Health Care and Dependent Day Care Spending Accounts and Dependent Care Reimbursement Fund
Summary Plan Description for New York and New England Associates

V-B-AA-N-R-68933-1/13

Contents

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

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

About This SPD

This document is the summary plan description (SPD) for the Verizon Health Care Spending Account and Dependent Care Spending Account for New York and New England Associates (the Plan). The Plan is subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. This document meets ERISA's requirements for an SPD and is based on Plan provisions and bargained-for changes effective January 1, 2013. This SPD is a summary of this Plan. In addition, this document describes the Dependent Care Reimbursement Fund, a program that is not subject to ERISA, but which may affect your contribution decision for the Dependent Care Account. This book updates and replaces all previous SPDs and other descriptions of the Plan, as well as all previous descriptions of the Dependent Care Reimbursement Fund.

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

This SPD is divided into the following major sections:

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

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

- **Dependent Care Reimbursement Fund.** This section describes the Dependent Care Reimbursement Fund, which provides Company funding for reimbursement of eligible dependent care expenses to employees who qualify under certain earned income guidelines.

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

- **Administrative Information,** This section includes administrative provisions of the Plan.

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

Important Note:

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

FSA Contacts

Plan	Contact	Reason to Contact
Flexible Spending Accounts	**BenefitsConnection website:** Via the Internet at: www.verizon.com/benefitsconnection (User ID and password required) Via About You on the VzWeb **Member Services** 1-855-4Vz Bens (1-855-489-2367) Representatives are available from 8 a.m. to 6 p.m., Eastern time, Monday through Friday Fax: 1-855-785-3471 **Mailing Address:** Verizon Benefits Center PO Box 8999 Norfolk, VA 23501-8999	• Verify your Health Care and/or Dependent Day Care Spending Account balance. • Ask about covered expenses. • Submit claims. • Check the status of a claim. • Order additional Health Care Spending Account (HCSA) cards for eligible family members. • View a list of eligible providers that accept the HCSA card.
General Benefits Information		
BenefitsConnection	Via the Internet at: www.verizon.com/benefitsconnection (User ID and password required) Via About You on the VzWeb	• Enroll for coverage. • Verify overall eligibility and coverage. • Review personal benefits information. • Make changes to your coverage due to a qualified life event. • Update dependent information. • Verify eligibility for COBRA coverage. • Enroll for COBRA coverage. • Update COBRA coverage due to a qualifying life event.
Verizon Benefits Center	1-855-4Vz-Bens(1-855-489-2367) Representatives are available from 8 a.m. to 6 p.m., Eastern time, Monday through Friday	
Internal Revenue Service Forms & Publications	www.irs.gov	• Review IRS forms

Verizon Benefits Center

The Verizon Benefits Center offers a website called BenefitsConnection where you'll find tools to help you manage your benefits. You can access BenefitsConnection on the "About You" page on the Verizon eWeb or on the Internet at www.verizon.com/benefitsconnection.

The website makes finding information fast and easy as it guides you through your benefits transactions, including annual enrollment and qualified status changes (e.g. birth, marriage, divorce).In addition to enrolling on the site, you can:

- Link to other Verizon benefit provider sites.
- Review details about your health care and insurance plans.
- Select and update your beneficiary designations.
- Change your BenefitsConnection password.
- Give yourself a helpful “hint” in case you forget your password.

Verizon Benefits Center representatives are available should you have questions about your benefits. To reach the Verizon Benefits Center via telephone, call 1-855-4VzBens (1-855-489-2367). Using this toll-free telephone number, you also can connect with other Verizon benefit providers.

Changes to the Plan

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

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

Health Care Spending Account

Eligibility

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

A temporary employee's eligibility is governed by the applicable collective bargaining agreements.

"Associate," as used throughout this SPD includes any non-management employee.

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

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

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

Important Note

Plan the amount of your contribution carefully. IRS rules require that you forfeit any amount you contribute that you cannot claim for reimbursement at the end of the Plan year (calendar year). However, you have until May 31 of the following year to file claims. If you are enrolled in the Plan as of December 31 of the current Plan year, you will also have an additional 2½-month grace period to incur eligible expenses. This means if you are enrolled in the Plan on December 31 of the current Plan year, you may incur eligible expenses through March 15 of the following Plan year and apply these expenses towards your prior year account balance. This grace period is designed to help you avoid forfeiting money remaining in your account at the end of the Plan year.

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

Enrolling in the Health Care Spending Account

Initial Enrollment by Newly Hired Associates

If you are a new associate, you can begin making contributions as soon as you become eligible to participate. You automatically will receive enrollment information. You must enroll using the BenefitsConnection website or call the Verizon Benefits Center by the deadline included in your enrollment materials and indicate the amount you want to deposit in your account on a before-tax basis; otherwise, you will not be eligible to contribute to the account until the next election annual enrollment period, unless you have a status change during the year (see "Changing Your Elections").

You can contribute as little as $100 or as much as $2,500 per calendar year to your account. However, when you join in the middle of the year, your contribution is prorated for the portion of the year you will be contributing. Your contributions will begin as soon as administratively possible after you enroll and will be deducted on a before-tax basis from your paychecks over the course of the year.

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

Note:

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

If You Are Rehired

If you leave the Company and are rehired by the Company within 30 days, your benefits elections in place at the time of your termination will be reinstated and you cannot make changes, unless you experience a qualified status change.

If you leave the Company and are rehired by the Company after 30 days, you may reenroll in the Plan at any time during the calendar month following your reemployment.

Changing Your Elections

Annual Enrollment

After your initial enrollment opportunity, you will make a decision each year during the annual enrollment period about whether you want to participate for the following calendar year. Elections made during the annual enrollment period take effect on the following January 1 and remain in effect through December 31 of that year, unless you change the election during the year due to a change in qualified status change (or another permissible event described here).

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

Qualified Status Changes

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

Elections made due to qualified status changes must be made within 90 days of the status change; otherwise, a change will not be allowed. Any change will remain in effect until December 31 of the calendar year in which the change is made or, if sooner, until you experience another qualified status change and change your election. Your new election will take effect as soon as administratively possible after you call the Verizon Benefits Center, and deductions from your pay will be adjusted accordingly.

You Gain a New Dependent

If you gain a new, eligible dependent **through marriage, birth, adoption or placement for adoption** whom you claim as a dependent for income tax purposes, you can start or increase contributions to the Health Care Spending Account. To make a change, you must notify the Verizon Benefits Center of your status change within 90 days gaining the new dependent.

You Lose a Dependent Through Death or Divorce

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

Change in Employment for You, Your Spouse or a Dependent

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

Change in Dependent's Eligibility for Medical Plan Coverage

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

You or a Dependent Becomes Eligible or Loses Eligibility for Medicare or Medicaid

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

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

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

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a judgment from a state court or an order issued through an administrative process under state law that requires you to provide coverage for a dependent child under Verizon's health care plans, including the Health Care Spending Account. You may obtain a copy of the QMCSO administrative procedures, free of charge, from the Plan administrator in care of the Verizon Benefits Center. In any case, if subject to an order, you and each child will be notified about further procedures.

When Participation Ends

Your participation will end on the earliest date described below.

Event	Effect on Participation
Leaves of Absence	In general, if you go on a leave of absence, your participation continues in accordance with Company guidelines and as collectively bargained.
Leaves 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. Your payroll deductions stop when your leave begins. However, you may elect to continue your participation in the Health Care Spending Account through COBRA during an approved FMLA leave of absence. If you elect to continue your participation, you will be able to submit claims for expenses incurred during your unpaid FMLA leave. If you return within 30 days of your leave, your original balance is reinstated. Your monthly payroll deductions will then be increased to account for the missed payroll deductions and contributions. If you return after 30 days from your leave, then your Health Care Spending Account goal amount will be set to $0 and you would have to re-enroll. Call the Verizon Benefits Center for details. For information on non-FMLA Leaves of Absence, see your Additional Benefits and Programs Booklet.
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. Call the Verizon Benefits Center for details
Change in Employment Status	If your employment status changes from an associate to management status, your participation in the Health Care Spending Account will continue without interruption. Any contributions, account and claims activity will also be transferred to the account for management employees.
Long-Term Disability (LTD)	If you are receiving long-term disability benefits, your contributions to the account will end on the last day of the month in which your employment with Verizon ends due to long-term disability.
Cancellation of Coverage	If you stop contributions due to a change in status, your participation will end on the date you elect to stop contributing.
You Die	If you die while you are participating in the Health Care Spending Account, your dependents can file claims on any remaining amounts in your account for eligible expenses incurred up to the date of your death. Your dependents can file claims on these amounts until May 31 of the following year.

Event	Effect on Participation
End of Employment	Participation in the Plan will end on the last day of the month in which your employment ends for any reason not specified in this section. You can claim reimbursement for eligible expenses incurred up to the date your participation ends.
Plan Termination	Although Verizon does not intend to terminate the Plan, were the Plan to be terminated, all contributions would end on the date of termination.

Continuation of Coverage Under COBRA

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

Health Care Spending Account Highlights

Key features of the Health Care Spending Account are highlighted below.

