Contents

Your Vision Benefits

The Vision Care Plan (the Plan) is designed to provide you and your family with comprehensive vision care coverage. The Plan includes:

- Coverage that encourages regular exams and helps pay for vision care services and supplies when needed.
- Freedom to use any licensed vision care provider you choose for the Plan. Under the Video Display Terminal (VDT) User Eye Care Program, you must use an in-network vision care provider to receive benefits.
- The opportunity to reduce your share of expenses by using in-network vision care providers.
- Automatic participation for you in the VDT User Eye Care Program if you use a VDT as part of your normal work activities.

About This SPD

This book is the summary plan description (SPD) for the Verizon Vision Care Plan for New York and New England Associates, including the VDT User Eye Care Program. The Plan is subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. This book meets ERISA's requirements for an SPD and is based on Plan provisions effective January 1, 2001. It updates and replaces all previous SPDs and other descriptions of the benefits provided by the Plan. This SPD is part of this Plan.

Important Note

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

This SPD is divided into the following major sections:

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

- **Your Coverage.** This section describes the vision coverage available to you. Refer to it when you need information about your coverage and benefits.

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

- **What Is Not Covered.** This section lists services and supplies not covered under the Plan.

- **How to File a Claim.** This section provides information on when you need to file a claim to receive benefits.

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

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

Getting More Information

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

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

- **For specific details about coverage provisions,** call Davis Vision, Inc.'s Member Services directly (see your Important Benefits Contacts insert for the telephone number).

Every effort has been made to ensure the accuracy of the information included in this SPD, which constitutes part of the Plan document, as restated effective January 1, 2001. Copies of Plan documents are available by contacting the Plan administrator in writing at the address provided on page 38 in the "Additional Information" section.

Changes to the Plan

While the Company expects to continue the Plan indefinitely, the Verizon Employee Benefits Committee (VEBC), formerly named the Bell Atlantic Corporate Employees' Benefits Committee, also reserves the right to amend, modify, suspend or terminate the Plan at any time, at its discretion, with or without advance notice to participants, subject to any duty to bargain collectively. The Plan may be amended by publication of any SPD, summary of material modification, enrollment materials or other communication relating to the Plan, as approved by the chairperson of the VEBC or an individual in a Director level position or above in the employee benefit design or delivery or the communications branch of the Company's Human Resources organization. The Company also reserves the right to change the amount of required participant contributions for coverage under the Plan at any time, with or without advance notice to participants, subject to any duty to bargain collectively.

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

Participating in the Plan

Eligibility

You are eligible for Plan coverage after you have completed three months of net credited service if you are employed by a Verizon participating company (see page 43) and are a regular full-time, part-time or eligible temporary New York or New England associate. A full-time associate includes an employee who is regularly scheduled to work 25 or more hours per week, as well as a job-sharing employee who is regularly scheduled to work at least 40 percent of a regular full-time employee's hours.

"Service" is based on net credited service provisions of the Verizon Pension Plan for New York and New England Associates.

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

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

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

VDT User Eye Care Program

You immediately are eligible to participate in the Video Display Terminal (VDT) User Eye Care Program if you use a VDT as part of your normal work activities.

Note: There is no dependent coverage under this program.

Eligible Dependents

Dependents must be enrolled through the InTouch Center to have coverage. You can enroll only your eligible Class I Dependents who meet the Plan definition for eligibility, as described below.

Dependent Eligibility Requirements		
Dependent Class	**Who They Are**	**Relationship**
Class I Dependents	• Your legal spouse whether or not separated	• Spouse
	• Your unmarried children until the end of the calendar year in which they reach age 19, provided they receive more than 50% of their support from you. Children means children by birth, as well as legally adopted children or children placed for adoption, stepchildren who live in your home and children who live in your home and for whom you or your spouse is the legal guardian	• Child
	• Your unmarried children (as defined above) from age 19 through the end of the calendar year in which they reach age 25 and are full-time students at an accredited educational institution, provided they receive more than 50% of their support from you, until the end of the month they no longer qualify as full-time students or, if earlier, the end of the calendar year in which they reach age 25	• Full-Time Student
	• Your unmarried children (as defined above) of any age who are dependent on you for support due to physical or mental disability if the disability began before age 19 or age 25 while a full-time student and they were covered continuously	• Disabled Child
	• Your same-sex domestic partner and his or her children may be eligible for coverage. For more information on eligibility requirements and tax implications, call the InTouch Center and speak with a representative	• Domestic Partner • Domestic Partner's Child
	• Your unmarried children (as defined above and including any age requirements) who are alternate recipients under an approved qualified medical child support order (QMCSO)	• Child

Note: Class II Dependents and Sponsored Children are not eligible for coverage under the Plan.

Qualified Medical Child Support Order

If you are required to provide vision coverage to a child pursuant to a court- or state agency-issued qualified medical child support order (QMCSO), the Plan will allow you to cover that child in accordance with procedures established by the Plan administrator. For a copy of the procedures, contact the Qualified Order Team at the telephone number listed on your Important Benefits Contacts insert.

