Your Health Care and Dependent Care Accounts

Contents

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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.

About This SPD

This document is the summary plan description (SPD) for Verizon Plan 552, the Verizon Health Care Account and Dependent Care Account for Mid-Atlantic 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 effective January 1, 2004, including legislative and administrative updates through December 31, 2006. It updates and replaces all previous SPDs and other descriptions of the benefits provided by the Plan. This SPD is a summary of this Plan.

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

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.
- **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.

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.

This SPD describes Plan benefits for eligible Verizon Mid-Atlantic CWA and IBEW associates and Verizon Connected Solutions Inc. technicians.

Verizon Benefits Center

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

- Hotlink to other Verizon benefit provider sites.
- Create and print personalized provider listings and maps to providers' offices for most options.
- Review details about your healthcare and insurance plans. For overview information, use the comparison charts. For more detailed information, use the Benefits Manual.
- Select and update your beneficiary designations.
- Change Your Benefits Resources password.
- Give yourself a helpful "hint" in case you forget your password.

Verizon Benefits Center representatives are available should you have questions about your benefits. To reach the Verizon Benefits Center via telephone, call 1-877-4VzBens. Via 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 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.

Your Benefits Resources™ is a registered trademark of Hewitt Associates LLC.

Health Care Account

Eligibility

You are eligible to participate in the Health Care Account if you meet all of the following requirements:

- Are employed by a Verizon participating company.
- Are a regular or term full-time or part-time Mid-Atlantic associate or a Verizon Connected Solutions Inc. technician. Occasional and temporary associates are not eligible.
- Have completed three months of service; however, if you are a Verizon Connected Solutions Inc. technician, you must have completed six months of service to participate in the Health Care Account.

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

"Service" means net credited service as defined by the Verizon Pension Plan for Mid-Atlantic Associates or your applicable Verizon Pension Plan.

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

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

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

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.

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 Verizon Benefits 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 benefits renewal period, unless you have a status change during the year (see "Changing Your Elections").

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 Health Care Account on 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.

If You Are Rehired

If you leave the Company and are rehired by the Company, you will make new elections for the accounts.

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.

Changing Your Elections

Benefits Renewal

After your initial enrollment opportunity, you will make a decision each year during the benefits renewal period about whether you want to participate for the following calendar year. Elections made during the benefits renewal period take effect on the following January 1 and remain in effect through December 31 of that year, unless you change the election during the year due to a change in status.

If you do not make changes, your current elections remain in effect for the next calendar year.

Status Changes

Between benefits renewal 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 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 Health Care Account. To make a change, you must notify the Verizon Benefits 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 start, stop, increase or decrease your contributions to the Health Care Account by calling the Verizon Benefits 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 Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates—for example, when coverage ends due to age requirements or a change in student status—you may be eligible to change the amount of your contribution to your account. 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 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 Health Care Account by calling the Verizon Benefits Center.

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

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, including the Health Care Account. 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.

When Participation Ends

Your participation will end on the earliest date described below.

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, you may elect to continue your participation in the Health Care Account during approved FMLA leaves of absence. If you elect to continue your participation, 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 and contributions. 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 Verizon Benefits Center for details. For information on non-FMLA Leaves of Absence, see your Additional Benefits and Programs Booklet.
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 a manager, your contributions to the account will end on the last day of the month in which you become a manager of Verizon or an affiliate of Verizon. 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 Verizon 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 up 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. 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 in accordance with the 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.

Health Care Account Highlights

Health Care Account	
Before-Tax Contribution You Can Deposit Each Year	Minimum: $100 per year Maximum: $5,000 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, visit Your Spending Account Web site (see your Important Benefits Contacts insert for the address)	• 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 benefits renewal period, you decide if you want to participate and elect the amount you want to contribute by calling the Verizon Benefits 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 “Eligible Health Care Expenses” for a list.) 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:** You cannot carry over your unused Health Care Account contributions from one plan year to the next. However, 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 chart below shows how an employee earning $50,000 annually saves $226 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 2006 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	- 6,314	- 6,540
Expenses Paid Without Account	- 0	- 1,000
Income Remaining	$ 42,686	$ 42,460
Tax Savings	**$ 226**	

In this example, the employee reduces his or her taxes by **$226** 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

- For federal income tax purposes, you can only deduct eligible health care expenses that exceed 7.5% of your adjusted gross income, assuming you are itemizing deductions. However, when you receive reimbursement from the Health Care Account 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 Health Care Account.

