



# Update to Your SPD Benefit Booklets: Summary of Benefit Changes Resulting From Collective Bargaining

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## The Purpose of This Update

This information is a supplement to your summary plan description (SPD) booklets for these plans:

- Verizon Pension Plan for Mid-Atlantic Associates,
- Verizon Savings and Security Plan for Mid-Atlantic Associates,
- Verizon Dental Expense Plan for Mid-Atlantic Associates,
- Verizon Vision Care Plan for Mid-Atlantic Associates,
- Verizon Health Care Spending Account for Mid-Atlantic Associates,
- Verizon Sickness and Accident Disability Benefit Plan for Mid-Atlantic Associates, and
- Verizon Long-Term Disability Plan for Mid-Atlantic Associates.

This update is a summary of material modification (SMM) and includes the most recent collective bargaining provisions related to benefits agreed to between your union and Verizon for the plans listed above. The most recent collective bargaining provisions related to your medical benefits are communicated separately. Specifically, your medical benefits SPD booklet for the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates has been updated to include these provisions. Please keep this SMM with your SPD booklets for future reference.

If you have any questions after reading this information, please call the Verizon Benefits Center at 1-877-Ask-VzHR (1-877-275-8947) and speak with a representative.

## **Verizon Pension Plan for Mid-Atlantic Associates**

### **Single Lump-Sum Payment Included in Supplemental Benefit Calculation**

Supplemental earnings taken into account in determining a participant's supplemental monthly pension benefit will include in 2003 the single lump-sum payment equal to 3% of the associate's basic weekly wage for one year. This payment was calculated as of August 3, 2003 and paid by October 31, 2003.

### **Temporary 5% Pension Band Basic Monthly Benefit Increase and Cashout Opportunity**

For an associate participating in the pension plan who terminates employment with a vested benefit between October 1, 2003 and December 31, 2003:

- The pension band used to calculate the associate's basic monthly benefit will be increased by 5%. For associates with multiple bands, the 5% pension band increase will apply to all pension band values used in the associate's benefit calculation. (The increase does not apply to any supplemental benefit or to the minimum monthly pension benefit, if applicable.)
- The associate will have the opportunity to elect a lump-sum distribution (cashout) of his or her pension benefit. The associate may elect to receive a lump-sum distribution on a commencement date that is the day following termination of employment or the first day of any following month. However, any commencement date must be elected in writing in advance of such date. Additionally, if termination of employment occurs no later than November 30, 2003, the associate's lump-sum distribution amount will be the larger of the lump sums determined using:
  - The third quarter 2003 interest rate and mortality table basis, or
  - The interest rate and mortality table basis effective under the pension plan when the associate's commencement date occurs.

### Scheduled Pension Band Basic Monthly Benefit Increases

The pension band basic monthly benefits shown on page 18 of your pension plan booklet will increase as shown in the chart below over the term of the collective bargaining contract. These pension band basic monthly benefit amounts reflect a 2% increase effective November 1, 2004, and a 3% increase per year thereafter effective October 1, 2005, October 1, 2006 and October 1, 2007. The increased monthly benefit amounts apply to associates with “pension effective dates” (i.e., first day following the last day on the payroll) on or after the applicable effective dates shown in the table below.