If Your Spouse or Same-Sex Domestic Partner Is a Verizon Employee

For vision coverage, if your spouse or same-sex domestic partner is employed by Verizon or affiliates, the following rules apply:

- Children can be covered by one Verizon parent or the other, but not by both.
- You can be covered as an employee or as a dependent under a Verizon-sponsored Vision Plan, but not as both. To be covered as a dependent under another plan, you must be eligible to and must waive coverage under this Plan.
- Your spouse or same-sex domestic partner can be covered as an employee or as a dependent under a Verizon-sponsored Vision Plan, but not as both. To be covered as your dependent under this Plan, your spouse or same-sex domestic partner must be eligible to and must waive coverage under his or her plan. If he or she is not eligible to waive coverage under his or her plan, your spouse or same-sex domestic partner cannot be covered under your Plan.

How Do I Enroll or Make Changes?

Call the InTouch Center at the telephone number listed on your Important Benefits Contacts insert. The voice response system is available 24 hours a day, seven days a week. InTouch Representatives are available to help you from 8:00 a.m. to 5:00 p.m. Eastern time, Monday through Friday (excluding holidays).

Enrolling for Coverage

Initial Enrollment by Newly Hired Associates

The following enrollment rules apply based on your work schedule:

- If you are a full-time associate or a part-time associate who is scheduled to work less than 25 hours a week who has been employed continuously by the Company since December 31, 1980, you automatically are enrolled for vision coverage when you become eligible. Your coverage begins on the first day of the month in which you attain three months of net credited service.
- If you are a part-time associate scheduled to work less than 25 hours a week and have not been employed continuously by the Company since December 31, 1980 and you want vision coverage, you must enroll for it through the InTouch Center after you complete three months of net credited service and agree to pay the required cost by payroll deduction; otherwise, you will not have coverage. If you enroll before the deadline shown on your Enrollment Worksheet, your coverage takes effect on the first day of the month in which you attain three months of net credited service. For example, if your hire date is June 20, your coverage is effective September 1. Otherwise, your coverage begins the first day of the month after you call the InTouch Center and enroll.

Enrollment Worksheet

Before your three-month enrollment date or if you change from a management position to an associate position, the InTouch Center will send you an Enrollment Worksheet with your vision coverage options listed.

- If you are changing from a management position to a full-time associate position, your coverage automatically begins the first day of the month following the date your payroll changes for the change in position. If you are changing to a part-time associate position for which you're scheduled to work less than 25 hours a week, you must enroll for coverage (as described on page 8).

Regardless of your employment status, you must call the InTouch Center to enroll any Class I Dependent you want included under your coverage. You can choose coverage for yourself plus one dependent or for yourself plus two or more dependents. You will need to provide each dependent's name, date of birth and Social Security number. If you enroll eligible dependents before the deadline shown on your Enrollment Worksheet, their coverage begins on the same date as your coverage. Otherwise, coverage begins the first day of the month after you call the InTouch Center and enroll them.

Changing Your Elections

Open Enrollment

Each year during the open enrollment period:

- If you are an eligible full-time associate or an eligible part-time associate scheduled to work less than 25 hours a week who has been employed continuously by the Company since December 31, 1980, you will have an opportunity to change your covered dependents.

- If you are an eligible part-time associate scheduled to work less than 25 hours a week who has not been employed continuously by the Company since December 31, 1980, you may start or waive vision coverage for you and your dependents, as well as change your covered dependents.

Elections made during the open enrollment period take effect on the following January 1 and remain in effect through December 31 of that year, unless you change the election during the year due to a change in status.

Status Changes

Between open enrollment periods, you may be able to change your covered dependents if you or a dependent has a change in status that affects eligibility for coverage; and if you're a part-time associate scheduled to work less than 25 hours a week who has not been employed continuously since December 31, 1980, you may be able to start or waive vision coverage for you and your dependents. An election change can be made due to a change in status if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan. Elections made due to status changes remain in effect until you make a change during an open enrollment period or due to another status change.

You Gain a New Dependent

If you gain a new, eligible dependent through marriage, acquisition of a domestic partner, birth, adoption or placement for adoption, you can enroll that dependent in the Plan by calling the InTouch Center. Your election will take effect:

- On the date that you gained the new dependent, if you make your election within 90 days of gaining the new dependent.

- On the first day of the month following your election, if you make your election more than 90 days after the event.

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

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

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

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

If you lose a dependent through legal separation, coverage for your spouse continues, unless you call the InTouch Center to remove him or her from your coverage.

A Dependent Loses Eligibility

If a dependent loses eligibility for the Plan, the dependent's coverage will continue until the end of the month in which the event occurs that causes the dependent to lose eligibility. An exception occurs if the dependent is a child who loses eligibility because he or she reaches an age limit for coverage. In this case, the child's coverage will continue until December 31 of the year in which the age limit is reached. However, if a child reaches the age 25 limit and is a full-time student who graduates prior to December 31 of his or her 25th year or no longer maintains his or her full-time student status, his or her coverage will terminate on the last day of the month in which he or she loses full-time student status.

