merchants that primarily sell health care products and services (for example, pharmacies, grocery stores, physician’s offices, hospitals, and dentist’s offices).

You can use your spending account debit card just like any other credit or debit card. You will have a choice to select either "credit" or "debit." For the "credit" option, you will be required to provide your signature. For the "debit" option, you will be prompted to enter your PIN to complete your transaction. Note that some merchants may not accept "debit" purchases but still accept the "credit" option.
Some merchants do not accept the card if they are not an IIAS or a 90% Merchant. In such cases,

the card will simply be declined, and you will need to pay out of pocket. Be sure to save supporting documentation or Explanation of Benefits (EOB) so you can submit it along with your spending account claim online (fastest method) or with a paper claim form to be mailed or faxed for reimbursement from your HCSA.

The card does not permit cash advances and cannot be used at ATMs.

With each debit card purchase, your available HCSA balance is reduced by that amount. Other Ineligible Expenses, such as cosmetics or food items, must be paid for separately.

**Important: Save your Explanation of Benefits (EOB) and supporting documentation**

All spending account debit card transactions must be verified as eligible health care expenses; therefore, you may be required to provide the Verizon Benefits Center with supporting documentation to validate your expenses. Make sure you save your supporting documentation or Explanation of Benefits (EOB) from your health plan.

**How to use the spending account debit card during the Grace Period**

**The plan has a "Grace Period" that extends from January 1 to March 15.**

This means that if you are enrolled in the Plan as of December 31 of the current Plan Year, you may incur Eligible Expenses through March 15 of the following Plan Year (calendar year) and apply those expenses toward your prior year account balance.

**For example**, if you are enrolled in the Plan as of December 31, 2023, you may continue to incur Eligible Expenses through March 15, 2024, and apply those expenses against any remaining 2023 account balance.

When using your spending account debit card during the Grace Period, your card will use the funds remaining in your 2023 HCSA first. When your 2023 HCSA balance reaches zero, the card will then take money from your 2024 HCSA for the claims you incur in 2024 – even claims incurred during the Grace Period.

When you use your spending account debit card, be sure that:

- The date of your service for your eligible expense is within the Plan Year in which you are enrolled in the HCSA, and
- Your HCSA has a large enough balance to cover your expense.

**For example**, Assume you went to the doctor on December 1, 2023 but you didn't pay for the office visit with your spending account debit card until January 15, 2024. You can submit this claim to your 2023 HCSA as long as you have enough funds remaining in your 2023 HCSA to cover the expense. If you do not have enough funds in the HCSA, the claim cannot be submitted to your 2024 HCSA since the date of service was in 2023.

### Lost or stolen cards

If your spending account debit card is lost or stolen - or you believe that there has been any unauthorized use of your card - you must contact the Verizon Benefits Center immediately at 855.4vz.bens (855.489.2637). You can also report your spending account debit card lost or stolen on BenefitsConnection. From the Home Page, select Spending Accounts > My Debit Cards > Report Lost or Stolen Card.

### Validation of spending account debit card transactions

#### Automatic validation with approved merchants

When you purchase eligible health care items using your spending account debit card with approved merchants, your transaction can be validated automatically without having to provide supporting documentation. To be “approved,” a merchant must have an inventory information approval system (IIAS) installed. These IIAS-Certified Merchants have the ability to identify eligible items at the point of sale, which eliminates the need for additional documentation. They have programmed their systems to only allow eligible items and services to be processed on the spending account debit card. For a complete listing of certified merchants, visit BenefitsConnection. From the home page, select > Library > Spending Accounts > External Links > List of IIAS merchants. Please note that the listing is subject to change at any time.

Any ineligible items must be paid for with another form of payment. For a complete listing of Eligible Expenses visit BenefitsConnection. From the Home Page select > Library > Spending Accounts > Eligible Expenses > List of eligible Health Care Spending Account expenses.

#### Automatic validation for other medical providers

Your spending account debit card can also be used for other types of health care transactions without the need for submission of supporting documentation or further review. These transactions include recurring expenses, Copayments, or prescription purchases. Below is a brief explanation of each type of transaction.

- **Recurring transactions** - If you purchase an eligible health care item or service using your spending account debit card, that same item or service will be validated automatically the next time you purchase it with your spending account debit card (at the same provider and for the same dollar amount) in the current Plan Year only. Any recurring spending account debit card transactions will not carry over to the new Plan Year for participants who re-enroll in a HCSA. You will need to provide supporting documentation in the new Plan Year.
- **Copayments** - Your spending account debit card is programmed to recognize your Verizon health plan’s Copayment amounts without any additional validation being required. For example, if you go to the doctor and have a $20 Copayment, that amount is a recognized Copayment and will be automatically approved.
- **Prescriptions covered by Express Scripts** - If you have coverage with Express Scripts through Verizon, your prescription purchases will typically be validated automatically – simply present your spending account debit card at the time of purchase. Although your expense should be validated automatically, it is good practice to save your supporting documentation in case the Verizon Benefits Center requests it.

**Spending account debit card transactions requiring documentation**

The following transactions require documentation before processing:

- **Merchants registered under the IRS 90% Pharmacy Rule (also referred to as the 90% Participating Merchant Rule by BenefitsConnection).** Purchases at a merchant registered under the IRS 90% Pharmacy Rule (a merchant that does not use the IRS-approved inventory approval system but certifies that a particular store location's sales consist of 90% medical expenses) must be substantiated. While your spending account debit card will work at a participating 90% Merchant, you must substantiate the expense afterward. This is an IRS requirement and is not set by Verizon. To review the participating 90% Merchant locations, go to BenefitsConnection. From the Home Page, select Library > Spending Accounts. Under External Links select List of 90% Merchants. Please note that the listing is subject to change at any time.
- **Non-Copayments in a Verizon health plan.** Purchases at, or payments to, a health care provider in a Verizon health plan if the amount is:
  - Not a fixed Copayment amount or a multiple of up to 5 times a fixed Copayment amount
  - A Deductible amount
  - A Coinsurance amount
- **Any payments in a non-Verizon health plan.** Purchases at, or payments to, a health care provider in a non-Verizon health plan if the amount is:
  - Any Copayment amount for a non-Verizon health plan (i.e., you are not a subscriber under a Verizon health plan, but participate in a non-Verizon health plan)
  - Any Coinsurance amount in a non-Verizon health plan
  - Any Deductible amount in a non-Verizon health plan

**Important Note:**

Any payments in a non-Verizon health plan are not automatically substantiated using the spending account debit card. You must submit additional documents (e.g., Explanation of Benefits (EOB) statements from your insurance company or supporting documentation from the provider) afterward to substantiate any Coinsurance paid with the spending account debit card.

**Supporting documentation**

Any debit card transaction not validated automatically will require supporting documentation. Debit Card purchases are conditionally reimbursed, pending validation of the expenses. The process for debit card transactions is outlined below:

- The merchant is reimbursed for the amount of the charge, and your available HCSA balance is reduced
- You will be sent a letter or email informing you that supporting documentation is required to validate the spending account debit card transaction
- If the documentation you provided is insufficient, you will be sent a letter or email instructing you to provide more documentation, such as an EOB

Expenses for which you do not provide adequate documentation are considered ineligible and treated as overpayments. If you do not provide the requested information or fail to repay any Ineligible Expenses, the ineligible amount may be added to your taxable income.

**Overpayment process**

If you have one or more spending account debit card transactions that have not been verified within 52 days from the date of the transaction as an eligible health care expense, your spending account debit card will be suspended and your HCSA will be considered to be in overpayment.
Your spending account debit card will remain suspended until your overpayment is satisfied.

The primary situations that could result in an overpayment are:

- You fail to respond to validation requests for spending account debit card transactions after three initial requests are sent by the Verizon Benefits Center
- Your spending account debit card transactions were authorized at the point of sale, and then later deemed ineligible after the validation process was completed

To resolve this overpayment and have your spending account debit card reactivated, you can do one of the following:

- Submit online and upload supporting documentation or an Explanation of Benefits (EOB) corresponding to the Transaction ID and Claim ID that includes:
  - Provider name and address
  - Patient name
  - Date(s) of service
  - Type of service
  - Dollar amount of the debit card transaction
  - Prescription name (for prescription drug claims)
- Provide documentation for other eligible health care expenses that are equal to or greater than the amount of this transaction and for which you have not yet received reimbursement to offset the unsubstantiated spending account debit card transaction
- Repay your account for the amount of this transaction

Please note, that even if your spending account debit card has been suspended, your HCSA remains active and you can continue to submit claims through BenefitsConnection, or by fax or mail with a paper claim form.

**When not to use your spending account debit card for Coinsurance-related payments**

If you enrolled in a plan that has Coinsurance and you visit your doctor, wait until after your doctor submits a claim to your health plan to pay for any Coinsurance using your spending account debit card. Doctors often have negotiated reduced rates, so using your spending account debit card at the time of service may result in an overpayment. Once your health plan pays its portion of the claim, your doctor will bill you for your portion. At that time, you may use your spending account debit card to pay your portion of the bill. Remember to save your supporting documentation in case the Verizon Benefits Center requests it.

**Important information regarding errors, liability, and related disclosures**

The following disclosures relate to issues concerning the spending account debit card. Any other issues that relate to your flexible spending account (such as benefit eligibility, participation, enrollment, claims or validation) that are governed under the terms of your Plan with respect to the

HCSA and the Employee Retirement Income Security Act of 1974 (ERISA), will be subject to the dispute procedures available under the plan offered by or through Verizon.

**Consumer liability**

You must notify the Verizon Benefits Center immediately if you believe your spending account debit card has been lost or stolen. Call the Verizon Benefits Center to prevent the loss of all of the money you have accrued under the Plan, although there is no guarantee that such a loss will not occur. You can also print a Debit Card Transaction Dispute form. Go to BenefitsConnection, from the Home Page, select Spending Accounts > Resource Center > Claim Forms > Debit Card Transaction Dispute. Please consult the Cardholder Agreement provided to you upon issuance of your debit card for further details regarding what to do upon the loss or theft of your debit card.

If you view a transaction online and it shows spending account debit card transactions that you did not authorize, you must notify the Verizon Benefits Center within 60 days from the date of the transaction. If you do not inform the Verizon Benefits Center within this time frame, you will not be able to recover any money you lost after the 60 days. If there is a valid reason that prevented you from contacting the Verizon Benefits Center (such as a long trip or a hospital stay), the time period for notification will be extended.

Federal law limits credit card holders' liability for fraudulent charges to $50. Spending account debit card holders, on the other hand, are liable for $50 if they report fraud within two days and up to $500 if they report within 60 days. After 60 days, customers are generally responsible for all fraudulent spending account debit card charges.

Many issuers, however, feature policies that exceed federal mandates. All cards issued through the Visa payment network have zero liability policies that preclude account holders from having to pay even the $50 minimum on unauthorized transactions.

**Account Activity**

Information regarding your account activity is available under the Spending Accounts Tab on BenefitsConnection.