Pension Band Number	Monthly Benefit Effective July 1, 2003*	Monthly Benefit Effective November 1, 2004	Monthly Benefit Effective October 1, 2005	Monthly Benefit Effective October 1, 2006	Monthly Benefit Effective October 1, 2007
101	\$31.36	\$31.99	\$32.95	\$33.94	\$34.96
102	\$32.66	\$33.31	\$34.31	\$35.34	\$36.40
103	\$33.98	\$34.66	\$35.70	\$36.77	\$37.87
104	\$35.31	\$36.02	\$37.10	\$38.21	\$39.36
105	\$36.63	\$37.36	\$38.48	\$39.63	\$40.82
106	\$37.97	\$38.73	\$39.89	\$41.09	\$42.32
107	\$39.28	\$40.07	\$41.27	\$42.51	\$43.79
108	\$40.59	\$41.40	\$42.64	\$43.92	\$45.24
109	\$41.96	\$42.80	\$44.08	\$45.40	\$46.76
110	\$43.25	\$44.12	\$45.44	\$46.80	\$48.20
111	\$44.58	\$45.47	\$46.83	\$48.23	\$49.68
112	\$45.88	\$46.80	\$48.20	\$49.65	\$51.14
113	\$47.22	\$48.16	\$49.60	\$51.09	\$52.62
114	\$48.55	\$49.52	\$51.01	\$52.54	\$54.12
115	\$49.85	\$50.85	\$52.38	\$53.95	\$55.57
116	\$51.19	\$52.21	\$53.78	\$55.39	\$57.05
117	\$52.48	\$53.53	\$55.14	\$56.79	\$58.49
118	\$53.84	\$54.92	\$56.57	\$58.27	\$60.02
119	\$55.17	\$56.27	\$57.96	\$59.70	\$61.49
120	\$56.47	\$57.60	\$59.33	\$61.11	\$62.94
121	\$57.78	\$58.94	\$60.71	\$62.53	\$64.41
122	\$59.13	\$60.31	\$62.12	\$63.98	\$65.90
123	\$60.44	\$61.65	\$63.50	\$65.41	\$67.37
124	\$61.76	\$63.00	\$64.89	\$66.84	\$68.85
125	\$63.08	\$64.34	\$66.27	\$68.26	\$70.31
126	\$64.40	\$65.69	\$67.66	\$69.69	\$71.78
127	\$65.74	\$67.05	\$69.06	\$71.13	\$73.26
128	\$67.03	\$68.37	\$70.42	\$72.53	\$74.71
129	\$68.38	\$69.75	\$71.84	\$74.00	\$76.22
130	\$69.67	\$71.06	\$73.19	\$75.39	\$77.65
131	\$71.03	\$72.45	\$74.62	\$76.86	\$79.17
132	\$72.36	\$73.81	\$76.02	\$78.30	\$80.65
133	\$73.66	\$75.13	\$77.38	\$79.70	\$82.09
134	\$75.00	\$76.50	\$78.80	\$81.16	\$83.59
135	\$76.28	\$77.81	\$80.14	\$82.54	\$85.02

\*A temporary 5% pension band increase applies to these basic monthly benefit amounts for associates who terminated employment during the period October 1, 2003 and December 31, 2003.

To find out your pension band, please refer to the most current collective bargaining agreement.

## **If You're a Commission Directory Advertising Salesperson**

In determining your basic monthly pension benefit:

- Your average annual compensation will be based on the three highest consecutive calendar years of pay in the ten calendar years before January 1, 2003 (instead of January 1, 2000).
- Fixed annual average pay will be based on the average median maximum annual basic rate of pay for CWA associates in pension band number 135 on the pension determination date (January 1, 2003 – instead of January 1, 2000 – for all retirements after August 8, 2003) and as of the two preceding calendar years. For example, the median maximum pay on January 1, 2003 was \$71,201.

### **Lump-Sum Distribution (Cashout) Option**

As noted above, lump-sum distributions are available for associates who terminate employment between October 1, 2003 and December 31, 2003. Lump-sum distributions will also be available for associates who terminate employment on or after November 1, 2004 and on or before August 2, 2008. An associate who is eligible to take a lump-sum distribution may choose to receive a lump-sum distribution on a commencement date elected by the associate that occurs on or after the date the associate's written request is received by the pension plan administrator and that is either the day following termination of employment or the first day of any month following termination. (The 90-day window for receiving a lump-sum distribution has been eliminated.)

Please note that associates who terminate employment during the period January 1, 2004 through October 31, 2004 will **not** be eligible to receive a lump-sum distribution option **unless**:

- The associate's lump-sum distribution value is \$3,500 or less. In this case, the associate will automatically receive his or her benefit in a lump-sum distribution.
- The associate is eligible for a vested or a service pension and terminates employment due to the exhaustion of 52 weeks of sickness disability benefits. In this case, the associate will have the option to receive a lump-sum distribution of his or her vested or service pension. (The associate may not receive a lump-sum distribution of any disability pension for which he or she may qualify – see page 37 of the pension plan booklet.)

### **Changes to Preretirement Survivor Death Benefits**

The following changes apply to preretirement survivor death benefits:

- If an associate dies while employed between January 1, 2004 and October 31, 2004 and his or her beneficiary is eligible to receive a preretirement survivor death benefit, the associate's beneficiary is eligible to receive a lump-sum distribution. The beneficiary's lump-sum death benefit will equal the greater of:
  - The lump-sum value of the 65% preretirement survivor death benefit (or in the case of a nonspouse beneficiary who is more than 25 years younger, the 50% preretirement survivor death benefit) that is otherwise payable under the pension plan, or
  - The lump-sum benefit the associate would have received if he or she had terminated employment at death and received payment in a lump sum on the beneficiary's commencement date.