When a dependent loses eligibility, you must notify the Company by calling the InTouch Center before the dependent's coverage ends. Even if you do not notify the Company, you are responsible for any claims and expenses incurred after the date the coverage should have ended.

Change of Union Affiliation

If you change jobs and it results in a change of union affiliation, your vision coverage automatically will change to the coverage provided under your new union's collective bargaining agreement.

Special Enrollment Rules

If you are a part-time associate who waived vision coverage for yourself and/or you are a part-time or full-time associate who did not cover your spouse or same-sex domestic partner and eligible dependents because of other vision insurance coverage, you may be able to enroll yourself or your dependents in the Plan if you later lose that other insurance due to:

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

If you enroll yourself or your dependents in the Plan:

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

In addition, if you gain a new dependent as a result of marriage, birth, adoption, placement for adoption or acquisition of a same-sex domestic partner and his or her children, you may be able to enroll yourself if you are a part-time associate; if you are a full-time or part-time associate, you may be able to enroll your dependents. If you enroll:

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

Cost of Coverage

The Company pays the full cost of vision coverage for you and your enrolled Class I Dependents if you have at least three months of net credited service and are as follows:

- A full-time associate working at least 25 hours a week
- A part-time associate hired before January 1, 1981 and continuously employed by the Company since that date.

If you have not been employed continuously by the Company since December 31, 1980 and you work at least 17 but less than 25 hours a week, the Company contributes 50 percent of the amount it contributes for full-time employees. In order to have coverage, you must enroll and agree to pay the other 50 percent of the cost by payroll deduction.

If you have not been employed continuously by the Company since December 31, 1980 and you work less than 17 hours a week, you can enroll for coverage if you call the InTouch Center and agree to pay the full cost.

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

VDT User Eye Care Program

If you are eligible for the VDT User Eye Care Program, the Company pays the full cost of your program coverage if you use a VDT terminal; there is no cost to you.

When Participation Ends

This section explains when participation in the Plan ends for you and your dependents.

Associate Coverage

An associate's coverage will end on the earliest date described below.

Leaves of Absence

In general, if you go on a leave of absence, your coverage continues in accordance with Company guidelines.

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

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

- **Anticipated Disability Leaves of Absence, Care for Newborn Children Leaves of Absence, Enhanced Educational Leaves of Absence, Family Care Leaves of Absence and Union Leaves of Absence (Maximum Benefit Period Leave of Absence for New England associates only).** Under these leaves, Verizon will pay the amount it normally does for your coverage. If you contribute to the cost of your vision coverage, however, you must continue making contributions during your leave. The Company will bill you monthly for these charges.

- **Education Leaves of Absence or Personal Leaves of Absence.** Under an Education Leave of Absence or a Personal Leave of Absence, coverage for you and your eligible dependents will end on the last day of the month in which your leave begins.

Change in Employment Status

If your employment status changes from associate to management status, coverage under the Plan will end on the last day of the month in which you become a manager of the Company or an affiliate of the Company.

VDT User Eye Care Program

In addition to the rules listed under "When Participation Ends," the following rules apply to when your VDT User Eye Care Program coverage ends:

- Coverage under the program will end when you no longer use a VDT as part of your normal work activities.
- You no longer can use the VDT benefit when you are on a leave of absence (including an FMLA Leave of Absence). VDT benefit coverage automatically will resume when you return to work from your leave of absence.

Long-Term Disability
If you are receiving long-term disability benefits, coverage under the Plan will end on the last day of the month in which your employment ends due to long-term disability.

Cancellation of Coverage
If you are a part-time associate enrolled for vision coverage and you cancel coverage due to a change in status, your coverage will end on the last day of the month in which you elect to cancel coverage.

Failure to Submit Payment (If Required)
If you are a part-time associate enrolled for vision coverage and you are required to make a payment and it is not received on time, your coverage will end on the first day of the month for which payment is not received.

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

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

Dependent Coverage
A dependent's coverage will end on the earliest date described in the following section.

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

Associate Dies
When the associate dies, coverage for all dependents will end on the last day of the month in which the associate dies.

Dependent Ceases to Meet the Class I Eligibility Requirements

A dependent's coverage will end on the earlier of either the date the dependent is covered as an employee under any Company-sponsored Vision Plan or the last day of the month in which the dependent no longer qualifies as a dependent under the Plan, subject to the following:

- Coverage for your spouse ends on the day he or she becomes divorced from you. Coverage for a legally separated spouse will end on the day you elect coverage to end.
- Coverage for a same-sex domestic partner ends on the day he or she fails to meet the definition of a same-sex domestic partner.
- Coverage for a child ends on the last day of the calendar year in which he or she reaches age 19 (if not a full-time student), or the last day of the month in which the child is married, if earlier.
- Coverage for a stepchild ends on the last day of the month in which he or she no longer lives with you.
- Coverage for a full-time student ends on the earlier of the last day of the calendar year in which the student reaches age 25 or the last day of the month in which he or she no longer qualifies as a full-time student.
- Coverage for a disabled child ends on the last day of the month in which he or she no longer meets the definition of a disabled child.
- Coverage for a child under a QMCSO ends on the date the associate no longer is required to provide coverage for this child or, if earlier, the date the child no longer would be eligible for coverage, as defined on page 7.
- Coverage for a child of a same-sex domestic partner ends on the last day of the calendar Plan year in which the child reaches age 19 or age 25 (if a full-time student), as applicable, or the last day of the month in which the child otherwise fails to meet the definition of a child of a partner (or the partner no longer meets the definition of a same-sex domestic partner), as defined on page 7.