**The Verizon Benefits Center liability**

If the Verizon Benefits Center does not complete a transaction on time or for the correct amount, according to the Cardholder Agreement, it will be liable for your losses or damages. However, some exceptions apply. The Verizon Benefits Center will not be liable if, for example:

- You do not have enough available funds at Verizon or under the Plan (through no fault of the Verizon Benefits Center) to make the transaction
- Circumstances beyond the Verizon Benefits Center's control (such as fire or flood) prevented the completion of the transaction, despite reasonable precautions that had been taken
- Any other exceptions stated in the Cardholder Agreement apply

**Confidentiality**

The Verizon Benefits Center may disclose information to third parties about your spending account debit card account or the transactions that you make using the card under any of the following circumstances:

- When it is necessary for completing transactions
- To verify the existence and condition of your spending account debit card account for a third party
- To comply with a government agency or court order
- As provided in the Cardholder Agreement or in the plan
- If you give the Verizon Benefits Center your written permission

**In case of errors relating to your spending account debit card**

Call the Verizon Benefits Center at the number provided on the back of your card as soon as possible if you think a spending account debit card transaction is wrong or if you need more information about a transaction. The Verizon Benefits Center must receive notification of any errors no later than 60 days (either via BenefitsConnection or by mail) after the problem or error appeared. If you call the Verizon Benefits Center, you may be required to send your complaint or question in writing within 10 business days. When you contact the Verizon Benefits Center, be prepared to:

- Provide your name, Social Security number (when applicable) and spending account debit card number
- Describe the error or the spending account debit card transaction that you are unsure about and explain the reason you believe there is an error or why you need more information
- Provide the dollar amount of the suspected error

The Verizon Benefits Center will coordinate with the spending account debit card issuer to determine whether an error occurred within 60 business days after it receives notification from you and will correct any error promptly. If more time is needed to correct the error, however, the Verizon Benefits Center may take up to 45 days to investigate your complaint or question. If this additional time is necessary, the Verizon Benefits Center will credit the monies held by Verizon for the amount that you think is in error, so that you will have use of the total amount during the investigation. If the Verizon Benefits Center requests that you put your complaint or question in writing and it does not receive the information within 60 business days, the Verizon Benefits Center may not provide this credit. The Verizon Benefits Center will inform you of the results within three business days after completing the investigation. If the Verizon Benefits Center decides that there was no error, a written explanation will be mailed to you. You may ask for copies of the documents that were used in the investigation.

**Filing a claim for reimbursement**

As you incur Eligible Expenses, you can submit claims online through BenefitsConnection, via fax, or by mail. You can also contact the Verizon Benefits Center for information about claiming a reimbursement from your HCSA.

You will only be reimbursed for services that have been incurred in which you are submitting a claim. The HCSA will not reimburse you for future dated expenses.

**Claim processing**

If you are enrolled in the Plan as of December 31 of the current Plan Year, you have an additional 2 ½ month Grace Period to incur eligible health care expenses. This means you may incur Eligible Expenses through March 15 of the following Plan Year and apply those expenses towards your prior account balance.

Claims must be received by May 31 of the year following the Plan Year in which they are incurred; otherwise, they are not eligible for reimbursement. For example, if you have an expense in October of the current year, you have until May 31 of the next Plan Year to file a claim for reimbursement. IRS rules require that any account balance not used by March 15 and submitted by May 31 will be forfeited.

You can be reimbursed up to the total amount of your annual election, regardless of the amount you actually have contributed at the time you file your claim.

**Submitting claims to BenefitsConnection**

You have multiple options to submit a claim for your HCSA:

- **Option 1** - submit your claim online. Go to BenefitsConnection from Inside Verizon or verizon.com/benefitsconnection . From the Home Page, select Spending Accounts > File a Claim.
- **Option 2** - submit your claim by fax. Fax the completed claim form and supporting documentation to 855.785.3471. Make sure that you fax these items together. The claim form should be the first page in the stack of pages that you fax.
- **Option 3** - submit your claim by mail with a claim form to: Verizon Benefits Center, P.O. Box 8999, Norfolk, VA 23501-8999

To obtain a claim form, go to BenefitsConnection > Spending Accounts > Resource Center > Claim Form.

Claims submitted using a claim form or submitted online are reimbursed via check mailed to your home address (or through direct deposit if you have elected to sign up for it).

Your claim will be processed as soon as administratively possible, and generally no later than 10 days after the Verizon Benefits Center receives your paperwork.

**Supporting documentation**

You must provide proper supporting documentation so that your claim can be processed. This supporting documentation may include an itemized receipt, an Explanation of Benefits (EOB) statement from your health plan or a Letter of Medical Necessity Form.

**HCSA claims**

Supporting documentation or Explanation of Benefits (EOB) must include the following:

- Provider name and address
- Patient name
- Date(s) of service
- Type of service

- Amount you owe for the service or expense
- Prescription name (for prescription drug claims)

**If your claim is denied**

If your claim for reimbursement is denied, you or your beneficiary are entitled to a written explanation of the denial. You also may file a written request for review of the decision. For details, refer to the "Additional information" section.

## Continuation of coverage under COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), created the right to continue coverage.

This section:

- Contains important information about your right to COBRA continuation coverage under the HCSA. Please note DCSAs are not eligible for continuation under COBRA
- Explains when COBRA coverage may become available
- Describes what you need to do to protect your right to receive COBRA coverage

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

### What COBRA continuation coverage is

COBRA coverage is a temporary continuation of participation in the HCSA when it otherwise would end because of a life event, known as a "qualifying event."

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

Qualified beneficiaries who elect COBRA continuation coverage must pay for it on an after-tax basis.

### COBRA qualified beneficiaries

- **Employees**. You become a COBRA qualified beneficiary if you lose your coverage under the Plan because of one of the following qualifying events:
  - Your hours of employment are reduced
  - Your employment ends for any reason other than your gross misconduct
- **Spouse of employee**. Your Spouse becomes a COBRA qualified beneficiary if he or she loses coverage under the Plan because of one of the following qualifying events:
  - You die
  - Your hours of employment are reduced
  - Your employment ends for any reason other than gross misconduct
  - You become divorced from your spouse
- **Dependent children**. Dependent children become COBRA qualified beneficiaries if they lose coverage under the Plan because of one of the following qualifying events:
  - The parent-employee dies
  - The parent-employee's hours of employment are reduced
  - The parent-employee's employment ends for any reason other than his or her gross misconduct

**When COBRA coverage is available**

The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Verizon Benefits Center has been notified that a qualifying event has occurred. (See the “Administrative information” section for contact information.)

**Notification of qualifying events**

When the qualifying event is the end of employment or reduction in hours of employment or death of the employee, Verizon will notify the Verizon Benefits Center (the COBRA administrator) of the qualifying event.

For other qualifying events (divorce of the employee and Spouse or a dependent child losing eligibility for coverage as a dependent child), you or the qualified beneficiary must notify the Verizon Benefits Center within 90 days after the qualifying event occurs by calling 855.4vz.bens (855.489.2367).

If you or the qualified beneficiary fails to notify the Verizon Benefits Center within 90 days after the qualifying event, your dependent will not be entitled to elect COBRA continuation coverage.

**How COBRA coverage is offered**

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

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

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

**How long COBRA coverage lasts**

You and your eligible dependents may be eligible to continue participation in the HCSA for the remainder of the calendar year in which participation otherwise would end.

You and your eligible dependents have 60 days from the date coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect continued participation under COBRA. If you or eligible dependents fail to elect COBRA coverage within the applicable time frame, the opportunity to continue coverage under COBRA will be lost.

**What COBRA coverage costs**

During the continuation period, you or your dependent must make monthly contributions on an after-tax basis.

Payment is due at enrollment, but there is a 45-day Grace Period from the date you enroll in COBRA either on BenefitsConnection or by calling the Verizon Benefits Center. The initial payment includes coverage for the current month, plus any previous month(s).

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

If you or your dependent elects COBRA continuation coverage:

- You or your dependent can keep the same level of coverage you had as an active employee or choose a lower level of coverage.
- Your or your dependent's coverage is effective as of the date of the qualifying event. However, if you waive COBRA coverage and then revoke the waiver within the 60-day election period, your elected coverage begins on the date you revoke your waiver.
- You or your dependent may change your coverage:
  - If you have a Qualified Life Event (see the "Qualified Life Events" section for more information)
  - If you have a change in circumstance recognized by the Internal Revenue Service (IRS) and Verizon

**When COBRA coverage ends**

COBRA coverage ends on the last day of the Plan Year in which participation otherwise would end or before that date if one of the following occurs:

- You fail to make timely contributions as required
- Verizon stops providing health benefits to any employee

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

**If you have questions**

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

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

**IMPORTANT:**

If you have questions about COBRA or wish to enroll, contact the Verizon Benefits Center or access BenefitsConnection.

## Dependent Day Care Spending Account (DCSA)

You can use the DCSA to pay Eligible Expenses for many types of dependent care arrangements, including child and/or elder day care services. (See “Eligible dependent care expenses” and “Ineligible dependent care expenses” sections for more information.)

Generally, IRS rules require that the care for your dependent(s) be necessary for you and your Spouse to work or to look for work. You also can use the account if your Spouse is a full-time student at least five months of the year or is unable to care for himself or herself due to a mental or physical disability.

Expenses are not eligible if they are for services provided while you are out socially or on vacation.

**Who can provide care**

Dependent care services can be provided inside or outside your home by anyone except:

- Your Spouse
- Your child under age 19
- Anyone considered your dependent for income tax purposes, including parents or grandparents

**Eligibility**

You are eligible to participate in the DCSA on the first day of your employment if you meet the following requirements:

- Are employed by a Verizon participating company (see the “Additional information” section for details)
- Are a regular full-time, part-time or an eligible temporary New York or New England associate. A temporary employee’s eligibility is governed by the applicable collective bargaining agreement.

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

- You are paid by a temporary staffing or placement agency or another 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 individual included in the above explanation of an ineligible employee should be treated as an eligible 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 and is expressly ineligible for benefits under the Plan.

**Eligible dependents**

An eligible dependent under the DCSA is:

- A Qualifying Child, generally a person who:
  - Is a U.S. citizen or resident
  - Is under the age of 13
  - Is your child, grandchild, brother, sister, stepbrother or stepsister, niece or nephew
  - Does not provide over one-half of his or her own support for the calendar year
- Lives with you for more than one-half of the calendar year
- Your Spouse or dependent of any age if he or she is physically or mentally incapable of caring for himself or herself and lives with you for more than one-half of the calendar year. In addition, he or she must be a U.S. citizen or resident.

If you are divorced or separated and are the:

- Custodial parent, your child is an eligible dependent even if you do not claim him or her as a dependent on your federal income tax return.
- Noncustodial parent, you generally cannot treat your child as an eligible dependent for DCSA purposes, even if you claim him or her as a dependent on your federal income tax return. However, if the custodial parent signs an agreement, and the noncustodial parent attaches the agreement to his or her tax return, he or she may be able to treat the child as an eligible dependent. You should check with your tax advisor regarding the details of this procedure.

For this purpose, custodial parent means the parent that the child lives with for the greater part of the calendar year.

**Enrolling in the Dependent Day Care Spending Account**

**Initial enrollment by newly hired associates**

If you are a new associate, you can begin making contributions as soon as you become eligible to participate. You automatically will receive enrollment information. You must complete your enrollment on BenefitsConnection or call the Verizon Benefits Center by the deadline included in your enrollment materials to indicate the amount you want to deposit in your account on a before-tax basis. Otherwise, you will not be eligible to contribute to the account until the next Annual Enrollment period, unless you have a Qualified Life Event during the year (see “Changing your elections”).

