verizon

Disability Benefits
Summary Plan Description for
Mid-Atlantic Associates

AA-S-ST/LT--58566-1/13

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Your Disability Benefits

The Verizon Disability Benefit Plans (the Plans) are designed to provide you with continuing income if an illness or injury prevents you from working for more than seven consecutive calendar days. You automatically are enrolled for disability coverage upon eligibility. The Plans include a number of different types of benefits:

- **Sickness Disability benefits**. If you are absent from work for more than seven consecutive calendar days due to sickness or an off-duty injury, beginning on the eighth consecutive calendar day of your absence, you may receive Sickness Disability benefits for up to 52 weeks.

- **Accident Disability benefits**. If you are unable to work due to an on-duty injury, you may receive Accident Disability benefits beginning on the first day of your disability. If you are partially unable to work due to an on-duty injury, you may receive partial Accident Disability benefits.

- **Long-Term Disability benefits**. When Sickness Disability benefits end after 52 weeks, you may be eligible for Long-Term Disability (LTD) benefits.

Important Note

If you are absent from work for seven or fewer consecutive calendar days, you may be eligible for Incidental Absence payments. Contact your supervisor.

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

About This SPD

This document is the SPD for Verizon Plan 553. Verizon Plan 553 incorporates the following "component" Plans:

- Verizon Sickness and Accident Disability Benefit Plan for Mid-Atlantic Associates.

- Verizon Long-Term Disability Plan for Mid-Atlantic Associates.

References in this SPD to "Sickness Disability Plan," "Accident Disability Plan," "Long-Term Disability Plan," "Plan" or "Plans" refer to the benefits provided under Verizon Plan 553, as described in these "component" Plan documents.

The Plans are 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 September 19, 2012, including legislative and administrative updates through December 31, 2012 (i.e., the SPD is effective as of January 1, 2013 unless otherwise noted). It updates and replaces all previous SPDs and other descriptions of the benefits provided by the Plans. This SPD is summary of these Plans.

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" section.

This SPD is divided into the following major sections:

- **Participating in the Plans**. This section explains your eligibility and when eligibility ends.
- **Sickness Disability Benefits**. This section describes benefits if you are unable to work due to sickness or an off-duty injury for more than seven consecutive calendar days.
- **Accident Disability Benefits**. This section describes benefits if you are totally or partially unable to work due to an on-duty injury.
- **Long-Term Disability Benefits**. This section provides information about Long-Term Disability (LTD) benefits if you continue to be disabled for more than 52 weeks.
- **Additional Information**. This section provides additional details about the provisions of the Plans and your legal rights.
- **Administrative Information**.This section includes additional details about the administrative provisions of the Plans
- **Glossary**. Certain terms used in this SPD are defined in the glossary.

Verizon Benefits Center

The Verizon Benefits Center offers a website called BenefitsConnection where you will 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. In addition to enrolling on the site, you can:

- Link to other Verizon benefit provider sites.
- Create and print personalized provider listings and maps to providers’ offices for most options.
- Review details about your health care and insurance plans.
- Select and update your beneficiary designations.
- Verify your Verizon elections that are on file at the Verizon Benefits Center.
- 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, call 1-855-4VzBens (1-855-489-2367). Via this toll-free telephone number, you also can connect with other Verizon benefit providers.

Changes to the Plans

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

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

Participating in the Plans

Eligibility

You are eligible for Plan coverage if you are employed by a Verizon participating company as a regular full-time, part-time or term Mid-Atlantic associate.

"Associate," as used throughout this SPD includes any non-management employee who is represented by a union that has negotiated participation in the Plans.

Your coverage is effective as follows:

- Your Accident Disability benefit coverage begins on your first day of work.
- Your Sickness Disability benefit coverage begins after you have six months of net credited service.
- Your Long-Term Disability (LTD) benefit coverage begins after you have six months of net credited service.

Notes:

- "Service" means net credited service as defined by The Mid-Atlantic Associate Pension Plan. In general, it is the entire period of your continuous employment with the Company. It also is a factor that is used to determine the amount of your disability benefit.
- If you terminate your employment with the Company and later are rehired by a participating company, your net credited service for purposes of eligibility to participate in the Plans will be determined according to the provisions of the Mid-Atlantic Associate Pension Plan. However, if immediately prior to your re-employment you were a retired participant (as defined in the applicable Company-sponsored retiree medical plan), you will be eligible for coverage as of the first day of the month following your re-employment.

You are not eligible to participate in the Plans 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.
- You are a working retiree.

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 Plans.

State Disability Law and Your Verizon Benefits

If you are employed in New Jersey, you may be eligible for state-mandated sickness disability benefits if:

- You are not eligible to participate in the Plans.
- You are not eligible for benefits under the Plans because you have not reached the service requirement yet.
- You are not eligible for benefits under the Plans due to insufficient medical certification.

There may be a mandatory premium withheld from your pay for these benefits. Contact the appropriate state office if you want more information on applying for state-mandated benefits.

You can be covered by a state-mandated plan and the Plans at the same time. However, any Plan benefits for which you are eligible may be offset by any state-mandated plan benefits you receive.

Important Note

Verizon complies with the Family and Medical Leave Act of 1993 (FMLA). The FMLA entitles eligible employees to take up to 12 weeks of unpaid, job-protected leave each year for specified family and medical reasons. Any leave taken under the FMLA will run concurrently with any approved Verizon Short-Term Disability benefits. For more information regarding FMLA leaves, contact MetLife's Verizon FMLA Helpline (see the “Administrative Information” section for the telephone number to call).

Cost of Coverage

The Company pays the full cost of your coverage under the Plans, with the exception of any state-mandated premiums you may be required to pay.

