Contents

Your Long-Term Care Benefits

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

- Eligibility when you complete three months of net credited service. You also can enroll your spouse, your parents and/or your parents-in-law.
- Coverage for expenses related to care you need when you are unable to perform certain basic activities of daily living.
- The choice of two types of coverage.
- If you die at or before age 70, reimbursement to your estate of a portion of the premiums you paid, less any benefits that you received or will be payable to your estate.

About This SPD

This book is the summary plan description (SPD) for the Verizon Long-Term Care Insurance Plan for New York and New England Associates. 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.

Verizon has 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 long-term care insurance coverage available to you. Refer to it when you need information about your coverage and benefits.

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

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

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

- **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 the insurance company, John Hancock Life Insurance Company (John Hancock), 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 23 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 Company also reserves the right to change the amount of required participant contributions for coverage under the Plan at any time, with or without advance notice to participants, subject to any duty to bargain collectively. The Plan may be amended by publication of any SPD, summary of material modification, enrollment materials or other communication relating to the Plan, as approved by the chairperson of the VEBC or an individual in a Director level position or above in the employee benefit design or delivery or the communications branch of the Company's Human Resources organization.

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

Participating in the Plan

Eligibility

You are eligible for Plan coverage if you are an active full-time or part-time associate who is employed by a participating company (see page 27) and you have at least three months of net credited service. A full-time associate includes a job sharing employee who is regularly scheduled to work at least 40 percent of a regular full-time employee's hours. In addition, you are eligible if you retire on or after August 9, 1986 and receive a pension under the Verizon Pension Plan for New York and New England associates.

Coverage is not available to residents of Kansas.

Note:

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

- If a court, the Internal Revenue Service or any other enforcement authority or agency finds that an 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.

If you want long-term care insurance, you must enroll for it through John Hancock Life Insurance Company (John Hancock) when you are eligible.

Eligible Family Members

When you are eligible for coverage, the following eligible family members may apply for coverage in the Plan as well:

For additional information on family member eligibility, call John Hancock (see your Important Benefits Contacts insert for the telephone number).

- Your spouse, as long as he or she is age 18 or older on his or her birthday nearest to the effective date of coverage

- Your parents or parents-in-law, as long as they are younger than age 80 on their birthday nearest to the effective date of coverage.

Spouses, parents and parents-in-law are eligible to apply for coverage even if you decline coverage under the Plan.

Note: Same-sex domestic partners, ex-spouses and dependent children are not eligible for coverage under the Plan.

If Your Spouse Is a Verizon Employee

For the Plan, if your spouse is employed by Verizon, you can be covered as an employee or as a family member, but not as both.

Enrolling in the Plan

You can apply for coverage in the Plan any time after you are eligible. To request enrollment materials, call the Long-Term Care Customer Service Center. (See your Important Benefits Contacts insert for the telephone number.)

Your application form must be approved by John Hancock before coverage begins. (See below.) In addition, you may have to submit a Statement of Health Form:

- If you are a full-time or part-time associate and you enroll within 31 days of the date you attain three months of net credited service (your "initial enrollment period"), you are guaranteed coverage without providing a Statement of Health Form. If you are on a leave of absence or a disability leave when your initial enrollment period is scheduled to begin, your initial enrollment period instead will begin on the day you return to work as an active associate.

- If you are a full-time or part-time associate and you enroll after your initial enrollment period, you must submit a Statement of Health Form. John Hancock will contact you and may contact your physician to provide additional information.

If your eligible family member wants to apply for coverage in the Plan, he or she must provide a Statement of Health Form regardless of when he or she enrolls.

When Coverage Begins

You'll receive a certificate from John Hancock if your application form is approved, which typically is within a month. Coverage begins the first of the month following the date your application is approved.

If you are an active associate but are not actively at work on the date your coverage is scheduled to begin, coverage will be delayed until the first day of the month after you return to work as an active associate.

If your covered dependent is disabled when coverage is scheduled to begin, his or her coverage will be delayed until the disability ends. Coverage will begin on the first day of the month after he or she no longer is disabled, as long as he or she still is eligible for coverage under the Plan.

Changing Your Coverage

You may increase your daily maximum benefit amount under your current option. Daily maximum benefit amounts may be increased once a year, and participants are subject to underwriting approval. (See page 8 for coverage options.)

