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Your Health Care and Dependent Care Accounts and the Dependent Care Reimbursement Fund

You can use the Health Care and Dependent Care Accounts 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 book is the summary plan description (SPD) for the Verizon Health Care Spending Account and Dependent Care Spending Account 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 book meets ERISA's requirements for an SPD and is based on Plan provisions effective January 1, 2001. This SPD is part of this Plan. In addition, this book describes the Dependent Care Reimbursement Fund, a program that is not subject to ERISA, but which may affect your contribution decision for the Dependent Care Account. This book 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 divided into the following major sections:

- **Health Care Account.** This section explains how the Health Care Account works, eligible health care expenses and how to file claims.

- **Dependent Care Account.** This section describes eligible dependents for whom you can claim expenses, how the account works, eligible dependent care expenses and how to file claims.

Important Note

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

- **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 the administrative provisions of the Plan and your legal rights.

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

Getting More Information

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

For general information about the Plan or the Reimbursement Fund:

- Call Verizon's Bell Atlantic InTouch Center (or its successor) at the telephone number listed on your Important Benefits Contact insert. The voice response system is available 24 hours a day, seven days a week. InTouch Representatives are available to answer your questions from 8:00 a.m. to 5:00 p.m. Eastern time, Monday through Friday (excluding holidays).

For specific details about eligible expenses and filing claims:

- Call Acordia National Member Services directly for questions regarding the Plan (see your Important Benefits Contact insert for the telephone number).

- Call your Work and Family Coordinator for questions about the Dependent Care Reimbursement Fund.

Every effort has been made to ensure the accuracy of the information included in this SPD, which constitutes part of the Plan document, as amended and restated effective January 1, 2001. Copies of Plan documents are available by contacting the Plan administrator in writing at the address provided on page 40 in the "Additional Information" section.

Changes to the Plan

While the Company expects to continue the Plan indefinitely, the Verizon Employee Benefits Committee (VEBC), formerly named the Bell Atlantic Corporate Employees' Benefits Committee, 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 the chairperson of the VEBC or an individual in a Director level position or above in the employee benefit design or delivery or the communications branch of the Company's Human Resources organization.

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

Health Care Account

Eligibility

You are eligible to participate in the Health Care Account on the first day of your employment if you are employed by a Verizon participating company (see page 44) and are a regular full-time or part-time New York or New England associate.

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

Note: If a court, the Internal Revenue Service 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.

> **Note**
>
> A full-time associate includes an employee who is regularly scheduled to work 25 or more hours per week, as well as a job-sharing employee who is scheduled to work at least 40 percent of a regular full-time employee's hours.

Enrolling in the Health Care 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 call the InTouch Center by the deadline on your Enrollment Worksheet 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 open enrollment period, unless you have a status change during the year (see pages 5 through 6).

You can contribute as little as $100 or as much as $3,500 per calendar year to your account. 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.

> **Important Note**
>
> Plan the amount of your contribution carefully. IRS rules require that you forfeit any amount you contribute that you cannot claim for reimbursement.

If you are changing from a management position to an associate position, you may participate in the Health Care Account the first day of the month following the change in status. Your contributions, account and claims activity will be transferred to the account for associates if you contributed to the account as a manager and elect to continue participating as an associate. If you elect to contribute to the account, you will receive additional information from the claims administrator on how the accounts work and claim forms to use for requesting reimbursements.

If You Are Rehired

If you leave the Company and are rehired by the Company within the same calendar year, your prior contribution elections resume automatically. If you are rehired in a following calendar year, you will make new elections for the accounts.

Changing Your Elections

Open Enrollment

After your initial enrollment opportunity, you will make a decision each year during the open enrollment period about whether you want to participate for the following calendar year. Elections made during the open 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 change in status.

Status Changes

Between open enrollment periods, you will be able to change your contribution amount or stop or start contributing, provided that you have a change in status that affects eligibility for using the account and the election change you make is consistent with the change in status. 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.

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.

Elections made due to status changes must be made within 90 days of the status change; otherwise, a change will not be allowed. 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 status change and change your election. Your new election will take effect as soon as administratively possible after you call the InTouch 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 Health Care Account. To make a change, you must notify the InTouch Center of your status change within 90 days of the event.

You Lose a Dependent Through Death or Divorce

If you lose a dependent through death or divorce, you may stop, start, increase or decrease your contributions to the Health Care Account by calling the InTouch Center within 90 days. Note that your change must be consistent with your status change.

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 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 Verizon Medical Expense Plan for New York and New England Associates (for example, when coverage ends due to age requirements or a change in student status), you may be eligible to change your account contribution amount. You are eligible to make a change 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 Health Care Account by calling the InTouch 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 Health Care Account by calling the InTouch Center.

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

Qualified Medical Child Support Order

If you are required to provide health care coverage to a child pursuant to a court- or state agency-issued qualified medical child support order (QMCSO), the Plan will allow you to change your elections under the Health Care Account in accordance with the procedures outlined by the Plan administrator. For a copy of the procedures, contact the Qualified Order Team at the telephone number listed on your Important Benefits Contact insert. Alternatively, if your spouse is required to provide coverage for your child, you may change your election consistent with the change in your child's status.

When Participation Ends

Your participation will end on the earliest date described below.

You Do Not Reenroll

If you do not reenroll during the open enrollment period, participation in the account ends on December 31 of the current year.