When Coverage Ends

Coverage ends under the following circumstances:

- Your Sickness and Accident Disability benefit coverage ends when your employment terminates (including retirement) or when you receive the maximum benefits payable under the Plan. However, if your employment terminates while you are receiving benefits and prior to your reaching the maximum benefits payable under the Plan, your Sickness or Accident Disability benefits will continue until you no longer are certified as disabled or you receive the maximum benefit, whichever occurs first.
- Your LTD benefit coverage ends when your employment terminates (unless you are receiving Sickness Disability Benefits on the date your employment terminates) or if you are on a leave of absence (other than a Medically Restricted Leave of Absence).
- You are no longer assigned to an “Associate” position that is covered by a collective bargaining agreement providing participation under this Plan.

Summary of Benefits

Disability benefit	Level of benefits you may receive while disabled	When payments begin	When payments end
Sickness Disability	50% pay, 100% pay or a combination of both, depending on your length of service (i.e., net credited service) as of your eighth consecutive calendar day of absence.	If you have at least six months of service, benefits begin on the eighth consecutive calendar day after you have been absent for the seven prior consecutive calendar days due to sickness or an off-duty injury.	The earliest of the date you no longer are totally disabled, you receive the maximum benefits payable (52 weeks), or you commence a service or deferred vested pension.* If you do not return to work at the end of your approved Sickness Disability benefit period, your employment may be terminated as of the last day of your approved disability, unless you are eligible and approved for FMLA leave, or an authorized leave of absence, including a leave of absence under the Americans with Disabilities Act ("ADA").
Accident Disability	Full pay for at least 13 weeks (longer if you have 15 years of net credited service – see "Benefits for Total Disability" under the "Accident Disability Benefits" section), half pay for the remaining period you are disabled until you retire.	On the first scheduled work day absent due to your on-duty injury.	When you no longer are totally disabled or, if earlier, when you commence a service or deferred vested pension.*
Partial Accident Disability	The difference between your pre-disability pay and what you are capable of earning while partially disabled. (After 13 weeks, the benefit is 50% of this amount.)	When you are unable to perform all of the functions of your position due to your on-duty injury but you are not totally disabled.	The earliest of the date you are no longer partially disabled, you receive the maximum amount of Partial Disability benefits (6 years, inclusive of any period for which you received Accident Disability benefits for total disability as a result of your on-duty injury) or you commence a service or deferred vested pension.*

Disability benefit	Level of benefits you may receive while disabled	When payments begin	When payments end
Long-Term Disability**	50% of your monthly base pay (minus certain other sources of income, such as Social Security disability benefits, disability pension benefits and Workers' Compensation benefits).	If you continue to be disabled after 52 weeks, Sickness Disability benefits or MR-LOA ends, your employment is terminated, and Long-Term Disability benefits may begin.	The earlier of the date when you no longer are disabled or you die.

* If you are eligible for and commence a service or deferred vested pension benefit under the Mid-Atlantic Associate Pension Plan, your Sickness Disability or Accident Disability benefits will be discontinued when pension payments begin. However, if the Sickness Disability or Accident Disability benefits are greater than the pension payments, you may (1) elect in writing to defer pension payments and receive the disability payments; or (2) commence the Mid-Atlantic Associate Pension Plan payments and receive supplemental disability payments so that the total benefit payment is not less than the amount of your Sickness Disability or Accident Disability benefit.
** The amount of your Long-Term Disability benefit will be reduced by any vested or service pension benefit, including a pension benefit under the Mid-Atlantic Associate Pension Plan. Additional offsets apply.

Sickness Disability Benefits

Applying for a Benefit

To apply for Sickness Disability benefits, call the benefits administrator by your eighth consecutive calendar day of absence and follow the instructions to certify your disability (see the “Administrative Information” section for the telephone number to call).

In addition to calling the benefits administrator by the eighth consecutive calendar day of absence, your claim for Sickness Disability benefits must be submitted within 60 days from the first day of absence on account of sickness or off-duty injury. Failure to submit your claim may result in denial of Sickness Disability benefits.

When Benefits Begin

You may be eligible to receive Sickness Disability benefits after you have been totally unable to work for more than seven consecutive calendar days due to sickness or an off-duty injury.

In addition, ***you must***:

- Be under a qualified physician’s care.
- Receive proper medical treatment.
- Take proper care of yourself.
- Maintain communication as required by the claims administrator, provided your condition and location do not prevent you from doing so.
- Be certified as disabled by the claims administrator. Also, once you have been certified as disabled, the Company reserves the right to require periodic recertification for review and consideration by the claims administrator.
- Obtain permission from the claims administrator if you plan to recuperate away from home at any time during your absence.

Failure to comply with the above requirements may result in the discontinuation of your Sickness Disability benefits.

Important Note

If you are absent from work for seven or fewer consecutive calendar days, you may be eligible for Incidental Absence payments. Contact your supervisor.

How Your Benefit Is Determined

Your net credited service on the date your Sickness Disability benefits begin determines how long you may receive full-pay benefits. When full-pay benefits end, you may receive half-pay benefits for the remainder of the 52-week period.

The following chart shows the benefit level provided by the Plan according to the amount of net credited service you have on the eighth consecutive calendar day of your initial absence and providing you remain certified as disabled by Verizon or its claims administrator.

Net credited service	You receive full pay up to…	Then you receive half pay up to…
At least six months but less than two years	–	52 weeks
Two years but less than five years	4 weeks	48 weeks
Five years but less than 15 years	13 weeks	39 weeks
15 years but less than 20 years	26 weeks	26 weeks
20 years but less than 25 years	39 weeks	13 weeks
25 years or more	52 weeks	–

Note: You are not entitled to receive Sickness Disability benefits while wages are paid to you by Verizon. In addition, if you are eligible for any Workers' Compensation or other state-mandated disability payments, your Sickness Disability benefits may be reduced by these payments. Your Sickness Disability benefits also are impacted if you are eligible for and receive benefits under the Mid-Atlantic Associate Pension Plan. Contact the Verizon Benefits Center for details.