Account Feature	How It Works
Before-Tax Contribution You Can Deposit Each Year	Minimum: $100 per year Maximum: $2,500 per year
Using Your Account	You can use the Health Care Spending Account Visa Debit Card (HCSA card) to pay for many eligible health care expenses. See the “Using your HCSA Card” section for more information. Otherwise, you submit a claim for reimbursement whenever you have paid an eligible expense for you or an eligible dependent[1]. The money will be taken out of your account up to the amount you have elected to deposit for the year, less any prior reimbursements, and at checkout, you will receive reimbursement according to your preference of direct deposit or check.
Some Eligible Expenses To verify what is an eligible expense, go to BenefitsConnection> Spending Accounts> Tools and Resources>List of Eligible Health Care Spending Account Expenses	• Copayments • Deductibles • Coinsurance • Amounts you pay above health care plan limits • Unreimbursed dental expenses, including amounts above a plan's benefit limit (for example, orthodontic expenses) • Unreimbursed vision and hearing care expenses
Some Expenses That Are Not Eligible	• Health insurance premiums • Cosmetic surgery or procedures that are not medically necessary • Over-the-counter vitamins, even if prescribed by a physician

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

How the Account Works

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

To use the account:

- **Step 1:** During your initial enrollment and each annual enrollment period, you decide if you want to participate and elect the amount you want to contribute by enrolling via the BenefitsConnection website or by calling the Verizon Benefits Center. This contribution should be based on a careful estimate of the eligible health care expenses you and your family members expect to incur during the upcoming calendar year.

- **Step 2:** During the year, your contribution will be deducted from your paychecks in installments—before federal income and Social Security taxes are figured. In most cases, you also will avoid state and local taxes on your contributions.

- **Step 3:** When you have eligible health care expenses, you can file a claim for reimbursement—there is no minimum required to file a claim. (See “Eligible Health Care Expenses” for a list.) If your claim exceeds your Health Care Spending Account balance, you receive up to the amount you have elected to deposit for the year, reduced by any prior reimbursements. You can also use your HCSA card to pay for eligible health care expenses.

- **Step 4:** You cannot carry over your unused Health Care Spending Account contributions from one Plan year to the next. However, if you are enrolled in the Plan as of December 31 of the current Plan year, any amounts remaining in your account through March 15 of the next calendar year can be used to reimburse eligible expenses that you incur through March 15. If you do not incur enough eligible expenses by March 15 to claim all of your contributions for the previous calendar year, the law requires you to forfeit the remaining unused amount. You have until May 31 of the following calendar year to file all claims incurred through March 15 of the next calendar year.

Example of Tax Savings

The chart below shows how an employee earning $50,000 annually saves $226 in taxes by using the Health Care Spending Account to pay for $1,000 in eligible expenses. The example assumes this employee is married, claims three exemptions and takes the standard deduction. Tax savings are based on 2013 tax rules.

	With Account	Without Account
Annual Pay	$50,000	$50,000
Expenses Paid With Account	- 1,000	- 0
Taxable Income	$ 49,000	$ 50,000
Estimated Federal Income and Social Security Taxes	- 6,621	- 6,847
Expenses Paid Without Account	- 0	- 1,000
Income Remaining	$ 42,379	$ 42,153
Tax Savings	**$ 226**	

In this example, the employee reduces his or her taxes by **$226** by using the account. In other words, the employee has increased his or her income after taxes by this amount.

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

Additional Tax Considerations

- For federal income tax purposes if you're under age 65, you can only deduct eligible health care expenses that exceed 10% of your adjusted gross income, assuming you are itemizing deductions. (From January 1, 2013 through December 31, 2016, if you or your spouse is age 65 or older before the close of your tax year and you are itemizing your deductions, you can deduct eligible health care expenses that exceed 7.5% of your adjusted gross income.) However, when you receive reimbursement from the Health Care Spending Account for these expenses, you cannot take a tax deduction on your federal income tax return for the same expenses. You have to choose whether you want to take the tax deduction or receive reimbursement through the Health Care Spending Account.

  Generally, if you do not itemize your tax deductions or if your health care expenses are less than 10% (7.5% if you're age 65 or older as described above) of your adjusted gross income, it may be more beneficial to participate in the Health Care Spending Account.

  Consult a tax advisor for guidance on your specific situation.

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

- If you earn less than the Social Security Wage Base ($113,700 in 2013) and contribute to the Health Care Account, your future Social Security benefits may be reduced slightly. The impact generally is very small—less than one percent—after years of using the account.

Eligible Health Care Expenses

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

Eligible Expenses

Expenses for "medical care" that are incurred during the Plan year but not covered by a health care plan are eligible for reimbursement. Generally, an expense for medical care means that it must diagnose, cure, mitigate, treat or prevent disease or affect a structure or function of the body. Under the Affordable Care Act, expenses incurred for any non-prescription medication or drug (other than insulin) are not eligible for reimbursement through your Health Care Spending Account, unless you have a prescription.

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

- Copayments, deductibles and coinsurance that you pay under any health care plan.
- Expenses that may not be covered in whole or in part by a health care plan, such as:
  - Alcohol and/or drug dependency treatment center costs.
  - Capital expenses to install special equipment or make home improvements, such as installing entrance and exit ramps, if the main purpose is your or a dependent's medical care.
  - Cardiac rehabilitation classes.
  - Childbirth classes.
  - Eye glasses.
  - Hearing aids and batteries.
  - Laboratory tests.
  - Over-the-counter medications that are accompanied by a prescription.
  - Prescription birth control devices.
  - Routine hearing exams.
  - Routine physical exams.
  - Smoking cessation programs and prescription drugs used to treat nicotine withdrawal.
  - Transportation expenses if transportation is primarily for and essential to medical care.

— Weight-loss programs (for example, the cost of participation in a weight-loss program and fees for periodic meetings) for treatment of a specific disease or ailment, diagnosed by a doctor (such as obesity, hypertension, or heart disease). This does not include the purchase of related food items.

— X-rays.

Ineligible Health Care Expenses

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

- Cosmetics.
- Cosmetic surgery, unless it is for the treatment of a disfiguring illness or injury.
- Cosmetic dental procedures, such as bleaching and implants.
- Dietary supplements.
- Expenses incurred before your participation in the Health Care Spending Account begins or after your participation ends in each calendar year.
- Expenses incurred for individuals who are not eligible dependents under the health care spending account.
- Former spouse's medical bills.
- Health care expenses that are reimbursable under any other health plan or insurance.
- Health club or gym fees (unless recommended by a physician for a medical condition and accompanied by a letter of medical necessity).
- Household help expenses, even if your doctor recommends you have help because you physically are unable to do housework.
- Illegal surgical procedure and drug charges.
- Living expenses.
- Long-term care.
- Over –the-counter medications (except insulin), unless accompanied by a prescription.
- Over-the-counter vitamins (unless medically necessary).
- Premium payments for disability insurance, life insurance and group health coverage, including payments for COBRA coverage.

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

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

For More Information

For a more complete listing of eligible/ineligible expenses, visit BenefitsConnection > Spending Accounts>Tools & Resources > List of Eligible Health Care Spending Account Expenses.

The HCSA Card Program

You can use the Health Care Spending Account Visa Card (HCSA card) to pay for eligible health care expenses. As you use your prepaid HCSA card, eligible health care expenses will be deducted automatically from your Health Care Spending Account.

How the HCSA Card Program Works

You will receive a package containing one HCSA card issued in your name, activation instructions, a Cardholder Agreement, Additional Disclosures and information explaining approved use of the card. You will also receive a separate letter with a unique personal identification number (PIN) that allows you to use your HCSA card as a debit card. You may request additional cards for your eligible dependents under the plan through the BenefitsConnection website.

The HCSA card remains active for up to four years as long as your account is in good status, you continue to participate in a health care spending account and you remain actively employed. Your card will be cancelled upon termination of employment or termination of participation in the Plan–inactive participants may not use the HCSA card.

By signing and using the card, you certify that:

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

You can present your HCSA card for eligible health care expenses at select merchants. The HCSA card has been designed for use at merchants and providers that primarily sell health care products and services (for example, pharmacies, grocery stores, physician's offices, hospitals and dentist's offices). Each time you use the card at an approved merchant location for an eligible health care expense, you will be required to provide your signature. **If your transaction prompts you to choose between "credit" and "debit," you may choose either option– however, if you choose debit, you'll also need to enter your PIN.** With each HCSA card purchase, your available health care account balance is reduced by that amount. Other ineligible expenses, such as cosmetics or food items, must be paid for separately.

Most pharmacies and health care providers accept the HCSA card:

- To pay your copay or other expenses at a merchant or provider that accepts the card, just swipe it. Select “debit” and enter your PIN, or select “credit” and sign your name.

- Some merchants don’t accept credit transactions. In this case you’ll still be able to use the card as a debit card.

- Some merchants don’t accept the HCSA card. In that case, the card will simply be declined and you’ll need to pay out-of-pocket. Be sure to receive a detailed receipt so you can submit a spending account claim online (fastest method) or with a paper claim form to be reimbursed from your HCSA.

Important: Save your itemized receipts

Because all your HCSA card transactions must be verified as eligible health care expenses, you may be required to provide the Verizon Benefits Center with supporting documentation to validate your expenses. Make sure that you save all of your itemized receipts or Explanation of Benefits (EOB) from your health plan, indicating the provider name and address, patient name, date(s) of service, type of service or the name of the product or prescription medication and the dollar amount of the debit card transaction or the amount paid by you. Refer to the Cardholder Agreement or the BenefitsConnection website for more information.