Notify the InTouch Center If a Dependent Is Ineligible

It is your responsibility to notify the InTouch Center if your dependents no longer meet eligibility requirements.

Periodically, you may be asked to provide proof of your dependents' eligibility. If such proof is not provided, those dependents will lose their eligibility for the Plan, effective retroactively as of the date determined by the Plan administrator.

Any claims incurred by an ineligible dependent become your financial responsibility. Your dependent also may lose the right to purchase continued vision care benefits under COBRA if you do not notify the InTouch Center within 60 days of a dependent losing eligibility. Call the InTouch Center for details.

Certificate of Coverage

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

Continuation of Coverage Under COBRA

In some instances, a person whose eligibility for coverage under this Plan ends still may be able to continue coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments. Continuation of coverage under COBRA is described on pages 22 through 26 of this summary plan description (SPD).

Your Coverage

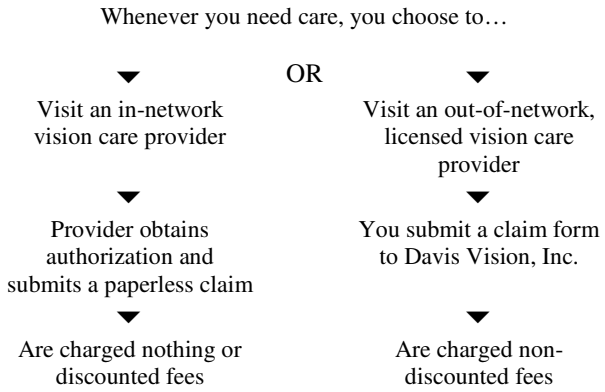
The Plan provides comprehensive coverage to meet your vision care needs. The Plan includes a network of vision care providers who have agreed to charge discounted fees for their services.

The Video Display Terminal (VDT) User Eye Care Program covers certain expenses at 100 percent when you use an in-network provider who participates in the VDT User Eye Care Program. There is no coverage if services are received from an out-of-network provider.

Vision Care Plan

When you need care, you can visit any vision care provider. The same expenses are covered whether or not you use an in-network provider. However, when you use a vision care provider in the network, exams are covered in full and your out-of-pocket expenses either for glasses or contacts generally will be lower. If you receive covered services outside the network, you will be charged non-discounted fees, which means your share of expenses after the Plan pays a benefit could be higher.

The chart below illustrates your choices under the Plan.



A list of in-network vision care providers can be obtained by calling your claims administrator at the telephone number listed on your Important Benefits Contacts insert. The claims administrator also has an Internet site where you can get information about in-network vision care providers online.

How Benefits Are Determined

Covered services and supplies are available once every 24 months from **either** an in-network provider **or** an out-of-network provider. The 24-month period begins on the date of your vision exam **or** the date lenses and frames or contact lenses are ordered, as applicable. You will receive coverage up to the maximum benefit for the same expenses regardless of the vision care provider you use. However, your share of expenses generally will be less when you use in-network providers because you will be charged discounted fees. These fees are negotiated by the administrator and usually are less than fees charged by out-of-network providers.

- If you receive covered services from an in-network provider, your exam will be covered in full and one pair of glasses or contact lenses also will be covered in full subject to the limitations outlined in the chart on page 19. In addition, you can choose scratch-resistant coating, anti-reflective coating, color coating, mirror and ski-type coating, solid tints or plastic gradient dye with applicable member copayments.

- If you receive covered services from an out-of-network provider, you pay the charges when you receive the service or supply. You then must obtain a claim form from Davis Vision, Inc. and file the claim form for reimbursement up to the maximum benefit amount. Your reimbursement will not exceed the actual charges. You are responsible for the portion of any charges above the maximum benefit amount.

Plan Benefits

For you and each of your enrolled dependents, the following benefits are payable once every 24 months:

What Is Covered	Maximum Benefit Paid	
	In-Network	Out-of-Network
Vision examination	Covered in full	$25
Pair of prescription contact lenses[1] ***or*** Pair of prescription eyeglasses (lenses and frames)[1]	Covered up to $85	$85
• Single vision lenses	Covered in full	$30
• Bifocal lenses	Covered in full	$40
• Trifocal lenses	Covered in full	$50
• Lenticular lenses for those who have had cataracts removed surgically	Covered in full	$90
• Eyeglass frames	"Tower Collection" Fashion level frames covered in full; fixed copayment for Designer or Premier level; $30 retail allowance toward non-Collection frames	$30

[1]Benefits are limited to either one pair of prescription contacts or disposable contacts up to $85 ***or*** one pair of prescription lenses with frames.