  Generally, if you do not itemize your tax deductions or if your health care expenses are less than 7.5% of your adjusted gross income, it may be more beneficial to participate in the Health Care Account.

  Consult a tax advisor for guidance on your specific situation.

- 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 ($97,500 in 2007) 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

Expenses that are incurred during the plan year but not covered by a health care plan are eligible for reimbursement. For a complete listing of eligible expenses, visit Your Spending Account Web site.

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

- Copayments, deductibles and coinsurance that you pay under any health care plan.

- Expenses that may not be covered by a health care plan, such as:

  — Routine physical exams.

  — Routine laboratory tests and X rays not related to a diagnosis.

  — Over-the-counter medications such as antacids, aspirin, cough medicine, allergy medications and other non-prescription medications used to treat an illness or injury.

  — Childbirth classes.

  — Cardiac rehabilitation classes.

- Prescription birth control devices.
- Routine hearing exams.
- Hearing aids and batteries
- Capital expenses to install special equipment or make home improvements, such as installing entrance and exit ramps, if the main purpose is a dependent's medical care.
- Transportation necessary for medical care.
- Expenses for alcohol and/or drug dependency treatment centers.
- Smoking cessation programs and prescription drugs used to treat nicotine withdrawal.
- 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. This does not include the purchase of related food items.
- Charges that you have to pay for eligible expenses because they exceed the amount the plan will pay.

- Charges for services and supplies not covered.

Expenses That Are Not Eligible

Here are examples of expenses that are **not** eligible for reimbursement under the Health Care Account:

- Cosmetics.
- Cosmetic surgery, unless it is for the treatment of a disfiguring illness or injury.
- Cosmetic dental procedures, such as bleaching.
- Dietary supplements.
- Premium payments for disability insurance, life insurance and group health coverage, including payments for Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage.
- Health care expenses that are reimbursable under any other health plan or insurance.
- Health club or gym fees.
- Living expenses.
- Long-term care.

- Over-the-counter vitamins (unless medically necessary).

- 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).

- The cost of household help, even if your doctor recommends you have help because you physically are unable to do housework.

- For each calendar year, expenses that are incurred before your participation in the Health Care account begins or after your participation ends.

- A former spouse's medical bills.

- Charges for illegal surgical procedures and drugs.

- Expenses incurred for individuals who are not eligible dependents under the Health Care Account.

Keep in mind that you can only be reimbursed for eligible expenses that were incurred while contributing to the Health Care Account.

For More Information

For a complete listing of eligible expenses, visit Your Spending Account Web site or call the Verizon Benefits Center.

Filing Your Claim for Reimbursement

You may be eligible for automatic reimbursement under the Health Care Account. Otherwise, as you incur eligible expenses, you can submit claims to Your Spending Account within the Verizon Benefits Center for reimbursement.

You have until May 31 of the next calendar year to submit claims for the current plan year's expenses – those incurred January 1, 2007 – March 15, 2008.

Automatic Reimbursement

Several Verizon health care plans automatically submit expenses that are not paid by the health care plan, to the Health Care Account for reimbursement to you. This feature eliminates the need for you to submit a claim to the Health Care Account.

You automatically are reimbursed for your eligible out-of-pocket healthcare expenses if you participate in one of these Verizon health care plans:

- A medical option administered by Aetna (not including HMOs).

- A medical option administered by United Healthcare.

- A dental option administered by MetLife.

- A dental option administered by Aetna.
- The prescription program administered by Medco.
- The vision plan administered by Davis Vision.

If you participate in a Verizon health care option that is not listed above, you must submit a claim to be reimbursed for your eligible out-of-pocket health care expenses.