How Pay Is Determined

The amount of your Sickness Disability benefits depends on your base pay, the number of hours you regularly are scheduled to work, and your net credited service as of the eighth consecutive calendar day of your absence.

For part-time employees, benefit payments are prorated based on the number of hours scheduled to work.

For purposes of the Plan, your pay at the time your disability begins includes your basic pay rate and may include shift differentials, commissions and temporary increases per your collective bargaining agreement. Your pay **does not** include overtime, awards, incentives or allowances.

Overpayments

If you are entitled to or receive an award from a third party, such as state statutory benefits or Workers' Compensation benefits, Verizon has the right to recover the overpayment according to state law and the collective bargaining agreement.

In addition, Verizon will begin the recovery process for any payments you have received from MetLife if it is not able to approve benefits on your claim, in accordance with the collective bargaining agreement.

When Benefits End

You will continue to receive Sickness Disability benefits as long as you are certified as disabled, up to 52 weeks. If you do not return to work at the end of your approved Sickness Disability benefit period, your employment may be terminated as of the last day of your approved disability, unless you are eligible and approved for FMLA leave or an authorized leave of absence, including a leave of absence under the Americans with Disabilities Act ("ADA").

Otherwise, if you continue to be disabled due to sickness or an off-duty injury for more than 52 weeks, your employment ends and you may be eligible for Long-Term Disability (LTD) benefits and/or pension benefits.

If you die while receiving Sickness Disability benefits, any benefits owed to you but not yet paid at the time of your death may be paid to your spouse or other appropriate individual. For example, if you died on a Thursday, your family would receive the payments owed to you for the four days of that week. (You already would have been paid for the previous weeks.) The Verizon Claims Review Committee determines who will receive the payments for the balance owed as of the date of your death.

If you separate from service for any reason while receiving Sickness Disability benefits, you will continue to receive disability benefits until you are no longer disabled or the end of the 52-week benefit period, whichever occurs first. For example, if you are receiving Sickness Disability benefits on February 15 and terminate employment on that date, you will continue to receive disability benefits until your disability ends or the end of the 52-week benefit period, whichever occurs first. If you recover April 3, you will no longer be eligible to receive Sickness Disability benefits, even if you suffer a relapse on April 5.

Recurrences and Successive Disabilities

If you return to work after being disabled and have a recurrence or another unrelated disability, you still may be eligible for Sickness Disability benefits. However, if a recurrence or new disability occurs within the first 13 weeks after returning to work, both periods of disability will be counted toward your 52-week maximum and in determining your full-pay and half-pay periods during the 52-week period. If a recurrence or new disability occurs after you have been back at work for more than 13 weeks and continuously engaged in the performance of your duties, you will be eligible for a new 52-week benefit period.

Example:

Effect of a Recurrent or New Disability on Your Sickness Disability benefits

Assume that:

- Based on your net credited service, you are eligible for Sickness Disability benefits of 13 weeks of full pay and 39 weeks of half pay.

- You receive 6 weeks of Sickness Disability benefits on a full-pay basis during your first period of disability.

If you have a recurrence within the first 13 weeks that you are back at work, you will be eligible for an additional 7 weeks of full pay (13 weeks - 6 weeks = 7 weeks). A maximum of 46 additional weeks of benefits (52 weeks - 6 weeks = 46 weeks) may be paid to you.

If you have been back at work and continuously engaged in the performance of your duties for more than 13 weeks when you have a recurrence, you will be eligible for a new 52-week benefit period.

The following chart summarizes when your Sickness Disability benefits may resume after a recurrence.

If you have returned to work for…	Your Sickness Disability benefits begin…
Less than two weeks	On the first scheduled work day of your absence
More than two weeks but less than 13 weeks	On the eighth consecutive calendar day of your absence*
More than 13 weeks	On the eighth consecutive calendar day of your absence, with eligibility for a new Short-Term Disability benefit period*

* You may be eligible for Incidental Absence payments during the seven-day period before Short-Term Disability benefits begin.

Independent Medical Examination

If there is a dispute between the Company or benefits administrator and your physician regarding your eligibility or continued eligibility for Sickness Disability benefits, the benefits administrator will schedule an independent medical examination. The independent medical exam will be conducted by a physician, which may include a physician specialist, who will determine eligibility for Sickness Disability benefits. The Company will pay for this examination. Your benefits will continue until a determination is made as long as you attend the examination and fully cooperate. However, in no case will your benefits continue for more than 52 weeks or past the date on which you otherwise would be ineligible for benefits.

In addition, if you are able to work, and there is a dispute between the Company or the benefits administrator and your physician regarding medical restrictions (such as the number of hours you can work or the weight you can lift) or the duration of such restrictions on your work, the benefits administrator will schedule an independent medical functional capacity exam (“FCE”). You must attend this examination. While the FCE is being scheduled and until the FCE report is received from the FCE provider, you will work within the restrictions determined by your treating physician.

The independent medical examiner’s determination will be binding on all parties, subject to any ERISA claims and appeals process.

Effect on Your Other Benefits Coverage

The health care and life insurance coverage that you have in effect for you and your eligible dependents will continue for as long as you are an active employee. You will be responsible for any required contributions. For further information, refer to your Medical, Dental, Vision and Survivor Benefits Program SPDs.

Accident Disability Benefits

Applying for a Benefit

To apply for Accident Disability benefits:

- Immediately call the designated local contact for an on-duty injury. This contact usually is your immediate supervisor, who will file an accident report and notify the Safety, Health and Environment Compliance Service Center.
- Follow the instructions provided for certification of your on-duty injury.
- Place yourself under a qualified physician's care.