You can contribute a minimum of $100 per year and a maximum of $5,000 per calendar year to the DCSA depending on your marital status and how you file your federal income tax return. However, when you join in the middle of the year, your contribution is prorated for the portion of the year you will be contributing. Your contributions will begin as soon as administratively possible after you enroll and will be deducted on a before-tax basis from your paychecks over the course of the year.

If you elect to contribute to the account, you will receive additional information from the claims administrator on how the account works.

**If you are rehired**

If you leave the Company and are rehired within 30 days, your DCSA election in place at the time of

your termination will be reinstated and you cannot make changes, unless you experience a Qualified Life Event.

If you leave the Company and are rehired after 30 days, you may re-enroll in the Plan effective the date you are rehired.

**Important Note:**

Plan the amount of your contributions carefully. Under the IRS “use it or lose it” rule, all unused funds remaining in your DCSA at the end of the Plan Year (calendar year) are forfeited, subject to the applicable “Grace Period” described below. Forfeited amounts are applied toward the administrative costs of providing the DCSA.

**Changing your elections**

**Annual Enrollment**

After your initial enrollment opportunity, you will make a decision each year during the Annual Enrollment period about whether you want to participate the following calendar year. Elections made during the Annual Enrollment 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 Qualified Life Event. If you do not make changes, your current elections remain in effect for the next calendar year.

**Qualified Life Events**

Between Annual Enrollment periods, you will be able to change your contribution amount or stop or start contributing, provided that you have a Qualified Life Event that affects eligibility for using the account, and the election change you make is consistent with the Qualified Life Event. For example, you can start contributing if you have or adopt a baby, or you can stop or decrease your contributions in the event of your dependent’s death.

Elections made due to Qualified Life Events must be made within 90 days and consistent with the Qualified Life Event; otherwise, a change will not be allowed. If you reduced your election amount, your election was limited to the amount you had contributed year to date or the amount that you had been reimbursed, whichever was greater. If you elected to enroll in the DCSA or increase your spending account election, the new amount will be taken ratable over the remaining paychecks in the year. Any change will remain in effect until December 31 of the calendar year in which the change is made or, if sooner, until you experience another Qualified Life Event and change your election. Your new election will take effect as soon as administratively possible after you call the Verizon Benefits Center, and deductions from your pay will be adjusted accordingly.

**You gain a new dependent**

If you gain a new, eligible dependent whom you claim as a dependent for income tax purposes, you can start or increase contributions to the DCSA. To make a change, you must notify the Verizon Benefits Center of your Qualified Life Event within 90 days of the event.

**You lose a dependent**

If you lose a dependent through death or divorce, or a dependent no longer is eligible, you can stop or decrease your contributions to the DCSA by notifying the Verizon Benefits Center within 90 days. Note that your contribution change must be consistent with your Qualified Life Event.

**Change in employment for you, your Spouse or a dependent**

If you, your Spouse, or a dependent has a change in employment status that affects your eligibility to use the account, you can make a contribution change consistent with the Qualified Life Event. Eligible events include the end or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, changes in worksite or any other change in an individual's employment status.

**Change in Spouse's eligibility with his or her employer**

If your Spouse participates in a similar plan with his or her employer and he or she makes a change under that plan either at that plan's Annual Enrollment or at any other time due to a Qualified Life Event, you can make a change under your DCSA. Your change must be on account of and consistent with your Spouse's change under his or her plan.

**A change in cost for dependent care services**

If you have a significant cost change for your dependent care services imposed by a provider who is not related to you, you can make an election change. You can make the change on BenefitsConnection or by calling the Verizon Benefits Center.

**Leaves under the Family and Medical Leave Act (FMLA)**

Verizon 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. Your participation in the DCSA will be terminated. Your participation in the DCSA ends when your leave (paid or unpaid) begins. Participation can resume when you return to work with the Company; however, you must re-elect this benefit through the Verizon Benefits Center if your leave is more than 30 days and you wish to continue in the DCSA. See the "Qualified Life Events" section for more information.

**Leaves under the Uniformed Services Employment and Reemployment Rights Act (USERRA)**

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. Call the Verizon Benefits Center for details.

**When participation ends**

Your participation ends on the earliest date described below.

| Event | Effect on your participation |
|---|---|
| **Leaves of Absence** | In general, if you go on a leave of absence, your participation continues in accordance with Company guidelines and as collectively bargained. |
| **Leaves of Absence Under the Family and Medical Leave Act** | Verizon 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. Your DCSA contributions will terminate during approved leaves of absence but may be continued on the day of your return to work. |

| Event | Effect on your participation |
|---|---|
| | For information on non-FMLA Leaves of Absence, go to Inside Verizon > Leaves of Absence. |
| **Leaves of Absence Under the Uniformed Services Employment 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. |
| **Change in Employment Status** | If your employment status changes from associate to management status, your participation in the DCSA will continue with no interruption. Your contributions, account and claims activity will be transferred to the new account for managers if you contributed to the account as an associate. |
| **Disability** | If you become disabled, your HCSA participation will continue as long as you are receiving short-term disability (STD) benefits; however, your DCSA participation will end. If your employment with Verizon ends after your STD benefits end or if your employment ends as a result of a long-term disability, you may be able to continue your HCSA participation through COBRA. |
| **Cancellation of Coverage** | If you stop contributions due to a Qualified Life Event, your participation will end on the date you elect to stop contributing. |
| **You Die** | If you die while you are participating in the DCSA, your dependents can file claims on any remaining amounts in your account for Eligible Expenses incurred up to the date of your death. Your dependents can file claims on these amounts up until May 31 of the following year. |
| **End of Employment** | Participation in the Plan will end on the last day of your employment. You can claim reimbursement for Eligible Expenses incurred up to the date your coverage ends. |
| **Plan Termination** | Although Verizon does not intend to terminate the Plan, were the Plan to be terminated, all contributions would end on the date of termination. |

**Dependent Day Care Spending Account highlights**

Here are some highlights of how the DCSA works.

| Account feature | How it works |
|---|---|
| **Before-Tax Contribution You Can Deposit Each Year** | Minimum: $100 per year<br>Maximum: $5,000 per year (see the “Contribution limits” section for details) |
| **Using Your Account** | You can submit a claim for reimbursement whenever you have paid an eligible expense. The money will be taken out of your account up to the amount you have contributed to date, less any prior reimbursements. Note your claim will not be paid in full if you do not have the money available in your account, the unpaid |

| Account feature | How it works |
|---|---|
| | balance will be carried forward. The DCSA will not reimburse you for future dated expenses. |
| **Some Eligible Expenses**<br>To verify who is an IRS-eligible dependent and what an IRS-eligible expense is, visit BenefitsConnection from Inside Verizon or verizon.com/benefitsconnection. From the Home Page, select Library > Spending Accounts > Eligible Expenses. | • Pre-school<br>• Childcare or adult day care at a center that meets state and local regulations<br>• Work-related baby sitting<br>• Care of an adult dependent who is mentally or physically incapable of caring for himself/herself and who lives with you at least eight hours a day<br>• Relative who cares for eligible dependents, as long as that relative is not a person you list as a dependent for income tax purposes or your child under age 19<br><br>Expenses must be for an IRS-eligible dependent[2]:<br>• Your children under age 13<br>• Your disabled children of any age who are incapable of self-care<br>• Your physically or mentally disabled Spouse who is incapable of self-care<br>• Anyone else you claim as a dependent for tax purposes who is incapable of self-care |
| **Some Expenses That Are Not Eligible** | • 24-hour nursing home care<br>• Non-work-related baby sitting<br>• Remote, online or overnight camp<br>• Costs for dependent care when you - or your Spouse - are not working |

**How the account works**

With the account, you make contributions on a before-tax basis through payroll deductions. This reduces your taxable income, which means you pay less taxes. When you have eligible dependent care expenses during the year, you reimburse yourself from the account. Keep in mind, in most cases, you do not pay any taxes on this money when you are reimbursed.

To use the account:

- **Step 1:** During your initial enrollment and each Annual Enrollment period, you decide if you want to participate and elect the amount you want to contribute by enrolling on BenefitsConnection or calling the Verizon Benefits Center. This contribution should be based on a careful estimate of your expected dependent care expenses for the upcoming year.
- **Step 2:** During the year, your contributions will be deducted from your paychecks before federal income and Social Security taxes are calculated. In most cases, you also will avoid state and local taxes on your contributions. Some states, such as New Jersey and Pennsylvania, and certain municipalities—such as Yonkers, New York—treat the money you deposit in the DCSA as taxable income for state and local taxes.

  **Step 3:** When you have incurred eligible dependent care expenses, you can file a claim—

[2] Expenses for non-tax-qualified dependents are not eligible for reimbursement under the DCSA.

there is no minimum required to file a claim. (See the “Eligible dependent care expenses” section for a list.) You will receive a tax-free reimbursement for your claim, up to the amount you have available in your account when you file your claim. You must provide the Tax Identification Number of your care provider in order to claim expenses under the DCSA.

**NOTE:**

If your claim is not paid in full because you do not have the money available in your account, the unpaid balance is carried forward. As you make additional contributions to your account, this money automatically will be used to reimburse you for any unpaid balance. This means you will not have to resubmit the same claim. However, you cannot be reimbursed for any expenses you have not yet incurred.

- **Step 4:** You have an additional 2 ½ month Grace Period to incur eligible dependent care expenses. This means you may incur Eligible Expenses towards your prior year account balance. Note, reimbursement of more than $5,000 maximum in one year from your DCSA, could result in tax implication. You should consult with your tax advisor for guidance on your specific situation.

**Contribution limits**

You can contribute a minimum of $100 per year and a maximum of $5,000 per year to the DCSA depending on your marital status and how you file your federal income tax return.

| If this is your situation… | Then your maximum annual contribution is… |
|---|---|
| You are single and file your federal income tax return as the “head of household” | $5,000 |
| You are married and you or your Spouse earns less than $5,000 | The income of the lower-paid Spouse |
| You are married, your Spouse also participates in a similar account, and you file a joint federal income tax return | $5,000 combined for both accounts |
| You are married and you and your Spouse file separate federal income tax returns | $2,500 each |
| You are married and file jointly and your Spouse does not participate in a similar account | $5,000 |
| Your Spouse is a full-time student or incapable of self-care because of a disability | $3,000 a year for 1 eligible dependent or up to $5,000 a year if you have 2 or more eligible dependents |

**If you also receive benefits from the Dependent Care Reimbursement Fund**

If you are eligible to participate in the Company’s Dependent Care Reimbursement Fund, you should be aware that the same eligible dependent care expenses qualify for reimbursement under both plans; however, you cannot be reimbursed twice for the same expenses, and any reimbursements you receive from the fund reduce your reimbursement limit under the DCSA.

Therefore, when you estimate your eligible dependent care expenses for the upcoming calendar year, you should take into consideration any amounts that you can claim for reimbursement under the Dependent Care Reimbursement Fund.

Amounts not reimbursed by the fund then can be claimed under the DCSA, up to your annual limit based on both plans combined, as described above.