Opting out of automatic reimbursement

You must opt out of automatic reimbursement and file a claim if you:

- Participate in one of the plans listed above **and** in another employer's health care plan.
- Prefer to submit claims yourself.

To opt out of automatic reimbursement, contact a Your Spending Account representative within the Verizon Benefits Center.

Claim Processing

You can be reimbursed for eligible health 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 visit a doctor on March 1, 2008 and submit a claim toward any balance remaining in your 2007 Health Care Account for the cost of that visit. Any money 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 Your Spending Account

You can begin the claim submission process online. To get started, log on to Your Spending Account via Your Benefits Resources Web site. You will be asked to enter relevant claim information and review your claim. Print a copy of the form, sign it and fax or mail it to Your Spending Account with the required documentation of your expenses (such as itemized receipts) for processing.

If you do not have Internet access, you can request a paper claim form from a Your Spending Account representative within the Verizon Benefits Center. After you complete and sign the claim form, include itemized receipts or other required documentation of your expenses, and fax or mail the claim form and supporting documentation to Your Spending Account for processing.

Fax your claim form to 1-866-209-5276 or mail it to:

Your Spending Account
P.O. Box 785094
Orlando, FL 32878-5094

Supporting documentation

You must provide proper supporting documentation so that your claim can be processed. This documentation includes itemized receipts or other documentation, such as an explanation of benefits (EOB) statement from your health plan.

Your claim will be processed as soon as administratively possible, and generally no later than 10 days after Your Spending Account receives your paperwork. For fastest processing, fax your signed and completed claim form and supporting documentation to Your Spending Account.

An itemized receipt must include the following:

- Date(s) of service.
- Name of service provider.
- Name of patient (not required for over-the-counter drugs).
- Description of service.
- Amount paid.

If the receipt is handwritten, it must include the service provider's signature. For prescription drugs, submit the receipt that the pharmacist has attached to the prescription, instead of the cash register receipt.

If you lose a receipt, contact your doctor or pharmacy to request a copy or call your health plan for an EOB. Visit Your Spending Account Web site for more documentation requirements.

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.

Coverage continuation rights under the Consolidated Omnibus Budget Reconciliation Act of 1985

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 Health Care Account.
- 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 (see your Important Benefits Contacts insert for contact information).

What COBRA continuation coverage is

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

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.

  — The parents become divorced.

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 60 days after the qualifying event occurs by calling 1-877-4VzBens. If you or the qualified beneficiary fails to notify the Verizon Benefits Center within 60 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 Health Care Account **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 your eligible dependents fail to elect COBRA coverage within the applicable timeframe, they will lose the opportunity to continue coverage under COBRA.

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 mail your enrollment form to make the initial payment. 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 change in status (see the "Status Changes" 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 calendar 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 Web site at www.dol.gov/ebsa.

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

Important Note

If you have questions about COBRA or wish to enroll, contact the Verizon Benefits Center or access Your Benefits Resources Web site.

You can also call your COBRA administrator via the Verizon Benefits Center or via the telephone number shown on your Important Benefits Contacts insert.

Dependent Care Account

Eligibility

You are eligible to participate in the Dependent Care Account if you meet the following requirements:

- Are employed by a Verizon participating company (see the "Additional Information" section for details).
- Are a regular or term full-time or part-time Mid-Atlantic associate or a Connected Solutions Inc. technician. Occasional and temporary associates are not eligible.

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 (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 employee and is expressly ineligible for benefits under the Plan.

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. An eligible dependent under the Dependent Care Account 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 dependent day care account 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.

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.

Enrolling in the Dependent Care Account
Initial Enrollment by Newly Hired Associates
If you are a new associate, you can begin making contributions immediately. You automatically will receive enrollment information. You must call the Verizon Benefits 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 benefits renewal period, unless you have a status change during the year (see “Changing Your Elections”).

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.

If You Are Rehired
If you leave the Company and are rehired by the Company, you will make new elections for the accounts.

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.

Changing Your Elections

After your initial enrollment opportunity, you will make a decision each year during the benefits renewal period about whether you want to participate the following calendar year. Elections made during the benefits renewal period take effect on the following January 1 and remain in effect through December 31 of that year, unless you change the election during the year due to a change in status.