Your claim for Accident Disability benefits must be submitted within 60 days from the date of the on-the-job accident. Failure to submit your claim may result in denial of Accident Disability benefits.

When Benefits Begin

You may be eligible to receive Accident Disability benefits on day one of your accident. You ***must***:

- Be under a qualified physician's care.
- Receive proper medical treatment.
- Take proper care of yourself.
- Maintain communication as required by the claims administrator, provided your condition and location do not prevent you from doing so.
- Be certified as disabled by the claims administrator. Also, once you have been certified as disabled, the Company reserves the right to require periodic recertification for review and consideration by the claims administrator.
- Obtain permission from the claims administrator if you plan to recuperate away from home at any time during your absence.

Failure to comply with the above requirements may result in the discontinuation of Accident Disability benefits.

When Benefits Are Paid

Accident Disability benefits may provide you with a period of full- and half-pay replacement if you are unable to work due to an on-duty injury arising out of and in the course of the performance of your job duties. The length of your service with the Company is used to determine the duration of your full- and/or half-pay benefits. Occupational illnesses, which may develop over a period of time, are not considered Accident Disability benefits under the terms of the Plan.

If you are disabled due to an on-duty accident and cannot return to work, you may receive Accident Disability benefits from the first day of your absence, provided you have followed the proper reporting procedures. See "Applying for a Benefit" above for more information on the reporting procedures. Accident Disability benefits are not the same as Workers' Compensation payments.

Part-Time Service

If you were an active employee on December 31, 1980 and have worked part-time on or after January 1, 1981, with no breaks in service since January 1, 1981, you are eligible to receive Accident Disability benefits as if you were a full-time employee.

If you are a part-time employee and you were hired or rehired on or after January 1, 1981, you are eligible to receive Accident Disability benefits based on your part-time pay rate and your scheduled work hours.

Benefits for Total Disability

Under the Plan, total disability means you are unable to work at **any** job due to your disability.

In general, Accident Disability benefits for total disability provide a combination of full-pay and half-pay replacement for as long as you are certified as disabled. The duration of your full-pay benefit depends on the years of net credited service you have when you are injured in an on-duty accident:

Net credited service	You can receive full pay up to…	And then, half pay
Less than 15 years	13 weeks	You can receive half pay for as long as you remain totally disabled or, if earlier, until you commence a service or deferred vested pension.
15 years but less than 20 years	26 weeks	
20 years but less than 25 years	39 weeks	
25 years or more	52 weeks	

Note: You are not entitled to receive Accident Disability benefits while wages are paid to you by Verizon. In addition, full- and half-pay benefits are offset by any Workers' Compensation payments or other state-mandated disability payments. Your Accident Disability benefits also are impacted if you are eligible for and receive benefits under the Mid-Atlantic Associate Pension Plan. Contact the Verizon Benefits Center for details.

Example:

Determining Total Disability Accident Disability Benefits

Assume that:

- Your weekly pay at the time of your on-duty injury is $1,000.
- You qualify to receive $400 weekly in Workers' Compensation benefits.

In this example, your weekly Accident Disability benefit is $600 ($1,000 - $400 = $600) while you are receiving full-pay benefits, and $100 ($500 - $400 = $100) during any half-pay benefit period.

How Pay Is Determined

For purposes of the Plan, your pay at the time your disability begins includes your basic pay rate and may include shift differentials, commissions and temporary increases per your collective bargaining agreement. Your pay does not include overtime, awards, incentives or allowances.

Recurrences and Successive Disabilities

You can still receive Accident Disability benefits if you return to work after being disabled and either suffer another unrelated on-duty accident or have a recurrence.

- If you have been back at work less than 13 weeks and are absent again due to the original injury, the absence is considered a recurrence and you will receive benefits beginning on the first day it occurs, as if your previous disability period never had ended.

- If a recurrence occurs after you are back at work and continuously engaged in the performance of your duties for more than 13 weeks, you will begin a new disability period.

- Regardless of how soon a second, unrelated disability occurs, it will be treated as an entirely new benefit period for payment purposes.

Benefits for Partial Disability

If you become unable to fully perform the functions of your position or if you are totally disabled and recover sufficiently to be able to work but you are not able to return to your pre-disability job, you may receive benefits for partial disability

The amount of time you have received total disability benefits will be counted toward your partial disability benefit maximum period of six years.

Partial disability means you are unable to perform all of the functions of your pre-disability job with the Company due to your injury. In this situation, your Accident Disability benefits take into account any wages you still are capable of earning, as determined by the benefits administrator.

Your benefit amount is the difference between what you were earning at the time you first became disabled and the amount you are capable of earning while you are injured.

Payment for any period of partial disability after the first 13 weeks of disability shall be 50 percent of the difference between full pay at the time you are declared partially disabled and wages that, in the judgment of the benefits administrator, you are capable of earning.

Example:

Determining Partial Disability Accident Disability Benefits

Assume that:

- Your weekly pay at the time of your on-duty injury is $1,000.

- You qualify to receive $400 monthly in Workers' Compensation benefits.

- You can earn $300 with your partial disability as determined under the Plan.

In this example, your monthly Accident Disability benefit is $300 ($1,000 - $400 - $300 = $300) while you are receiving full-pay benefits (based on your net credited service – see the chart under "Benefits for Total Disability"). If your partial disability continues beyond the full-pay period, you will continue to receive half of your partial disability Accident Disability benefit for as long as you are disabled, up to a maximum of six years.

Independent Medical Examination

If there is a dispute between the Company or benefits administrator and your physician regarding your eligibility or continued eligibility for Accident Disability benefits, the benefits administrator will schedule an independent medical examination. The independent medical exam will be conducted by a physician, which may include a physician specialist, who will determine eligibility for Accident Disability benefits. The Company will pay for this examination. Your benefits will continue until a determination is made as long as you attend the examination and fully cooperate. However, in no case will your benefits continue past the date on which you otherwise would be ineligible for benefits.