Special Claim Processing Rules

The HCSA card can remain active for up to **three years**. For example, if you enroll for the first time and receive a card but do not enroll the second year, the balance on the card will be zero. If you decided to reenroll the third year, the **existing** card would reflect your new available balance.

How to Use the HCSA Card During the Grace Period

The plan has a “grace period” that extends from January 1 to March 15, 2015.
This means that if you are enrolled in the Plan as of December 31 of the current Plan year, you may incur eligible expenses through March 15 of the following Plan year (calendar year) and apply those expenses toward your prior year account balance.

For example, if you are enrolled in the Plan as of December 31, 2014, you may continue to incur eligible expenses through March 15, 2015 and apply those expenses against any remaining 2014 account balance.

When using your debit card during the grace period, your debit card will use the funds remaining in your 2014 Health Care Savings Account first. When your 2014 Health Care Savings Account balance reaches zero, the card will then take money from your 2015 Health Care Savings Account for the claims you incur in 2015 – even claims incurred during the grace period.

It is important that you DO NOT USE your HCSA card after March 15 to pay for claims with a date of service from the prior plan year. If you still have money left in your 2014 Health Care Savings Account, you may submit those claims online or with a paper claim form. You have until May 31 of the current plan year to submit claims from the prior plan year.

When you use your HCSA debit card, be sure that:

- The date of service for your eligible expense is within the Plan year in which you are enrolled in the Health Care Savings Account, and

- Your Health Care Savings Account has a large enough balance to cover your expense.

For example, assume you went to the doctor on December 1, 2014 but you didn't pay for the office visit with your HCSA debit card until January 15, 2015. Since the date of service was in 2014, you must have enough funds remaining in your 2014 Health Care Savings Account in order for this expense to be covered. If you don't have enough funds in your 2014 Health Care Savings Account, the expense will be applied to your 2015 Health Care Savings Account. Since the date of service is in 2014, the claim will be denied because it will appear that you are trying to substantiate a 2015 HCSA card transaction for a service that occurred in 2014.

Lost or Stolen Cards

If your HCSA card is lost or stolen – or you believe that there has been any unauthorized use of your card – you must contact the Verizon Benefits Center immediately at 1-855-4-VzBens (1-855-489-2367). Benefits Center representatives are available to assist you between 8:00 a.m. and 6:00 p.m. Eastern time, Monday through Friday (excluding applicable holidays).

Validation of HCSA Card Transactions

All HCSA card transactions must be validated electronically at the point of sale or by submitting paper documentation afterward. This process involves requesting itemized receipts or other supporting documentation from you to verify that the card transaction is for an eligible health care expense. You should retain your itemized receipts for all transactions, as they may be required for validation purposes.

Automatic Validation with Approved Merchants

When you purchase eligible health care items using your HCSA card with approved merchants, your transaction can be validated automatically without having to provide an itemized receipt or supporting documentation. To be "approved," a merchant must have an inventory information approval system (IIAS) installed. These IIAS-certified merchants have the ability to identify eligible items at the point of sale, which eliminates the need for additional documentation. They have programmed their systems to only allow eligible items and services to be processed on the HCSA card.

Any ineligible items must be paid for with another form of payment. For a complete listing of eligible expenses and certified merchants, visit the BenefitsConnection website. Please note that the listing is subject to change at any time.

Automatic Validation for Other Medical Providers

Your HCSA card can also be used for other types of health care transactions without the need for submission of itemized receipts or further review. These transactions include recurring expenses, copayments, a specific merchant category code and prescription purchases covered by Express Scripts. Below is a brief explanation of each type of transaction.

Recurring Transactions

If you purchase an eligible health care item or service using your HCSA card, that same item or service will be validated automatically the next time you purchase it with your HCSA card (at the same provider and for the same dollar amount). In addition, any recurring HCSA card transactions will carry over to the new plan year for participants who reenroll in a health care account – this means you will be able to continue purchasing the same health care item or service (provided that the dollar amount does not change) without having to submit supporting documentation to the Verizon Benefits Center again the following Plan year.

Copays
Your HCSA card will be programmed to recognize your Verizon health plan's copay amounts without any additional validation being required. For example, if you go to the doctor and have a $20 copay, that amount is a recognized copay and will be automatically approved.

Labs
Your HCSA card is programmed to recognize lab fees of $25 or less without any additional validation being required. For example, if you go to the hospital and have lab work done, charges of $25 or less will be automatically approved.

Prescriptions Covered by Express Scripts
If you have coverage with Express Scripts through Verizon, your prescription purchases will typically be validated automatically – simply present your HCSA card at the time of purchase. Although your expense should be validated automatically, it is good practice to save your itemized receipts in case the Verizon Benefits Center requests supporting documentation.

HCSA Card Transactions Requiring Documentation
The following transactions require documentation before processing:

- **Merchants registered under the IRS 90% Pharmacy Rule (also referred to as the 90% Participating Merchant Rule by BenefitsConnection)**. Purchases at a merchant registered under the IRS 90% Pharmacy Rule (a merchant that does not use the IRS-approved inventory approval system but certifies that a particular store location's sales consist of 90% medical expenses) must be substantiated. While your debit card will work at a merchant registered under the IRS 90% Pharmacy Rule, you must substantiate the expense afterward. This is an IRS requirement, and is not set by Verizon. To review the 90% Participating Merchant locations, log on to the BenefitsConnection website, www.verizon.com/benefitsconnection, click on the Spending Accounts tab, go to the "Tools & Resources" section and click on the List 90% Participating Merchants.

- **Non-copays in a Verizon health plan**. Purchases at, or payments to, a Health Care provider in a Verizon health plan if the amount is:

  — Not a fixed copay amount or a multiple of up to five times a fixed copay amount.

  — A deductible amount.

  — A coinsurance amount.

- **Any payments in a non-Verizon health plan.** Purchases at, or payments to, a health care provider in a non-Verizon health plan if the amount is:

  — Any copay amount for a non-Verizon health plan (i.e., you are not a subscriber under a Verizon health plan, but participate in a non-Verizon health plan)

  — Any coinsurance amount in a non-Verizon health plan

  Important note: Coinsurance payments are not automatically substantiated using the debit card. You must submit additional documents (e.g., Explanation of Benefits (EOB) statements from your insurance company or an itemized receipt from the provider) afterward to substantiate any coinsurance paid with the HCSA card.

Supporting Documentation

Manual claim submission and supporting documentation are sometimes required for the purchase of a prescription drug or health care service or item that is not validated automatically. These types of purchases are conditionally reimbursed, pending validation of the expenses. The process for supporting documentation is outlined below:

- The merchant is reimbursed for the amount of the charge, and your available health care account balance is reduced.
- You will be sent a letter or email informing you that itemized receipts or other documentation are required to validate the HCSA card transaction.
- If the documentation you provided is insufficient, you will be sent a letter or email instructing you to provide more documentation.

Expenses for which you do not provide adequate documentation are considered ineligible and treated as overpayments.

Overpayment Process

If you have one or more HCSA card transactions that have not been verified as eligible health care expenses, your debit card will be suspended and your Health Care Spending Account is considered to be in overpayment.

Your HCSA card will remain suspended until your overpayment is satisfied.

The primary situations that could result in an overpayment are:

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

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

1. Submit an itemized receipt or Explanation of Benefits (EOB) corresponding to the Transaction ID and Claim ID listed above that includes:
   - Provider name and address.
   - Patient name.
   - Date(s) of service.
   - Type of service.
   - Dollar amount of the debit card transaction.
   - Prescription name (for prescription drug claims).
2. Provide documentation for other eligible health care expenses that are equal to or greater than the amount of this transaction and for which you have not yet received reimbursement to offset the unsubstantiated HCSA card transaction.

3. Repay your account for the amount of this transaction.

Please note, even though your HCSA debit card has been suspended, your Health Care Savings Account remains active and you can continue to submit claims through BenefitsConnection or by fax or mail with a paper claim form.

When Not to Use Your HCSA Card – Coinsurance

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

Important Information Regarding Errors, Liability and Related Disclosures

The following disclosures relate to issues concerning the HCSA card. Any other issues that relate to your flexible reimbursement plan (such as benefit eligibility, participation, enrollment, claims or validation) that are governed under the terms of your Plan with respect to the Health Care Spending Account and the Employee Retirement Income Security Act of 1974 (ERISA), will be subject to the dispute procedures available under the plan offered by or through Verizon.

Consumer Liability

You must notify the Verizon Benefits Center immediately if you believe your HCSA card has been lost or stolen. Call the Verizon Benefits Center to prevent the loss of all of the money you have accrued under the plan, although there is no guarantee that such a loss will not occur. If you believe your HCSA card has been lost or stolen and you notify the Verizon Benefits Center within two business days after you learn of the loss or theft, you will not lose any money if someone used your card without your permission.

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

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

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

Documentation
Information regarding HCSA card transactions under the plan will be made available on BenefitsConnection.