**Additional tax considerations**

Eligible dependent care expenses may qualify for tax deductions. A percentage of these expenses can be claimed as a tax credit on your federal income tax return, whether or not you itemize your deductions.

However, you cannot use Eligible Expenses that you claim for reimbursement through your DCSA when you calculate the dependent care tax credit on your federal income tax return. This means that your annual contribution to your DCSA must be subtracted from your total dependent care expenses before you can calculate the tax credit.

If you use the DCSA to reimburse yourself, you cannot use these same expenses for the Child and Dependent Care tax credit on your federal income tax return. The tax credit allows up to $3,000 for one dependent and up to $6,000 if you have two or more dependents.

For example: if you have one dependent and receive $3,000 in benefits from the DCSA, you cannot claim the Child and Dependent Care tax credit on your income tax return. However, if you receive a lesser amount in benefits from the DCSA, you are eligible for a portion of the credit as a tax credit on your federal tax return.

Visit the Internal Revenue Service (IRS) website at irs.gov for specific information about the tax credit or consult a tax advisor for guidance on your specific situation.

**Eligible dependent care expenses**

In general, you can use the DCSA for dependent care expenses that you pay for someone to care for your eligible dependent (your child under age 13 or an individual of any age if disabled) so that you and your Spouse, if you are married, can work, or look for work. These expenses include payments you make to someone who comes to your home or for care provided outside your home, such as a day care center.

Dependent care expenses must meet all of the following requirements to be eligible for reimbursement:

- The expenses must be provided primarily for the well-being and protection of the dependent.
- The day care provider must meet certain tax-identification requirements and comply with state and local laws. You must include your day care provider's Social Security number or taxpayer identification number when you submit a claim for reimbursement.
- The care/service must be necessary for you to work and, if you are married, for your Spouse to work, look for work or attend school full time (unless your Spouse is disabled).
- The care/services must be rendered during your enrollment in the DCSA, not prior to or after your enrollment ends.

For a complete listing of eligible dependent care expenses, go to BenefitsConnection. From the Home Page, select Library > Spending Accounts > Eligible Expenses.

Examples of expenses eligible for reimbursement through the DCSA include, but are not limited to:

- Care provided:
  - At licensed nursery schools or day camps (not expenses for kindergarten level or above or overnight camps). To qualify, the school or center must comply with state and local laws and receive a fee for its services if it cares for seven or more children.
  - At an adult day care facility (but not expenses for an overnight nursing home facility)
  - Before-school or after-school programs
  - By an individual service provider (the individual service provider will need to give you their Social Security number before you can submit a claim for the day care services, they provide and they will have to declare any monies that you pay them from your DCSA as taxable income).
  - Inside or outside your home by anyone (other than your Spouse, a person you list as your dependent for income tax purposes, or your child under age 19)
- Household services related to the care of qualifying dependents who live with you
- Any other qualified dependent care expense as defined by the Internal Revenue Code

Remember, the Verizon Benefits Center will only reimburse for services that have been incurred and been billed up to the day in which you are submitting a claim. The Verizon Benefits Center will not reimburse you for future dated expenses.

**Ineligible dependent care expenses**

Here are examples of expenses that are not eligible for reimbursement under the DCSA:

- Amounts paid for the care of a person in a nursing home or convalescent facility
- Amounts paid to your Spouse or dependent or child under the age of 19
- Cost of food, clothing, shelter, insurance, medical treatment, or vacations of a qualifying dependent
- Costs for dependent care when you or your Spouse are not working
- Education expenses for any child in or beyond kindergarten
- Items you intend to claim as a credit for federal tax purposes
- Remote, online or overnight camp

**Filing a claim**

As you incur eligible health care and dependent day care expenses, you can submit claims online at BenefitsConnection, via fax or by mail. You can also contact the Verizon Benefits Center for information about claiming a reimbursement from your accounts.

You can only be reimbursed for services both incurred and billed through the day before you submit your claim. The DCSA will not reimburse you for future dated expenses.

**Advance Reimbursement**

You can receive Advance Reimbursement of dependent care expenses for up to six weeks of

contributions – up to the annual maximum you elected to contribute. This Advance Reimbursement feature is available:

- At the beginning of each Plan Year. When participation begins for new hires.
- At a new enrollment due to a Qualified Life Event

Here is an example. Assume that you choose to contribute $5,000 to the DCSA.

| **An example…** | |
|---|---|
| DCSA election | $5,000 |
| Divided by weeks of contributions | ÷ 52 |
| Equals the weekly contributions | $96.15 |
| Multiply this amount by six weeks | × 6 |
| Equals the amount of money available | $576.90 |

You can be reimbursed as soon as you have paid $576.90 in dependent care expenses and received the associated services, even if that amount has not yet been withheld from your pay, as long as the total is within the annual maximum you elect to contribute.

If you stop participating in the account during the first six weeks of the contribution period, you can only submit claims for reimbursement up to your actual contribution amount (not the Advance Reimbursement amount). Any claims paid under the Advance Reimbursement feature (before termination of your contributions) that exceed your actual contribution amount will be considered an overpayment and will be subject to recovery and/or taxability.

**Claim processing**

If you are enrolled in the plan as of December 31 of the current Plan Year, you have an additional 2 ½ month Grace Period to incur eligible dependent care expenses. This means that you may incur Eligible Expenses through March 15 of the following Plan Year (calendar year) and apply these expenses towards your prior year account balance. Note, reimbursement of more than the $5,000 maximum in one year from your DCSA, could result in tax implication. You should consult with your tax advisor for guidance on your specific situation.

Claims must be received by May 31 of the year following the Plan Year in which they are incurred; otherwise, they are not eligible for reimbursement. For example, if you have an expense in October of the current year, you have until May 31 of the next Plan Year to file a claim for reimbursement. IRS rules require that any money remaining in your FSAs after the claims filing deadline will be forfeited.

**Submitting claims to BenefitsConnection**

You have multiple options to submit a claim for your DCSA.

- **Option 1** - Submit your claim online. Go to BenefitsConnection from Inside Verizon or verizon.com/benefitsconnection and select Spending Accounts > File a Claim

- **Option 2** - Submit your claim by fax. Fax the completed claim form and supporting documentation to 855.785.3471. Make sure that you fax these items together. The claim form should be the first page in the stack of pages that you fax.
- **Option 3** - Submit your claim by mail to: Verizon Benefits Center, P.O. Box 8999, Norfolk, VA 23501-8999

To obtain a claim form, go to BenefitsConnection from Inside Verizon or verizon.com/benefitsconnection. Select Spending Accounts > Resource Center > Claim Forms. Under Claim Forms select Dependent Day Care Spending Account Claim Form.

Claims submitted using a claim form are reimbursed via check mailed to your home address (or through direct deposit if you have elected to sign up for it).

Your claim will be processed as soon as administratively possible, and generally no later than 10 days after the Verizon Benefits Center receives your paperwork.

**Supporting documentation**

You must provide proper supporting documentation so that your claim can be processed.

**Dependent Day Care Spending Account claims**

If you use a care provider or day care service, your receipt must contain the following:

- Name and address of the care provider
- Tax ID number or Social Security Number of the care provider
- Date(s) of service(s) for which you are being charged
- Amount you are being charged.
- Name of dependent receiving services

Alternatively, to providing separate documentation, you can have the provider sign your completed claim form as verification of the expense.

**If your claim is denied**

If your claim for reimbursement is denied, you or your beneficiary are entitled to a written explanation of the denial. You also may file a written request for review of the decision. For details, refer to the “Additional Information” section.

## Dependent care reimbursement fund

### Eligibility

You are eligible to participate in the Dependent Care Reimbursement Fund if you are a regular full-time or Part-time Associate or a benefit-eligible temporary associate who works for a participating company. There are two funds, and the fund guidelines for the net credited service requirement, the gross family income limit and the weekly reimbursement limits that apply to you depend on your geographic location and/or bargaining unit:

- If you are a New England CWA member, IBEW Local 2213 member, or a New York CWA member with six months of net credited service, you may be eligible and are covered under the CWA guidelines.
- If you are a New England non-bargaining unit associate or an IBEW member, you may be eligible and are covered under the IBEW guidelines.

### Eligible dependents

You can use the Dependent Care Reimbursement Fund to receive reimbursements from the Company for your eligible dependent care expenses.

**IMPORTANT:**

The definition for a dependent is the same as for the DCSA. However, it is to your advantage to claim Eligible Expenses under the Dependent Care Reimbursement Fund first. Then, to the extent your expenses exceed the amount reimbursed by the fund, you may contribute before-tax dollars to the DCSA and receive tax-free reimbursements. However, your combined non-taxable reimbursements from both Company-sponsored Plans and, if applicable, a dependent care account in which your Spouse participates cannot exceed $5,000 in a calendar year or $2,500 if you are married and file a separate tax return. (See the “Government Limits” section for details.)

If you are married, you are eligible to receive fund reimbursements only if your Spouse also works, is a full-time student, is looking for a job or is unable to care for himself or herself due to a mental or physical disability.

### Enrolling in the Dependent Care Reimbursement Fund

To participate in the fund, you will need to complete an enrollment form and attach a copy of your entire federal income tax form (1040) and W-2 for you and your Spouse, if applicable. Please check with your New York or New England Work and Family management coordinator for enrollment materials and income limit criteria.

### When participation ends

Your eligibility to participate in the Dependent Care Reimbursement Fund ends on the earliest of these dates:

- Your employment ends with the Company for any reason
- You no longer meet the fund criteria (for example, your gross family income exceeds the applicable limit for the year in which you are applying for reimbursement)
- Your Spouse becomes unemployed, or he or she stops attending school on a full-time basis

If you take a leave of absence, you can receive reimbursement for Eligible Expenses incurred prior to your leave and for which you had not claimed reimbursement yet.

**How the fund works**

The fund helps you pay for your eligible dependent care expenses. If you are eligible, you can receive a tax-free reimbursement for a portion of your expenses.

When you have Eligible Expenses during the year, you file a claim for reimbursement before the second Friday of the month for prior month expenses. No retroactive payments are disbursed. In most cases, you do not pay any taxes on the money you are reimbursed, unless reimbursements exceed your non-taxable limit. See New York and New England guidelines for further information.

To use the fund:

- **Step 1:** If you determine that you meet the eligibility requirements, you may enroll by completing the enrollment materials, available from your Work and Family Coordinator
- **Step 2:** After you are enrolled and you have incurred eligible dependent care expenses, you can file a claim each month. (See “Eligible dependent care expenses” in the "Dependent Care Spending Account" section for a list of Eligible Expenses.)
- **Step 3:** You will receive the tax-free reimbursement payment in your payroll check from the Company for your claim, up to the fund’s maximum reimbursement rate for each dependent

Call the Work and Family Coordinator in your area for information about the current reimbursement limits that apply for your eligible dependents.

**NOTE:**

You must provide the Social Security number or Tax Identification Number of your care provider in order to claim expenses under the Dependent Care Reimbursement Fund. The care provider must be licensed or operating legally.