In addition, if you are able to work, and there is a dispute between the Company or benefits administrator and your physician regarding medical restrictions (such as the number of hours you can work or the weight you can lift) or the duration of such restrictions on your work, the benefits administrator will schedule an independent medical functional capacity exam ("FCE"). You must attend this examination. While the FCE is being scheduled and until the FCE report is received from the FCE provider, you will work within the restrictions determined by your treating physician. The independent medical examiner's determination will be binding on all parties, subject to any ERISA claims and appeals process.

Situations That May Affect Your Benefits

The following situations may affect your benefits under the Plan:

- You fail to immediately report an on-duty injury to your supervisor, complete an accident report and follow the proper claims procedures listed in "Applying for a Benefit."

- You bring a suit for damages or other legal action against Verizon because of an injury.

Effect on Your Other Benefits Coverage

Your health care and life insurance coverage you have in effect for you and your eligible covered dependents will continue while you are disabled. You will be responsible for any required contributions. For further information, refer to your Medical, Dental, Vision and Survivor Benefits Program SPDs.

Note: If you lose a limb or your eyesight as a result of an on-duty accident, you also may be eligible for Accidental Death and Dismemberment (AD&D) Insurance benefits. See your Survivor Benefits Program SPD for more information.

Long-Term Disability Benefits

If you remain disabled after you receive 52 weeks of Sickness Disability benefits or have been on a Medically Restricted Leave of Absence (MR-LOA) for 52 weeks (26 weeks of MR-LOA for new hires with less than three years of net credited service), your employment may be terminated, unless you are eligible and approved for FMLA leave or an authorized leave of absence, including a leave of absence under the Americans with Disabilities Act ("ADA").

Otherwise, if you continue to be disabled due to sickness or an off-duty injury for more than 52 weeks or you are on an MR-LOA for 52 weeks (26 weeks of MR-LOA for new hires with less than three years of net credited service), your employment with Verizon will end and you may be eligible to receive Long-Term Disability (LTD) benefits. These benefits generally provide you with income replacement of 50 percent of your pre-disability monthly base pay, for as long as you are totally and permanently disabled. Your LTD benefit will be offset by any pension benefit, as well as certain other income you receive, such as Social Security disability benefits.

Important Note

To be eligible for LTD benefits, your employment must have ended due to your disability, with no guarantee of re-employment. In addition, if you no longer are disabled and seek re-employment, you may or may not be rehired by the Company.

Applying for a Benefit

You must apply for LTD benefits; they do not begin automatically. To apply for LTD benefits, you will need to complete and return an application, which includes a section that must be completed by your physician. You will receive the application from the claims administrator in the mail when you reach the 44th week of Sickness Disability benefits.

You must complete the application and submit all required proof and medical evidence of the disability prior to the expiration of the waiting period (i.e., when you are receiving Sickness Disability benefits or an MR-LOA) in order for your LTD benefits to commence.

It is possible that Verizon or the benefits administrator initially may require you to see a physician of its choice and on a periodic basis thereafter. If you refuse to be examined by such a physician, you may be denied benefits. You also may be asked on occasion to submit other evidence of your continuing disability.

When Benefits Are Paid

LTD benefits may begin after you have received 52 weeks of Sickness Disability benefits or have been on an MR-LOA for 52 weeks (26 weeks of MR-LOA for new hew hires with less than three years of net credited service). To receive benefits, ***you must*** meet one of the following conditions:

- You must be unable to work in any occupation or employment for which you are qualified or may become reasonably qualified by training, education or experience.

- As a result of your disability, you only are able to work at a job that pays less than half of your basic pay rate at the time you became disabled.

In addition, you must be under the care of a qualified physician who must provide appropriate documentation of your disability. You also must take proper care of yourself and receive proper medical treatment. If you do not meet these conditions, you will not be eligible for benefits.

How Your Benefit Is Determined

General Rule

Your LTD benefit – in combination with certain other sources of income – provides you with income equal to 50 percent of your monthly base pay as if you had been in active service on the day immediately before the start of the LTD period.

Waiting Period That Consists of MR-LOA

If your waiting period consists of time spent on an MR-LOA, your LTD benefit – in combination with certain other sources of income – will be equal to 50 percent of your monthly base pay as of the day immediately before you were initially placed on the MR-LOA.

In determining your monthly LTD benefit, income from the following sources is subtracted from half of your monthly base pay (so the total income you receive equals 50 percent of your base pay):

- Social Security disability and old-age benefits (family benefits are not considered).
- Workers' Compensation or other legislated benefits of a similar nature.
- State or federal disability benefits, except veterans' benefits.
- Payments from the Mid-Atlantic Associate Pension Plan or any other Company-sponsored Pension Plan from which you are entitled to receive benefits.
- Disability, vested and service pension benefits (including the monthly single life annuity equivalent of any vested or service pension cash out) payable to you as a participant under any qualified or non-qualified Plan maintained by Verizon.
- Wage-loss payments that result from any payment errors or omission of a third party that may be at fault for the accident that caused you to become disabled.

Note: In the event any income from the above identified sources is paid as a lump sum, the lump-sum payment shall reduce the monthly LTD benefit. The reduced LTD benefit amount will be based on the time period to which the lump sum benefit applies. If there is no time period specified, the lump sum will be converted to a monthly benefit payable over your expected lifetime, as determined by Verizon, and this monthly benefit amount will offset the monthly LTD benefit.

Example:

Determining an LTD Benefit

Assume that:

- You are age 50 when you begin receiving benefits.
- Your weekly base pay is $690, or $3,000 per month ($690 × 4.35).
- The only other income you are receiving is a monthly Social Security benefit of $900.

