Your Long-Term Care Benefits

Contents

Your Long-Term Care Benefits

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

- Immediate eligibility on your date of hire. You also can enroll your spouse, your parents and/or your parents-in-law.
- Coverage for expenses related to care you need when you are unable to perform certain basic activities of daily living.
- The choice of two types of coverage.
- Optional reimbursement of a portion of your premiums if you enroll and later decide to cancel coverage.

About This SPD

This document is the summary plan description (SPD) for the Verizon Long-Term Care Insurance Plan for Mid-Atlantic Associates. The Plan is subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. This document meets ERISA's requirements for an SPD and is based on Plan provisions effective January 1, 2004, including legislative and administrative updates through December 31, 2006. It updates and replaces all previous SPDs and other descriptions of the benefits provided by the Plan. This SPD is a summary of this Plan.

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

This SPD is divided into the following major sections:

- **Participating in the Plan.** This section explains your eligibility, which of your dependents are eligible to be covered and when eligibility ends.
- **Your Coverage.** This section describes the long-term care insurance coverage available to you. Refer to it when you need information about your coverage and benefits.
- **What Is Not Covered.** This section lists services and supplies not covered under the Plan.
- **How to File a Claim.** This section provides information on when you need to file a claim to receive benefits.
- **Additional Information.** This section provides additional details about the administrative provisions of the Plan and your legal rights.
- **Glossary.** Certain terms used in this SPD are defined in the glossary.

Important Note

Verizon has the discretionary authority to interpret the terms of the plan and this SPD and determine your eligibility for benefits under their terms.

Getting More Information

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

- **For general information about the Plan**, call Mutual of Omaha at the telephone number listed on your Important Benefits Contacts insert..

- **For specific details about your coverage**, review this document or call the insurance company, Mutual of Omaha, directly. You also can call the Verizon Benefits Center at 1-877-4VzBens. Enter your Social Security number and say “Benefits Center.” By calling this number, you can transfer to Mutual of Omaha.

Changes to the Plan

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

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

Participating in the Plan

Eligibility

You are eligible for Plan coverage if you are an active full-time or part-time associate who is employed by a participating company.

In addition, you are eligible if you retire and receive a pension under the Verizon Pension Plan for Mid-Atlantic Associates.

"Associate," as used throughout this summary plan description (SPD) includes any non-management employee.

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

If you want long-term care insurance, you must enroll for it through Mutual of Omaha.

Eligible Family Members

When you are eligible for coverage, the following family members, if they are under age 80, may apply for coverage in the Plan:

- Your spouse.

- Your parent or parent-in-law. Both you and your spouse may enroll one male and one female parent. Your designation of a parent may not be changed after you apply for coverage.

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

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

If Your Spouse Is a Verizon Employee

For the Plan, if your spouse is employed by Verizon and covered by another long-term care plan, you can be covered as an employee under this plan or as a family member under your spouse's plan, but not as both.

Important Note

Coverage is not available to residents of Connecticut.

For More Information

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

Enrolling in the Plan

You can enroll in the Plan at any time. To request enrollment materials and an outline of coverage, call the Mutual of Omaha Long-Term Care Hotline. (See your Important Benefits Contacts insert for the telephone number.)

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

- If you are a full-time associate and you enroll within 31 days of your first day of employment (your "initial enrollment period"), you have guaranteed acceptance and will not need to provide a Statement of Health Form. If you are on a leave of absence or a disability leave when your initial enrollment period is scheduled to begin, your initial enrollment period instead will begin on the day you return to work as an eligible active associate.

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

- If you are a part-time associate, you must submit a Statement of Health Form regardless of when you apply.

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

Note: Long-term care insurance coverage is dependent on Statement of Health Form review by Mutual of Omaha.

When Coverage Begins

Mutual of Omaha will send you a certificate validation form and certification booklet when your application is approved. Your coverage begins on the date shown on the certificate validation form if you actively are at work on that day. If you are away from work on the day coverage otherwise would begin, your coverage begins on the first day of the month after you return to active work.