Leaves Under the Family and Medical Leave Act

The Company complies with the Family and Medical Leave Act of 1993 (FMLA). All leaves of absence qualifying under the FMLA will be administered in accordance with the terms of the FMLA. Your payroll deductions stop when your leave begins. However, you may elect to continue your participation in the Health Care Account during an approved FMLA leave of absence. If you elect to continue your contributions, you will be able to submit claims for expenses incurred during your unpaid FMLA leave. Upon your return, your monthly payroll deductions will be increased to account for the missed payroll deductions. If you elect not to participate, you can elect not to have your payroll deductions reinstated when you return to work. Your Health Care Account goal amount will be reduced due to the missed payroll deductions. Call the InTouch Center for details.

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 InTouch Center for details.

Change in Employment Status

If your employment status changes from an associate to a manager, your contributions to the account will end on the last day of the month in which you become a manager of the Company or an affiliate of the Company. However, your contributions, account and claims activity will be transferred to the account for managers if you elect to continue participating as a manager.

Long-Term Disability

If you are receiving long-term disability benefits, your contributions to the account will end on the last day of the month in which your employment with the Company ends due to total and permanent disability.

Cancellation of Coverage

If you stop contributions due to a change in status, your participation will end on the date you elect to stop contributing.

You Die

If you die while you are participating in the Health Care Account, 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.

End of Employment

Coverage under the Plan will end on the last day of the month in which your employment ends for any reason not specified in this section.

Plan Termination

Although the Company 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 in accordance with a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments. Continuation of coverage under COBRA is described on pages 15 through 17 of this summary plan description (SPD).

Health Care Account Highlights

	Health Care Account
Before-Tax Contribution You Can Deposit Each Year	Minimum: $100 per year Maximum: $3,500 per year
Using Your Account	You submit a claim for reimbursement 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 a check will be sent to you
Some Eligible Expenses To verify what is an eligible expense, call the claims administrator (see your Important Benefits Contacts insert for the telephone number)	• Copayments • Deductibles • Coinsurance • Amounts you pay above reasonable and customary (R&C) limits • Unreimbursed dental expenses, including amounts above a plan's benefit limit (for example, orthodontic expenses) • Unreimbursed vision and hearing care expenses
Some Expenses That Are Not Eligible	• Health insurance premiums • Cosmetic surgery or procedures that are not medically necessary • Over-the-counter vitamins, even if prescribed by a physician

[1] Expenses for non-tax-qualified dependents are not eligible for reimbursement under the Health Care Account.

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.

To use the account:

- **Step 1:** During your initial enrollment and each open enrollment period, you decide if you want to participate and elect the amount you want to contribute by calling the InTouch Center. This contribution should be based on a careful estimate of the 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—there is no minimum required to file a claim. (See pages 11 through 13 for a list of eligible expenses.) If your claim exceeds your Health Care Account balance, you receive up to the amount you have elected to deposit for the year, reduced by any prior reimbursements.

- **Step 4:** After the end of the calendar year, any contributions you do not claim are forfeited, as required by IRS rules. However, you have until May 31 of the following calendar year to file all claims incurred through December 31 of the prior calendar year.

Example of Tax Savings

The chart below shows how an employee earning $50,000 annually saves $225 in taxes by using the Health Care Account to pay for $1,000 in eligible expenses. The example assumes this employee is married, claims three exemptions and takes the standard deduction. Tax savings are based on 2000 tax rules.

	With Account	Without Account
Annual Pay	$ 50,000	$ 50,000
Expenses Paid With Account	- 1,000	- 0
Taxable Income	$ 49,000	$ 50,000
Estimated Federal Income and Social Security Taxes	- 8,737	-8,962
Expenses Paid Without Account	- 0	- 1,000
Income Remaining	$ 40,263	$ 40,038
Tax Savings	**$ 225**	

In this example, the employee reduces his or her taxes by **$225** by using the account. In other words, he or she has increased his or her income after taxes by this amount.

Your actual federal income and Social Security tax savings will depend on your personal tax situation and the amount you contribute. In most cases, factoring in state and local taxes could save you even more.

Additional Tax Considerations

- The same eligible health care expenses can be applied toward consideration for a federal income tax deduction. However, you cannot receive a tax-free reimbursement from your account and claim the same expense as a deduction. The federal income tax deduction is available only to the extent that your eligible health care expenses exceed a certain percentage of your adjusted gross income (in 2000, 7.5 percent). By comparison, the Health Care Account provides a tax advantage on every dollar you contribute.

- Some states, such as New Jersey and certain municipalities, treat the money you deposit in a health care account as part of your taxable income for purposes of determining state and local income taxes.

- If you earn less than the Social Security Wage Base ($80,400 in 2001) and contribute to the Health Care Account, your future Social Security benefits may be reduced slightly. The impact generally is very small—less than one percent—after years of using the account.

Eligible Health Care Expenses

In general, you can use the Health Care Account 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.

Eligible Expenses

The expenses that are eligible for reimbursement from the Health Care Account include the portion of most medical, dental and vision care expenses not paid by another plan—either the Company-sponsored Medical, Dental or Vision Care Plan or your spouse's health plan with his or her employer. These eligible expenses include:

- Health care plan deductibles and copayments
- Amounts above a plan's limits for expenses, such as dental (for example, orthodontia expenses), vision care and psychiatric or psychological counseling
- Amounts you pay above reasonable and customary (R&C) charges
- Charges for out-of-network care you receive in a Health Maintenance Organization (HMO)
- Preventive care services or supplies that may not be covered, depending on your medical coverage.