- Also, a lump-sum distribution (cashout) will be available to the beneficiary of an associate who dies after terminating employment and before his or her commencement date if the associate was otherwise eligible to elect a lump-sum distribution at the time he or she died. In this case, the death benefit will be the greater lump-sum value of:
  - The lump-sum value of the 65% preretirement survivor death benefit (or in the case of a nonspouse beneficiary who is more than 25 years younger, the 50% preretirement survivor death benefit) otherwise payable under the pension plan, or
  - The lump-sum benefit the associate would have received on the commencement date for a lump sum elected by the associate prior to his or her death, or if no lump-sum election was in effect, the lump-sum benefit the associate would have received on the beneficiary's commencement date.

### **Updated Claims and Appeals Procedures**

The "Claims and Appeals Procedures" section of your pension plan SPD has changed. For all pension claims, except disability pension, the procedure remains as described in the pension plan SPD, with the exception of where to direct your claims. The P.O. Box of your claims and appeals administrator has changed, as follows:

Verizon Claims Review Committee  
c/o Verizon Claims Review Unit  
P.O. Box 1438  
Lincolnshire, IL 60069-1438

Claims should be directed to the Verizon Claims Review Unit, while appeals should be directed to the Verizon Claims Review Committee in care of the Verizon Claims Review Unit. In either case, the P.O. Box is 1438.

In addition, to ensure that your claim is properly directed, you may want to request a Claim Initiation Form by calling the Verizon Benefits Center at 1-877-Ask-VzHR (1-877-275-8947).

However, for disability pension claims, the following chart applies in place of the “Filing a Claim,” “Claim Denial,” “Filing an Appeal” and “Review of Your Appeal” sections of your pension plan SPD. If you have an Employee Retirement Income Security Act of 1974 (ERISA) claim for a disability pension plan benefit, you should follow these procedures. While these procedures were previously communicated, in general, the following chart provides more details. It applies to disability pension claims initially filed on or after January 1, 2002.

Claims and Appeals Procedures	
<b>Step 1</b>	
<b>How to file a claim</b>	<p>To file a claim, request a disability kit from the Verizon Benefits Center at 1-877-Ask-VzHR (1-877-275-8947). You (or your authorized representative) must return the disability pension request form (“Disability Form”) to the Verizon Benefits Center at the address on the form.</p> <p>You must include:</p> <ul style="list-style-type: none"> <li>• A description of the benefits you’re applying for</li> <li>• The reason(s) for the request and</li> <li>• Relevant documentation</li> </ul> <p>If you do <b>not</b> return the Disability Form within 90 days, your request expires. If you do return the Disability Form, the ERISA claims process for disability pension benefits begins (e.g., the ERISA claims time frames described in this chart commence upon the Verizon Benefits Center’s receipt of your Disability Form).</p> <p>The Verizon Benefits Center forwards your Disability Form to the disability vendor for processing</p>
<b>When you will be notified of the claims decision</b>	You will be notified of the decision within 45 days of Verizon Benefits Center’s receipt of your Disability Form (75 or 105 days, when special circumstances apply)
<b>Failure to provide sufficient information</b>	<p>If you fail to provide sufficient information, the claim may be decided based on the information provided. However, the Verizon Benefits Center or the disability vendor may notify you within either the 75- or 105-day extension period that additional information is needed. In some cases, you may be required to have an Independent Medical Examination.</p> <p>You will have 45 days to provide the additional information. Otherwise, the claim will be decided based on the information originally provided.</p> <p>If you provide additional information, you will be notified of the decision by the Verizon Benefits Center no later than 105 days after the initial claim was submitted, not including the time that it takes you to provide the additional information</p>