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

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

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

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

In Case of Errors Relating to Your HCSA Card
Call the Verizon Benefits Center at the number provided on the back of your card as soon as possible if you think an HCSA card transaction is wrong or if you need more information about a transaction listed in the statement or receipt. The Verizon Benefits Center must receive notification of any errors no later than 60 days (either via BenefitsConnection or by mail) after the problem or error appeared. When you contact the Verizon Benefits Center, be prepared to:

- Provide your name, social security number (when applicable) and HCSA card number.
- Describe the error or the HCSA card transaction that you are unsure about, and explain the reason you believe there is an error or why you need more information.
- Provide the dollar amount of the suspected error. If you call the Verizon Benefits Center, you may be required to send your complaint or question in writing within 10 business days.

The Verizon Benefits Center will coordinate with the HCSA card issuer to determine whether an error occurred within 10 business days after it receives notification from you, and will correct any error promptly. If more time is needed to correct the error, however, the Verizon Benefits Center may take up to 45 days to investigate your complaint or question. If this additional time is necessary, The Verizon Benefits Center will credit the monies held by Verizon for the amount that you think is in error, so that you will have use of the total amount during the investigation. If the Verizon Benefits Center requests that you put your complaint or question in writing and it does not receive the information within 10 business days, the Verizon Benefits Center may not provide this credit. The Verizon Benefits Center will inform you of the results within three business days after completing the investigation. If the Verizon Benefits Center decides that there was no error, a written explanation will be mailed to you. You may ask for copies of the documents that were used in the investigation.

Filing a Claim for Reimbursement

As you incur eligible expenses, you can submit claims on the BenefitsConnection website, via fax, or by mail. You can also contact the Verizon Benefits Center for information about claiming a reimbursement from your Health Care Spending Account.

You have until May 31 of the next calendar year to submit claims for the current Plan year's expenses – those incurred January 1, 2013 – March 15, 2014

Claim Processing

If you were enrolled in Plan as of December 31 of the current Plan year, you can be reimbursed for eligible health care expenses that you incur through March 15 of the next calendar year. You have through May 31 of that next calendar year to submit claims for the current calendar year's expenses. For example, if you incur an eligible health care expense on March 1, 2014, you have until May 31, 2014 to submit a claim toward any balance remaining in your 2013 Health Care Spending Account. Any account balance not used by March 15 and submitted by May 31 will be forfeited.

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

Submitting Claims to BenefitsConnection

You have two options to submit a claim for your Health Care Spending Account:

- **Option 1** is to submit your claim online. This is a paperless process and you won't need to submit paper anymore. To submit your claim online, visit the BenefitsConnection website at www.verizon.com/benefitsconnection, click on the "Spending Accounts" tab and select "Submit New Claim".

- **Option 2** is to submit your claim using a Health Care Spending Account claim form. To obtain a claim form, visit the BenefitsConnection website at www.verizon.com/benefitsconnection, click on the "Spending Accounts" tab, then select the Health Care Spending Account Claim Form under the "Tools and Resources" section. Follow the instructions on the claim form to properly submit your claim. Fax the completed form and supporting documentation to 1-855-785-3471. Make sure that you fax the form and supporting documentation together. The claim form should be the first page in the stack of pages that you fax.

Alternatively, you may also mail your claims to: Verizon Benefits Center, P.O. Box 8999, Norfolk, VA 23501-8999.

This information is also provided on the claim form. Claims submitted on the Health Care Spending Account claim form are reimbursed via a check mailed to your home address (or through direct deposit, if you have elected to sign up for it).

Supporting Documentation

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

Your claim will be processed as soon as administratively possible, and generally no later than 10 days after the Verizon Benefits Center receives your paperwork. For fastest processing, fax your signed and completed claim form and supporting documentation to the Verizon Benefits Center using the fax number provided on the form.

An itemized receipt must include the following:

- Provider name and address
- Patient name
- Date(s) of service.
- Type of service (or the name of the product or prescription medication).
- Amount paid by you or amount of the debit card transaction.

If you lose a receipt, contact your doctor or pharmacy to request a copy or call your health plan for an EOB. Visit the BenefitsConnection website for more documentation requirements.

If Your Claim Is Denied

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

Continuation of Coverage Under COBRA

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

This section:

- Contains important information about your right to COBRA continuation coverage under the Health Care Spending Account.
- Explains when COBRA coverage may become available.
- Describes what you need to do to protect your right to receive COBRA coverage.

For additional information about your rights and obligations under the Plan and under federal law, contact the Verizon Benefits Center (see your Important Benefits Contacts insert for contact information).

What COBRA Continuation Coverage Is

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

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

Qualified beneficiaries who elect COBRA continuation coverage must pay for it.

COBRA Qualified Beneficiaries

- **Employees.** You become a COBRA qualified beneficiary if you lose your coverage under the Plan because of one of the following qualifying events:

  — Your hours of employment are reduced.

  — Your employment ends for any reason other than your gross misconduct.

- **Spouse of employee.** Your spouse becomes a COBRA qualified beneficiary if he or she loses coverage under the Plan because of one of the following qualifying events:

  — You die.

  — Your hours of employment are reduced.

  — Your employment ends for any reason other than gross misconduct.

  — You become divorced from your spouse.

- **Dependent children.** Dependent children become COBRA qualified beneficiaries if they lose coverage under the Plan because of one of the following qualifying events:

  — The parent-employee dies.

  — The parent-employee's hours of employment are reduced.

  — The parent-employee's employment ends for any reason other than his or her gross misconduct.

  — The parents become divorced.

When COBRA Coverage Is Available

The Plan offers COBRA continuation coverage to qualified beneficiaries **only after** the Plan administrator has been notified that a qualifying event has occurred. (See the "Administrative information" section for contact information.)

Notification Of Qualifying Events

When the qualifying event is the end of employment or reduction in hours of employment or death of the employee, **the employer must notify** the Plan administrator of the qualifying event.

For other qualifying events (divorce of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child), **you or the qualified beneficiary must notify** the Verizon Benefits Center within 90 days after the qualifying event occurs by calling 1-855-VzBens (1-855-489-2367).

How COBRA Coverage Is Offered

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

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

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

How Long COBRA Coverage Lasts

You and your eligible dependents may be eligible to continue participation in the Health Care Spending Account **for the remainder of the calendar year** in which participation otherwise would end.

You and your eligible dependents have 60 days from the date coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect continued participation under COBRA.

What COBRA Coverage Costs

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

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

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

If you or your dependent elects COBRA continuation coverage:

- You or your dependent can keep the same level of coverage you had as an active employee or choose a lower level of coverage.

- Your or your dependent's coverage is effective as of the date of the qualifying event. However, if you waive COBRA coverage and then revoke the waiver within the 60-day election period, your elected coverage begins on the date you revoke your waiver.

- You or your dependent may change your coverage:

  — If you have a qualified change in status (see the “Status Changes” section for more information).

  — If you have a change in circumstance recognized by the Internal Revenue Service (IRS) and Verizon.

When COBRA Coverage Ends

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

- You fail to make timely contributions as required.

- Verizon stops providing health benefits to any employee.

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

If You Have Questions

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

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

Important Note:

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

Dependent Day Care Spending Account

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

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

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

Who Can Provide Care

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

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

Eligibility

You are eligible to participate in the Dependent Day Care Spending Account on the first day of your employment if you are employed by a participating company (see the “Additional Information” section for details) and are a regular full-time, part-time or an eligible temporary New York or New England associate.

A temporary employee’s eligibility is governed by the applicable collective bargaining agreement.

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

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

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

Eligible Dependents for Whom You Can Claim Expenses

You can use the Dependent Day Care Spending Account to reimburse yourself for amounts you pay someone to care for an eligible dependent while you and, if you are married, your spouse are working. If you are married, you are eligible to use the account only if your spouse also works, is a full-time student at least five months during the year, is looking for a job or is unable to care for himself or herself due to a mental or physical disability.

An eligible dependent under the Dependent Day Care Spending Account is:

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

If you are divorced or separated and are the:

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

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

Enrolling in the Dependent Day Care Spending Account

Initial Enrollment by Newly Hired Associates

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

You can contribute as little as $100 or as much as $5,000 per calendar year to your account. However, when you join in the middle of the year, your contribution is prorated for the portion of the year you will be contributing. Your contributions will begin as soon as administratively possible after you enroll and will be deducted on a before-tax basis from your paychecks over the course of the year.

If you are changing from a management position to an associate position, your participation in the Dependent Day Care Spending Account will continue without interruption. Your election,, contributions, account and claim activity will be transferred to the account for associates if you contributed to the account as a manager.

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

If You Are Rehired

If you leave the Company and are rehired by the Company within 30 days, your benefits elections in place at the time of your termination will be reinstated and you cannot make changes, unless you experience a qualified life event.

If you leave the Company and are rehired by the Company after 30 days, you may reenroll in the Plan at any time during the calendar month following your reemployment.

Important Note

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

Changing Your Elections

Annually

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

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

Status Changes

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

Elections made due to status changes must be made within 90 days of the status change; otherwise, a change will not be allowed. Any change will remain in effect until December 31 of the calendar year in which the change is made or, if sooner, until you experience another status change and change your election. Your new election will take effect as soon as administratively possible after you call the Verizon Benefits Center, and deductions from your pay will be adjusted accordingly.

You Gain a New Dependent
If you gain a new, eligible dependent whom you claim as a dependent for income tax purposes, you can start or increase contributions to the Dependent Day Care Spending Account. To make a change, you must notify the Verizon Benefits Center of your status change within 90 days of the event.