Also, you can cancel your coverage at any time. Special rules apply if you have participated in the Plan continuously for 10 or more years when you cancel coverage. (See page 11.)

For additional information on changing coverage, contact John Hancock (see your Important Benefits Contacts insert for the telephone number).

Cost of Coverage

Your or your family member's cost ("premium") for long-term care coverage is based on three factors:

- Your or your family member's age on your birthday closest to the date John Hancock receives your application form
- The coverage option you select
- The level of benefits you select within the coverage option.

For details on the coverage options and the benefit levels offered under each option, see pages 8 through 12.

Once you become insured, your premiums cannot be increased due to age, changing health or benefit claims. Your cost for coverage will be adjusted only if premiums are adjusted for everyone in your class or group.

Your enrollment materials will include a table of monthly premiums based on age, coverage option and benefit level. Call the John Hancock Long-Term Care Customer Service Center to request enrollment materials. (See your Important Benefits Contacts insert for the telephone number.)

Paying for Coverage

Premiums for you and/or your spouse will be deducted from your paycheck on an after-tax basis. Your parents and parents-in-law will be billed directly.

When Participation Ends

Your coverage or your covered family member's coverage will end on the earliest of:

- The end of the period covered by your last premium payment, unless the premiums are waived or you have elected to continue your coverage under the reduced paid-up benefit.

- The date you reach the lifetime maximum benefit for your coverage.

- The date you no longer are eligible for the Plan, at which time you may continue your coverage under the Verizon policy for up to 36 months, provided you continue to pay premiums directly to the insurance company when they are due and you have not reached the lifetime maximum benefit. Then, your coverage automatically is continued under a conversion policy issued by John Hancock, provided you continue to pay premiums directly to the insurance company when they are due and you have not reached the lifetime maximum benefit.

- The date the Company policy terminates, at which time you can continue your coverage through direct premium payment under a replacement policy or under a conversion policy issued by John Hancock.

Continuation of Coverage

If the Plan ends for any reason or if you leave Verizon, you may continue your long-term care insurance coverage, as described above.

Upon the conversion of your coverage, John Hancock will bill you directly. You will be charged an additional administrative fee of no more than two percent of the premium to cover these billing costs.

Your Coverage

The Plan offers two coverage options for financial protection if you need extended care as the result of an illness or accident, or due to the loss of functional ability brought on by aging. You choose between:

- **Nursing home only coverage,** which pays benefits for care received in a nursing home only

- **Comprehensive coverage,** which includes nursing home care, home health care, adult day care and homemaker services provided as a form of respite care.

Under each option, you also choose a benefit level. Each benefit level includes a daily maximum benefit and a lifetime maximum benefit:

- The daily maximum benefit is the most the Plan will pay each day for your care.

- The lifetime maximum benefit is the total amount the Plan will pay for all types of long-term care expenses combined. This amount is intended to provide benefits for at least five years in a nursing home.

Only actual charges are applied to the lifetime maximum benefit. For example, if your daily nursing home charges are less than your full daily maximum benefit, only the actual daily nursing home charges will be applied to the lifetime maximum.

Once you or a covered family member has reached the lifetime maximum benefit, no further benefits will be paid for that individual and coverage ends.

Option I: Nursing Home Only Coverage

Nursing home only coverage covers skilled and intermediate nursing care and/or custodial care you receive in a qualified nursing home facility.

Under nursing home only coverage, if you are a resident of a state other than Connecticut or Delaware, you choose from three benefit levels:

Benefit Level	Daily Maximum Benefit	Lifetime Maximum Benefit
A	$ 80.00	$146,000.00
B	$ 120.00	$219,000.00
C	$ 165.00	$301,125.00

Note: If you are a resident of Connecticut or Delaware, your daily maximum benefit amounts will vary slightly. Call John Hancock (see your Important Benefits Contacts insert for the telephone number) for information.

Option II: Comprehensive Coverage

Comprehensive coverage covers the following services:

- Skilled and intermediate nursing care and custodial care in a qualified nursing facility.
- Home health care, including:
  - — Part-time skilled nursing care received from a registered nurse or licensed practical nurse
  - — Physical, respiratory, occupational or speech therapy provided by licensed therapists in their field of practice
  - — Custodial care received in your home or a rest home, from home health aides who are certified or employed by qualified home health care agencies (home health care services provided by a family member or by a person who ordinarily resides in your home are not covered).
- Adult day care, including a range of physical and social support services provided by a qualified adult day care center.