<b>Claims and Appeals Procedures</b>	
<b>How you will be notified of the claim decision</b>	<p>If your claim is <b>approved</b>, the Verizon Benefits Center will provide you with a letter explaining approval</p> <p>If your claim is <b>denied</b>, in whole or in part, the Verizon Benefits Center will notify you in writing. Your denial notice will contain:</p> <ul style="list-style-type: none"> <li>• The specific reason(s) for the denial</li> <li>• The plan provisions on which the denial was based</li> <li>• Any additional material or information you may need to submit to complete the claim</li> <li>• Any internal procedures or clinical information on which the denial was based and</li> <li>• The plan’s appeal procedures</li> </ul>
<b>Step 2</b>	
<b>About appeals and the claims fiduciary</b>	<p>Before you can bring any action at law or at equity to recover plan benefits, you <b>must</b> 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 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.</p>
<b>How to file an appeal</b>	<p>If your claim is denied and you want to appeal it, you must file your appeal within 180 days from the date you receive written notice of your denied claim. You may request access to all documents relating to your appeal. To file your appeal, write to the address specified on your claim denial notice.</p> <p>You should include:</p> <ul style="list-style-type: none"> <li>• A copy of your claim denial notice</li> <li>• The reason(s) for the appeal and</li> <li>• Relevant documentation</li> </ul> <p>The individual/committee (and any medical professional) 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 experience. You are entitled to the identity of such a professional, upon request.</p>
<b>When you will be notified of the appeal decision</b>	<p>You will be notified of the decision within 45 days of the Claims Review Committee’s receipt of your appeal (90 days, when special circumstances apply)</p>

<b>Claims and Appeals Procedures</b>	
<b>How you will be notified of the appeal decision</b>	<p>If your appeal is <b>approved</b>, the Claims Review Committee will generally notify you in writing</p> <p>If your appeal is <b>denied</b>, in whole or in part, the Claims Review Committee will notify you in writing. Your denial notice will contain:</p> <ul style="list-style-type: none"> <li>• The specific reason(s) for denial</li> <li>• The plan provisions on which the denial was based</li> <li>• Any internal procedures or clinical information on which the denial was based</li> <li>• A statement regarding the documents that you are entitled to and</li> <li>• The following statement: “You and your plan may have other voluntary 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.”</li> </ul>
<b>Step 3</b>	
<b>How to proceed if necessary</b>	The decision on your appeal is final. As a result, Verizon will not review your matter again, unless new facts are presented. You have a right to bring a civil action.

### **Verizon Savings and Security Plan for Mid-Atlantic Associates**

For purposes of determining your contribution to the plan as a percentage of pay, annual pay in 2003 will include the single lump-sum payment equal to 3% of the associate’s basic weekly wage for one year. This payment was calculated as of August 3, 2003 and paid by October 31, 2003.

### **Voluntary Termination Bonus**

Effective August 3, 2003 and continuing through August 2, 2008, if an associate accepts a voluntary offer to leave the company under the provisions of the Verizon Income Security Plan for Mid-Atlantic Associates and leaves the company pursuant to that offer, the following additional benefits will be provided:

- A lump-sum benefit of \$10,000 (reduced for applicable taxes and withholdings), and
- Medical coverage continued for the associate and eligible dependents at no cost for six months if the associate is not otherwise eligible for continuation of coverage at no cost for at least six months. The medical coverage will be at the same level of benefits that the associate had as of the associate’s last day actively at work, pursuant to the terms of Verizon Plan 550, including the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates. This benefit currently is reflected in the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates and its corresponding SPD booklet.

These additional benefits are not part of (and do not modify in any way) the Verizon Income Security Plan for Mid-Atlantic Associates.

## **Verizon Dental Expense Plan for Mid-Atlantic Associates**

Effective January 1, 2004, the plan will cover services related to dental implants, with reimbursement consistent with plan coverage for other major restorative services such as dental bridges. In addition to the implant procedure, the dental plan covers any separate charge related to a finishing crown.

For each covered individual, the maximum benefit payable for all covered dental services is \$1,500 per calendar year.

## **Updated Healthcare Claims and Appeals Procedures**

Please note that the “If a Benefit Is Denied” section of your updated medical plan SPD applies to claims under these healthcare plans, as well:

- Verizon Dental Expense Plan for Mid-Atlantic Associates,
- Verizon Vision Care Plan for Mid-Atlantic Associates and
- Verizon Health Care Spending Account for Mid-Atlantic Associates.

## **Updated Disability Claims and Appeals Procedures**

The “Claims and Appeals Procedures” section of your disability benefits SPD has changed. It applies to disability claims initially filed on or after January 1, 2004. Specifically, the procedure is slightly different, depending on whether you have an “eligibility” claim or a “benefit” claim. An eligibility claim is a claim for eligibility to have coverage in a plan. A benefit claim is any claim that is not a claim for eligibility. An example of a benefit claim is a claim for disability benefits due to alleged failure to satisfy the definition of “disabled” under the Verizon Long-Term Disability Plan for Mid-Atlantic Associates.

The authority and discretion to designate each of the claims and appeals administrators is granted to the Verizon Employee Benefits Committee (VEBC) and the Verizon Claims Review Committee (VCRC), and to the individuals who chair each of these committees. At this time, for eligibility-related claims, the claims and appeals administrator is the VCRC. For benefit-related claims, the claims and appeals administrator is MetLife.