**Government limits**

In general, there is a $5,000 calendar-year limit on the non-taxable amount you can be reimbursed from the Dependent Care Reimbursement Fund in combination with other dependent care plans available to you (such as the DCSA), as well as your Spouse’s account, if you are married. This limit may be reduced by one or more of the government rules described below:

- If you are married and you and your Spouse file separate federal income tax returns, the most you can be reimbursed tax-free from the plans is $2,500 in a calendar year.
- Your annual tax-free reimbursement cannot exceed the lesser of your earned income for the year or your Spouse’s earned income. For this purpose, during any month your Spouse is a full-time student or disabled, your Spouse’s assumed earned income for the month is $200 if you have Eligible Expenses for one dependent or $400 if you have expenses for two or more dependents.

**NOTE:**

If your reimbursements from the Company exceed the applicable non-taxable limit for you in a year, you still can receive reimbursement from the Company; however, the portion above the non-taxable limit will be taxable.

**The company's plans and the federal tax credit**

The same Eligible Expenses you can claim under the Dependent Care Reimbursement Fund and the DCSA also are eligible for consideration in determining a tax credit for child and dependent care expenses on your federal income tax return (the federal tax credit considers child and dependent care expenses up to $3,000 for one dependent and up to $6,000 if you have two or more dependents). However, to the extent you use both the Dependent Day Care Reimbursement Fund and the DCSA, you lower the amount of expenses you can apply toward the tax credit, dollar for dollar.

For example, if you have one dependent and you claim $3,000 or more in expenses through the Company's Plans, you cannot use the federal tax credit. On the other hand, if you have two or more dependents and you claim $5,000 through the Company's Plans, you would figure your federal tax credit on only $1,000 of the $6,000 maximum allowable expenses for two or more qualifying dependents.

You may want to consult with a tax advisor if you have questions about any tax implications for you.

**Eligible dependent care expenses**

In general, the same expenses are eligible for reimbursement under the Dependent Care Reimbursement Fund as the DCSA. (See the "Eligible dependent care expenses" section in the "Dependent Day Care Spending Account" section for details.) However, you cannot receive reimbursement from this fund and claim the same expense under the Dependent Care Account.

**NOTE:**

Registration expenses are not eligible under the Dependent Care Reimbursement Fund.

**Filing your claim for reimbursement**

When you have eligible dependent care expenses, you need to have your provider sign the form or submit the receipt for services, along with a Request for Reimbursement form.

**Reimbursement**

To receive reimbursements during the year, you must complete and submit a Request for Reimbursement form.

To file a claim:

- Complete the Request for Reimbursement form, including the Tax Identification Number of the care provider
- Sign the form and attach your supporting documentation from the person who provided the care. Your documentation should include expense amounts and dates of service. Also, you must include the care provider's name, address and Tax Identification Number or Social Security number. The Company will determine whether the expense is eligible for reimbursement based on the law and from the bills or documentation you submit. Cancelled checks are not acceptable documentation. Send the form and the receipt to the claims administrator at the address shown on the form.
- Keep a copy for your records
- After the form and the receipt are processed, you will receive your reimbursement

## Situations that can affect your participation

### If you take a leave of absence

If you take an approved leave of absence, you can continue to claim amounts from the Dependent Care Reimbursement Fund for your Eligible Expenses you incurred before your leave began.

### If you retire or leave the company

Your participation in the Dependent Care Reimbursement Fund stops when you retire or leave the Company. However, you can submit claims for Eligible Expenses incurred during the current year's employment with the Company.

### If you die

If you die, your Spouse and/or dependents can submit claims for Eligible Expenses incurred up to the date you died.

### Changes or termination of the plan

The Company reserves the right to change or end the Plan at any time, subject to any duty to bargain collectively. Note that this Plan is not subject to ERISA and therefore is not afforded the specific ERISA protections described in the "Your Rights Under ERISA" subsection of the "Additional information" section.

## Additional information

### Forfeitures

If you were enrolled in the HCSA and/or DCSA as of December 31 of the current Plan Year, you can be reimbursed for eligible health care and dependent care expenses that you incur through March 15 of the next calendar year. You have until May 31 of that next calendar year to submit claims for the current calendar year's expenses. Any money not used by March 15 and submitted by May 31 of the following calendar year will be forfeited.

### Health Care Spending Account (HCSA)

Contributions to the HCSA will be used to pay eligible claims and administrative fees (as determined by Verizon). Any amounts forfeited under the HCSA will be used as follows:

- First, these amounts will be applied to offset participating company contributions for health care claims that are in excess of participating individuals' contributions to the account
- Then, these amounts will be applied toward the cost and expenses of administering the Plan

### Dependent Day Care Spending Account (DCSA)

Contributions to the DCSA will be used to pay eligible claims and administrative fees, as determined by Verizon.

### 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.

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

### Claims regarding eligibility to participate in the plan

The Verizon Claims Review Committee (VCRC) has discretionary authority to determine claims and appeals related to eligibility and enrollment in the Plan.

### Claims regarding scope/amount of benefits under the plan

The Verizon Benefits Center has discretionary authority to determine claims for Plan benefits. The Verizon Claims Review Committee (VCRC) has discretionary authority to determine appeals for Plan benefits.

The addresses of the claims and appeals administrators for the Plan are listed in the "Administrative information" section. If you have a claim or appeal, you should contact the appropriate claims and appeals administrator for the type of claim or appeal you have.

The claims and appeals administrators have discretionary authority to:

- Interpret the 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 either by 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 or appeals administrator's decision was an abuse of administrator discretion.

**The claims administrator and its authority to review claims**

The following section pertains to ERISA claims and appeals rules and only applies with respect to the benefit under your FSA that is considered a group health plan benefit (i.e., counseling services with a licensed health care professional). The Verizon Employee Benefits Committee (VEBC) has delegated its authority to finally determine claims to the Verizon Claims Review Committee (VCRC). In some cases, the VCRC will delegate the authority to finally determine claims to certain other organizations on behalf of Verizon. Benefits under the Plan are paid only if the VEBC, or its delegate, decides in its discretion that the applicant is entitled to them.

The claims administrators have:

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

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

**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, including the HCSA. While these procedures legally do not apply to the DCSA and the Dependent Care Reimbursement Fund, due to their not being an ERISA covered plans, the Verizon Benefits Center also will review dependent care claims as outlined in this section.

This section explains the steps you or your authorized representative are required to take to file an ERISA claim or appeal. This 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 the HCSA or to change the amount of your Before-tax Contributions. An eligibility claim is more than a question concerning eligibility for coverage; an eligibility claim requires the submission of a Claim Initiation Form that is linked to a claim for a benefit.

A benefit claim is a claim for reimbursement under the Plan, such as a claim to have a particular health care service reimbursed by the HCSA.

If any portion of your submitted claim to the Verizon Benefits Center is not eligible for reimbursement, you will receive notification from the Verizon Benefits Center in the form of an Explanation of Benefits (EOB). If you believe that your claim (or a portion of it) was decided or denied incorrectly, contact a representative within the Verizon Benefits Center. If the representative determines that the claim (or a portion of it) was correctly denied, then you may request a review of the denial by following the steps below for eligibility and benefit claims.

| | **Eligibility 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 855.489.2367. You (or your authorized representative) must return the form to the Verizon Claims Review Unit at the address on the form.<br><br>You must include:<br>• A description of the request.<br>• The reason for the request.<br>• Relevant documentation. | To file a **benefit** claim, request a Claim Review Form from the Verizon Benefits Center at 855.489.2367. You (or your authorized representative) must complete and return the form to the Verizon Benefits Center at the address on the form.<br><br>You must include:<br>• A description of the request.<br>• The reason for the request.<br>• Relevant documentation. |
| **When you will be notified of the claim decision** | You will be notified of the decision within 30 days of the Claims Review Unit's receipt of your Claim Initiation Form. The 30-day period may be extended for 15 days. | You will be notified of the decision within 30 days of the Verizon Benefits Center's receipt of your claim for benefits. The 30-day period may be extended for 15 days. |
| **Failure to provide sufficient information** | If you fail to provide sufficient information, the claim may be decided based on the information provided. However, the Claims Review Unit may notify you within 30 days that additional information is needed.<br><br>You will have 45 days to provide the additional information. Otherwise, the claim will be decided based on the information originally provided. | If you fail to provide sufficient information, the claim may be decided based on the information provided. However, the Verizon Benefits Center may notify you within 30 days that additional information is needed.<br><br>You will have 45 days to provide the additional information. Otherwise, the claim will be decided based on the information originally provided. |

| | Eligibility claims procedure | Benefit claims procedure |
|---|---|---|
| | If you provide additional information, you will be notified of the decision by the Claims Review Unit within the time period remaining for the initial claim. | If you provide additional information, you will be notified by the Verizon Benefits Center within the time period remaining for the initial claim. |
| **How you will be notified of the claim decision** | The Claims Review Unit will notify you in writing.<br><br>If your claim is **denied**, in whole or in part, your written denial notice will contain:<br>• The specific reason(s) for the denial<br>• The Plan provisions on which the denial was based<br>• Any additional material or information you may need to submit to complete the claim<br>• The Plan's appeal procedures | The Verizon Benefits Center will notify you in writing.<br><br>If your claim is **denied**, in whole or in part, your written denial notice will contain:<br>• The specific reason(s) for the denial<br>• The Plan provisions on which the denial was based<br>• Any additional material or information you may need to submit to complete the claim<br>• The Plan's appeal procedures |
| **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 the Verizon Benefits Center, also known as the claims administrator. The Claims Review Committee has delegated its authority to finally determine claims to the Verizon Benefits Center. As such, the Verizon Benefits Center 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 the Verizon Benefits Center are final and binding on all parties. |
| **How to file an appeal** | If your claim is denied (adverse benefit determination) and you want to appeal it, you must file your appeal within 180 days from the date you receive notice of your denied claim. You may request | If your claim is denied (adverse benefit determination) and you want to appeal it, you must file your appeal within 180 days from the date you receive notice of your denied claim. You may request |

| | Eligibility claims procedure | Benefit claims procedure |
|---|---|---|
| | access, free of charge, to all documents relating to your appeal. To file an appeal, you must write to:<br><br>Verizon Claims Review Committee<br>c/o Verizon Claims Review Unit<br>P.O. Box 8998<br>Norfolk, VA 23501-8998<br><br>You should include:<br>• A copy of your claim denial notice<br>• The reason(s) for the appeal<br>• Relevant documentation<br><br>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 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. | access, free of charge, to all documents relating to your appeal. To file an appeal, you must contact the Verizon Benefits Center and request an appeal form. Your completed form should be sent to:<br><br>Verizon Benefits Center<br>Box 8999<br>Norfolk, VA 23501-8999<br><br>You should include:<br>• A copy of your EOB<br>• The reason(s) for the appeal<br>• Relevant documentation<br><br>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 Verizon Benefits Center 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. |
| **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. | You will be notified of the decision within 60 days of the Verizon Benefits Center's receipt of your appeal. |
| **How you will be notified of the appeal decision** | Regardless of whether your appeal is approved or denied, the Claims Review Committee will notify you in writing.<br><br>If your appeal is denied, in whole or in part, your written denial notice will contain:<br>• The specific reason(s) for the denial<br>• A statement regarding the documents to which you are entitled upon request and free of charge<br>• Any internal procedures or clinical information on which the | Regardless of whether your appeal is approved or denied, Verizon Benefits Center will notify you in writing.<br><br>If your appeal is denied, in whole or in part, your written denial notice will contain:<br>• The specific reason(s) for the denial<br>• A statement regarding the documents to which you are entitled upon request and free of charge<br>• Any internal procedures or clinical information on which the |

| | Eligibility claims procedure | Benefit claims procedure |
|---|---|---|
| | denial was based (or a statement that this information will be provided free of charge, upon request)<br>• The Plan provisions on which the denial was based<br>• 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." | denial was based (or a statement that this information will be provided free of charge, upon request)<br>• The Plan provisions on which the denial was based<br>• 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. |
| **Step 3:** | | |
| **How to proceed if necessary** | The decision on your appeal is final. 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. The Verizon Benefits Center, the claims administrator, will not review your matter again, unless new facts are presented. You have a right to bring a civil action. |

**Your rights under ERISA**

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. ERISA provides that all Plan participants shall be entitled to the following:

**Receive information about your plan and benefits**

- Examine, without charge at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the 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 SPD. The Plan administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish you with a copy of this summary annual report.