Daily maximum benefit amounts under comprehensive coverage depend on the type of care received.

You may assign your long-term care insurance benefits to be paid directly to the provider of services. Otherwise, benefits will be paid only to you or your legal representative.

- Homemaker services (for respite care) needed to give temporary relief to a family member or another informal caregiver who has been caring for you. The services covered are shopping, menu planning, meal preparation and light housekeeping (homemaker services provided by a family member or by a person who ordinarily resides in your home are not covered). There is an annual maximum benefit for homemaker services (see below).

- Nursing home care, home health care or adult day care needed for respite care. Homemaker services are covered only when provided for respite care.

Under comprehensive coverage, if you are a resident of a state other than Connecticut or Delaware, you choose from three benefit levels:

Benefit Level	Nursing Home Daily Maximum Benefit	Home Health Care/Adult Day Care/ Homemaker Services Daily Maximum Benefit	Lifetime Maximum Benefit
A	$ 80.00[1]	$ 40.00	$ 146,000.00
B	$120.00	$ 60.00	$ 219,000.00
C	$165.00	$ 82.50	$ 301,125.00

[1] Due to New York State Insurance Department regulations, Benefit Level A under comprehensive coverage is not available to residents of metropolitan New York (boroughs of Manhattan, Queens, Brooklyn, the Bronx and Staten Island, and the counties of Suffolk, Nassau, Westchester and Rockland). New York State law sets the minimum nursing home daily maximum benefit under comprehensive coverage at $100 for this geographic area.

Note: If you are a resident of Connecticut or Delaware, your daily maximum benefit amounts will vary slightly. Call John Hancock for information. (See your Important Benefits Contacts insert for the telephone number.)

Annual Benefit for Homemaker Services

Homemaker services must be approved by a long-term care case manager (see pages 15 through 16). If you are a resident of a state other than Connecticut or Delaware, the maximum amount of benefits you can receive for homemaker services provided in any calendar year is 20 times the home health care/adult day care/homemaker services daily maximum benefit:

- $800 under Benefit Level A

- $1,200 under Benefit Level B

- $1,650 under Benefit Level C.

Note: If you are a resident of Connecticut or Delaware, your annual benefit for homemaker services will vary slightly. Call John Hancock for information. (See your Important Benefits Contacts insert for the telephone number.)

These amounts apply toward the lifetime maximum benefit.

Special Features of the Plan

The following features are available to you regardless of the coverage you choose.

Reduced Paid-Up Coverage

When you have paid premiums for 10 years, you can stop making payments and still be eligible to receive 30 percent of your daily maximum benefit and lifetime maximum benefit.

For each year past the tenth year that you continue to pay premiums, the amount of reduced coverage available increases by three percent. The maximum reduced coverage, after 25 years or more of premium payments, is 75 percent of your original daily maximum benefit.

For example, assume you are covered with the $120 nursing home daily maximum benefit. If you stop premium payments after 10 years, your nursing home daily maximum benefit would be $36 ($120 × 30%). If you stop premium payments after 12 years, your nursing home daily maximum benefit would be $43.20 ($120 × 36%—30% plus 3% increases for the two extra years).

The total number of years you have paid premiums will not include any time your premiums are waived. Premiums are waived during any period you are eligible to receive long-term care benefits.

Return of Premium Upon Death

If you die at or before age 65, the Plan will pay an amount equal to 100 percent of the premiums you have paid up to the date of your death, less any benefits paid or still payable for any charges you incurred.

Beginning on your 66th birthday, the percentage of premium that may be returned is reduced by 20 percent each year, so that by age 70, none of your premium is returned if you die. There is no return of premium if coverage is in reduced paid-up status.

Any return of premium benefits due will be paid to your estate.

Inflation Adjustment Provision

Every three years, John Hancock reviews the cost of nursing home and home health care using the Consumer Price Index or other appropriate indexes. If costs have increased, you'll be given an opportunity to increase your elected daily maximum benefit amount without providing a Statement of Health Form.