The addresses of the claims and appeals administrators for the disability benefit plans are:

VCRC  
c/o Verizon Claims Review Unit  
P.O. Box 1438  
Lincolnshire, IL 60069-1438

Metropolitan Life Insurance Company (MetLife)  
P.O. Box 3017  
Utica, NY 13504

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, as the claims fiduciaries, have discretionary authority to:

- Interpret the plans based on their provisions and applicable law and make factual determinations about claims arising under the plans,
- Determine whether a claimant is eligible for benefits,
- Decide the amount, form and timing of benefits, and
- Resolve any other matter under the plans 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 plans 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.

The “Filing a Claim,” “If Your Claim Is Denied,” “Filing an Appeal” and “Review of Your Appeal” sections of your disability benefits SPD are updated by the following chart, which outlines the process that applies if you have an ERISA claim or appeal for a disability plan benefit.

	<b>Disability plan <i>eligibility</i> claims procedure</b>	<b>Disability plan <i>benefit</i> claims procedure</b>
<b>Step 1</b>		
<b>How to file a claim</b>	<p>To file an eligibility claim, request a Claim Initiation Form from the Verizon Benefits Center at 1-877-Ask-VzHR (1-877-275-8947). You (or your authorized representative) must return the form to the Verizon Claims Review Unit at the address on the form.</p> <p>You must include:</p> <ul style="list-style-type: none"> <li>• A description of the benefits you’re applying for</li> <li>• The reason(s) for the request and</li> <li>• Relevant documentation</li> </ul>	<p>To file a claim, write to the disability administrator for the plan, (MetLife), and include:</p> <ul style="list-style-type: none"> <li>• A description of the benefits you’re applying for</li> <li>• The reason(s) for the request and</li> <li>• Relevant documentation</li> </ul>
<b>When you will be notified of the claims decision</b>	You will be notified of the decision within 45 days of the Claims Review Unit’s receipt of your Claim Initiation Form (75 or 105 days, when special circumstances apply)	You will be notified of the decision within 45 days of the disability administrator’s receipt of your written claim (75 or 105 days, when special circumstances apply)

	Disability plan <i>eligibility</i> claims procedure	Disability plan <i>benefit</i> claims procedure
<b>Failure to provide sufficient information</b>	<p>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 either the 75- or 105-day extension period that additional information is needed.</p> <p>You will have 45 days to provide the additional information. Otherwise, the claim will be decided based on the information originally provided.</p> <p>If you provide additional information, you will be notified of the decision by the Claims Review Unit no later than 105 days after the initial claim was submitted, not including the time that it takes you to provide the additional information</p>	<p>If you fail to provide sufficient information, the claim may be decided based on the information provided. However, the disability administrator may notify you within either 75- or 105-day extension period that additional information is needed. In some cases, you may be required to have an independent medical examination.</p> <p>You will have 45 days to provide the additional information. Otherwise, the claim will be decided based on the information originally provided.</p> <p>If you provide additional information, you will be notified of the decision by the disability administrator no later than 105 days after the initial claim was submitted, not including the time that it takes you to provide the additional information</p>
<b>How you will be notified of the claim decision</b>	<p>If your claim is <b>approved</b>, the Claims Review Unit will generally notify you by telephone</p> <p>If your claim is <b>denied</b>, in whole or in part, the Claims Review Unit will notify you in writing. Your denial notice will contain:</p> <ul style="list-style-type: none"> <li>• The specific reason(s) for the denial</li> <li>• The plan provisions on which the denial was based</li> <li>• Any additional material or information you may need to submit to complete the claim</li> <li>• Any internal procedures on which the denial was based and</li> <li>• The plan’s appeal procedures</li> </ul>	<p>If your claim is <b>approved</b>, the disability administrator will notify you by telephone or in writing</p> <p>If your claim is <b>denied</b>, in whole or in part, the disability administrator will notify you in writing. Your denial notice will contain:</p> <ul style="list-style-type: none"> <li>• The specific reason(s) for the denial</li> <li>• The plan provisions on which the denial was based</li> <li>• Any additional material or information you may need to submit to complete the claim</li> <li>• Any internal procedures or clinical information on which the denial was based and</li> <li>• The plan’s appeal procedures</li> </ul>