Step 1: Calculate 50% of your monthly base pay.
$3,000 × 0.50 = $1,500

Step 2: Subtract your $900 Social Security benefit.
$1,500 (50% of pay) - $900 (Social Security) = **$**600 (LTD benefit)

So, in this example, your monthly LTD benefit is $600, and your total monthly disability income from all sources is $1,500 ($600 + $900 = $1,500), or 50 percent of your monthly base pay.

Applying for Social Security

After you are disabled for more than six months, you may be eligible for Social Security benefits. You are required to apply for Social Security disability benefits, and you can begin the application process for Social Security disability benefits after five months of disability. Your Social Security disability benefit (or an estimated benefit if you have not yet started receiving Social Security benefits) or if applicable, old-age benefit **will** be deducted from your LTD benefit.

Caution: If you initially are denied a Social Security disability benefit, you must make at least one appeal of the Social Security administrator's decision. Your Social Security benefits (or an estimate, until you receive your actual benefits) will be deducted from your LTD benefit. Also, if you receive retroactive Social Security benefits, you will be required to repay the Company for any past over-payment of your LTD benefits.

When Benefits End

In general, you can continue to receive LTD benefits until you no longer qualify as disabled under the Plan or you die.

If You Take Another Job

If you physically are able to work and you take another job with any employer that pays less than half of what you were earning before you were disabled, your LTD benefits can continue on a reduced level. However, your LTD benefit – in combination with your job earnings and your other sources of income – cannot total more than 75 percent of the base pay you were receiving when you became disabled.

You are required to notify the LTD claims administrator if you take another job while receiving LTD benefits. If you fail to make this notification, you may forfeit future eligibility for LTD benefits and may be responsible for reimbursement of any overpayments.

Recurrences and Successive Disabilities

If you are rehired by Verizon after receiving LTD payments and you suffer another disability or a recurrence, you still are covered by the Plan as follows:

- If you have been back at work for a period of not more than 13 consecutive weeks when your disability recurs or a successive disability occurs, you may receive LTD benefits beginning with the first day you are disabled. No new waiting period will apply and the second disability shall be considered a continuation of the first disability.

- If you have been back at work in active service for more than 13 consecutive weeks when your disability recurs or a successive disability occurs, for purposes of LTD Plan eligibility, you will be treated as a newly disabled employee and will need to be eligible for and receive 52 weeks of Sickness Disability benefits or be on a MR-LOA for 52 weeks (26 weeks for new hires with less than three years of net credited service) before you will be eligible to apply for LTD benefits. You may receive LTD benefits after Sickness Disability payments end if you are eligible for LTD benefits.

Effect on Your Other Benefits Coverage

While you are receiving LTD benefits:

- Your medical coverage continues under the retiree medical plan. You will be required to pay medical contributions in accordance with the retiree plan. See the retiree Medical SPD for additional information. **Note:** Once you have been entitled to Social Security disability benefits for 24 consecutive months, Medicare becomes primary and Company retiree medical coverage is secondary.

- Your dental coverage ends, unless you choose to continue coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (see your Dental SPD).*

- Your vision coverage ends, unless you choose to continue coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments (see your Vision SPD).

- Your Survivor benefit coverage may continue for a period of time (see your Survivor Benefits Program SPD).* However, your Employee, Spouse and Child Accidental Death and Dismemberment benefits will cease.

- If you participate in a Company-sponsored Savings Plan, you can receive a final distribution of your account (see your Savings Plan SPD).You may be eligible to retire with a service or disability pension under a Company-sponsored Pension Plan (see your Pension Plan SPD).

***** Special provisions apply if you are eligible for a service or disability pension benefit (see your Pension Plan SPD).

When Benefits Are Not Paid

You are not eligible for LTD benefits if your disability results from:

- Your commission or attempted commission of a felony.

- Active participation in a riot, insurrection, rebellion or civil commotion.

- Military service.

- War, whether declared or undeclared.

- Intentionally self-inflicted injuries, while sane or insane.

Additional Information

Permission to Leave Home

If you are receiving Sickness and Accident Disability Benefit Plan benefits and wish to travel or vacation, you must obtain approval from the claims administrator prior to vacation or overnight travel. This requirement includes all vacation and overnight travel that is not related to the current medical treatment for the current condition.

Otherwise, benefits will not be paid for your period of absence.

Leaves of Absence

You may be eligible to take a leave of absence for certain types of disability. See your Additional Benefits and Programs book for information.

Subrogation and Third-Party Reimbursement

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

You can contact the subrogation vendor directly with questions. See the "Administrative Information" section for contact information.

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

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

The Plan is not responsible for your legal costs.

Right of Recovery

If, for any reason, the claims administrator overpays benefits or makes a payment in error, the claims administrator has a right to recover the excess amount from the person or agency who received it. The person receiving benefits must produce any instruments or papers necessary to ensure this right of recovery.

Claims and Appeals Procedures

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 Sickness and Accident Disability Benefit Plan for Mid-Atlantic Associates or the Verizon Long-Term Disability Plan for Mid-Atlantic Associates.

If you began receiving disability benefits before January 1, 2004 (even if you were receiving disability benefits before the change in regulations on January 1, 2002) and Verizon through a periodic review determines that you are no longer disabled, the determination will be considered a claim denial. Therefore, your subsequent request for benefits will be considered an appeal and will be determined using the procedure specified in this SPD (even though your disability first began before January 1, 2004).

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 Plans are:

VCRC
c/o Verizon Claims Review Unit
P.O. Box 8998
Norfolk, VA 23501-8998

MetLife
P.O. Box 14590
Lexington, KY 40511-4590

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.
- 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 following chart outlines the process that applies if you have an ERISA claim or appeal for a disability Plan benefit.