Family members approved for coverage receive a certificate validation form stating the effective date of coverage (as determined by Mutual of Omaha). However, if the family member is confined in a hospital, institution or other facility or is confined at home under the care of a physician, coverage will begin on the first day of the month after the confinement ends.

Changing Your Coverage

If you enroll in one coverage option and later want to change to the other coverage option, you must cancel your original coverage and enroll in the new option as a new participant. (See the "Your Coverage" section for coverage options.)

You can cancel your coverage at any time. You may be eligible for reimbursement of your premium payments. (See "Return of Premium Provision" under "Special Plan Features" in the "Your Coverage" section for more information.)

Cost of Coverage

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

- Your or your family member's age on the coverage effective date.
- The coverage option you selected.
- The level of benefits you selected within the coverage option.

For details on the coverage options and the benefit levels offered under each option, see the "Your Coverage" section.

Once you enroll for coverage, your premiums cannot be increased due to age, changing health or benefit claims. However, your cost for coverage may increase based on Plan experience.

If you later elect an increase in coverage, your premium increase will be based on your age at that time and will not affect the premium rates for your original coverage.

Paying for Coverage

Premiums for you and/or your spouse will be deducted from your paycheck on an after-tax basis. Your parents and parents-in-law will be billed directly and payments must be made directly to Mutual of Omaha.

Monthly Premiums

Your enrollment materials will include premium information. Call the Mutual of Omaha Long-Term Care Hotline to request enrollment materials. (See your Important Benefits Contacts insert for the telephone number.)

When Participation Ends

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

- The end of the period covered by your last premium payment, unless the premiums are waived.
- The date you reach the lifetime maximum benefit for your policy.
- As an active associate, the last day of the month you no longer are eligible for the Plan and/or payroll deductions stop (for example, during an unpaid leave of absence), unless you continue your coverage and, if applicable, your spouse's coverage by direct premium payment with Mutual of Omaha.
- The date the Company policy terminates, at which time you can continue your coverage directly with Mutual of Omaha.

Continuation of Coverage

If the Plan ends for any reason or if you leave Verizon, you may continue your long-term care insurance coverage, provided you continue to pay the premiums directly to Mutual of Omaha when they are due and you have not reached the lifetime maximum benefit. You will continue to pay group rates for your coverage. You also will pay a billing fee unless you pay annually or by Mutual of Omaha's Bank Service Plan.

To continue coverage, you must request continuation from Mutual of Omaha in writing within 31 days of your coverage end date.

Your Coverage

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

- **The basic option**, which generally covers eligible services at 80 percent, up to option maximums.
- **The enhanced option**, which generally covers eligible services at 100 percent, up to option maximums.

Both options cover the same services, but differ in the level of benefits paid.

Covered Services

Covered services under each option include both non-confinement and confinement services.

Non-confinement covered services include:

- Home health care, ordered and directed by a physician, furnished in the patient's home through a home health agency and under a home health care plan, including:
  - Part-time (less than an eight-hour shift) nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.).
  - Physical, occupational or speech therapy by a licensed therapist.
  - Part-time or intermittent home health aide services by a home health aide and under the supervision of an R.N.
  - Respite care services provided on a 24-hour basis, with the advance approval of a long-term care eldercare specialist.
- Adult day care services received in an adult day care center.
- Home hospice care, ordered and directed by a physician, furnished in the patient's home through a home health or hospice agency and under a hospice care plan, including:
  - Part-time (less than an eight-hour shift) nursing care by an R.N. or an L.P.N.
  - Physical, occupational or speech therapy by a licensed therapist.
  - Part-time or intermittent home health aide services by a home health aide and under the supervision of an R.N.
- Respite care.