	Disability plan <i>eligibility</i> claims procedure	Disability plan <i>benefit</i> claims procedure
<b>Step 2</b>		
<b>About appeals and the claims fiduciary</b>	<p>Before you can bring any action at law or at equity to recover plan benefits, you <b>must</b> 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.</p>	<p>Before you can bring any action at law or at equity to recover plan benefits, you <b>must</b> exhaust this process. Specifically, you must file an appeal as explained in this Step 2 and the appeal must be finally decided by the disability administrator. The Claims Review Committee has delegated its authority to finally determine claims to the disability administrator. As such, MetLife 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 disability administrator are final and binding on all parties, unless it is later proven that the administrator's decision was an abuse of discretion.</p>
<b>How to file an appeal</b>	<p>If your claim is denied and you want to appeal it, you must file your appeal within 180 days from the date you receive written notice of your denied claim. You may request access to all documents relating to your appeal. To file your appeal, write to the address specified on your claim denial notice.</p> <p>You should include:</p> <ul style="list-style-type: none"> <li>• A copy of your claim denial notice</li> <li>• The reason(s) for the appeal and</li> <li>• Relevant documentation</li> </ul> <p>The individual/committee reviewing your appeal will be independent from the individual/committee who reviewed your claim</p>	<p>If your claim is denied and you want to appeal it, you must file your appeal 180 days from the date you receive written notice of your denied claim. You may request access to all documents relating to your appeal. To file your appeal, write to the disability administrator for the plan and include:</p> <ul style="list-style-type: none"> <li>• A copy of your claim denial notice</li> <li>• The reason(s) for the appeal and</li> <li>• Relevant documentation</li> </ul> <p>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 disability administrator will consult with a healthcare professional who has appropriate relevant experience. You are entitled to the identity of such an expert, upon request.</p>
<b>When you will be notified of the appeal decision</b>	You will be notified of the decision within 45 days of the Claims Review Committee's receipt of your appeal (90 days, when special circumstances apply)	You will be notified of the decision within 45 days of the disability administrator's receipt of your appeal (90 days, when special circumstances apply)

	<b>Disability plan <i>eligibility</i> claims procedure</b>	<b>Disability plan <i>benefit</i> claims procedure</b>
<b>How you will be notified of the appeal decision</b>	<p>If your appeal is <b>approved</b>, the Claims Review Committee will generally notify you in writing</p> <p>If your appeal is <b>denied</b>, in whole or in part, the Claims Review Committee will notify you in writing. Your denial notice will contain:</p> <ul style="list-style-type: none"> <li>• The specific reason(s) for denial</li> <li>• The plan provisions on which the denial was based</li> <li>• Any internal procedures on which the denial was based</li> <li>• A statement regarding the documents that you are entitled to and</li> <li>• The following statement: “You and your plan may have other voluntary 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.”</li> </ul>	<p>If your appeal is <b>approved</b>, the disability administrator will notify you in writing or by telephone</p> <p>If your appeal is <b>denied</b>, in whole or in part, the disability administrator will notify you in writing. Your denial notice will contain:</p> <ul style="list-style-type: none"> <li>• The specific reason(s) for denial</li> <li>• The plan provisions on which the denial was based</li> <li>• Any internal procedures or clinical information on which the denial was based</li> <li>• A statement regarding the documents that you are entitled to</li> <li>• The plan’s voluntary appeal procedures and</li> <li>• The following statement: “You and your plan may have other voluntary 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.”</li> </ul>

	Disability plan <i>eligibility</i> claims procedure	Disability plan <i>benefit</i> claims procedure
<b>Step 3</b>		
<b>How to proceed if necessary</b>	The decision on your appeal is final. As a result, Verizon will not review your matter again, unless new facts are presented. You have a right to bring a civil action.	<p><b>Voluntary benefit appeals:</b> If you had a benefit appeal that was denied at Step 2, you may submit a voluntary appeal to the disability administrator. You must file your voluntary appeal within 60 days from the date you receive written notice of your denied appeal. To file your voluntary appeal, write to the disability administrator at the address provided to you in your Step 2 denial letter and include:</p> <ul style="list-style-type: none"> <li>• A copy of your appeal denial notice</li> <li>• The reason(s) for the appeal and</li> <li>• Relevant documentation</li> </ul> <p>This appeal is voluntary. You have a right to bring a civil action without submitting a voluntary appeal.</p>
<b>When you will be notified of the voluntary appeal decision</b>	Not applicable	You will receive a response within 45 days of the disability administrator's receipt of your voluntary appeal (90 days when special circumstances apply)