This increase will not be available to you if you are age 85 or over on your birthday closest to the increase effective date, if you were certified as dependent in two or more significant activities of daily living (SADLs) (see page 15) during the two years before the date the increase is offered or if your coverage is reduced paid-up coverage.

If you opt to increase your coverage, the premium for the daily maximum benefit you originally elected will not change due to this election, but you will have to pay an additional premium for the additional coverage. Your new premium for the additional coverage will be based on your age on your birthday closest to the date on which the increase takes effect.

What Is Not Covered

In most states, the Plan does not cover expenses for care in the following situations:

- Care resulting from any pre-existing condition for which you incur an expense or receive medical advice or treatment during the first six months your coverage has been in effect. However, pre-existing conditions are covered after your long-term care coverage has been in effect for at least six months.

- Expenses for care during the 60-day qualification period (see page 16).

- Mental or emotional disorders without demonstrable organic disease, such as neurosis, psychoneurosis, psychopathy and psychosis as listed in the most recent edition of the International Classification of Disease. Alzheimer's disease and other organically-caused brain disorders are covered.

- Care specifically provided for detoxification or rehabilitation for alcohol or drug abuse.

- Care for a condition caused by an intentionally self-inflicted injury.

- Conditions caused by committing or attempting to commit a felony, or participating in an insurrection or riot.

Other exclusions may apply. Contact John Hancock for details. (See your Important Benefits Contacts insert for the telephone number.)

- Care or treatment provided outside the United States and its possessions.

- Care for conditions caused by war, acts of war or service in the armed forces.

- A service or supply covered under a government program, except as required by law. However, this exclusion does not apply to programs established by the federal government for its civilian employees, or to Medicare and Medicaid.

- A service or supply for which a charge would not have been made in the absence of insurance.

Note: Plan provisions may be changed or deleted to comply with individual state requirements.

How to File a Claim

Filing a Claim

Before you can receive benefits, you must be certified as dependent in two of the five significant activities of daily living, and you must complete a 60-day qualification period to ensure that the care you need is long term.

Certifying Long-Term Care Needs

To qualify for long-term care benefits, you must be certified by a case manager as dependent in two of the significant activities of daily living (SADLs) due to a condition covered under the Plan.

The five SADLs used for certification purposes are:

- Bathing and/or dressing
- Eating (but does not include preparing or serving food)
- Toileting
- Transferring from a bed to a chair
- Maintaining continence.

Certification of dependency will be determined by a John Hancock Life Insurance Company (John Hancock) case manager, who will review information received from you, your family, your doctor and other care providers. In some cases, a local nurse may meet with you at your home or care facility to help evaluate your condition. This visit will be paid for by John Hancock.

In some cases, a person may be able to perform an activity physically, but not appropriately. For example, a person with Alzheimer's disease physically is able to put on clothing, but may need help selecting the proper clothes for the weather. The case manager will determine whether you or a covered family member is able to perform an activity independently and appropriately—without supervision or assistance from another person.

For purposes of this Plan, you are dependent if you need help from another person most of the time to perform a major part of two of the significant activities of daily living.

The Certification Process

If you or a covered family member needs long-term care services covered under this Plan, call a case manager at the John Hancock Long-Term Care Customer Service Center. (See your Important Benefits Contacts insert for the telephone number.)

Case managers are registered nurses who will certify your need for long-term care and assist you in locating sources of care in your community. They also can recommend the type of facility and level of care that is appropriate for your needs.

You are under no obligation to follow the recommendations of your case manager. However, you must call the case manager to begin the process of certification and qualifying for benefits. If you are eligible for benefits, your doctor, your family and you make the final decision concerning the type of care you should receive.

The Qualification Period

Your qualification period begins on the date you are certified as dependent in at least two SADLs and ends 60 days later, provided you remain certified during that time. You do not have to receive care to complete the qualification period.

When Benefits Begin

After the qualification requirements are met, the Plan will pay benefits for the cost of the covered services you receive, as long as you remain certified, up to your daily maximum benefit and lifetime maximum benefit.

Premium Waiver

Your premiums will be waived during any period you are eligible to receive benefits, and will resume on the first day of the month after you no longer are eligible for benefits under the Plan.