You Lose a Dependent Through Death or Divorce or a Dependent No Longer Is Eligible
If you lose a dependent through death or divorce, or a dependent no longer is eligible, you may change your contribution election to the Dependent Day Care Spending Account by calling the Verizon Benefits Center within 90 days. Note that your contribution change must be consistent with your status change.

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

Change in Spouse's Eligibility With His or Her Employer
If your spouse participates in a similar plan with his or her employer and he or she makes a change under that plan either during that plan's annual enrollment period or at any other time due to a status change, you can make a change under your Dependent Day Care Spending Account. Your change must be on account of and consistent with your spouse's change under his or her plan.

An Increase in Cost for Dependent Care Services
If you have a significant cost increase for your dependent care services imposed by a provider who is not related to you, you can make an election change. You can make the change on the BenefitsConnection website or by calling the Verizon Benefits Center.

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

Leaves Under the Family and Medical Leave Act
Verizon complies with the Family and Medical Leave Act of 1993 (FMLA). All leaves of absence qualifying under the FMLA will be administered in accordance with the terms of the FMLA. Your participation in the Dependent Day Care Spending Account will be terminated. Your participation in the dependent day care spending account ends when your leave (paid or unpaid) begins. Participation can resume when you return to work with the company; however, you must re-elect this benefit through the Verizon Benefits Center if you wish to continue in the dependent day care spending account. See the "Status Changes" section for more information.

Leaves Under the Uniformed Services Employment and Reemployment Rights Act
All military leaves of absence qualifying under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) will be administered in accordance with the terms of USERRA. Call the Verizon Benefits Center for details.

When Participation Ends

Your participation ends on the earliest date described below.

Event	Effect on Your Participation
Leaves of Absence	In general, if you go on a leave of absence, your participation continues in accordance with Company guidelines and as collectively bargained.
Leaves of Absence Under the Family and Medical Leave Act	The Company complies with the Family and Medical Leave Act of 1993 (FMLA). All leaves of absence qualifying under the FMLA will be administered in accordance with the terms of the FMLA. Your Dependent Day Care Spending Account contributions will be suspended during approved leaves of absence, but may be continued on the first day of the month following your return to work. For information on non-FMLA Leaves of Absence, see your Additional Benefits and Programs Booklet.
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.
Change in Employment Status	If your employment status changes from associate to management status, your participation in the Dependent Day Care Spending Account will continue with no interruption. Your contributions, account and claims activity will be transferred to the new account for managers if you contributed to the account as an associate.
Long-Term Disability (LTD)	If you are receiving long-term disability benefits, your contributions to the account will end on the last day of the month in which your employment with Verizon ends due to long-term disability.
Cancellation of Coverage	If you stop contributions due to a change in status, your participation will end on the date you elect to stop contributing.
You Die	If you die while you are participating in the Dependent Day Care Account, your dependents can file claims on any remaining amounts in your account for eligible expenses incurred up to the date of your death. Your dependents can file claims on these amounts up until May 31 of the following year.
End of Employment	Coverage under the Plan will end on the last day of the month in which your employment ends for any reason not specified in this section. You can claim reimbursement for eligible expenses incurred up to the date your coverage ends.
Plan Termination	Although Verizon does not intend to terminate the Plan, were the Plan to be terminated, all contributions would end on the date of termination.

Dependent Day Care Spending Account Highlights

Here are some highlights of how the Dependent Day Care Spending Account works.

Account Feature	How It Works
Before-Tax Contribution You Can Deposit Each Year	Minimum: $100 per year Maximum: $5,000 per year (see the "Contribution Limits" section for details)
Using Your Account	You submit a claim for reimbursement whenever you have paid an eligible expense. The money will be taken out of your account up to the amount you have deposited and a check will be sent to you You must include your day care provider's Social Security number or taxpayer identification number when you submit a claim for reimbursement
Some Eligible Expenses To verify who is an IRS-eligible dependent and what is an IRS-eligible expense, visit the BenefitsConnection website at www.verizon.com/benefitsconnection	• Pre-school • Child care or adult day care at a center that meets state and local regulations • Baby-sitter • Nurse at home • Relative who cares for eligible dependents, as long as that relative is not your dependent or your child under age 19 **Expenses must be for an IRS-eligible dependent[1]:** • Your children under age 13 • Your disabled children of any age who are incapable of self-care • Your physically or mentally disabled spouse who is incapable of self-care • Anyone else you claim as a dependent for tax purposes who is incapable of self-care
Some Expenses That Are Not Eligible	• 24-hour nursing home care • "Saturday night" baby-sitting • Overnight camp

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

How the Account Works

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

To use the account:

- **Step 1:** During your initial enrollment and each annual enrollment period, you decide if you want to participate and elect the amount you want to contribute by enrolling on the BenefitsConnection website or calling the Verizon Benefits Center. This contribution should be based on a careful estimate of your expected dependent care expenses for the upcoming year.

- **Step 2:** During the year, your contributions will be deducted from your paychecks before federal income and Social Security taxes are calculated. In most cases, you also will avoid state and local taxes on your contributions. Some states, such as New Jersey and Pennsylvania, and certain municipalities—such as Yonkers, New York—treat the money you deposit in the Dependent Day Care Spending Account as taxable income for state and local taxes.

- **Step 3:** When you have incurred eligible dependent care expenses, you can file a claim—there is no minimum required to file a claim. (See "Eligible Dependent Care Expenses" for a list.) You will receive a tax-free reimbursement for your claim, up to the amount you have available in your account when you file your claim. You must provide the tax identification number of your care provider in order to claim expenses under the Dependent Day Care Spending Account.

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

- **Step 4:** Under IRS rules, you forfeit any money left in your account at the end of the year. However, you have until May 31 of the following year to submit requests for reimbursement of eligible expenses you incurred for the current plan year's expenses – those incurred January 1, 2015 – March 15, 2016.

Example of Tax Savings

The chart below shows how an employee earning $50,000 annually saves $226 in taxes by using the Dependent Day Care Account to pay for $1,000 in eligible expenses. The example assumes this employee is married, claims three exemptions and takes the standard deduction. Tax savings are based on 2006 tax rules.

	With Account	Without Account
Annual Pay	$50,000	$50,000
Expenses Paid With Account	- 1,000	- 0
Taxable Income	$49,000	$50,000
Estimated Federal Income and Social Security Taxes	- 5,712	- 6,938
Expenses Paid Without Account	- 0	- 1,000
Income Remaining	$ 43,288	$ 43,062
Tax Savings	**$ 226**	

In this example, the employee reduces his or her taxes by **$226** by using the account. In other words, he or she has increased his or her income after taxes by this amount.

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

Contribution Limits

You can contribute a minimum of $100 per year and a maximum of $5,000 per year to the dependent day care spending account depending on your marital status and how you file your federal income tax return. If you have a domestic partner or a same-sex spouse, you will be treated as a single participant.

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

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If You Also Receive Benefits From the Dependent Care Reimbursement Fund

If you are eligible to participate in the Company’s Dependent Care Reimbursement Fund, you should be aware that the same eligible dependent care expenses qualify for reimbursement under both plans; however, you cannot be reimbursed twice for the same expenses, and any reimbursements you receive from the fund reduce your reimbursement limit under the Dependent Day Care Spending Account. Therefore, when you estimate your eligible dependent care expenses for the upcoming calendar year, you should take into consideration any amounts that you can claim for reimbursement under the Dependent Care Reimbursement Fund.

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

Additional Tax Considerations

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

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

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

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

- If you earn less than the Social Security Wage Base ($113,700 in 2013) and contribute to the Dependent Day Care Spending Account, your future Social Security benefits may be reduced slightly. The impact generally is very small—less than one percent—after many years of using the account.

Eligible Dependent Care Expenses

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

Eligible Expenses

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

- The expenses must be provided primarily for the well-being and protection of the dependent.

- The day care provider must meet certain tax-identification requirements and comply with state and local laws.

- The care/service must be necessary for you to work and, if you are married, for your spouse to work, look for work or attend school full time (unless your spouse is disabled).

For a complete listing of eligible dependent care expenses, go to: BenefitsConnection > Spending Accounts >Tools and Resources >List of eligible Dependent Day Care Expenses.

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

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

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

Ineligible Dependent Care Expenses

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

- Amounts paid for the care of a person in a nursing home or convalescent facility.
- Amounts paid to your spouse or dependent, or child under the age of 19.
- Cost of food, clothing, shelter, insurance, medical treatment, or vacations of a qualifying dependent.
- Education expenses for any child in or beyond kindergarten.
- Items you intend to claim as a credit for federal tax purposes.
- Overnight camp expenses.
- Costs for dependent care when you – or your spouse – are not working.
- For each calendar year, expenses incurred before your participation in the Dependent Day Care Spending Account begins or after your participation ends.

Filing a Claim

You may be eligible for advance reimbursement under the Dependent Day Care Spending Account. Otherwise, as you incur eligible expenses, you can submit claims on the BenefitsConnection website or by faxing or mailing your claim to the Verizon Benefits Center for reimbursement.

You have until May 31 of the next calendar year to submit claims for the current Plan year's expenses– those incurred January 1, 2015 – March 15, 2016.