In general, the Health Care Account can be used 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 expense:

- Acupuncture or treatment provided by a chiropractor or a Christian Science practitioner
- Prescription eyeglasses, prescription sunglasses and contact lenses
- Guide dog for a blind or deaf individual
- "Halfway house" or other programs designed to help mentally disabled individuals adjust to community living
- Hearing aids
- Inpatient hospital care, including meals and lodging

- Installation and repair of special telephone and television equipment for the deaf

- Legal assistance needed for authorizing treatment for mental illness

- Non-refundable advance payments for institutional care, treatment or training of the mentally disabled

- Non-surgical treatments for foot problems

- Nursing home, retirement home and convalescent care facility for the portion of expenses, if any, attributable to medical care

- Operations or treatments, including obstetrical expenses, legal abortion and legal vasectomy

- Organ donation and kidney transplant expenses

- Physician and nursing care services

- Routine physical examinations and related services, such as vaccinations and immunizations

- Smoking cessation programs and prescription medications designed to alleviate nicotine withdrawal

- Special equipment for the handicapped, such as modified automobiles and wheelchairs

- Special schooling for deaf individuals or children who have severe learning disabilities caused by mental or physical conditions

- Special training and educational devices for the sight impaired or blind, such as Braille books, magazines and typewriters, but only the portion of the expense that exceeds the cost of the same item for a seeing individual can be claimed for reimbursement

- Telephone and television audio display equipment for the hearing impaired

- Transportation costs related to medical care treatments

For More Information

If you are uncertain about whether an expense is eligible for reimbursement, call the claims administrator or the InTouch Center (see your Important Benefits Contacts insert for the telephone number).

- Treatment of work-related illness or injury that is not covered by Workers' Compensation

- Weight-loss programs undertaken at a physician's direction to treat an existing medical condition, such as hypertension, arteriosclerosis or diabetes.

Expenses That Are Not Eligible

Examples of expenses that are **not** eligible for reimbursement include:

- Athletic club dues, exercise equipment and fees for dance classes or similar social activities, as well as any other services or supplies primarily intended for the promotion of general health and well-being

- Automobile or life insurance premiums

- Bottled water

- Cosmetic surgery performed for reasons other than the correction of congenital birth defects

- Custodial care in an institution

- Diapers

- Expenses incurred prior to the date you enroll in the Plan, or after or during a month you fail to make a required contribution to the Plan

- Funeral, cremation or burial expenses

- Health care insurance premiums

- Household or domestic help

- Illegal health care treatments or surgical procedures

- Lodging or meals that are not prescribed for the treatment of illness or injury

- Marriage or family counseling, unless provided by an M.D., Ph.D., psychologist, licensed and certified psychologist or licensed social worker

- Non-prescription drugs

- Nursing care for a healthy newborn
- Over-the-counter pregnancy tests and hygiene products
- Special schools for children who have disciplinary problems
- Toiletries or cosmetics
- Transportation expenses to and from work and any other travel that is not essential to medical care
- Uniforms or other special clothing
- Over-the-counter vitamins, even if prescribed by a physician
- Weight-reduction programs to maintain general health.

Filing Your Claim for Reimbursement

When you have an eligible expense, you first will need to file a claim with your health care plan(s). Then, you can submit a claim for reimbursement to the Health Care Account for any amount that is not paid by your coverage.

Reimbursement

If you elect to contribute to the Health Care Account, you will receive an information packet from the claims administrator, which will include claim forms for reimbursement.

To file a claim:

- Complete the claim form once you have incurred eligible expenses. There is no minimum required to file a claim.
- Attach paid receipts, which must include the following:
  - Name of health care provider
  - Patient's name
  - Date service was performed or item provided
  - Nature of service or item
  - Itemized charge for each service and item.

- Send the form and the receipts to the claims administrator at the address shown on the form.

- Keep a copy for your records.

For health care expenses, your receipts should include a copy of a bill or your claims administrator's Explanation of Benefits (EOB) form for medical and dental expenses for which you have had to pay a portion of the cost. For health plan copayments, submit a bill or receipt from your physician.

Claim Processing

Eligible claims for expenses incurred in a calendar year must be filed no later than May 31 of the following year. Your eligible health care claims will be reimbursed up to the maximum you elected to contribute for the year reduced by any reimbursements you already have received.

If Your Claim Is Denied

If your claim for reimbursement is denied, you or your beneficiary is 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

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments provides special rules that allow you and your eligible dependents (qualified beneficiaries) to continue participation in the Health Care Account for the remainder of the calendar year in which coverage otherwise would end. Special COBRA rules would apply if Verizon ever were to become bankrupt. For more information, contact the Plan administrator.

Eligible dependents include your spouse or same-sex domestic partner and children who meet the eligibility requirements under the Verizon health care plans. Note that same-sex domestic partners are not included under COBRA rules, but Verizon has chosen to extend COBRA-like coverage to same-sex domestic partners in the same manner as to an eligible covered spouse. Also, if you have or adopt a child or if a child is placed with you for adoption during the continuation period, the child will become a qualified beneficiary. During the continuation period, you or your dependent must contribute on an after-tax basis, in addition to paying a two percent administrative charge.