Coordination of Benefits

Coordination of benefits (COB) rules are designed to prevent duplicate payments for the same service when you or your family members are covered by more than one insurance 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 primary plan's payment is subtracted from the allowable expense, not from the amount otherwise payable by the Plan. The Plan's secondary payment (if any) and the primary plan's payment, added together, never will exceed 100 percent of the allowable expenses.

The Plan coordinates with other group medical plans, employer-sponsored long-term care insurance plans and Medicare. However, the Plan does not coordinate with Medicaid or any individual long-term care policies you may have. If you are an active employee and you or your covered spouse is age 65 or older, the Plan will be primary to Medicare.

Priority of Payment

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

- The plan that provides benefits for the covered person as an active employee pays before a plan that covers the individual as a dependent.
- The plan that provides benefits for the covered person as an employee who is neither retired nor laid off **or** the dependent of such an individual is considered primary to a plan that covers the person as a laid off or retired employee or the dependent of such an individual.

When the previous rules do 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 a shorter period of time is the secondary plan.

Generally, expenses covered by this Plan are not covered by medical plans. However, coordination of benefits rules apply if there is some overlap in coverage.

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 two claims and appeals administrators for the Plan:

Claims Regarding Eligibility to Participate in the Plan

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

Claims Regarding Scope/Amount of Benefits Under the Plan

John Hancock Life Insurance Company (John Hancock) has discretionary authority to determine claims and appeals for Plan benefits.

The addresses of the claims and appeals administrators for the Plan are listed on page 26. 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 Plan has two claims and appeals administrators:

- The administrator for claims and appeals that pertain to eligibility to participate in the Plan or issues relating to enrollment or changes in enrollment under the Plan (see page 19)
- The administrator for claims and appeals that pertain to the scope or amount of benefits under the Plan (see page 19).

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 23.
- 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 John Hancock 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 26 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 19.

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 John Hancock 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 19).

Claims and Appeals Administrators

There are two claims and appeals administrators for the Plan.

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

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

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

See your Important Benefits Contacts insert for the telephone number.

John Hancock Life Insurance Company (John Hancock)

John Hancock is the claims administrator for claims relating to the scope or amount of benefits under the Plan. John Hancock can be reached at the following address:

John Hancock Financial Services, Inc.
Group Long-Term Care, Division C-7
P.O. Box 111
Boston, MA 02117-9809

See your Important Benefits Contacts insert for the telephone number.

Plan Funding

The Plan is insured fully through John Hancock Life Insurance Company (John Hancock). Employees pay premiums to the insurance company for coverage.

Plan Identification

Long-term care coverage is provided through the Verizon Long-Term Care Insurance Plan for New York and New England Associates. It is a welfare plan, listed with the Department of Labor under two numbers: The Employer Identification Number (EIN) is 23-2259884 and the Plan Number (PN) is 538.

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 25.

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

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

Official Plan Document

This SPD is part of the official Plan documents.

Participating Companies

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

- Empire City Subway Co. Ltd.
- Telesector Resources Group, Inc.
- Verizon New England Inc.
- Verizon New York Inc.
- Verizon Yellow Pages Co.

Glossary

C

Custodial Care

Custodial care is care administered primarily for the purpose of assistance in the activities of daily living, such as bathing or eating. This type of care can be provided by someone without medical skills or training. However, it must be provided under the orders of a physician and be supervised by a registered nurse (RN) or licensed practical nurse (LPN). It also is the most common form of long-term care, and generally is not covered by Medicare or by the Verizon-sponsored Medical Plans.

P

Participating Company

Verizon or any corporation or partnership which is an affiliate of Verizon that has elected to participate in the Plan.

Pre-Existing Condition

Any sickness or physical condition for which an expense was incurred or for which medical advice or treatment was recommended or received within six months prior to the date your coverage takes effect.

Q

Qualified Nursing Facility

A nursing home that is licensed to provide at least one of the following:

- Skilled nursing care
- Intermediate nursing care
- Custodial care.

R

Reduced Paid-Up Coverage
When you continuously have paid premiums for 10 years or more and choose to stop making premium payments, you still are eligible to receive between 30 percent and 75 percent (depending on the length of time you paid the premiums—see page 11) of your original daily maximum benefit and lifetime maximum benefit if you later qualify to receive long-term care benefits.

Respite Care
Short-term care that provides temporary relief to a family member or other informal caregiver.