**Continue group health plan coverage**

- Continue healthcare coverage for yourself, your Spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review your SPD and the documents governing the Plan on your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**Prudent actions by plan fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the persons who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

**Enforce your rights**

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 Qualified 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 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
dol.gov/agencies/ebsa

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

## HIPAA privacy rights

The information provided in the notice that follows is required under the Health Insurance Portability and Accountability Act (HIPAA). The following section pertains to HIPAA and only applies with respect to the benefits that are considered group health plan benefits.

### HIPAA privacy notice

### NOTICE OF PRIVACY PRACTICES FOR THE VERIZON HEALTH PLANS

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

#### I. Background information and effective date

The United States Department of Health and Human Services has published final regulations under HIPAA addressing the privacy of Protected Health Information (as defined in section II below) (the "Privacy Rule"). This Notice, which is required by the Privacy Rule, is effective on October 1, 2021 (the "Effective Date"). This Notice summarizes some of the requirements of the Privacy Rule; it is not a contract or guarantee and does not provide any additional rights not expressly provided under and required by HIPAA and the Privacy Rule.

#### II. Plans on behalf of which this Notice is being provided

For purposes of this Notice, the term "Verizon Health Plans" means all group health plans maintained by Verizon Communications Inc. and its applicable affiliates ("Verizon"). All such group health plans collectively are referred to in this Notice as the "Verizon Health Plans." Please Note: some or all of the Verizon Health Plans may be hybrid entities under the Privacy Rule. In that case, this Notice shall only apply and be interpreted to apply to that portion of a plan that is subject to the Privacy Rule as a group health plan.

If you are covered by a Verizon Health Plan that is insured, the insurer will provide you with a separate notice that describes the insurer's use and disclosure of your Protected Health Information.

#### III. Health Information to Which This Notice Applies

This Notice applies to "Protected Health Information," which is defined as any written, oral, or electronic health information that meets the following three requirements:

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

This includes any of the following documentation, if the documentation reveals your identity and your health status or payment issues: medical records (such as hospital charts or doctor's notes); medical bills (such as bills for hospital or doctor's services); claims data (such as data

on claims payments made by one of the Verizon Health Plans on your behalf); and insurance payment information (such as an Explanation of Benefits). Protected Health Information does not include employment records held by Verizon in its role as an employer or health information that does not identify an individual (including de-identified health information).

## IV. Uses and Disclosures of Protected Health Information by the Verizon Health Plans

The Verizon Health Plans may use or disclose your Protected Health Information for purposes of making or obtaining payment for your health care, for purposes of conducting health care operations, or for certain other specified purposes. The Verizon Health Plans are part of an organized health care arrangement under the Privacy Rule. As applicable, the Verizon Health Plans participating in the organized health care arrangement will share Protected Health Information with each other, as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement. The Verizon Health Plans have established a policy to guard against unnecessary uses and disclosures of your Protected Health Information.

The Verizon Health Plans and their business associates may use and disclose your Protected Health Information as permitted or required by the Privacy Rule, including for the following purposes:

### A. For Treatment

Treatment is the provision, coordination, or management of health care and related services, including consultations and referrals between one or more of your providers. For example, the Plans may disclose to a treating specialist the name of your treating provider and other information relating to you so that the specialist may ask for relevant medical information from your provider.

### B. To make or obtain payment for health care

The Verizon Health Plans may use or disclose your Protected Health Information to make payment for, or to obtain or facilitate payment of, your health care claims. Payment for health care includes such activities as: making eligibility or coverage determinations; claims management or adjudication; claims appeals determinations; coordination of benefits with another health plan; determination of cost sharing amounts; medical necessity determinations; concurrent or retrospective review of services; utilization review of services; pre-certification or pre-authorization of services; subrogation of claims; billing; risk adjusting based on enrollee health status and demographics; disclosure to consumer reporting agencies; obtaining payment under a contract of reinsurance; and collection activities.

For example, a Verizon Health Plan may provide Protected Health Information regarding your coverage or treatment to other health plans to coordinate the payment of benefits between or among the other plans and the Verizon Health Plan.

### C. To conduct health care operations

The Verizon Health Plans may use or disclose your Protected Health Information to facilitate the administration and operation of the Verizon Health Plans. Health care operations include such activities as: case management and care coordination; conducting or arranging for medical review, auditing, or legal services; population-based activities to improve health or reduce health care costs; contacting health care providers or patients with information regarding treatment alternatives, and related functions that do not include treatment; clinical guideline and protocol development; reviewing the competence or

qualifications of health care professionals and evaluating health plan performance; underwriting and premium rating; fraud and abuse detection and compliance programs; activities relating to the creation, renewal, or replacement of a health care contract; business planning and development, including cost-management activities; and business management and administrative activities, including merger and acquisition activities.

**NOTE:** The Verizon Health Plans (excluding long-term care plans) do not use or disclose Protected Health Information that is genetic information for underwriting purposes. Underwriting purposes means: (1) rules for, or determination of, eligibility (including enrollment and continued eligibility) for, or determination of, benefits under the Plan (including changes in deductibles or other cost sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); (3) the application of any pre-existing condition exclusion under the Plan, coverage, or policy; and (4) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. However, underwriting purposes does not include determinations of medical appropriateness where an individual seeks a benefit under the Verizon Health Plans.

For example, a Verizon Health Plan may use Protected Health Information regarding your coverage or treatment for case management to help ensure that appropriate treatment is being provided for your condition.

**D. Disclosure to you**

The Verizon Health Plans may disclose your protected health information to you or your personal representative. The Verizon Health Plans will disclose your Protected Health Information to you as required by the Privacy Rule provisions relating to access to Protected Health Information or an accounting of disclosures of Protected Health Information.

**E. Disclosure to the Verizon Health Plans' Business Associates**

A Business Associate is a person or entity (such as a third-party administrator) that provides certain services to or on behalf of the Verizon Health Plans, and such services involve the receipt, creation, use, maintenance, transmission, and disclosure of Protected Health Information. The Verizon Health Plans may disclose Protected Health Information to a Business Associate, for such Business Associate's use or disclosure permitted or required by the Business Associate contract or as required by law.

**F. To assist Verizon as Plan Sponsor**

The Verizon Health Plans may disclose your Protected Health Information to Verizon, as sponsor of the Verizon Health Plans, to assist Verizon in the performance of plan administrative functions and for underwriting purposes. 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 and whether you are participating in the Plans to Verizon as plan sponsor. The Verizon Health Plans and Verizon are prohibited from using or disclosing for underwriting purposes protected health information that is genetic information.

### G. When legally required

The Verizon Health Plans may use or disclose your Protected Health Information when required to do so by any federal, state, or local law. The Verizon Health Plans may also disclose your Protected Health Information when required by the Secretary of the United States Department of Health and Human Services for purposes of investigating or determining the plans' compliance with the Privacy Rule.

### H. In connection with judicial and administrative proceedings

The Verizon Health Plans may disclose your Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by the order. The Verizon Health Plans also may disclose your Protected Health Information in the course of any judicial or administrative proceeding in response to a subpoena, discovery request, or other lawful process, but only when the Verizon Health Plan involved receives satisfactory assurance from the party seeking the Protected Health Information that that party made reasonable efforts to either notify you about the request or to obtain an order protecting your Protected Health Information.

### I. For law enforcement purposes

The Verizon Health Plans may disclose your Protected Health Information to a law enforcement official for certain law enforcement purposes. For example, the Verizon Health Plans may disclose your Protected Health Information pursuant to a law requiring the reporting of certain types of wounds or other physical injuries, or may disclose your Protected Health Information to assist the law enforcement official with identifying or locating certain individuals.

### J. For health oversight activities

The Verizon Health Plans may disclose your Protected Health Information to a health oversight agency for health oversight activities authorized by law, including: audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of the health care system, certain government benefit programs, certain entities subject to government regulatory programs, or certain entities subject to civil rights laws. The Verizon Health Plans may not disclose your Protected Health Information if you are the subject of an investigation and the investigation does not arise out of and is not directly related to your receipt of health care or public benefits.

### K. In the event of a serious threat to health or safety

Under certain circumstances, the Verizon Health Plans may, consistent with applicable law and standards of ethical conduct, use or disclose your Protected Health Information if the Verizon Health Plans, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or to the health or safety of the public.

### L. For specified government functions

Under certain circumstances, the Verizon Health Plans may use or disclose your Protected Health Information to facilitate specified government functions related to: the military and veterans; national security and intelligence activities; the provision of protective services for the President of the United States and other authorized persons; or correctional institutions and inmates.

**M. For public health activities**

The Verizon Health Plans may use or disclose your Protected Health Information for public health activities, such as to assist public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other public health activities as specified in the Privacy Rule.

**N. For disaster relief purposes**

Under certain circumstances, the Verizon Health Plans may use or disclose your Protected Health Information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, as permitted by the Privacy Rule.

**O. In connection with decedents**

The Verizon Health Plans may disclose your Protected Health Information to funeral directors, coroners, or medical examiners to enable them to carry out their lawful duties.

**P. For Workers' Compensation purposes**

The Verizon Health Plans may disclose your Protected Health Information when authorized by and to the extent necessary to comply with laws related to Workers' Compensation or similar programs established by law that provide benefits for work-related injuries or illnesses without regard to fault.

**Q. For involvement in, and notification of, your care**

The Verizon Health Plans may use or disclose to your family member, other relative, close personal friend, or other person you identify, Protected Health Information directly relevant to such person's involvement in your health care or payment related to your care. The Verizon Health Plans may use or disclose your Protected Health Information to notify a family member, your personal representative, or another person responsible for your care, about your location, condition, or death. In these situations, when you are present and not incapacitated, the Verizon Health Plans will either: (1) obtain your agreement; (2) provide you with an opportunity to disagree to the use or disclosure; or (3) using reasonable judgment, infer from the circumstances that you do not object to the disclosure. If you are not present, or you cannot agree or disagree to the use or disclosure due to incapacity or emergency circumstances, the Verizon Health Plans may use professional judgment to determine that the disclosure is in your best interests and disclose Protected Health Information relevant to such person's involvement in your care, payment related to your health care, or notification purposes. If you are deceased, the Verizon Health Plans may disclose to such persons involved in your care or payment for your health care prior to your death, the Protected Health Information that is relevant to the person's involvement, unless you have previously instructed otherwise to the Verizon Health Plans.