Confinement covered services include:

- Skilled or intermediate nursing care, received while confined as a resident patient in a nursing care facility.
- Custodial nursing care, received while confined as a resident patient in a nursing care facility.
- Inpatient hospice care in any of the following situations:
  - No suitable caregivers are available to provide home hospice care.
  - The hospice agency determines that home hospice care is impractical because the patient is unmanageable by home hospice providers.
  - Hospice respite care is needed.

Benefits Payable

This chart summarizes the benefits payable for covered service after the applicable waiting period (see “Waiting Period” under the “How to File a Claim” section) under each option:

Plan Features	Basic Option	Enhanced Option
Maximum daily benefit	$100[1]	$100[1]
Lifetime maximum benefit	1,825 units of service[2]	$182,500[2]
Non-confinement, including home health care, adult day care, respite care[3] and home hospice care	Option pays 80%, up to $50 a day (1/2 unit)	Option pays 100%, up to $50 a day
Confinement, including skilled nursing care, intermediate nursing care and inpatient hospice care	Option pays 80%, up to $100 a day (1 unit)	Option pays 100%, up to $100 a day
Custodial care: Charges for assistance with personal care while confined	Option pays 80%, up to $50 a day (1/2 unit)	Option pays 100%, up to $100 a day
Benefit increase provision	$20 every 5 years, up to 5 times	$20 every 5 years, up to 5 times
Waiting period	90 days for confinement; 45 days for non-confinement	You choose either: • 90 days for confinement; 45 days for non-confinement • 60 days for confinement; 30 days for non-confinement

Plan Features	Basic Option	Enhanced Option
Return of premium schedule provision	You can receive a refund of a percentage of the premiums you paid to the Plan if your coverage ends after 1 year of participation	You choose among the following return of premium schedules: • 1-year • 5-year • No return of premium
Automatic inflation protection provision	Not available	You choose either: • Automatic inflation protection, which increases your maximum daily benefit by $5 each year you are insured under the Plan • No inflation protection

[1]The maximum benefit applies to all confinement and non-confinement services combined. For respite care, each 12-consecutive hour period is payable at 80 percent of the expense incurred up to $50 (and counts as 1/2 unit of service), and each 24-consecutive-hour period is payable at 80 percent of the expense incurred up to $100 (and counts as one unit of service).
[2]The maximum benefit increases if you increase your maximum daily benefit under the benefit increase provision or the automatic inflation protection provision. The maximum benefit applies to all confinement services combined. For respite care, each 12-consecutive-hour period is payable up to $50, and each 24-consecutive-hour period is payable up to $100.
[3]Prior approval from the Patient Care Advocate is required for respite care.

Each option includes a daily maximum benefit and a lifetime maximum benefit:

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

- The lifetime maximum benefit is the total amount the Plan will pay for all types of long-term care expenses combined.

  Under the basic option, your lifetime maximum benefit is expressed as units of service. Each full day of service counts as either a full unit or one-half unit, depending on the type of service:

Service	Unit Value
Skilled or intermediate nursing care	1 unit per day
Inpatient hospice care	1 unit per day
Custodial nursing care	1/2 unit per day
Home health care	1/2 unit per call day
Respite care	1/2 unit per 12-hour period
Adult day care	1/2 unit per day
Home hospice care	1/2 unit per call day

Under the enhanced option, your lifetime maximum benefit is expressed as a dollar amount.

Under either option, you can increase the daily and lifetime maximum benefits available to you through the benefit increase provision. Under the enhanced option, you also can increase these amounts through automatic inflation protection. (See the “Special Plan Features” section for information on the benefit increase provision and automatic inflation protection.)

Special Plan Features

Depending on the option you choose, you may be eligible to use the following special Plan features.

Benefit Increase Provision

You are eligible to elect the benefit increase provision regardless of the option you choose. Under both options, your maximum daily benefit is $100 per day for most types of confinement services. If you elect the benefit increase provision, your maximum daily benefit can increase up to $200. Under the benefit increase provision, you can increase your maximum daily benefit by $20 every five years. You can elect this provision up to five times before you reach age 80. The additional premiums for your benefit increase are based on your age at the time you elect the increase. Premiums for your original long-term care insurance coverage are not affected by benefit increases.