In-network providers also have agreed to provide the following vision supplies:

- **Lenses:** Clear glass or plastic lenses will be provided at no charge to you up to the maximum benefit. However, if you need or desire photo-sensitive, anti-reflective or blended bifocal lenses, you will have to pay the additional charge.

- **Contact lenses:** Hard or soft contact lenses instead of eyeglass lenses will be provided at no charge to you up to the maximum benefit. However, if you need or desire extended-wear, toric, bifocal, aphakic or gas-permeable contact lenses, you will have to pay the additional charge. Also, if there is a separate charge for kits or for follow-up visits, you will be responsible for those charges.

- **Frames:** You choose eyeglass frames from the Davis Vision, Inc. "Tower Collection" of frames. Fashion level frames are available at no cost to you; Designer and Premier level frames are available for a fixed copayment. If you prefer, you instead can choose to take a $30 retail allowance and apply it to the cost of any other non-Davis Vision "Tower Collection" eyeglass frame from the in-network provider's private selection.

Below you will find lens and frame enhancements available to associates and their dependents. These examples are not guaranteed and are subject to change.

Examples include:

- Fashion/gradient tinting
- Polycarbonate lenses for eligible individuals and their dependents
- Unconditional one-year warranty against breakage on Plan eyeglasses
- Free membership to Lens 123
- Oversized lenses.

VDT User Eye Care Program

The VDT User Eye Care Program pays the full cost of a VDT vision examination and one pair of prescription eyeglasses when they are prescribed by an in-network provider for occupational use.

If eyeglasses are prescribed for occupational use, you can select your frames from among a group that has been established for Company employees. If you choose a frame that is not included in that group, you will be required to pay the additional cost. Single, bifocal, trifocal or lenticular lenses are provided at no cost to you. You are responsible for the cost of any non-covered options.

After your initial exam, you are entitled to the following benefits every 12 months:

- VDT vision examination by an in-network provider
- A pair of prescription eyeglasses if determined to be necessary by your in-network provider and your VDT vision exam.

All services must be received from an in-network provider and can be provided at the same time as your routine eye exam.

Associates may return broken eyewear to the original provider in order to be repaired or replaced within one year of dispensing the order. Additional eye exams related to replacement eyeglasses are not covered.

Note: There is no coverage under this program if you use an out-of-network provider. Also, your dependents are not eligible for coverage under this program.

In-Network Providers

For information on VDT User Eye Care Program in-network providers in your area, call the claims administrator (see your Important Benefits Contacts insert for the telephone number).

VDT Questionnaire

Before you receive services from an in-network provider, you must complete a VDT Questionnaire to verify that you use a VDT as part of your normal work activities. Your provider will give you this questionnaire at your appointment.

Continuing Coverage

Generally, your coverage or a dependent's coverage will end when your eligibility or a dependent's eligibility for the Plan ends. In some circumstances, however, coverage can be continued for a period of time if you agree to pay the cost.

Continuation of Coverage Under COBRA

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

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

VDT User Eye Care Program

When your eligibility for the Video Display Terminal (VDT) User Eye Care Program ends (see page 13), your coverage is not eligible for continuation.

Coverage continuation is available in the following situations:

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

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

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

Important Note

These 18- and 36-month periods will run concurrent with (not in addition to) any period of continuation coverage provided under USERRA.

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

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

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

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

Note: If the Company's vision care coverage changes during the period that you, your spouse or your dependents are continuing coverage, the changes apply to your COBRA coverage and are applicable under your vision option.

Notification Requirements

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

If you are terminated or lose coverage because of a reduction in work hours, you will receive additional information from the Company about your opportunity to continue coverage under COBRA. It is your responsibility, however, to notify the Company **within 60 days** when a spouse or dependent child becomes ineligible for coverage, so he or she can receive information about continued coverage opportunities.

Important Note

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

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

See your Important Benefits Contacts insert for the telephone number.

Paying for Your Continued Coverage

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

How Continued Coverage Could End

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

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

What Is Not Covered

Vision Care Plan and VDT User Eye Care Program

The Plan, including the Video Display Terminal (VDT) User Eye Care Program, does not cover the following expenses for you or for a covered dependent under the Plan:

- Services or supplies covered under any other Verizon Plan.
- Services or supplies for a condition covered under Workers' Compensation laws or for any other occupational condition, ailment, injury or disease occurring on the job for all employees and dependents if:

  — The covered person's employer provides reimbursement for such charges or makes a settlement for such charges

  — The covered person fails to assert his or her rights to receive employer reimbursement.