**R. To assist victims of abuse, neglect, or domestic violence**

The Verizon Health Plans may, under certain circumstances, disclose Protected Health Information about individuals who are reasonably believed to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive such reports.

**S. For cadaveric organ, eye, or tissue donation**

The Verizon Health Plans may use or disclose Protected Health Information to organ procurement organizations or other entities engaged in the procurement, banking, or

transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye, or tissue donation and transplantation.

**T. For certain government-approved research activities**

The Verizon Health Plans may use or disclose Protected Health Information about you for research as provided under the Privacy Rule.

**U. To other covered entities**

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

**V. With an authorization**

Other than as stated or described above or required by law, the Verizon Health Plans will not use or disclose your Protected Health Information without your written authorization. Your written authorization is also required for:

- Most uses or disclosures of psychotherapy notes (where appropriate)
- Uses or disclosures of your Protected Health Information for marketing purposes. Marketing does not include communications, involving no financial remuneration, for certain treatment or health care operations purposes, such as communications about entities that participate in a health plan network, health plan enhancements or replacements, case management or care coordination, or contacting individuals about treatment alternatives.
- Disclosures of Protected Health Information that are considered a sale of Protected Health Information under the Privacy Rule

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. To revoke your authorization, please direct your written request to the appropriate privacy contact identified in paragraph IX below. 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.

The privacy laws of a particular state or other federal laws might impose a stricter or more stringent privacy standard. If these stricter or more stringent laws apply and are not superseded by federal preemption, the Verizon Health Plans will comply with the stricter law.

## V. Your rights regarding your Protected Health Information

You have the following rights regarding the Protected Health Information retained by a Verizon Health Plan:

***A.*** **Right to request restrictions**

You have the right to request that a Verizon Health Plan restrict:

- Uses and disclosures of your Protected Health Information to carry out payment or health care operations
- Certain uses and disclosures for disaster relief and other notification purposes and for involvement in your health care and payment for your care

If you make a request to a Verizon Health Plan for a restriction as described above, the Verizon Health Plan is not required to agree to such a restriction.

If you wish to make a request for a restriction, please make a request in writing to the privacy contact identified in paragraph IX below. Your request should include the following: (1) what uses and/or disclosures you want to limit; and (2) to whom you want the restriction to apply (for example, disclosures to your spouse).

***B.*** **Right to receive confidential communications**

You have the right to request that a Verizon Health Plan communicate with you in a certain way if you feel that the disclosure of your Protected Health Information could endanger you. For example, you may ask that a Verizon Health Plan only communicate with you at a certain telephone number. If you wish to receive confidential communications, please make your request in writing to the privacy contact identified in paragraph IX below. Your request must be reasonable and should include the following: (1) an alternative address or other means of contacting you; (2) a statement that the disclosure of all or part of the Protected Health Information to which the request pertains could endanger you; and (3) information on how payment, if any, will be handled. The Verizon Health Plan(s) will attempt to accommodate these requests for confidential communications.

***C.*** **Right to inspect and copy**

In general, you have the right to inspect and obtain a copy of your Protected Health Information in a designated record set, for as long as the Protected Health Information is maintained in that designated record set. However, you do not have a right to inspect and obtain a copy of psychotherapy notes and information that is compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

If your Protected Health Information is maintained in one or more designated record sets electronically and if you request an electronic copy of your Protected Health Information, the Verizon Health Plans will provide access in the electronic form and format you requested, if it is readily producible in that form and format; if it is not readily producible, access will be provided in a readable electronic form and format that is mutually agreed upon. You may request that a Verizon Health Plan provide a copy of your Protected Health Information to another person that you designate. Your request must be in writing, be signed by you, and clearly identify the designated person and where to send the copy of the information.

A request to inspect or obtain a copy of your Protected Health Information must be made in writing to the privacy contact identified in paragraph IX below and must include: (1) the desired form or format of access; (2) a description of the Protected Health Information to which the request applies; and (3) appropriate contact information. If you request a copy of your Protected Health Information, you may be charged a reasonable cost-based fee for labor for copying the Protected Health Information requested (paper or electronic form), mailing, supplies for creating the paper copy or electronic media if you request that the electronic copy be provided on portable media, and (as agreed upon) preparing an explanation or summary of the Protected Heath Information.

Under very limited circumstances, your request to inspect or obtain a copy of your Protected Health Information may be denied. In most cases, if your request is denied, you may request a review of the denial; a description of how you may exercise such review rights and how you may file a complaint will be included in the written denial.

***D.*** **Right to amend**

If you believe that Protected Health Information a Verizon Health Plan has about you is inaccurate or incomplete, you may ask that Verizon Health Plan to amend that Protected Health Information or record about you in a designated record set, for as long as your Protected Health Information is maintained in the designated record set.

A request to amend your Protected Health Information must be made in writing to the privacy contact identified in paragraph IX below. The request to amend must include the name of the Verizon Health Plan(s) to which the request applies, a description of the amendment requested, and a reason to support the request.

Your request for an amendment may be denied if you request an amendment of Protected Health Information that the Verizon Health Plan determines: (1) was not created by the Verizon Health Plan, unless the originator of the Protected Health Information is no longer available to make the amendment; (2) is not part of the Verizon Health Plan's records or designated record set; (3) is not Protected Health Information that you would be permitted to inspect or copy; or (4) is accurate and complete.

If your request for an amendment is denied, you will be provided with a written denial that explains the basis for the denial and how to submit a written statement of disagreement, and that describes how you may file a complaint.

***E.*** **Right to an accounting of disclosures**

You have a right to request a list of the disclosures made by a Verizon Health Plan of your Protected Health Information. The list will not include the following types of disclosures: (1) disclosures to you of your own Protected Health Information; (2) disclosures for purposes of payment and health care operations; (3) disclosures you authorize; (4) disclosures to persons involved in your care or for disaster relief or other notification purposes; (5) disclosures for national security, intelligence, law enforcement purposes, or to correctional institutions; (6) disclosures that are part of a limited data set, as defined in the Privacy Rule; or (7) disclosures that are incident to a use or disclosure otherwise permitted or required by the Privacy Rule.

A request for an accounting must be made in writing to the privacy contact identified in paragraph IX below. The request must specify the name of the Verizon Health Plan(s) to which the request applies, as well as the time period for which you are requesting the accounting. The time period for which you request an accounting may not begin more than six years before the date of the request. The first accounting you request within a 12-month period will be free of charge. For additional accountings within that same 12-month period, you may be charged a reasonable fee for the costs of providing the accounting. You will be notified in advance of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

***F.*** **Right to receive a paper copy of this Notice**

You have the right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously or agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact the Verizon Benefits Center at 855.4vz.bens (855.489.2367).

### *G.* Disclosure of Protected Health Information to a personal representative

You may also request that the Verizon Health Plans disclose your Protected Health Information to your personal representative. A personal representative is an individual you designate to act on your behalf and make decisions about your health care. If you want a Verizon Health Plan to disclose your Protected Health Information to your personal representative, submit a written statement giving the Plan permission to release your Protected Health Information to your personal representative and documentation that this individual qualifies as your personal representative under state law, such as a power of attorney. Submit this request in writing to the appropriate privacy contact identified in paragraph IX below. A Verizon Health Plan will make sure this individual has the authority and can act on your behalf before making any disclosures to the personal representative. A Verizon Health Plan may elect not to treat a person as your personal representative if: (1) the Plan reasonably believes that you have been or may be subject to domestic violence, abuse, or neglect by such person, or that treating such person as your personal representative could endanger you; or (2) the Plan, using professional judgment, decides that it is not in your best interest to treat the person as your personal representative.

## VI. Other obligations of the Verizon Health Plans

In addition to the other obligations set forth in this Notice, the Verizon Health Plans are required to:

- Maintain the privacy and security of your Protected Health Information in a manner consistent with the Privacy Rule
- Provide you with this Notice of their legal duties and privacy practices with respect to your Protected Health Information
- Abide by the terms of this Notice currently in effect

When and as required by the Privacy Rule, the Verizon Health Plans will notify you of any impermissible acquisition, access, use, or disclosure of unsecured Protected Health Information.

## VII. Changes to this Notice

The Verizon Health Plans reserve the right to change this Notice and to make the revised or changed Notice effective for all Protected Health Information the Verizon Health Plans already have about you, as well as for any such information received in the future. If the Verizon Health Plans change any of their privacy policies and procedures, the Verizon Health Plans will revise the Notice as appropriate and will provide a copy of the revised Notice as required by the Privacy Rule. The Verizon Health Plans will post a copy of the current Notice on BenefitsConnection at  You may view the Notice on the website and/or print a paper copy from the website. You may also obtain a paper copy of this Notice from the Verizon Benefits Center at 855.4vz.bens (855.489.2367).

## VIII. Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the privacy officer for the Verizon Health Plans in care of the Verizon HIPAA Unit identified in paragraph IX below or with the United States Department of Health and Human Services Office for Civil Rights (OCR). You may file a complaint with OCR electronically via the OCR Complaint Portal, in writing via mail to OCR or email to OCRComplaint@hhs.gov. For more information on

filing a complaint with OCR, visit hhs.gov/ocr/privacy/hipaa/complaints. All complaints must be submitted in writing. You will not be retaliated against in any way for filing a complaint.

## IX. Contact information

In some cases, your Protected Health Information may be held internally at Verizon by members of the Verizon workforce who perform functions on behalf of the Verizon Health Plans. In most cases, however, your Protected Health Information will be held by privacy contacts, such as the health insurers or health plan option administrators, who pay claims on behalf of one or more of the Verizon Health Plans.

**Contact your health insurer or health plan option administrator:**

If you have a question, concern, complaint, or request regarding Protected Health Information held by a health insurer or health plan option administrator, contact your health insurer or health plan option administrator directly. Contact information for your health insurer or health plan option administrator can be found in your SPD, your insurance cards, on BenefitsConnection at verizon.com/benefitsconnection or by calling the Verizon Benefits Center toll free at 855.4vz.bens (855.489.2367).

**Contact the Privacy Officer for the Verizon Health Plans:**

If you have a question, concern, complaint, or request regarding Protected Health Information held internally at Verizon or a request regarding Protected Health Information held by a Business Associate other than a health plan option or claims administrator, contact the privacy officer for the Verizon Health Plans as follows:

HIPAA Privacy Officer
Verizon Benefits Center
c/o Verizon HIPAA Unit
Attn: HIPAA Privacy Officer
P.O. Box 8998
Norfolk, VA 23501-8998

(908) 559-3342

Fax: (908) 630-2639

lucy.romeo@verizon.com

**IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT THE PRIVACY OFFICER DESIGNATED IN PARAGRAPH IX ABOVE.**

The Notice of Privacy Practices for the Verizon Health Plans is available on the BenefitsConnection website at verizon.com/benefitsconnection. Generally, the Notice of Privacy Practices for the Verizon Health Plans available on BenefitsConnection is the most up to date. Once you have logged on to BenefitsConnection, select the Library link from the home page and then Plan Information and SPD's > Regulatory Notices > "HIPAA Privacy Policy in order to view the Notice. You may view the Notice on the website and/or print a paper copy from the website. You may also request a paper copy of the Notice at any time by calling the Verizon Benefits Center at 855.4vz.bens (855.489.2367).