No Statement of Health Form is required for active, full-time associates to increase coverage. Part-time associates and associates’ covered family members who are age 66 or older must submit Statement of Health Forms and receive approval to increase coverage.

You are not eligible to elect the benefit increase provision if:

- You are age 80 or older.
- You currently are receiving benefits from the Plan.
- You have elected continuation coverage through Mutual of Omaha.

If you elect the benefit increase provision under the basic or enhanced option, your total maximum benefit also increases.

Return of Premium Provision

You are eligible to elect the return of premium provision regardless of the option you choose. The return of premium provision refunds a certain portion of your paid Plan premiums if your coverage ends for any reason or if you die.

The percentage of premium refunded is determined by the number of years you have been covered, and is reduced by any benefits paid or pending benefits.

Return of Premium Schedule

Under the basic option, if you cancel your coverage or die after you have been covered by the Plan for one full year, you may be eligible for premium refunds, as shown in the chart below:

Full Years of Coverage	Percentage of Premium
0 up to 1 year	0 %
1 to 5 years	25 %
6 to 10 years	50 %
11 to 15 years	75 %
16 years or more	100%

Under the enhanced option, when you enroll, you may choose coverage with no return of premium, or you may choose a one-year or five-year return of premium schedule. If you choose the one-year or five-year return of premium schedule and you cancel your coverage or die, you may be eligible for premium refunds, as shown in the chart below:

Return of Premium Schedule	Full Years of Coverage	Percentage of Premium
One-year	0 up to 1 year 1 to 5 years 6 to 10 years 11 to 15 years 16 years or more	0 % 25 % 50 % 75 % 100%
Five-year	0 up to 4 years 5 to 9 years 10 to 14 years 15 to 19 years 20 years or more	0 % 25 % 50 % 75 % 100%
No return of premium	Not applicable	Not applicable

Important Note

Under the enhanced option, if you want to choose the shorter waiting period, you must elect one of the enhanced option custom coverage options shown in the chart below.

Automatic Inflation Protection Provision

You are eligible to elect the automatic inflation protection provision when you enroll only if you choose coverage under the enhanced option. If you elect this provision, your original daily maximum benefit automatically will increase by five percent of the original amount each year you remain covered by the Plan, even if you already are receiving long-term care benefits. The inflation protection increase is in addition to, and independent of, any other increase in your daily maximum benefit.

If you elect this feature, you pay higher premiums. However, your premiums are based on the rate for your age when you elect this provision, rather than your age when the increases become effective.

Important Note

Under the enhanced option, if you want to choose no return of premium or the five-year return of premium schedule, you must elect one of the enhanced option custom coverage options shown in the chart below.

Shorter Waiting Period Provision

You are eligible to elect the shorter waiting period when you enroll only if you choose coverage under the enhanced option. Under the standard enhanced option, you must satisfy the waiting period of 90 days for confinement services and 45 days for non-confinement services before the Plan pays benefits. However, when you enroll, you can choose a shorter waiting period: 60 days for confinement services and 30 days for non-confinement services.

Enhanced Option Custom Coverage

You can choose to tailor your enhanced option coverage by choosing one of the following combinations of custom coverage.