	Disability Plan *eligibility* claims procedure	**Disability Plan *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 benefits for which you are applying. • The reason(s) for the request. • Relevant documentation.	To file a claim, write to the disability administrator for the Plan (MetLife) and include: • A description of the benefits for which you are applying. • The reason(s) for the request. • Relevant documentation.
When you will be notified of the claim decision	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 *eligibility* claims procedure	Disability Plan *benefit* claims procedure
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 either the 75- or 105-day extension period 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 no later than 105 days after the initial claim was submitted, not including the time that it takes you to provide the additional information.	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 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. 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 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.
How you will be notified of the claim decision	If your claim is **approved**, the Claims Review Unit will generally notify you in writing. If your claim is **denied**, in whole or in part, the Claims Review Unit will notify you in writing. Your 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. • Any internal procedures on which the denial was based. • The Plan's appeal procedures.	If your claim is **approved**, the disability administrator will notify you in writing. If your claim is **denied**, in whole or in part, the disability administrator will notify you in writing. Your 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. • Any internal procedures or clinical information on which the denial was based (or a statement that such information will be provided free of charge). • The Plan's appeal procedures.

	Disability Plan *eligibility* claims procedure	Disability Plan *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 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.
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 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. You should include: • A copy of your claim denial notice. • The reason(s) for the appeal. • Relevant documentation. The individual/committee reviewing your appeal will be independent from the individual/committee who reviewed your claim.	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 disability administrator for the Plan and 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 disability administrator will consult with a health care professional who has appropriate relevant experience. You are entitled to the identity of such an expert, upon request.

	Disability Plan *eligibility* claims procedure	Disability Plan *benefit* claims procedure
When you will be notified of the appeal decision	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).
How you will be notified of the appeal decision	If your appeal is **approved**, the Claims Review Committee will generally notify you in writing. If your appeal is **denied**, in whole or in part, the Claims Review Committee will notify you in writing. Your denial notice will contain: • The specific reason(s) for the denial. • The Plan provisions on which the denial was based. • Any internal procedures or on which the denial was based. • A statement regarding the documents to which you are entitled. • 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."	If your appeal is **approved**, the disability administrator will notify you in writing. If your appeal is **denied**, in whole or in part, the disability administrator will notify you in writing. Your denial notice will contain: • The specific reason(s) for the denial. • The Plan provisions on which the denial was based. • Any internal procedures or clinical information on which the denial was based (or a statement that such information will be provided free of charge, upon request). • A statement regarding the documents to which you are entitled. • The Plan's voluntary appeal procedures. • 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."

	Disability Plan *eligibility* claims procedure	Disability Plan *benefit* claims procedure
Step 3:		
How to proceed if necessary	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.	**Voluntary benefits appeals** If you have 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: • A copy of your appeal denial notice. • The reason(s) for the appeal. • Relevant documentation. This appeal is voluntary. You have a right to bring civil action without submitting a voluntary appeal.
When you will be notified of the voluntary appeal decision	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).

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). 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 work sites 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 each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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 qualified status of a 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 is 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 at 1-866-444-3272.

Administrative Information

Administrative information about the Plans is provided in this section.

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). If you prefer, you can call the benefit providers directly via the telephone numbers provided in this section.

Plan Sponsor/Employer/Company

The Plan sponsor/employer/Company 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

Telephone number: 1-855-4VzBens (1-855-489-2367) and follow the instructions to reach the Verizon Benefits Center.

You may communicate to the Plan administrator in writing at the address above. The Verizon Benefits Center handles participant requests and certain benefits claims, but is not the Plan administrator. Claims relating to the scope and amount of benefits under the Plans are administered by the administrators listed under “Claims and Appeals Procedures.”

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

Do not send any benefit claims to the Plan administrator or to the Verizon legal department. Instead, submit them to the appropriate claims administrator for the Plans (see “Claims and Appeals Procedures”).

Benefits Administrator

Metropolitan Life Insurance Company (MetLife) is the benefits administrator for the Plans. As the benefits administrator, MetLife has the authority and responsibility to perform daily administration of benefits under the Plans. (See “Claims and Appeals Administrators” for MetLife’s telephone number and mailing address.)

Also, you can call or contact the **Verizon FMLA Helpline** provided by MetLife:

Telephone Number: 1**-**855-814-9344
Fax Numbers:
Forms: 1- 877-660-2660
Administrative Review**:** 1-877-786-4500
Email Address: Verizonleavemanagement@metlife.com
Mailing Address:
500 Summit Lake Drive
3rd Floor
Valhalla, NY 10595

Claims and Appeals Administrators

There are two claims and appeals administrators for the Plans.

Verizon Claims Review Committee (VCRC)

The VCRC is responsible for enrollment and eligibility-related claims. 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)

Metropolitan Life Insurance Company (MetLife)

MetLife is the claims administrator for claims relating to the scope or amount of benefits under the Sickness and Accident Disability and Long-Term Disability Plans. MetLife can be reached at the following address:

MetLife
P.O. Box 14590
Lexington, KY 40511-4590
1-800-638-4228
Fax: 1-800-230-9531

Plan Funding

The Plans are not financed by an insurance company, nor are Plan benefits guaranteed under a contract of insurance. The claims and appeals administrators listed under “Claims and Appeals Procedures” do not insure or guarantee Plan benefits.

The Company pays all claims out of the general assets of the Company.

Plan Identification

Disability coverage is provided under Verizon Plan 553, which is listed with the U.S. Department of Labor under an Employer Identification Number (EIN) and a single Plan Number: The Employer Identification Number (EIN) is 23-2259884 and the Plan Number is 553. Verizon Plan 553 is described in two "component" Plan documents:

- Verizon Sickness and Accident Disability Benefit Plan for Mid-Atlantic Associates.
- Verizon Long-Term Disability Plan for Mid-Atlantic Associates.