## Nondiscrimination and accessibility requirements

**Notice Informing Individuals about Nondiscrimination and Accessibility Requirements with respect to Verizon Welfare Benefit Plan for New York and New England Associates that is a "Covered Entity".**

**Discrimination is against the law.**

The Verizon Welfare Benefit Plan for New York and New England Associates that is a "covered entity" (referred to in this notice as "Verizon Welfare Benefit Plan for New York and New England Associates") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The Verizon Welfare Benefit Plan for New York and New England Associates [3]:

- Provides 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).

If you believe that Verizon Welfare Benefit Plan for New York and New England Associates 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

[3] With respect to the nondiscrimination rules explained in this notice The Verizon Welfare Benefit Plan for New York and New England Associates is a covered entity.

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.

ملاحظة: إذا كنت تتحدث اللغة العربية، فإن تدابير المساعدة اللغوية متاحة لك مجانًا. اتصل برقم الهاتف المكتوب على بطاقة الهوية 7632.984.558)

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 می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. با 855.489.2367 تماس بگیرید.

## 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).

### Important telephone numbers

You can connect to the Verizon Benefits Center and other Verizon benefit providers by calling 855.4vz.bens (855.489.2367).

### 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)

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

The Plan administrator or a person designated by the administrator has the full and final discretionary authority to publish the Plan document and benefit Plan communications, to prepare reports and make filings for the Plan and to otherwise oversee the administration of the Plan. However, most of your day-to-day questions can be answered by the Plan’s benefits administrator or a Verizon Benefits Center Representative.

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

### Benefits administrator

The Verizon Benefits Center is the benefits administrator for the Plan. As the benefits administrator, the Verizon Benefits Center has the authority and responsibility to perform daily administration of benefits under the Plan. Call 855.4vz.bens (855.489.2367) to reach a representative.

### Claims and appeals administrators

**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:**

Verizon Benefits Center
P.O. Box 8999
Norfolk, VA 23501-8999
855.4vz.bens (855.489.2367)

**Benefit 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)

**Qualified Medical Child Support Orders (QMCSOs)**

The Verizon Benefits Center is responsible for the administration of QMCSOs. The Verizon Benefits Center can be reached at the following address:

Verizon Benefits Center
P.O. Box 8998
Norfolk, VA 23501-8998
855.4vz.bens (855.489.2367)

**Plan funding**

The Plan is not financed by an insurance company, nor are Plan benefits guaranteed under a contract of insurance. The claims and appeals administrators listed above do not insure or guarantee Plan benefits. The Company pays all claims out of the general assets of the Company, funded by Before-tax Contributions made by the Plan participants.

**Plan identification**

Spending account participation is provided through the Verizon Welfare Benefit Plan for New York and New England Associates. 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 587.

**NOTE:**

Only the HCSA is covered by the Employee Retirement Income Security Act of 1974 (ERISA). The HCSA is an excepted benefit under ERISA reg. section 2590.732(c)(3)(v) and Treas. reg. section 54.9831-1(c)(3)(v) and therefore, is not subject to certain requirements under ERISA and the Internal Revenue Code, such as the Affordable Care Act group market (insurance) reforms. The DCSA and the Dependent Care Reimbursement Fund are not considered ERISA benefit plans.

**Plan Year**

Plan records are kept on a Plan-year basis, which is the same as the calendar year.

**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 above for the Plan administrator.

In addition, a copy of the legal process involving this Plan must be delivered to:

Verizon Legal Department
Employee Benefits Group
Verizon Communications Inc.
One Verizon Way
Basking Ridge, NJ 07920

**Collective bargaining agreements**

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

**Official plan document**

This SPD is a summary of the official Plan documents.

**Participating companies**

The following is a list of participating companies as of January 1, 2023. The list may change from time to time.

- Empire City Subway Company (Limited)
- Verizon Advanced Data Inc.
- Verizon Corporate Services Corp.
- Verizon New England Inc.
- Verizon New York Inc.
- Verizon Services Corp.

## Terms to know

**90% Merchant**

A merchant that does not use the IRS-approved inventory approval system but certifies that a particular store location's sales consist of 90% medical expenses.

**Advance Reimbursement**

Applies only to the DCSA. DCSA participants can only be reimbursed up to the amount they have contributed into the plan; however, DCSA participants and mid-year new hires can claim up to six weeks' worth of contributions at the beginning of the Plan Year. You will only be reimbursed for services that have been incurred up to the day in which you are submitting a claim.

**Affordable Care Act**

In March of 2010, Congress passed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. For purposes of this SPD, these laws, as they are amended from time to time, are collectively referred to as the "Affordable Care Act."

**After-tax Dollars**

Paying your share of health care expenses with After-tax Dollars means that you pay with your already-taxed dollars (your take-home pay).

**Before-tax Contributions**

For purposes of the Health Care and Dependent Care Accounts, contributions deducted from your pay before federal income and Social Security taxes are figured on your pay. You permanently avoid taxes on these contributions. State and local tax laws can vary with regard to their treatment of these contributions.

**COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1985, which is federal legislation requiring employers to allow former employees and/or their covered dependents to continue health plan coverage under certain circumstances when coverage would otherwise end.

**Coinsurance**

The percentage of a medical, dental, prescription drug or vision expenses that you may have to pay (in some cases, after you meet an annual Deductible). For instance, if your medical plan option pays 80 percent of Eligible Expenses and you pay the other 20 percent- your Coinsurance would be 20 percent.

**Copayment (Copay)**

Depending on your medical option, the set dollar amount you may be required to pay for certain Eligible Expenses such as doctor's office visits. After you pay the Copay, your medical, dental or vision plan generally pays the remainder of the eligible expense.

**Deductible**

If applicable, the amount of charges for covered services that each covered person (or a family) must satisfy each calendar year before the medical, dental or vision plan begins to pay benefits.

**Eligible Expenses**

Expenses that qualify for reimbursement under the Company's HCSA, DCSA, and Dependent Care Reimbursement Fund. For a complete listing of Eligible Expenses, visit BenefitsConnection. From the Home Page, select Library > Spending Accounts > Eligible Expenses.

**Explanation of Benefits (EOB)**

The statement you receive after a medical (there are no EOBs for most HMOs), dental or vision claim is processed that describes the expenses submitted, any exclusion or Deductible and the benefits paid, if any. Note that you also receive a HCSA EOB after you submit a Request for Reimbursement Form.

**Family and Medical Leave Act (FMLA)**

The Family and Medical Leave Act entitles you to take up to a 12-week leave of absence to care for a Spouse, child, or parent of if you have a serious health condition and are unable to perform the substantial and material duties of your job.

**Forfeiture**

You can be reimbursed for eligible health care and dependent care expenses that you incur through March 15 of the next calendar year. You have until May 31 of that next calendar year to submit claims for the current calendar year's expenses. For example, you can pay for dependent care provided on March 1, 2024 and submit a claim toward any balance remaining in your 2023 DCSA for the cost of the care. Any money not used by March 15 and submitted by May 31 will be forfeited.

**Full-time Associate**

A Full-time Associate is an 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**

The additional two-and-one-half month period, from January 1 through March 15, to incur eligible claims to apply towards the previous Plan Year's account balance. The Grace Period only applies to participants enrolled on December 31.

**IIAS Certified Merchant**

A merchant with an inventory information approval system (IIAS) installed.

**Ineligible Expenses**

Expenses that are not eligible for reimbursement under the Company's HCSA, DCSA and Dependent Care Reimbursement Fund. From the Home Page, select Library > Spending Accounts > Eligible Expenses

## IRS Tax Dependent

The definition of an IRS Tax Dependent for spending account purposes provided here is a summary of the Internal Revenue Code's complex rules for determining whether an individual is your IRS Tax Dependent. Verizon always recommends that you consult with a tax advisor to help you make this determination.

### General Rule

Your Spouse, as defined by IRS rules, is an IRS Tax Dependent. In addition, your child who has not attained the age of 27 as of the end of the taxable year is an IRS Tax Dependent. To meet this general rule, the child must be your (the associate's) son, daughter, stepson, stepdaughter, or eligible foster child.[4]

A son or daughter includes your legally adopted child or child who is lawfully placed with you for adoption. This exclusion does not apply to the child of your domestic partner.

### Other Categories

If you are covering an individual who is not an IRS Tax Dependent under the general rule, above, he or she may still be an IRS Tax Dependent if he or she is a U.S. citizen or resident who is a "Qualifying Child" or a "qualifying relative."

A "Qualifying Child" generally is a person who:

- Is younger than the employee covering the child
- Is unmarried (i.e., has not filed a joint tax return during the calendar year at issue)
- Is under the age of 19 (or 24 in the case of a full-time student) or is permanently and totally disabled
- Is your child, grandchild, brother, sister, stepbrother or stepsister or niece or nephew
- Does not provide over one-half of his or her own support for the calendar year.
- Lives with you for more than one-half of the calendar year

If a person does not meet the definition of "Qualifying Child," he or she might be an IRS Tax Dependent by satisfying the "qualifying relative" requirements.

A "qualifying relative" generally is a person who:

- Is not your Qualifying Child or any other taxpayer's Qualifying Child during the calendar year
- Receives over one-half of his or her support from you for the calendar year
- Is "related to you" or "lives with you for the entire calendar year as a member of your household"

## Letter of Medical Necessity

Letter of Medical Necessity – Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your HCSA when your doctor or

[4] A son or daughter includes your legally adopted child or a child who is lawfully placed with you for adoption.

other licensed health care provider certifies that they are medically necessary (that is, the services or products are recommended by your doctor or other licensed health care provider to treat or alleviate a medical condition). A Letter of Medical Necessity is completed by your provider and must indicate your (or your Spouse/domestic partner's or dependent's) specific diagnosis, the specific treatment needed, the length of treatment, and how this treatment will alleviate your medical condition. The Letter of Medical Necessity form can be found on BenefitsConnection. From the Home Page, select Library > Spending Accounts > Resource Center > Claim Forms > Letter of Medical Necessity

**Part-time Associate**

A Part-time Associate is an 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.

**Plan Year**

A calendar year, typically January 1 through December 31.

**Qualified Medical Child Support Order (QMCSO)**

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

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

**Qualified Life Event (QLE)**

A Qualified Life Event–also referred to as a qualified status change–is an event such as birth, marriage, divorce, etc. which permits you to make certain changes to your benefit elections outside of Annual Enrollment.

**Qualifying Child**

A "Qualifying Child" for DCSA purposes generally is a person who:

- Is a U.S. citizen or resident
- Is under the age of 13
- Is your child, grandchild, brother, sister, stepbrother or stepsister or niece or nephew
- Does not provide over one-half of his or her own support for the calendar year
- Lives with you for more than one-half of the calendar year

**Spouse**

Your Spouse is a person who is a husband or wife, pursuant to a legal union, under the laws of the state in which you live. The term Spouse includes a person of the same sex to whom you are married under state law. "State" means any domestic or foreign jurisdiction having the legal authority to sanction marriage.

**Tax Identification Number**

In order to receive reimbursement of DCSA expenses, the IRS requires the Company to obtain a Tax Identification Number before reimbursing your expenses. For individuals providing dependent care, this can be the individual's Social Security number.