Coverage continuation is available until the end of the calendar year in which the event occurs in the following situations:

- **If your participation ends** because of termination of employment (except for gross misconduct) or retirement (including disability retirement) or because of a reduction in your work hours, you and your covered dependents can continue to contribute on an after-tax basis and file claims for reimbursement of these contributions.

- **If you no longer can claim reimbursement for eligible expenses for your dependent because he or she no longer is an eligible dependent**, your dependent will have the opportunity to continue Verizon coverage.

Note: If the Company changes the account during the period that you, your spouse or your dependents are continuing coverage, the changes apply to your COBRA coverage and are applicable under your Health Care Account.

Notification Requirements

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

If you are terminated or lose coverage because of a reduction in work hours, you will receive additional information from the Company about your opportunity to continue participation under COBRA.

Important Note

If you have questions about COBRA or wish to enroll, contact the COBRA administrator, ADP COBRA Services:

ADP COBRA Services
2155 West Park Court
Stone Mountain, GA 30087

See your Important Benefits Contacts insert for the telephone number.

Making Continued Contributions

You have 45 days from the date of your election to continue participation under COBRA to make your first contribution to the Health Care Account. The first contribution will include contributions prior to the date of your COBRA election. Contributions will be due regularly thereafter. If you fail to make a required contribution, your participation will end 30 days after the required payment was due but not paid.

How Continued Participation Could End

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

- On December 31 of the calendar year (Plan year) that COBRA coverage began.
- You do not make the required monthly contributions on a timely basis.
- You or a dependent becomes eligible for participation under another health care account (for example, with a new employer) after electing COBRA.
- You or a dependent becomes entitled to Medicare after electing COBRA.
- The Health Care Account is terminated by the Company.

Dependent Care Account

Eligibility

You are eligible to participate in the Dependent Care Account after you have completed three months of service if you are employed by a participating company (see page 44) and are a regular full-time or part-time New York or New England associate.

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

Note:

- "Service" is based on net credited service provisions of the Verizon Pension Plan for New York and New England Associates.
- If a court, the Internal Revenue Service 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.

Note

A full-time associate includes an employee who is regularly scheduled to work 25 or more hours per week, as well as a job-sharing employee who is scheduled to work at least 40 percent of a regular full-time employee's hours.

Important Note

If you are married, you are eligible to use the account only if your spouse also works, is a full-time student at least five months during the year, is looking for a job or is unable to care for himself or herself due to a mental or physical disability.

Eligible Dependents for Whom You Can Claim Expenses

You can use the Dependent Care Account to reimburse yourself for amounts you pay someone to care for an eligible dependent while you and, if you are married, your spouse are working. To be eligible for reimbursement, the expenses must be for a dependent who is as follows:

- Your child under age 13 whom you claim as a dependent on your federal income tax return

- Your spouse, parent or another disabled person whom you claim as a dependent on your federal income tax return, who physically or mentally is incapable of self-care and for whom you pay more than one-half the cost of support. If the dependent care expenses are incurred for services provided outside your home, the dependent must be present in your home at least eight hours a day.

Enrolling in the Dependent Care 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 call the InTouch Center by the deadline on your Enrollment Worksheet 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 open enrollment period, unless you have a status change during the year (see pages 5 through 6).

You can contribute as little as $100 or as much as $5,000 per calendar year to your account. 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, you may participate in the Dependent Care Account the first day of the month following the change in status. Your contributions, account and claims activity will be transferred to the account for associates if you contributed to the account as a manager and elect to continue participating as an associate. If you elect to contribute to the account, you will receive additional information from the claims administrator on how the account works and claim forms to use for requesting reimbursements.

Important Note

Plan the amount of your contribution carefully. IRS rules require that you forfeit any amount you contribute that you cannot claim for reimbursement.

If You Are Rehired

If you leave the Company and are rehired by the Company within the same calendar year, your prior contribution elections resume automatically. If you are rehired in a following calendar year, you will make new elections for the accounts.

Changing Your Elections

After your initial enrollment opportunity, you will make a decision each year during the open enrollment period about whether you want to participate the following calendar year. Elections made during the open 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 change in status.

Status Changes

Between open enrollment periods, you will be able to change your contribution amount or stop or start contributing, provided that you have a change in status that affects eligibility for using the account and the election change you make is consistent with the change in status. 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 status changes must be made within 90 days of the status change; otherwise, a change will not be allowed. 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 status change and change your election. Your new election will take effect as soon as administratively possible after you call the InTouch 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 Dependent Care Account. To make a change, you must notify the InTouch Center of your status change within 90 days of the event.

You Lose a Dependent Through Death or Divorce or a Dependent No Longer Is Eligible

If you lose a dependent through death or divorce or a dependent no longer is eligible, you may change your contribution election to the Dependent Care Account by calling the InTouch Center within 90 days. Note that your contribution change must be consistent with your status change.

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 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 open enrollment or at any other time due to a status change, you can make a change under your Dependent Care Account. Your change must be on account of and consistent with your spouse's change under his or her plan.

An Increase in Cost for Dependent Care Services
If you have a significant cost increase for your dependent care services imposed by a provider who is not related to you, you can make an election change. Call the InTouch Center and speak with a representative for more information.

A Change in Dependent Care Providers
If you change your dependent care provider, you can make an election change. Call the InTouch Center and speak with a representative for more information.