If you do not make changes, your current elections remain in effect for the next calendar year.

Status Changes

Between benefits renewal 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 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 Dependent Care Account. To make a change, you must notify the Verizon Benefits 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 Verizon Benefits 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 benefits renewal 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 Verizon Benefits 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 Verizon Benefits Center and speak with a representative for more information.

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 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 Verizon Benefits Center for details.

When Participation Ends
Your participation ends on the earliest date described below.

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 Verizon or an affiliate of Verizon. However, your contributions, account and claims activity will be transferred to the new 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 Verizon 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 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. 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 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 the "Contribution Limits" section for details)
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, visit Your Spending Account Web site	• 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 benefits renewal period, you decide if you want to participate and elect the amount you want to contribute by 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 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 "Eligible Dependent Care Expenses" 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 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. 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:** Under IRS rules, you forfeit any money left in your account at the end of the year. However, you have until May 31 of the following year to submit requests for reimbursement of eligible expenses you incurred for the current plan year's expenses – those incurred January 1, 2007 – March 15, 2008.

Example of Tax Savings

The chart below shows how an employee earning $50,000 annually saves $226 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 2006 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	- 6,314	- 6,540
Expenses Paid Without Account	- 0	- 1,000
Income Remaining	$ 42,686	$ 42,460
Tax Savings	**$ 226**	

In this example, the employee reduces his or her taxes by **$226** 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 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.

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 Dependent Care Account when you calculate the dependent care tax credit on your federal income tax return. This means that your annual contribution to your Dependent Care Account must be subtracted from your total dependent care expenses before you can calculate the tax credit.

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

- 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 ($97,500 in 2007) and contribute to the Dependent Care Account, your future Social Security benefits may be slightly reduced. 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

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.
- 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).

For a complete listing of eligible dependent care expenses, visit Your Spending Account Web site.

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

- Before- and after-school care (if not included with tuition).
- Day care centers (including adult day care facilities).
- In-home day care providers.
- Wages or salary paid to a care provider, such as a neighbor or a home health aide, whether inside or outside your home – so you can work.
- Nursery schools.
- Social security (FICA) and other wage taxes you pay on behalf of a care/service provider.
- Expenses for certain household services, such as a housekeeper, maid or cook, provided those services are related to the care of an eligible dependent.
- Occasional baby-sitter – evenings and overnight – to allow you to work late or travel for work.

Expenses That Are Not Eligible

Here are examples of expenses that are **not** eligible for reimbursement under the dependent day care account:

- Education.
- Entertainment.
- Expenses reimbursable under any other plan or program.
- Food and clothing.
- Full-time nursing home care.
- Health care expenses.
- Overnight camp.
- Payments to a housekeeper while at home from work due to illness.
- Transportation.
- Costs for dependent care when you – or your spouse – is not working.
- Payments to an individual you claim or who could be claimed as a dependent on your (or your spouse's) tax return.
- Payments to your child who is under age 19.
- For each calendar year, expenses incurred before your participation in the dependent day care account begins or after your participation ends.
- Charges for services of a care provider who has no social security or taxpayer identification number, excluding churches and other tax-exempt organizations.
- Expenses incurred for an individual you cannot claim as a dependent for income tax purposes. An exception may apply if you are divorced or separated.

Filing Your Claim for Reimbursement

You may be eligible for advance reimbursement under the Dependent Care Account. Otherwise, as you incur eligible expenses, you can submit claims to Your Spending Account within the Verizon Benefits Center for reimbursement.

You have until May 31 of the next calendar year to submit claims for the current plan year's expenses – those incurred January 1, 2007 – March 15, 2008.

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 change in status.

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

An example…	
Dependent Care Account 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

You can be reimbursed for eligible 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, 2008 and submit a claim toward any balance remaining in your 2007 Dependent Care Account for the cost of the care. Any money not used by March 15 and submitted by May 31 will be forfeited.

Submitting Claims to Your Spending Account

You can begin the claim submission process online. To get started, log on to Your Spending Account via Your Benefits Resources Web site. You will be asked to enter relevant claim information and review your claim. Print a copy of the form, sign it and fax or mail it to Your Spending Account with the required documentation of your expenses (such as itemized receipts) for processing.