Advance Reimbursement

You can receive advance reimbursement of dependent care expenses for up to six weeks of contributions – up to the annual maximum you elected to contribute. This advance reimbursement feature is available:

- At the beginning of each Plan year.
- When participation begins for new hires.
- At a new enrollment due to a qualified change in status.

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

An example…	
Dependent Day Care Spending Account election	$5,000
Divided by weeks of contributions	÷ 52
Equals the weekly contributions	$96.15
Multiply this amount by six weeks	× 6
Equals the amount of money available	$576.90

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

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

Claim Processing

You can be reimbursed for eligible health care and dependent care expenses that you incur through March 15 of the next Plan year (calendar year). Claims must be received by May 31 of the year following the Plan year in which they are incurred; otherwise, they are not eligible for reimbursement. For example, if you have an expense in October of the current year, you have until May 31 of the next Plan year to file a claim for reimbursement. IRS rules require that any money remaining in your FSAs after the claims filing deadline will be forfeited.

Submitting Claims to BenefitsConnection

You have two options to submit a claim for your Dependent Day Care Spending Account.

Option 1 is to submit your claim online. This is a paperless process and you won't need to submit paper anymore. To submit your claim online, visit the BenefitsConnection website at www.verizon.com/benefitsconnection, click on the "Spending Accounts" tab and select "Submit New Claim".

Option 2 is to submit your claim using the Dependent Day Care Spending Account Claim Form. To obtain a claim form, go to: BenefitsConnection>"Spending Accounts">Tools & Resources>Dependent Day Care Spending Account Claim Form. Follow the instructions on the claim form to properly submit your claim. Fax the completed form and supporting documentation to 1-855-785-3471. Make sure that you fax the form and supporting documentation together. The claim form should be the first page in the stack of pages that you fax.

Alternatively, you may also mail your claims to: Verizon Benefits Center, P.O. Box 8999, Norfolk, VA 23501-8999.

This information is also provided on the claim form. Claims submitted on the Dependent Day Care Spending Account claim form are reimbursed via a check mailed to your home address (or through direct deposit, if you have signed up for it).

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

Supporting Documentation

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

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

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

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

Annual Dependent Care Claims

The annual claim process is available under the Dependent Day Care Account. You can submit one claim for the entire year (for example, dates of service January 1, 2015 – March 15, 2016) and be reimbursed as contributions accrue. Documentation provided with an annual claim must include the following:

- A statement from the care provider or service indicating the daily, weekly or monthly fee, and the annual total (individual totals for multiple dependents).

- Indication on the claim form of the date range (for example, January 1 through December 31), name of dependents for whom the services apply and the total amount being claimed.

If you choose to submit an annual claim, you are responsible for notifying the Verizon Benefits Center if your expenses for the care change.

If Your Claim Is Denied

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

Dependent Care Reimbursement Fund

Eligibility

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

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

- If you are a New England non-bargaining unit associate or an IBEW member, you may be eligible and are covered under the IBEW guidelines.

Eligible Dependents

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

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

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

Enrolling in the Dependent Care Reimbursement Fund

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

When Participation Ends

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

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

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

How the Fund Works

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

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

To use the fund:

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

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

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

Government Limits

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

- If you are married and you and your spouse file separate federal income tax returns, the most you can be reimbursed tax-free from the plans is $2,500 in a calendar year.

- Your annual tax-free reimbursement cannot exceed the lesser of your earned income for the year or your spouse's earned income. For this purpose, during any month your spouse is a full-time student or disabled, your spouse's assumed earned income for the month is $200 if you have eligible expenses for one dependent or $400 if you have expenses for two or more dependents.

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

The Company's Plans and the Federal Tax Credit

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

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

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

Eligible Dependent Care Expenses

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

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

Filing Your Claim for Reimbursement

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

Reimbursement

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

To file a claim:

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

Situations That Can Affect Your Participation

If You Take a Leave of Absence

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

If You Retire or Leave the Company

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

If You Die

If you die, your spouse and/or dependents can submit claims for eligible expenses incurred up to the date you died.

Changes or Termination of the Plan

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

Additional Information

Forfeitures Under the Health Care and Dependent Care Spending Accounts

If you were enrolled in the Plan as of December 31 of the current Plan year, you can be reimbursed for eligible health care and dependent care expenses that you incur through March 15 of the next calendar year. You have until May 31 of that next calendar year to submit claims for the current calendar year's expenses. For example, for the 2015 Plan year, you can pay for dependent care provided on March 1, 2016 and submit a claim toward any balance remaining in your 2015 Dependent day care account for the cost of the care. Any money not used by March 15 and submitted by May 31 will be forfeited.

Health Care Spending Account

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

- First, these amounts will be applied to offset participating company contributions for health care claims that are in excess of participating individuals' contributions to the account.

- Then, these amounts will be applied toward the cost and expenses of administering the Plan.

Dependent Day Care Spending Account

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

Claims and Appeals Procedures

The authority and discretion to designate each of the claims and appeals administrators is granted to the Verizon Claims Review Committee (VCRC), and to the individuals who chair each of these committees.

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

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

Claims Regarding Eligibility to Participate in the Plan

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

Claims Regarding Scope/Amount of Benefits Under the Plan

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

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

The claims and appeals administrators have discretionary authority to:

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

If a Claim Is Denied

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

This section explains the steps you or your authorized representative is required to take to file an ERISA claim or appeal. This procedure is slightly different, depending on whether you have an "**eligibility**" claim or a "**benefit**" claim. An **eligibility** claim is a claim to participate in the Health Care Spending Account or to change the amount of your before-tax contributions. A **benefit** claim is a claim for reimbursement under the plan, such as a claim to have a particular health care service reimbursed by the Health Care Spending Account. It typically will include your initial request for benefits.

The process is described in the following chart.

	***Eligibility* claims procedure**	***Benefit* claims procedure**
Step 1:		
How to file a claim	To file an eligibility claim, request a Claim Initiation Form from the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367). You (or your authorized representative) must return the form to the Verizon Claims Review Unit at the address on the form. You must include: • A description of the request. • The reason for the request. • Relevant documentation.	Your initial request for benefits is a "claim" for benefits under ERISA. So, the procedure outlined in the "Filing a Claim" section is the first step in the ERISA claims process for a benefit claim.
When you will be notified of the claims decision	You will be notified of the decision within 30 days of the Claims Review Unit's receipt of your Claim Initiation Form. The 30-day period may be extended for 15 days.	You will receive an Explanation of Benefits (EOB) within 30 days of the Verizon Benefits Center's receipt of your claim for benefits. The 30-day period may be extended for 15 days.
Failure to provide sufficient information	If you fail to provide sufficient information, the claim may be decided based on the information provided. However, the Claims Review Unit may notify you within 30 days that additional information is needed. You will have 45 days to provide the additional information. Otherwise, the claim will be decided based on information originally provided. If you provide additional information, you will be notified of the decision by the Claims Review Unit within the time period remaining for the initial claim.	If you fail to provide sufficient information, the claim may be decided based on the information provided. However, Verizon Benefits Center may notify you within 30 days that additional information is needed. You will have 45 days to provide the additional information. Otherwise, the claim will be decided based on information originally provided. If you provide additional information, you will be notified of the decision by the Verizon Benefits Center within the time period remaining for the initial claim.
How you will be notified of the claim decision	The Claims Review Unit will notify you in writing. If your claim is **denied**, in whole or in part, your written denial notice will contain: • The specific reason(s) for the denial. • The Plan provisions on which the denial was based. • Any additional material or information you may need to submit to complete the claim. • The Plan's appeal procedures.	The Verizon Benefits Center will notify you in writing by providing you with an EOB. If your claim is **denied**, in whole or in part, your EOB will contain: • The specific reason(s) for the denial. • The Plan provisions on which the denial was based. • Any additional material or information you may need to submit to complete the claim. • The Plan's appeal procedures.

	***Eligibility* claims procedure**	***Benefit* claims procedure**
Step 2:		
About appeals and the claims fiduciary	Before you can bring any action at law or in equity to recover Plan benefits, you **must** exhaust this process. Specifically, you must file an appeal as explained in this Step 2 and the appeal must be finally decided by the Claims Review Committee, the claims fiduciary. As such, the Claims Review Committee is authorized to finally determine eligibility appeals and interpret the terms of the plan in its sole discretion. All decisions by the Claims Review Committee are final and binding on all parties.	Before you can bring any action at law or in equity to recover plan benefits, you **must** exhaust this process. Specifically, you must file an appeal as explained in this Step 2 and the appeal must be finally decided by the Verizon Benefits Center Benefits Determination Review Team, also known as the claims administrator. The Claims Review Committee has delegated its authority to finally determine claims to the Verizon Benefits Center Benefits Determination Review Team. As such, the Verizon Benefits Center Benefits Determination Review Team is the claims fiduciary and is authorized to finally determine benefit appeals and interpret the terms of the plan in its sole discretion. All decisions by the Verizon Benefits Center Benefits Determination Review Team are final and binding on all parties.