Leaves Under the Family and Medical Leave Act
The Company complies with the Family and Medical Leave Act of 1993 (FMLA). All leaves of absence qualifying under the FMLA will be administered in accordance with the terms of the FMLA. Your Dependent Care Account contributions will be suspended during approved leaves of absence, but may be continued on the first day of the month following your return to work.

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 InTouch Center for details.

When Participation Ends

Your participation ends on the earliest date described below.

You Do Not Reenroll

If you do not reenroll during the open enrollment period, participation in the account ends on December 31 of the current year.

Change in Employment Status

If your employment status changes from associate to management status, your contributions will end on the last day of the month in which you become a manager of the Company or an affiliate of the Company. However, your contributions, account and claims activity will be transferred to the account for managers if you elect to continue participating as a manager.

Long-Term Disability

If you are receiving long-term disability benefits, your contributions to the account will end on the last day of the month in which your employment with the Company ends due to total and permanent disability.

Cancellation of Coverage

If you stop contributions due to a change in status, your participation will end on the date you elect to stop contributing.

You Die

If you die while you are participating in the Dependent Care Account, 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 March 31 of the following year.

End of Employment

Coverage under the Plan will end on the last day of the month in which your employment ends for any reason not specified in this section. You can claim reimbursement for eligible expenses incurred up to the date your coverage ends.

Plan Termination

Although the Company does not intend to terminate the Plan, were the Plan to be terminated, all contributions would end on the date of termination.

Dependent Care Account Highlights

	Dependent Care Account
Before-Tax Contribution You Can Deposit Each Year	Minimum: $100 per year Maximum: $5,000 per year, per family (see page 26)
Using Your Account	You 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 deposited and a check will be sent to you You must include your day care provider's Social Security number or taxpayer identification number when you submit a claim for reimbursement
Some Eligible Expenses To verify who is an IRS-eligible dependent and what is an IRS-eligible expense, call the IRS to request IRS Publication 503 or log-on to the IRS Internet site (www.irs.gov) and look under "Forms and Publications"	• Pre-school • Child care or adult day care at a center that meets state and local regulations • Baby-sitter • Nurse at home • Relative who cares for eligible dependents, as long as that relative is not your dependent or your child under age 19 **Expenses must be for an IRS-eligible dependent[1]:** • Your children under age 13 • Your disabled children of any age who are incapable of self-care • Your physically or mentally disabled spouse who is incapable of self-care • 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 • "Saturday night" baby-sitting • Overnight camp

[1] Expenses for non-tax-qualified dependents are not eligible for reimbursement under the Dependent Care Account.

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 open enrollment period, you decide if you want to participate and elect the amount you want to contribute by calling the InTouch 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 Dependent Care Account as taxable income for state and local taxes.

- **Step 3:** When you have incurred eligible dependent care expenses, you can file a claim—there is no minimum required to file a claim. (See pages 27 through 28 for a list of eligible expenses.) 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 Dependent Care Account.

  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 to the next month. As you make additional contributions to your account, this money automatically will be used to reimburse you for any unpaid balances. 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:** Under IRS rules, you forfeit any money left in your account at the end of the year. However, you have until March 31 of the following year to submit requests for reimbursement of eligible expenses you incurred on or before December 31.

Example of Tax Savings

The chart below shows how an employee earning $50,000 annually saves $225 in taxes by using the Dependent Care Account to pay for $1,000 in eligible expenses. The example assumes this employee is married, claims three exemptions and takes the standard deduction. Tax savings are based on 2000 tax rules.

	With Account	Without Account
Annual Pay	$ 50,000	$ 50,000
Expenses Paid With Account	- 1,000	- 0
Taxable Income	$ 49,000	$ 50,000
Estimated Federal Income and Social Security Taxes	- 8,737	- 8,962
Expenses Paid Without Account	- 0	- 1,000
Income Remaining	$ 40,263	$ 40,038
Tax Savings	**$ 225**	

In this example, the employee reduces his or her taxes by **$225** by using the account. In other words, he or she has increased his or her income after taxes by this amount.

Your actual federal income and Social Security tax savings will depend on your personal tax situation and the amount you contribute. In most cases, factoring in state and local taxes could save you even more.

Contribution Limits

In general, you can contribute up to $5,000 annually to your account, unless your reimbursement limit is reduced by one or more of the government rules described below:

- Reimbursements you receive from all similar dependent care plans combined cannot be more than $5,000 annually. So, if you receive reimbursements from the Dependent Care Reimbursement Fund (see pages 30 through 35) or if your spouse participates in a similar account, your contribution to this account combined with other plans cannot be more than $5,000 in a calendar year.

- If you and your spouse file separate federal income tax returns, the most you can contribute to your Dependent Care Account is $2,500 in a calendar year.

- Your annual contribution cannot exceed your earned income or, if you are married, your spouse's earned income for the year, if less. 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 eligible expenses for two or more 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 (see pages 30 through 35), 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 Dependent Care Account. 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 Dependent Care Account, up to your annual limit based on both plans combined, as described above.

Additional Tax Considerations

- The same eligible expenses you can claim under the Dependent Care Account also are eligible for a tax credit on your federal income tax return (in 2001, expenses up to $2,400 for one dependent and up to $4,800 if you have two or more dependents). However, if you use the Dependent Care Account to reimburse yourself with before-tax dollars, you lower the amount of expenses you can apply toward the federal tax credit, dollar for dollar. For example, if you have one dependent and you claim $2,500 in expenses through the Dependent Care Account, you cannot use the federal tax credit. In general, based on 2000 tax rules, you can gain a greater advantage using the Dependent Care Account if your total family income is more than $24,000 annually. You may want to consult with a tax advisor if you have questions.