If you do not have Internet access, you can request a paper claim form from a Your Spending Account representative within the Verizon Benefits Center. After you complete and sign the claim form, include itemized receipts or other required documentation of your expenses, and fax or mail the claim form and supporting documentation to Your Spending Account for processing.

Fax your claim form to 1-866-209-5276 or mail it to:

Your Spending Account
P.O. Box 785094
Orlando, FL 32878-5094

Supporting documentation

You must provide proper supporting documentation so that your claim can be processed. This documentation includes itemized receipts or other documentation.

Your claim will be processed as soon as administratively possible, and generally no later than 10 days after Your Spending Account receives your paperwork. For fastest processing, fax your signed and completed claim form and supporting documentation to Your Spending Account.

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

- Dates of service.
- Name of service provider.
- Name of dependent receiving services.
- Amount paid.

Or, you can have the provider sign your completed claim form as verification of the expense.

Annual Dependent Care Claims

The annual claim process is available under the Dependent Care Account. You can submit one claim for the entire year (for example, dates of service January 1, 2007 – March 15, 2008) and be reimbursed as contributions accrue. Documentation provided with an annual claim must include the following:

- A statement from the care provider or service indicating the daily, weekly or monthly fee, and the annual total (individual totals for multiple dependents).
- Indication on the claim form of the date range (for example, January 1 through December 31), name of dependents for whom the services apply and the total amount being claimed.

If you choose to submit an annual claim, you are responsible for notifying Your Spending Account if your expenses for the care change.

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.

Additional Information

Forfeitures

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, 2008 and submit a claim toward any balance remaining in your 2007 dependent day care account for the cost of the care. Any money not used by March 15 and submitted by May 31 will be forfeited.

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). 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.
- 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.

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) and the Verizon Claims Review Committee (VCRC), and to the individuals who chair each of these committees. At the time of publication of this summary plan description (SPD), there are two claims and appeals administrators for the Plan.

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

Claims Regarding Eligibility to Participate in the Plan

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

Your Spending Account 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 under "Claims and Appeals Administrators" in the "Administrative Information" section. If you have a claim or appeal, you should contact the appropriate claims and appeals administrator for the type of claim or appeal you have.

The claims and appeals administrators have discretionary authority to:

- Interpret the 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.

If a Claim Is Denied

Disagreements about benefit eligibility or benefit amounts can arise. If the Verizon Benefits Center is unable to resolve the disagreement, Verizon has formal appeal procedures in place for Employee Retirement Income Security Act of 1974 (ERISA)-covered plans, including the Health Care Account. While these procedures legally do not apply to the Dependent Care Account, the YSA Benefits Determination Review Team also will review dependent care claims as outlined by this section.

This section explains the steps you or your authorized representative is 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 Health Care Account or to change the amount of your before-tax contributions. 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 Health Care Account. It typically will include your initial request for benefits.

The process is described in the following chart.

	***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 1-877-4VzBens. You (or your authorized representative) must return the form to the Verizon Claims Review Unit at the address on the form. You must include: • A description of the request. • The reason for the request. • Relevant documentation.	Your initial request for benefits is a "claim" for benefits under ERISA. So, the procedure outlined in the "Filing a claim" section is the first step in the ERISA claims process for a benefit claim.
When you will be notified of the claims 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 receive an Explanation of Benefits (EOB) within 30 days of YSA'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. You will have 45 days to provide the additional information. Otherwise, the claim will be decided based on information originally provided. 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 fail to provide sufficient information, the claim may be decided based on the information provided. However, YSA may notify you within 30 days that additional information is needed. You will have 45 days to provide the additional information. Otherwise, the claim will be decided based on information originally provided. If you provide additional information, you will be notified of the decision by YSA 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. If your claim is **denied**, in whole or in part, your written denial notice will contain: • The specific reason(s) for the denial. • The plan provisions on which the denial was based. • Any additional material or information you may need to submit to complete the claim. • The plan's appeal procedures.	YSA will notify you in writing by providing you with an EOB. If your claim is **denied**, in whole or in part, your EOB will contain: • The specific reason(s) for the denial. • The plan provisions on which the denial was based. • Any additional material or information you may need to submit to complete the claim. • The plan's appeal procedures.