  The Plan has the right to recover or place a lien on any benefits if Workers' Compensation provides benefits for the same condition.
- Services or supplies provided under any Company safety lens program.
- Non-prescription lenses.
- Drugs and other medication. Benefits for prescription medicine may be covered by your medical plan.
- Medical or surgical treatment. Benefits for medical or surgical treatment may be covered by your medical plan.
- Free services or supplies.
- Services or supplies available from a government agency or covered by a government plan.
- Services or supplies provided by your immediate family member.

- Services or supplies provided or ordered either before you became eligible for coverage or after your coverage has ended.

- Services required as a result of injury or sickness caused by an act of declared or undeclared war while you are covered by the Plan or program.

- Charges for which there is no legal obligation to pay.

In addition, the Vision Care Plan does not cover the following vision expenses for you or a covered dependent:

- More than one vision examination every 24 months, unless an optometrist refers you to an ophthalmologist. In that case, an additional examination is covered within 60 days of the first examination, if it is medically necessary.

- More than one pair of prescription lenses—eyeglasses or contacts—every 24 months.

- Special or uncommon treatments, such as orthoptics, vision training, subnormal vision aids, aniseikonic lenses or tonography. However, some special or uncommon treatments may be covered by your medical plan.

- Services or supplies not provided by or prescribed by a licensed ophthalmologist, optometrist or optician.

- Services or supplies that are experimental, as determined by the claims administrator.

- Extra charges for photo-sensitive, anti-reflective or blended bifocal lenses, whether or not they are medically necessary.

- Extra charges for extended-wear, toric, bifocal, aphakic or gas-permeable contact lenses, and any separate charges for contact lens kits or follow-up visits.

- Services or supplies provided under the VDT User Eye Care Program (see page 20).

In addition, the VDT User Eye Care Program does not cover the following vision expenses for you:

- More than one VDT vision exam from an in-network doctor every 12 months
- Eyeglasses not intended specifically for use at a VDT
- Contact lenses (clear or colored)
- More than one pair of frames or lenses, except when broken, in each 12-month period
- Photo-sensitive or anti-reflective lenses
- Sunglasses
- Services and supplies from an out-of-network provider except when specifically authorized, in writing, by the claims administrator
- Services or supplies covered under the Plan (see pages 19 through 20).

How to File a Claim

To receive benefits, you or your vision care provider will need to submit a claim form to the claims administrator.

When Claims Are Required

Vision Care Plan

If you receive covered services or supplies from an in-network vision care provider, your provider files a claim with the claims administrator. The claims administrator directly reimburses the provider according to Plan provisions. You pay the provider any required copayment and amount you owe (if any) for services or supplies that exceed Plan benefits. If you use a Davis Vision, Inc. provider of your choice, no paperwork is necessary. To locate an in-network provider, call Davis Vision, Inc. or visit their Internet site (see your Important Benefits Contacts insert for the telephone number and Internet site address).

If you receive covered services or supplies from an out-of-network vision care provider, you must file a claim form for reimbursement with the claims administrator. Nonparticipating provider claim forms are available from Davis Vision, Inc. (see your Important Benefits Contacts insert for the telephone number and Internet site address).

You have the option at the point of service to either utilize assignment of benefits at providers accepting assignment of benefits or file for direct reimbursement after paying the full amount due to the provider:

- If assignment is chosen, the provider will submit the claim form directly to Davis Vision, Inc. for adjudication and payment.

- If direct reimbursement is chosen, you will submit the claim form to Davis Vision, Inc. for adjudication and payment.

Upon receipt of the completed nonparticipating provider claim form, Davis Vision, Inc. will process and make appropriate payment to either the provider or you directly, depending on the option you selected.

You should file the claim as soon as possible and in no case later than 15 months of receipt of the covered services or supplies.

VDT User Eye Care Program

If you receive covered services or supplies from an in-network VDT care provider, your provider files a claim with the claims administrator. The claims administrator directly reimburses the provider according to program provisions. You fill out the VDT Questionnaire (see page 21) and pay the provider any amount you owe (if any) for services or supplies that exceed program benefits. If you receive covered services or supplies from an out-of-network provider, the program pays no benefits.

Coordination of Benefits

Coordination of benefits (COB) rules are designed to prevent duplicate payments for the same service when you or your dependents are covered by more than one vision plan. When benefits coordinate, one plan will pay benefits first (the primary plan), another second (the secondary plan) and so on.

When the Plan is primary, it pays benefits based on the provisions described in this summary plan description (SPD).

When the Plan is secondary, the claims administrator subtracts the primary plan's payment from the amount that would have been paid if the Plan were primary. The Plan's secondary payment (if any) and the primary plan's payment, added together, never will exceed 100 percent of the applicable allowable expense.

If you have coverage through a prepaid vision plan, coordination will be based on the reasonable cash value of each service provided under the Plan for purposes of determining if the Plan will pay a benefit as the secondary plan.

VDT User Eye Care Program Coordination of Benefits

There is no coordination of benefits (COB) between the VDT User Eye Care Program and any other program or plan for vision or VDT benefits, including the Plan.

Priority of Payment

Under the Plan's COB provisions, the order of payment is as follows:

- A plan that covers a patient as an active, inactive or former employee pays before a plan that covers the patient as a dependent.