- Some states and municipalities treat the money you deposit in a Dependent Care Account as part of your taxable income. If you live or work in one of these areas, your tax savings will be limited to federal income and Social Security taxes.

- If you earn less than the Social Security Wage Base ($80,400 in 2001) and contribute to the Dependent Care Account, your future Social Security benefits may be reduced slightly. The impact generally is very small—less than one percent—after many years of using the account.

Eligible Dependent Care Expenses

In general, you can use the Dependent Care Account 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. 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.

Eligible Expenses

Based on IRS guidelines, you can claim reimbursement from the Dependent Care Account for the following expenses:

- Pre-school expenses

- Payments made for child care or adult day care at a center that meets state and local regulations and that provides care for more than six individuals and receives a fee for providing services for those individuals

- Wages and taxes paid for a baby-sitter, housekeeper or other care provider—such as a nurse—who comes to your home and provides care, as long as you include the care provider's Social Security number

- Payments made to a relative who cares for eligible dependents, as long as that relative is not your dependent or your child who is under age 19, and your relative provides his or her Social Security number

- Payments made to an individual who provides at-home day care, as long as the individual provides his or her provider's license or Social Security number and the care is for a dependent who is under age 13 or who spends at least eight hours a day in your home

- Payments made for after-school programs, summer day camp or school vacation programs.

Expenses That Are Not Eligible

Examples of expenses that are **not** eligible include:

- Dependent care expenses incurred prior to your participation in the Company Plan or for any month in which you failed to contribute to the Plan

- Expenses reimbursed from the Verizon Dependent Care Reimbursement Fund

- Expenses that are not considered employment-related expenses under the Internal Revenue Code

- Expenses for personal convenience (as determined by the claims administrator), rather than to enable you to be gainfully employed

- Kindergarten expenses that primarily are for education purposes

- Expenses for education in the first grade or higher

- Transportation expenses to and from the care site

- 24-hour nursing home expenses

For More Information

If you are uncertain about whether an expense is eligible for reimbursement, call the InTouch Center (see your Important Benefits Contacts insert for the telephone number) or request a list of eligible expenses from the IRS (see page 23).

- Overnight camp expenses

- Payments made to any person caring for your child when you or your spouse is **not** working, unless your spouse is a full-time student or disabled, or while you or your spouse is engaged in volunteer work.

Filing Your Claim for Reimbursement

When you have eligible expenses, you will need to submit the original receipt for services, along with a reimbursement request form, to the claims administrator.

Reimbursement

If you elect to contribute to the Dependent Care Account, you will receive an information packet from the claims administrator, which will include claim forms for reimbursement.

To file a claim:

- Complete and sign the claim form once you have incurred eligible expenses. There is no minimum required to file a claim.

- Attach your itemized receipt from the dependent day care provider, which must include the dependent's name, the care provider's name and address, expense amounts, tax identification number or Social Security number and dates that he or she provided the services. 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.

The claims administrator will determine whether the expense is eligible for reimbursement based on the law and from the bills or documentation you submit, and will issue a check accordingly.

Eligible claims for expenses incurred in a calendar year must be filed no later than March 31 of the following year.

Tax Identification Number Required

To file a claim and receive reimbursement, you must include the tax identification number of the care provider (the Social Security number if care is provided by an individual); otherwise, your claim cannot be processed.

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 CWA member or an IBEW Local 2213 member who works in New York, you are eligible if you have three months of net credited service. You are covered under the CWA guidelines.

- If you are a non-bargaining or bargaining unit associate who works in New England, excluding CWA members, you are eligible if you have three months of net credited service. You 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. To be eligible for reimbursement, the expenses must be for a dependent who is as follows:

- Your child under age 13 whom you claim as a dependent on your federal income tax return. An exception may apply for a child you do not claim if you are divorced or separated and have custody of your child for more than six months during the year.

- Your spouse, parent or other disabled person whom you claim as a dependent on your federal income tax return and who physically or mentally is incapable of self-care and for whom you pay more than one-half the cost of support. If the dependent care expenses are incurred for services provided outside your home, the dependent must be present in your home at least eight hours a day.

Important Note: The definition for a dependent is the same as for the Dependent Care Account. 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 Dependent Care Account 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 page 33 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 the first page of your federal income tax form (1040). For information on the gross family income maximum and the tax form verification requirements, call the Work and Family Coordinator in your area.

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. In most cases, you do not pay any taxes on the money you are reimbursed, unless reimbursements exceed your non-taxable limit.

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 pages 27 through 28 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.

The weekly reimbursement limits vary depending on the "category" of eligible dependents you have and the fund in which you participate. The eligible dependent categories are as follows:

- Each child under age six, disabled elder or other disabled dependent of any age
- Each child age six through age 12 who is as follows:

  — In child care less than 20 hours per week

  — In child care 20 or more hours per week.

Call the Work and Family Coordinator in your area for information about the current reimbursement limits that apply for your eligible dependents. Keep in mind, you can receive reimbursement for a portion of the cost of care for each eligible dependent for whom you pay eligible dependent care expenses.