	***Eligibility* claims procedure**	***Benefit* claims procedure**
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 YSA Benefits Determination Review Team, also known as the claims administrator. The Claims Review Committee has delegated its authority to finally determine claims to the YSA Benefits Determination Review Team. As such, the YSA Benefits Determination Review Team 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 YSA Benefits Determination Review Team are final and binding on all parties.
How to file an appeal	If your claim is denied and you want to appeal it, you must file your appeal within 180 days from the date you receive notice of your denied claim. You may request access to all documents relating to your appeal. To file an appeal, you must write to: Verizon Claims Review Committee c/o Verizon Claims Review Unit P.O. Box 1438 Lincolnshire, IL 60069-1438 You should include: • A copy of your claim denial notice. • The reason(s) for the appeal. • Relevant documentation. The individual/committee (and any medical expert) reviewing your appeal will be independent from the individual/committee who reviewed your claim. In addition, if your appeal involves a medical judgment, the Claims Review Committee will consult with a healthcare professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request.	If your claim is denied 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 access to all documents relating to your appeal. To file an appeal, you must contact YSA and request an appeal form. Your completed form should be sent to: Your Spending Account Benefit Determination Review Team P.O. Box 1444 Lincolnshire, IL 60069-1444 You should include: • A copy of your EOB. • The reason(s) for the appeal. • Relevant documentation. The individual/committee (and any medical expert) reviewing your appeal will be independent from the individual/committee who reviewed your claim. In addition, if your appeal involves a medical judgment, the YSA Benefit Determination Review Team will consult with a healthcare professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request.

	***Eligibility* claims procedure**	***Benefit* claims procedure**
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 YSA Benefit Determination Review Team'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. If your appeal is denied, in whole or in part, your denial notice will contain: • The specific reason(s) for the denial. • A statement regarding the documents to which you are entitled. • Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request). • The plan provisions on which the denial was based. • 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."	Regardless of whether your appeal is approved or denied, the YSA Benefit Determination Review Team will notify you in writing. If your appeal is denied, in whole or in part, your denial notice will contain: • The specific reason(s) for the denial. • A statement regarding the documents to which you are entitled. • Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request). • The plan provisions on which the denial was based. • 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 YSA Benefit Determination Review Team, 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 summary plan description (SPD). The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish 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 summary plan description and the documents governing the Plan on your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

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

- The information is created or received by a healthcare 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 healthcare to you.

— Your past, present or future physical or mental condition.

— The past, present or future payment for your healthcare.

The Notice of Privacy Practices for the Verizon health plans contains a complete explanation of your rights under the HIPAA Privacy Rule. The notice describes how Protected Health Information may be used and disclosed, and how you can get access to that information. The following is a summary of those uses and disclosures of Protected Health Information and your rights with respect to Protected Health Information:

- The Verizon health plans may use or disclose your Protected Health Information for purposes of conducting healthcare operations or paying your healthcare claims.

- The Verizon health plans may use or disclose your Protected Health Information to tell you about treatment alternatives, or to provide you with information about other health-related benefits or services that may be of interest to you.

- The Verizon health plans may disclose your Protected Health Information to Verizon, as sponsor of the Verizon health plans, to assist Verizon in the performance of plan administrative functions. The Verizon health plans also may provide summary health information to Verizon, as plan sponsor, so that Verizon may obtain premium bids or modify, amend or terminate the Verizon health plans. Summary health information does not directly identify you, but summarizes claims history, claims expenses or types of claims experienced. Finally, the Verizon health plans may disclose your enrollment and disenrollment information to Verizon as plan sponsor.

- The Verizon health plans may disclose your Protected Health Information when required to do so by any federal, state or local law, and when permitted to do so under the circumstances set out in the Verizon Notice of Privacy Practices.

- 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.