	***Eligibility* claims procedure**	***Benefit* claims procedure**
How to file an appeal	If your claim is denied and you want to appeal it, you must file your appeal within 180 days from the date you receive notice of your denied claim. You may request access to all documents relating to your appeal. To file an appeal, you must write to the Verizon Claims Review Committee c/o Verizon Benefits Center P.O. Box 8998 Norfolk, VA 23501-8998 You should include: • A copy of your claim denial notice. • The reason(s) for the appeal. • Relevant documentation. The individual/committee (and any medical expert) reviewing your appeal will be independent from the individual/committee who reviewed your claim. In addition, if your appeal involves a medical judgment, the Claims Review Committee will consult with a healthcare professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request.	If your claim is denied and you want to appeal it, you must file your appeal within 180 days from the date you receive notice of your denied claim. You may request access to all documents relating to your appeal. To file an appeal, you must contact the Verizon Benefits Center and request an appeal form. Your completed form should be sent to: Verizon Benefits Center P.O. Box 8998 Norfolk, VA 23501-8998 You should include: • A copy of your EOB. • The reason(s) for the appeal. • Relevant documentation. The individual/committee (and any medical expert) reviewing your appeal will be independent from the individual/committee who reviewed your claim. In addition, if your appeal involves a medical judgment, the Verizon Benefits Center Benefit Determination Review Team will consult with a healthcare professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request.

	***Eligibility* claims procedure**	***Benefit* claims procedure**
When you will be notified of the appeal decision	You will be notified of the decision within 60 days of the Claims Review Committee's receipt of your appeal.	You will be notified of the decision within 60 days of the Verizon Benefits Center Benefit Determination Review Team's receipt of your appeal.
How you will be notified of the appeal decision	Regardless of whether your appeal is approved or denied, the Claims Review Committee will notify you in writing. If your appeal is denied, in whole or in part, your denial notice will contain: • The specific reason(s) for the denial. • A statement regarding the documents to which you are entitled. • Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request). • The Plan provisions on which the denial was based. • The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."	Regardless of whether your appeal is approved or denied, the YSA Benefit Determination Review Team will notify you in writing. If your appeal is denied, in whole or in part, your denial notice will contain: • The specific reason(s) for the denial. • A statement regarding the documents to which you are entitled. • Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request). • The Plan provisions on which the denial was based. • The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."
Step 3:		
How to proceed if necessary	The decision on your appeal is final. Verizon will not review your matter again, unless new facts are presented. You have a right to bring a civil action.	The decision on your appeal is final. The Verizon Benefits Center Benefit Determination Review Team, the claims administrator, will not review your matter again, unless new facts are presented. You have a right to bring a civil action.

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

- Examine, without charge at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

- Continue healthcare coverage for yourself, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review your SPD and the documents governing the Plan on your COBRA continuation coverage rights.

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

If your claim for a benefit is denied or ignored in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a qualified medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim to be frivolous).

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

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

HIPAA Privacy Rights

The information provided in the notice that follows is required under the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA Privacy Notice

NOTICE OF PRIVACY PRACTICES FOR THE VERIZON COMMUNICATIONS INC. HEALTH PLANS

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

I. Background Information and Effective Date

The Department of Health and Human Services published a final regulation addressing the privacy of Protected Health Information (as defined in section III below) in August of 2002 (the "Privacy Rule"). As a result, the Verizon Communications Inc. ("Verizon") health plans listed in section II below will have to comply with the Privacy Rule, effective April 14, 2003 (the "Effective Date"). This Notice, which is required by the Privacy Rule, is effective on the Effective Date.

II. Plans on Behalf of Which this Notice is Being Provided

For purposes of this Notice, the term "Verizon Health Plans" has special meaning. This Notice applies to the following Verizon plans, which are referred to in this Notice as the "Verizon Health Plans:"

- Verizon Health Care Spending Account and Dependent Care Spending Account for New York and New England Associates (EIN: 23-2259884, PIN: 563)

Note: The Verizon Health Care Spending Account and Dependent Care Spending Account for New York and New England Associates is a hybrid entity under the Privacy Rule. In that case, this Notice shall only apply and be interpreted to apply to that portion of this plan that is subject to the Privacy Rule as a group health plan.

In addition, in the event you are covered by an insured health plan, your insurer will be providing you with a separate notice that describes the insurer's use and disclosure of your Protected Health Information.

III. Health Information to Which this Notice Applies

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

- The information is created or received by a health care provider, a Verizon Health Plan, or Verizon.

- The information includes specific identifiers that identify you or could be used to identify you.

- The information relates to one of the following:

—Providing health care to you;

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

—The past, present, or future payment for your health care.

This includes any of the following documentation, if the documentation reveals your identity and your health status or payment issues: medical records (such as hospital charts or doctor's notes); medical bills (such as bills for hospital or doctor's services); claims data (such as data on claims payments made by one of the Verizon Health Plans on your behalf); and insurance payment information (such as an Explanation of Benefits).

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

The Verizon Health Plans may use or disclose your Protected Health Information for purposes of making or obtaining payment for your health care, for purposes of conducting health care operations, or for certain other specified purposes. The Verizon Health Plans have established a policy to guard against unnecessary uses and disclosures of your Protected Health Information.

The purposes for which your Protected Health Information may be used and disclosed by the Verizon Health Plans may be summarized as follows:

A. To Make or Obtain Payment for Health Care

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

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

B. To Conduct Health Care Operations

The Verizon Health Plans may use or disclose your Protected Health Information to facilitate the administration and operation of the Verizon Health Plans. Health care operations include such activities as: case management and care coordination; conducting or arranging for medical review, auditing, or legal services; population-based activities to improve health or reduce health care costs; contacting providers or patients with information regarding treatment alternatives; clinical guideline and protocol development; reviewing the competence or qualifications of health care professionals and evaluating health plan performance; underwriting and premium rating; fraud and abuse detection; and activities relating to the creation, renewal, or replacement of a health care contract. Pursuant to the provisions of the Genetic Information Nondiscrimination Act of 2008, the Verizon Health Plans do not use or disclose Protected Health Information that is "genetic information" for underwriting purposes as defined under such Act.

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

C. For Treatment Alternatives or Distribution of Health-Related Benefits and Services

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

D. To Assist Verizon as Plan Sponsor

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

E. When Legally Required

The Verizon Health Plans may disclose your Protected Health Information when required to do so by any federal, state, or local law.

F. In Connection With Judicial and Administrative Proceedings

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

G. For Law Enforcement Purposes

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

H. For Health Oversight Activities

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

I. In the Event of a Serious Threat to Health or Safety

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

J. For Specified Government Functions

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

K. For Public Health Activities

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

L. For Disaster Relief Purposes

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

M. In Connection with Decedents

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

N. For Workers' Compensation Purposes

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

O. For Involvement In, and Notification Of, Your Care

The Verizon Health Plans may use or disclose your Protected Health Information to your relatives or other persons you identify who are involved in your care or payment for your care, or to notify family members or others responsible for your care of your condition or location. In these situations, when you are present and not incapacitated, the Verizon Health Plans will either: (1) provide you with an opportunity to disagree to the use or disclosure and, if you do not disagree, your Protected Health Information may be used or disclosed; or (2) obtain your agreement to the use or disclosure.

P. To Assist Victims of Abuse, Neglect, or Domestic Violence

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

Q. For Cadaveric Organ, Eye, or Tissue Donation

The Verizon Health Plans may use or disclose Protected Health Information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye, or tissue donation and transplantation.

R. For Certain Government-Approved Research Activities

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

S. To Other Covered Entities

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

T. With an Authorization

Other than as stated above, the Verizon Health Plans will not use or disclose your Protected Health Information without your written authorization. If you authorize a Verizon Health Plan to use or disclose your Protected Health Information, you may revoke that authorization in writing at any time. If you revoke the authorization, the Verizon Health Plan will no longer use or disclose your Protected Health Information for the reasons covered by your written authorization. Your revocation will not affect any uses or disclosures a Verizon Health Plan has already made prior to the date the Verizon Health Plan receives notice of the revocation.

V. Your Rights Regarding Your Protected Health Information

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

A. Right to Request Restrictions

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

- Uses and disclosures of your Protected Health Information to carry out payment or health care operations

- Certain uses and disclosures for disaster relief and other notification purposes and for involvement in your care

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

However, the Verizon Health Plan must comply with your requested restriction if: (1) except as otherwise required by law, you request a restriction on the disclosure to a health plan of your Protected Health Information for payment or health care operations; and (2) the Protected Health Information relates solely to a health care item or service for which a health care provider has been paid out of pocket in full.

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

B. Right to Receive Confidential Communications

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

C. Right to Inspect and Copy

In general, you have the right to inspect and obtain a copy of your Protected Health Information. If a Verizon Health Plan uses or maintains an electronic health record with respect to your Protected Health Information, you have the right to request and obtain a copy of this information in an electronic format. A request to inspect or obtain a copy of your Protected Health Information must be made in writing to the privacy contact identified in paragraph IX below and must include: (1) the desired form or format of access; (2) a description of the Protected Health Information to which the request applies; and (3) appropriate contact information. If you request a copy of your Protected Health Information, you may be charged a reasonable fee for the costs of copying, postage, and other supplies associated with your request. Under very limited circumstances, your request to inspect or obtain a copy of your Protected Health Information may be denied. In most cases, if your request is denied, you may request a review of the denial in accordance with the privacy complaint procedure, a copy of which can be obtained from the privacy officer in care of the Verizon HIPAA Unit at the address in paragraph IX below.