- For a dependent child, the Company uses the "birthday rule." This means that if a child is covered by both parents' group vision coverage, the plan of the parent whose birthday falls first during the calendar year pays benefits first. So, if the mother's birthday is April 27 and the father's birthday is October 23, the mother's plan pays benefits first. The parent's age has no effect on whose plan pays benefits first. If, however, the plan covering the parent who is not a Plan participant does not use the birthday rule, that plan pays benefits first.

- In the case of a divorce or separation, the plan of the parent with court-ordered financial responsibility for the dependent child pays benefits for the child first. If there is no court order establishing financial responsibility or if both parents have joint legal custody, the plan of the parent with physical custody of the child pays first. If the court order provides they have joint physical custody, the birthday rule applies.

Note: If both parents elect coverage under a Verizon-sponsored Vision Plan, their child can be covered under only one parent's Plan.

When the previous rules do not establish an order of benefit determination, the plan that covers the person as an active employee is the primary plan and the plan that covers the person as an inactive or former employee is the secondary plan. If this rule does not establish an order of benefit determination, the plan that has covered the person for the longer period of time is the primary plan and the plan that has covered the person for the shorter period of time is the secondary plan.

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

For active associates and covered persons eligible for Medicare, the Plan automatically still is the primary plan.

Subrogation and Third-Party Reimbursement

If you recover any charges for covered expenses from a third party (for example, as a result of a lawsuit from an automobile accident), the Plan's provision for subrogation and reimbursement takes effect. Under these procedures, the claims administrator's subrogation vendor tries to recover money that has been paid (or should be paid) on behalf of a third party (the other driver, in this example) whose negligence or wrongful actions caused illness or injury to a Plan participant. In this example of a car accident, should the Plan provide benefits because of your accident, the Plan has the right to recover the amount of those benefits from the negligent person or by obtaining a reimbursement from that person's insurance company—or from you if settlement amounts have been paid to you by the negligent person or his or her insurer.

The subrogation and reimbursement provisions also mean that if you make a liability claim against a third party after you have received benefits from the Plan, you must include the amount of those benefits as part of the damages you claim. If the claim proceeds to a settlement or judgment in your favor, you must reimburse the Plan for the benefits you received. You and your dependents must grant a lien to the Plan and you and your dependents must assign to the Plan any benefits received under any insurance policies or other coverages. As a condition of eligibility for benefits, you and your dependents must agree to cooperate with the claims administrator's subrogation vendor in carrying out the Plan's subrogation and reimbursement rights. Cooperation means you must respond promptly and fully with inquiries from the claims administrator's subrogation vendor and take what action the claims administrator's subrogation vendor requests to help recover the value of benefits provided under the Plan. If you don't, any amounts which could have been recovered through subrogation may be deducted from future Plan payments. In any case, Verizon will require payment from you only for amounts recovered that are net of your legal costs related to the action.

The covered person must sign any documents requested by the Plan to enable the Plan to exercise its rights under this provision.

The Plan is not responsible for your legal costs.

Right of Recovery

If, for any reason, the Plan pays a benefit that is larger than the amount allowed, the claims administrator has a right to recover the excess amount from the person or agency who received it. The person receiving benefits must produce any instruments or papers necessary to ensure this right of recovery.

Additional Information

Claims and Appeals Procedures

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

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

Claims Regarding Eligibility to Participate in the Plan

Verizon's Bell Atlantic InTouch Center (staffed by PricewaterhouseCoopers LLP—or its successor) has discretionary authority to determine claims and appeals related to eligibility and enrollment in the Plan.

Claims Regarding Scope/Amount of Benefits Under the Plan

Davis Vision, Inc. is the claims and appeals administrator who has discretionary authority to determine claims and appeals for Plan benefits.

The addresses of the claims and appeals administrators are listed on page 41. If you have a claim or appeal, you should contact the appropriate claims and appeals administrator for the type of claim or appeal you have.

The claims and appeals administrators have discretionary authority to:

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

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

Filing a Claim

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

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

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

- The administrator for claims and appeals that pertain to eligibility to participate in the Plan or issues relating to enrollment or changes in enrollment under the Plan (see page 34)
- The administrator for claims and appeals that pertain to the scope or amount of benefits under the Plan (see page 34).

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

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

If Your Claim Is Denied

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

Filing an Appeal

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

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

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

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

- Review pertinent Plan documents, which you can obtain as described on page 38.
- Send a written statement of the issues and any other documents in support of your claim to the appeals administrator.
- Request copies of written documents that are relevant to your appeal. There typically will be a reasonable charge per page.

Review of Your Appeal

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

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

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

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

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

Rights of Participants and Beneficiaries Under ERISA

Under ERISA, you have the following rights:

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

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

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

- You will receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish you with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the persons who are responsible for the operation of the Plan. The persons who operate your Plan, some of whom are named as "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

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

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court.

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

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

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

Administrative Information

Administrative information about the Plan is provided in this section.

Important Telephone Numbers

See your Important Benefits Contacts insert for information.