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

- Other than as permitted or required by law, the Verizon health plans will not use or disclose your Protected Health Information without your written authorization. If you authorize a Verizon health plan to use or disclose your Protected Health Information, you may revoke that authorization in writing at any time. If you revoke the authorization, the Verizon health plan no longer will 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 already has made prior to the date the Verizon health plan receives notice of the revocation.

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

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

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

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

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

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

- You have a right to request and receive a paper copy of the Notice of Privacy Practices for the Verizon health plans, even if you have received this notice previously or agreed to receive this notice electronically.

For more information regarding these rights and the privacy policies of the Verizon health plans, please review the Notice of Privacy Practices for the Verizon health plans. The Notice of Privacy Practices for the Verizon health plans is available on Your Benefits Resources Web site at www.verizon.com/benefits. Select “View or Print HIPAA Privacy Notice” in the “Learn More” section on the Benefits Overview page of the Benefits Manual. You may view the notice on the Web site and/or print a paper copy from the Web site.

You also may request a paper copy of the notice by calling the Verizon Benefits Center at 1-877-4VzBens. Have your User ID and Benefits Center password available. Listen to the main menu to make your selection and then follow the prompts to reach a representative. Benefits Center representatives are available from 8:00 a.m. until 6:00 p.m., Eastern time, Monday through Friday.

Administrative Information

Administrative information about the Plan is provided in this section.

Important Telephone Numbers

You can connect to the Verizon Benefits Center and other Verizon benefit providers by calling 1-877-4VzBens. If you prefer, you can call the benefit providers directly via the telephone numbers shown on your Important Benefits Contacts insert.

Plan Sponsor/Employer

The Plan sponsor/employer is:

Verizon Communications Inc.
One Verizon Way
Basking Ridge, NJ 07920

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 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 under “Claims Regarding Scope/Amount of Benefits Under the Plan” 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 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

Your Spending Account is the benefits administrator for the Plan. As the benefits administrator, Your Spending Account has the authority and responsibility to perform daily administration of benefits under the Plan. (See 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. The claims administrators have the authority to make final determinations regarding claims for benefits.

Verizon Claims Review Committee (VCRC)

The VCRC is responsible for enrollment and eligibility claims. The VCRC can be reached at the following address:

Verizon Claims Review Committee
c/o Verizon Benefits Center
100 Half Day Road
P.O. Box 1438
Lincolnshire, IL 60069-1438

See your Important Benefits Contacts insert for the telephone number.

Your Spending Account

Your Spending Account 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. Your Spending Account can be reached at the following address:

Your Spending Account
P.O. Box 785094
Orlando, FL 32878-5094

See your Important Benefits Contacts insert for the telephone number.

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's Benefits Center
100 Half Day Road
P.O. Box 1457
Lincolnshire, IL 60069-1457

You also can call the Verizon Benefits Center at 1-877-4VzBens.

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 Verizon Plan 552, the Verizon Health Care Account and Dependent Care Account for Mid-Atlantic 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 552.

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 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, 2007. The list may change from time to time.

- Verizon Advanced Data Inc.
- Verizon Connected Solutions Inc.
- Verizon Delaware Inc.
- Verizon Maryland Inc.
- Verizon New Jersey Inc.
- Verizon Pennsylvania Inc.
- Verizon Services Corp.
- Verizon Virginia Inc.

- Verizon Washington D.C. Inc.
- Verizon West Virginia Inc.
- Verizon Avenue, Inc.
- Verizon Corporate Services Corp.

Glossary

B

Before-Tax Contributions

For purposes of the Plan, 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 for Plan participation because of certain qualifying events.

E

Eligible Expenses

Expenses that qualify for reimbursement under the Plan.

F

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, 2008 and submit a claim toward any balance remaining in your 2007 dependent day care account for the cost of the care. Any money not used by March 15 and submitted by May 31 will be forfeited.

I

Ineligible Expenses

Expenses that are not eligible for reimbursement under the Plan.

S

Spouse

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

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

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.

Term Associate

A term associate is an associate whose employment is intended to last more than six months and not more than 30 months. A term associate's employment ends upon completion of the specific project for which he or she is hired.