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 Dependent Care Account), 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 Dependent Care Account also are eligible for consideration in determining a tax credit on your federal income tax return (the federal tax credit considers expenses up to $2,400 for one dependent and up to $4,800 if you have two or more dependents). However, to the extent you use both the Dependent Care Reimbursement Fund and the Dependent Care Account, 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 $2,400 or more in expenses through the Company's Plans, you cannot use the federal tax credit. If you have two or more dependents and you claim $4,800 or more through the Company's Plans, you cannot use the federal tax credit.

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 Dependent Care Account. (See pages 27 through 28.) 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 itemized receipt from the person who provided the care. Your receipt 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 "Additional Information" section that follows.

Additional Information

Forfeitures Under the Health Care and Dependent Care Accounts

The Internal Revenue Service (IRS) requires that you give up—or forfeit—any balances remaining in Health Care and Dependent Care Accounts at year-end for which you have not incurred eligible expenses. You may file claims for current-year expenses until March 31 of next calendar year for the Dependent Care Account and May 31 of next calendar year for the Health Care Account.

Health Care Account

Contributions to the Health Care Account will be used to pay eligible claims and administrative fees, as determined by the Verizon Employee Benefits Committee (VEBC), formerly named the Bell Atlantic Corporate Employees' Benefits Committee. Any amounts forfeited under the Health Care Account 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 Care Account

Contributions to the Dependent Care Account will be used to pay eligible claims and administrative fees, as determined by the VEBC. Any remaining amounts will be allocated to the accounts of participants who elect to contribute to the account for the following Plan year, in proportion to the amount each participant has elected to contribute for that year.

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), formerly named the Bell Atlantic Corporate Employees' Benefits Committee, and the Verizon Claims Review Committee (VCRC), and to the individuals who chair each of these committees. Each of them has the discretion to designate the claims and/or appeals administrator from time to time. Furthermore, the VCRC (and its chairperson) has the discretion to designate the VCRC as a "final appeals administrator," either in place of the existing appeals process under the Plan, or as an additional level of appeal beyond the existing two-tier or three-tier claims and appeals process, depending on whether a final appeals administrator has been appointed. If a final appeals administrator has been designated, the final appeals administrator has sole authority to exercise discretion in review and resolution of a final appeal of a claim denied upon initial appeal under the Plan.

At the time of publication of this summary plan description (SPD), there are two claims and appeals administrators for the Plan:

Claims Regarding Eligibility to Participate in the Plan

Verizon's Bell Atlantic InTouch Center (staffed by PricewaterhouseCoopers LLP—or its successor) 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

Acordia National has discretionary authority to determine claims and appeals for Plan benefits.

The addresses of the claims and appeals administrators for the Plan are listed on page 43. If you have a claim or appeal, you should contact the appropriate claims and appeals administrator for the type of claim or appeal you have.

The claims and appeals administrators have discretionary authority to:

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

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

Filing a Claim

You, your beneficiaries or someone claiming benefits through you as a participant has the right under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments to file a claim if you believe you are entitled to benefits and benefits have been denied or incorrectly determined under the Plan.

To submit a claim, put your concern in writing, explaining in your own words your understanding of your benefit issue, and provide any supporting information in writing to the appropriate claims administrator.

The health and welfare benefit plans subject to open enrollment have two claims and appeals administrators:

- The administrator for claims and appeals that pertain to eligibility to participate in the Plan or issues relating to enrollment or changes in enrollment under the Plan (see page 37)
- The administrator for claims and appeals that pertain to the scope or amount of benefits under the Plan (see page 37).

Once you have documented your claim and submitted any further information that you believe should be taken into account by the claims administrator, the claims administrator has 90 days to process your claim after receiving it.

If there are special circumstances requiring longer review, the claims administrator may take up to an additional 90 days to make a decision on your claim. The claims administrator will notify you in writing if more time is needed and of the final decision.

If Your Claim Is Denied

If your claim completely or partially is denied, a written notice of denial will tell you the specific reasons for the decision, the Plan provisions used to support the decision, a description of any outstanding materials needed to approve the claim and how you can appeal the decision.

Filing an Appeal

You (the participant or beneficiary who filed a claim that was denied) may file an appeal if:

- You receive no reply to your original claim within the initial 90 days
- The time for a decision on your original claim was extended for an additional 90 days, and you receive no reply after the additional 90 days
- You receive written denial of all or part of the claim and you want to appeal the denial.

You may appeal by submitting in writing a letter requesting an appeal and stating your concerns and any related facts to the appeals administrator. Your appeal letter must be received by the appeals administrator within 60 days after you receive the denial of your claim or fail to receive timely notice of a decision.

If you submit an appeal, you have the right to:

- Review pertinent Plan documents, which you can obtain as described on page 40.
- Send a written statement of the issues and any other documents in support of your claim to the appeals administrator.
- Request copies of written documents that are relevant to your appeal. There typically will be a reasonable charge per page.

Review of Your Appeal

The appeals administrator will review your appeal of the denied claim and will make a decision within 60 days after receiving your written request for review. Your appeal will be decided by a different appeals administrator or committee than the appeals administrator or committee that decided your initial claim. If the appeals administrator meets on a quarterly basis, a decision may be made at the next quarterly meeting.

If the appeals administrator needs more than 60 days or a period beyond the next quarterly meeting to make a decision, you will be notified in writing, within the initial 60-day period or calendar quarter, and you will be told why more time is needed. The extension, if needed, will be an additional 60 days or until the subsequent quarterly meeting.