In addition to the benefits described in this SPD, Verizon Plan 553 provides other benefits to Mid-Atlantic associate employees of Verizon (including Verizon Connected Solutions Inc. technicians) who will receive their own version of the SPD.

Plan Year

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

Agent for Service of Legal Process

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

In addition, a copy of the legal process involving these Plans must be delivered to:

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

Official Plan Document

This SPD is a summary of the official Plan documents.

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.

Participating Companies

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

Mid-Atlantic CWA

- Verizon Maryland Inc.
- Verizon Virginia Inc.
- Verizon Washington, D.C. Inc.
- Verizon Pennsylvania Inc.
- Verizon Delaware Inc.
- Verizon New Jersey Inc.
- Verizon Services Corp.
- Verizon Corporate Services Corp.
- Verizon Advanced Data Inc.
- Verizon South Inc. (Virginia)

Mid-Atlantic IBEW

- Verizon New Jersey Inc.
- Verizon Pennsylvania Inc.
- Verizon Services Corp.
- Verizon Advanced Data Inc.
- Verizon Corporate Services Corp.

Glossary

B

Base Pay or Basic Pay Rate

For purposes of the Disability Benefit Plans, your pay includes your basic pay rate. Your pay does not include overtime, awards, incentives or allowances.

C

Certified Disability

The claims administrator may request that your disability be certified under the Plan. Physician's documentation may be required to substantiate certification.

Credited Service

The total duration of your employment with Verizon or a participating company starting with your first day of work.

F

Full-Time Associate

A full-time associate is an employee who is regularly scheduled to work 25 or more hours a week; or an associate, other than a member of IBEW Local 1944, who is scheduled to work less than 25 hours a week and who has been employed continuously by the Company since before January 1, 1981.

I

Incidental Absence Payments

For the first five consecutive business days of your illness, you may be paid up to 100 percent of your base pay, depending on your local bargaining agreement. The payments for "incidental absence" are not paid under the Sickness and Accident Disability Benefit Plan; they are paid out of your department budget. You may have to wait a day or two before payments are made during that five-day period depending on your net credited service.

Independent Medical Examiner

A professional health care provider who is selected by the benefits administrator to perform a professional review of an associate's physical and/or medical condition for the purpose of rendering an independent professional opinion on the question of whether the associate is or was unable to work at a certain time.

M

Medically Restricted Leave of Absence (MR-LOA)

The Medically Restricted Leave of Absence (MR-LOA) is a leave of absence without pay for medical reasons in accordance with the MR-LOA Policy Amendment dated September 19, 2012. The MR-LOA will not exceed 52 weeks in total from the date the medical restriction was first approved ("52-week period"), including time on restriction during the prior 24 rolling calendar months. For new hires with less than three years of net credited service, the MR-LOA will not exceed 26 weeks in total from the date the medical restriction was first approved ("26-week period"), including time on restriction during the prior 24 rolling calendar months. FMLA leave and an MR-LOA run concurrently.

Mid-Atlantic Associate Pension Plan

Mid-Atlantic Associate Pension Plan means The Verizon Pension Plan for Mid-Atlantic Associates, which is a component of the Verizon Pension Plan for Mid-Atlantic and South Associates.

P

Part-Time Associate

A part-time associate is an employee who is scheduled to work less than 25 hours a week and who is a member of IBEW Local 1944 or who has not been employed continuously by the Company since before January 1, 1981.

Partial Disability

You are partially disabled if you become unable to fully perform the functions of your position, or if you are totally disabled and recover from a total disability sufficiently to be able to work but you are not able to return to your pre-disability job.

Participating Company

Verizon or any corporation or partnership which is an affiliate of Verizon that has elected to participate in the Sickness and Accident Disability Benefit Plan and the Long-Term Disability Plan.

T

Term Associate

A term associate is an associate whose employment is for a specific project. The parameters for the length of the assignment is based on the provisions of the associate's collective bargaining agreement as noted below:

Collective Bargaining Agreement	Provisions for Term Associate's Length of Assignment
CWA-represented associates—Potomac (Maryland, Washington D.C., Virginia and West Virginia)	Term of employment is intended to last more than 6 months but not more than 30 months.
CWA-represented associates—New Jersey Traffic/Commercial and Marketing	Term of employment is temporary in anticipation of future force reductions and is expected to continue until the time of the force reductions, although it may be terminated at any time on the part of the associate or the Company. (Upon completion of 3 years of net credited service, a term associate will be reclassified as a "regular employee".)
CWA-represented associates—Delaware Local 13101(Plant & Traffic) and Pennsylvania Local 13000(Plant and Financial)	Term of employment is intended to last more than 6 months but not more than 36 months.
CWA-represented associates—Pennsylvania Local 13500 (Commercial)	Term of employment is intended to last more than 12 months but not more than 36 months.
IBEW-represented associates—Pennsylvania Local 1944	Term of employment is intended to last more than 12 months but not more than 36 months.

Total Disability

- **Under the Sickness and Accident Disability Benefit Plan**, you are considered to be totally disabled if you are unable to work at any job due to your disability.

- **Under the Long-Term Disability Plan**, you are considered to be totally disabled if you are unable, due to sickness or injury documented by objective medical evidence, to perform any job for which you are or may become qualified by reason of education, training or experience, or any job that pays, on a full-time basis, 50 percent or more of your base pay.

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Working Retiree

A former associate employee who was represented by CWA immediately prior to leaving the Company and:

- Who retired on a service pension or who elected a service pension cash out under the Mid-Atlantic Associate Pension Plan.
- Who is re-employed by a participating company after 90 or more calendar days of retirement.
- Who shall not be employed by a participating company for more than 120 days in a calendar year.
- Whose employment and duration of employment is determined based on the local bargaining agreement.