D. Right to Amend

If you believe that Protected Health Information a Verizon Health Plan has about you is inaccurate or incomplete, you may ask that Verizon Health Plan to amend that Protected Health Information. You have the right to request an amendment for as long as the Protected Health Information is kept by the Verizon Health Plan.

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

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

If your request is denied, you may request a review of the denial in accordance with the privacy complaint procedure, a copy of which can be obtained from the privacy officer in care of the Verizon HIPAA Unit at the address in paragraph IX below.

E. Right to an Accounting of Disclosures

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

A request for an accounting must be made in writing to the privacy contact identified in paragraph IX below. The request must specify the name of the Verizon Health Plan(s) to which the request applies, as well as the time period for which you are requesting the accounting. The time period for which you request an accounting may not start earlier than the April 14, 2003 Effective Date of the Privacy Rule and may not be for a period of time going back more than six years. The first accounting you request within a 12-month period will be free of charge. For additional accountings within that same 12-month period, you may be charged a reasonable fee for the costs of providing the accounting. You will be notified in advance of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

F. Right to Receive a Paper Copy of this Notice

You have the right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously or agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

VI. Other Obligations of the Verizon Health Plans

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

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

When and as required, the Verizon Health Plans will notify you in the event of an impermissible or unauthorized acquisition, access, use, or disclosure of your Protected Health Information, that compromises the security or privacy of such Protected Health Information, under the Privacy Rule.

VII. Changes to this Notice

The Verizon Health Plans reserve the right to change this Notice and to make the revised or changed Notice effective for Protected Health Information the Verizon Health Plans already have about you, as well as for any such information received in the future. If the Verizon Health Plans change any of their privacy policies and procedures, the Verizon Health Plans will revise the Notice as appropriate and will provide a copy of the revised Notice to you within 60 days of the material change. You may also obtain a paper copy of this Notice from the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

VIII. Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the privacy officer in care of the Verizon HIPAA Unit identified in paragraph IX below or with the Secretary of the United States Department of Health and Human Services. All complaints must be submitted in writing. You will not be retaliated against in any way for filing a complaint.

IX. Contact Information

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

Contact your health insurer or health plan option administrator:

If you have a question, concern, complaint, or request regarding Protected Health Information held by a **health insurer or health plan option administrator**, contact your health insurer or health plan option administrator directly. Contact information for your health insurer or health plan option administrator can be found in your summary plan description, your insurance cards, on the BenefitsConnection website at www.verizon.com/benefitsconnection or by calling the Verizon Benefits Center toll free at 1-855-4VzBens (1-855-489-2367).

Contact the Privacy Officer for the Verizon Health Plans:

If you have a question, concern, complaint, or request regarding Protected Health Information held internally at Verizon, contact the privacy officer for the Verizon Health Plans as follows:

HIPAA Privacy Officer
c/o Verizon HIPAA Unit
P.O. Box 1483
Lincolnshire, IL 60069-1483
1-908-559-3628

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

The Notice of Privacy Practices for the Verizon Communications Inc. Health Plans is available on the BenefitsConnection website at www.verizon.com/benefitsconnection. Generally, the Notice of Privacy Practices for the Verizon Communications Inc. Health Plans available on BenefitsConnection is the most up to date. Once you have logged on to BenefitsConnection, select the Library link from the home page and then “HIPAA Privacy Policy” under “Benefit Forms” in order to view the Notice. You may view the Notice on the website and/or print a paper copy from the website. You may also request a paper copy of the Notice at any time by calling the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

Administrative Information

This section contains important information about how your benefits are administered and funded. It also contains information about your rights and responsibilities as a participant and steps you can take if certain situations arise (see the "Your rights under ERISA" section for more information).

Important Telephone Numbers

You can connect to the Verizon Benefits Center and other Verizon benefit providers by calling 1-855-4VzBens (1-855-489-2367).

Plan Sponsor/Employer

The Plan sponsor/employer is:

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

Plan Administrator

The Plan administrator is:

Chairperson of the VEBC
c/o Verizon Benefits Center
P.O. Box 8998
Norfolk, VA 23501-8998
1-855-4VzBens(1-855-489-2367)

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

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

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

Benefits Administrator

The Verizon Benefits Center is the benefits administrator for the Plan. As the benefits administrator, the Verizon Benefits Center has the authority and responsibility to perform daily administration of benefits under the Plan. Call 1-855-4VzBens (1-855-489-2367) to reach a representative.

Claims and Appeals Administrator

There are two claims and appeals administrators for the Plan. The claims administrators have the authority to make final determinations regarding claims for benefits.

Verizon Claims Review Committee (VCRC)

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

Verizon Claims Review Committee
c/o Verizon Benefits Center
P.O. Box 8998
Norfolk, VA 23501-8998
1-855-4VzBens (1-855-489-2367)

Verizon Benefits Center

The Verizon Benefits Center 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. The Verizon Benefits Center can be reached at the following address:

Verizon Benefits Center
P.O. Box 8998
Norfolk, VA 23501-8998
1-855-4VzBens (1-855-489-2367)

Qualified Medical Child Support Orders (QMCSOs)

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

Verizon Benefits Center
P.O. Box 8998
Norfolk, VA 23501-8998
1-855-4VzBens (1-855-489-2367)

Plan Funding

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

Plan Identification

Spending account participation is provided through the Verizon Health Care Spending Account and Dependent Care Spending Account for New York and New England Associates. It is a welfare plan, listed with the Department of Labor under two numbers: The Employer Identification Number (EIN) is 23-2259884 and the Plan Number is 563.

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

Plan Year

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

Agent for Service of Legal Process

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

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

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

Collective Bargaining Agreements

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

Official Plan Document

This SPD is a summary of the official Plan documents.

Participating Companies

The following is a list of participating companies as of January 1, 2013. The list may change from time to time.

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

Glossary

A

Affordable Care Act

In March of 2010, Congress passed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. These new laws are commonly referred to as "Health Care Reform." For purposes of this SPD, they are collectively referred to as the "Affordable Care Act."

After-Tax Dollars

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

B

Before-Tax Contributions

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

C

COBRA

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

Coinsurance

The percentage of a medical, dental, prescription drug or vision expenses that you may have to pay (in some cases, after you meet an annual deductible). For instance, if your medical option pays 80% of eligible expenses and you pay the other 20% — your coinsurance would be 20%.

Copayment (Copay)

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

D

Deductible

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

E

Eligible Expenses

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

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

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

Full-time Associate
A full-time associate is an employee who is regularly scheduled to work 25 or more hours per week. In addition, the definition of a full-time associate includes job-sharing employees who are regularly scheduled to work at least 40 percent of a regular full-time employee's hours.

Forfeiture
You can be reimbursed for eligible health care and dependent care expenses that you incur through March 15 of the next calendar year. You have until May 31 of that next calendar year to submit claims for the current calendar year's expenses. For example, you can pay for dependent care provided on March 1, 2016 and submit a claim toward any balance remaining in your 2015 Dependent Day Care Account for the cost of the care. Any money not used by March 15 and submitted by May 31 will be forfeited.

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

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

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

General Rule

Your spouse, as defined by IRS rules, is an IRS tax dependent. IRS rules define a spouse to be a person of the same or opposite sex to whom you are married under state law. The term "state" means any domestic or foreign jurisdiction having the legal authority to sanction marriages. In addition, your child who has not attained the age of 27 as of the end of the taxable year is an IRS tax dependent. To meet this general rule, the child must be your (the employee's) son, daughter, stepson, stepdaughter or eligible foster child[1]. A son or daughter includes your legally adopted child or child who is lawfully placed with you for adoption. This exclusion does **not** apply to the child of your domestic partner.

Other Categories

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

A "qualifying child" generally is a person who:

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

If a person does not meet the definition of "qualifying child," he or she might be an IRS tax dependent by satisfying the "qualifying relative" requirements.

A "qualifying relative" generally is a person who:

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

[1] An "eligible foster child" is an individual who is placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

Example
Your domestic partner might be your IRS tax dependent if he or she is a U.S. citizen or resident, receives over one-half of his or her support from you and lives with you for the entire calendar year as a member of your household. Even though a domestic partner is not a "relative" in the traditional sense, he or she may meet the definition of "qualifying relative." Your domestic partner's child typically will not be your IRS tax dependent, unless the domestic partner also is your tax dependent.

P

Part-time Associate

A part-time associate is an employee who is regularly scheduled to work fewer than 25 hours per week, other than an employee who has been continuously employed since December 31, 1980 and other than a job-sharing employee who is considered a full-time associate.

Plan Year

A calendar year, January 1 through December 31.

Q

Qualifying Child

A "qualifying child" for dependent day care spending account purposes generally is a person who:

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

S

Spouse

Before January 1, 2014, spouse is defined under the Plan as follows:

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

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

On and after January 1, 2014, Spouse is defined under the Plan as follows:

Your spouse is a person of the opposite or same sex who is a husband or wife, pursuant to a legal union, defined as "marriage" under state law. The term "State" means any domestic or foreign jurisdiction having the legal authority to sanction marriages.

T
Tax Identification Number

In order to receive reimbursement of Dependent Day Care Account expenses, the IRS requires the Company to obtain a tax identification number before reimbursing your expenses. For individuals providing dependent care, this can be the individual's Social Security number.