Plan Sponsor

The Plan sponsor is:

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

Plan Administrator

The Plan administrator is:

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

You may communicate to the Plan administrator in writing at the address above. But, for questions about Plan benefits, you should write or call the InTouch Center (see page 41 for the address and your Important Benefits Contacts insert for the telephone number). The InTouch Center administers enrollment and handles participant questions, requests and certain benefits claims but is not the Plan administrator. Claims relating to the scope and amount of benefits under the Plan are administered by the administrator listed on page 34.

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

Do not send any benefit claims to the Plan administrator or to the legal department. Instead, submit them to the claims administrator for the Plan (see page 34).

Benefits Administrator

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

Claims and Appeals Administrators

There are several claims and appeals administrators for the Plan.

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

The InTouch Center is responsible for enrollment and eligibility claims under the Plan, excluding the VDT User Eye Care Program. The InTouch Center can be reached at the following address:

Verizon's Bell Atlantic InTouch Center
P.O. Box 435
Little Falls, NJ 07424

See your Important Benefits Contacts insert for the telephone number.

Davis Vision, Inc.

Davis Vision, Inc. is responsible for enrollment and eligibility claims under the VDT User Eye Care Program.

Davis Vision, Inc. 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, including the VDT User Eye Care Program. Davis Vision, Inc. can be reached at the following address:

Davis Vision, Inc.
150 Express Street
Plainview, NY 11803

See your Important Benefits Contacts insert for the telephone number.

QMCSOs

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

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

Plan Funding

The Plan is not financed by an insurance company, nor are benefits guaranteed under a contract of insurance. The claims and appeals administrators listed on page 34 do not insure or guarantee Plan benefits. The Company pays all claims out of the general assets of the Company.

Plan Identification

Vision coverage is provided through the Verizon Vision Care Plan for New York and New England Associates, including the VDT User Eye Care Program. 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 (PN) is 572.

Plan Year

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

Agent for Service of Legal Process

The agent for service of legal process is the Plan administrator. Legal process must be served in writing to the Plan administrator at the address stated for the Plan administrator on page 40.

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

Verizon Legal Department
Employee Benefits Group
Verizon Communications Inc.
1095 Avenue of the Americas
13th Floor, Room 3724
New York, NY 10036

Official Plan Document

This SPD is part of the official Plan documents.

Participating Companies

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

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

Glossary

C

COBRA
A federal law (Consolidated Omnibus Budget Reconciliation Act of 1985 and its subsequent amendments) allowing continuation of Plan coverage for a period of time at the participant's expense if a participant loses eligibility because of certain changes in status.

Covered Person
- Vision Care Plan: Any employee and his or her dependents enrolled in the Plan, or any eligible individual who has elected coverage under COBRA.

- VDT User Eye Care Program: Any employee who uses a Video Display Terminal (VDT) as part of his or her normal work activities.

Covered Services
The services, treatments or supplies identified as payable in the official Plan document.

I

In-Network Provider
- Vision Care Plan: An ophthalmologist, optometrist or optician who has contracted with the claims administrator to participate in the network and who has agreed to accept payment directly from the administrator for covered services except for applicable member copayments.

- VDT User Eye Care Program: An ophthalmologist, optometrist or optician who has signed an agreement with the program administrator to participate in the network and who has agreed to accept payment directly for covered services.

L

Legally Separated
An employee and his or her spouse are legally separated if they do not live together and if they have a signed document or a legal proceeding, such as a separation agreement, that indicates that the employee or his or her spouse intends to live separately.

Lenses
- Single vision lenses: Standard lenses that provide a single focal length

- Bifocal lenses: Lenses that have two focal lengths, one to adjust the eyes for close focus and one to adjust the eyes for distant focus

- Lenticular lenses: Lenses designed to reduce weight and thickness; primarily used for people who have had cataracts removed surgically

- Trifocal lenses: Bifocal lenses that have an additional narrow area to adjust the eye for intermediate focus.

Licensed Vision Care Provider
A medically licensed vision care provider, such as an ophthalmologist, optician or optometrist.

O

Out-of-Network Provider
A licensed vision care provider who is not affiliated with the Plan network or the VDT User Eye Care Program network.

P

Participating Company
Verizon or any corporation or partnership which is an affiliate of Verizon that has elected to participate in the Verizon Vision Care Plan for New York and New England Associates, including the VDT User Eye Care Program.

S

Same-Sex Domestic Partner

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

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

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

You must agree to notify the InTouch Center if your partner no longer meets the criteria listed above.

V

VDT

Any electronic video screen data presentation machine commonly called a Video Display Terminal (VDT) or Cathode Ray Tube (CRT). A VDT or CRT does not include hand-held processing devices, self-contained personal computers, memory typewriters, televisions, cash registers, calculators or oscilloscopes.

VDT Vision Examination

A VDT vision examination is an eye examination performed by an in network provider and usually includes but is not limited to internal and external examination of your eyes, as well as measurements to determine if corrective lenses are required for occupational use.