Normally, the appeals administrator will notify you of the decision in writing. However, if you do not receive a decision or notification within the appropriate time span, you should consider the appeal denied.

In the case of an appeal, the appeals administrator's decision is the final, conclusive and binding administrative remedy under the Plan. However, as a Plan participant, you may have further rights under ERISA after you have exhausted the claims and appeals process, as described in the next section.

Benefits under this Plan will be paid only if the applicable benefits administrator or, in the case of a claim or appeal, the applicable claims or appeals administrator, or its delegate, decides in its discretion that the participant or beneficiary is entitled to them.

Rights of Participants and Beneficiaries Under ERISA

Under ERISA, you have the following rights under the Plan:

- You may examine all Plan documents without charge. These include annual financial reports, Plan descriptions, collective bargaining agreement provisions pertaining to the Plan and all other official Plan documents and reports, including a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration. The Plan administrator makes these documents available for examination free of charge at specified sites, such as Verizon work locations. For information, write to the Plan administrator:

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

  Also, you may obtain copies of all Plan documents and other Plan information upon written request to the Plan administrator at the above address. Please include the full name of the Plan in your written request along with your name, Social Security number, mailing address and telephone number. You may be charged 25 cents per page for documents that you request.

- You will 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.

In addition to creating rights for Plan participants, ERISA imposes duties upon the persons who are responsible for the operation of the Plan. The persons who operate your Plan, some of whom are named as "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. 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 and to obtain copies of documents relating to the decision without charge.

You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the previous rights.

For instance, if you request materials from the Plan administrator that you have a right to receive 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. 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).

If you have any questions about the Plan, you should contact the InTouch Center, which the Plan administrator has established for purposes of administering benefits and responding to questions of participants and beneficiaries. 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 can contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries; Pension and Welfare Benefits Administration; U.S. Department of Labor;
200 Constitution Avenue, N.W.; Washington, D.C. 20210.

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

Administrative Information

Administrative information about the Plan is provided in this section.

Important Telephone Numbers

See your Important Benefits Contacts insert for information.

Plan Sponsor

The Plan sponsor is:

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

Plan Administrator

The Plan administrator is:

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

You may communicate to the Plan administrator in writing at the address above. But, for questions about Plan benefits, you should write or call the InTouch Center (see page 43 for the address and your Important Benefits Contacts insert for the telephone number). The InTouch 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 administrator listed on page 37.

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 an InTouch Representative.

Do not send any benefit claims to the Plan administrator or to the legal department. Instead, submit them to the claims administrator for the Plan (see page 37).

Benefits Administrator

Acordia National is the benefits administrator for the Plan. As the benefits administrator, Acordia National has the authority and responsibility to perform daily administration of benefits under the Plan. (See below for the address and your Important Benefits Contacts insert for the telephone number for the benefits administrator.)

Claims and Appeals Administrators

There are two claims and appeals administrators for the Plan.

Verizon's Bell Atlantic InTouch Center (staffed by PricewaterhouseCoopers LLP—or its successor)

The InTouch Center is responsible for enrollment and eligibility claims under the Plan and for all claims under the Dependent Care Reimbursement Fund. The InTouch Center can be reached at the following address:

Verizon's Bell Atlantic InTouch Center (or its successor)
P.O. Box 435
Little Falls, NJ 07424

See your Important Benefits Contacts insert for the telephone number.

Acordia National

Acordia National is the benefits administrator responsible for exercising the discretion to determine benefit payments, and also is the claims administrator for claims relating to the scope or amount of benefits under the Plan. Acordia National can be reached at the following address:

Acordia National
P.O. Box 2911
Charleston, WV 25330-2911

See your Important Benefits Contacts insert for the telephone number.

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 on page 37 do not insure or guarantee Plan benefits. The Company pays all claims out of the general assets of the Company.

Plan Identification
Spending account participation is provided through the Verizon Health Care Spending Account and Dependent Care Spending Account 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 563.

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

Agent for Service of Legal Process
The agent for service of legal process is the Plan administrator. Legal process must be served in writing to the Plan administrator at the address stated for the Plan administrator on page 42.

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

Verizon Legal Department
Employee Benefits Group
Verizon Communications Inc.
1095 Avenue of the Americas
37th Floor
New York, NY 10036

Official Plan Document
This SPD is part of the official Plan documents.

Participating Companies
The following is a list of participating companies as of January 1, 2001. The list may change from time to time.

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

Glossary

B

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.

C

COBRA

A federal law (Consolidated Omnibus Budget Reconciliation Act of 1985 and its subsequent amendments) allowing continuation of Health Care Account contributions on an after-tax basis for a period of time if a participant loses eligibility because of certain changes in status.

E

Eligible Expenses

Expenses that qualify for reimbursement under the Company's Health Care and Dependent Care Accounts and Dependent Care Reimbursement Fund.

F

Forfeiture

IRS rule which requires that you must give up—or forfeit—any balances remaining in the Health Care Account or Dependent Care Account at year-end for which you have not claimed reimbursement for eligible expenses. You may file claims for current-year expenses until March 31 of the next calendar year for the Dependent Care Account and May 31 of the next calendar year for the Health Care Account.

I

Ineligible Expense

Expenses that are **not** eligible for reimbursement under the Company's Health Care and Dependent Care Accounts and Dependent Care Reimbursement Fund.

T

Tax Identification Number

In order to receive reimbursement of Dependent Care Account 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.