Option	Waiting Period (Confinement/ Non-Confinement)	Return of Premium	Automatic Inflation Protection
2	90-day/45-day	1-year return	None
2A	90-day/45-day	5-year return	None
2B	90-day/45-day	None	None
2C	90-day/45-day	1-year return	5%
2D	90-day/45-day	5-year return	5%
2E	90-day/45-day	None	5%
2F	60-day/30-day	1-year return	None
2G	60-day/30-day	5-year return	None
2H	60-day/30-day	None	None
2I	60-day/30-day	1-year return	5%
2J	60-day/30-day	5-year return	5%
2K	60-day/30-day	None	5%

What Is Not Covered

The Plan does not cover the following services and supplies:

- Treatment for pre-existing and related conditions, unless the covered person has not received long-term care services for these conditions during the first 180 days of coverage.
- Treatment related to alcohol or drug addiction.
- Treatment of nervous or mental disorders, except organic brain disorders (such as Alzheimer's disease) as listed in the most recent edition of the International Classification of Diseases.
- Under the hospice care provision, the Plan does not cover any expenses, loss or charge for:
  - Services and supplies that are not specified as part of a hospice care plan.
  - Services provided by a caregiver or a person who lives in your home or is a member of your family.
  - Domestic or housekeeping services that are not related to the patient's care.
  - Services that provide a protective environment when no skilled service is required (such as companionship or sitter services).
- Other services that are not directly related to the covered person's condition, including but not limited to legal services, estate planning, drafting of wills, pastoral counseling or funeral arrangements or services; nutritional guidance or food services such as "Meals on Wheels"; or transportation services.
- Expenses for services incurred outside the United States or its territories or possessions.
- The portion of any expense that is covered by a Verizon-sponsored group health plan.
- Expenses for services incurred after coverage ends, unless the services are part of a confinement that begins before coverage ends and continues without interruption, subject to all maximums and limitations of the Plan.
- Services for any injury or sickness for which you are entitled to coverage under Workers' Compensation or occupational disease law.
- Expenses that exceed reasonable and customary (R&C) limits.
- Services or supplies that are not medically necessary or are not recommended by a physician.
- Expenses as a result of intentionally self-inflicted injury or illness, suicide or attempted suicide, whether the covered person is sane or insane.

- Expenses for any injury or loss resulting from participation in a riot or in the commission of a felony.

- Expenses that the covered person is not required to pay.

- Expenses for services or supplies that are not provided in accord with generally accepted professional medical standards, that are considered experimental or investigative or that are not approved as safe and effective.

- Expenses for services or supplies that are provided by or paid for by the federal government or its agencies, except those provided:

  — By the Veterans Administration to a veteran for a disability that is not service-related.

  — By a military hospital or facility to a retiree (or dependent of a retiree) from the armed services.

  — Under a group health plan established by a government for its own civilian employees and their dependents.

- Expenses for any injury or loss resulting from any war or act of war, whether declared or undeclared, or armed aggression.

- Expenses for any injury or loss incurred while the covered person is on active duty or training in the armed forces, national guard or reserves of any state or country, and for which any governmental body or agency is liable.

- Expenses for care incurred during the waiting period.

How to File a Claim

Filing a Claim

Before you can receive benefits, you must be certified as dependent in certain activities of daily living, and you must satisfy a waiting period to ensure that the care you need is long term.

Certifying Long-Term Care Needs

To qualify for long-term care benefits, you must be certified by an eldercare specialist as dependent in certain activities of daily living (ADLs) due to a condition covered under the Plan.

- For non-confinement services, you must be dependent in two of the ADLs.
- For confinement services, you must be dependent in three of the ADLs.

The six ADLs used for certification purposes are as follows:

- Bathing.
- Dressing.
- Eating.
- Taking medication.
- Toileting.
- Walking/transferring.

The Patient Care Advocate is available to work with your physician to verify which services are necessary and appropriate for you.

The Certification Process

If you or a covered family member needs long-term care services covered under this Plan, call an eldercare specialist at the Mutual of Omaha Long-Term Care Hotline to request a claim form. (See your Important Benefits Contacts insert for the telephone number.) You and your doctor will use the form to document your condition or incapacity.

Eldercare specialists have experience and training in eldercare issues, and will work directly with your physician to determine what services are necessary and appropriate for you.

Waiting Period

You must satisfy a specified waiting period before benefits begin. For the basic option and the standard enhanced option, you must receive 90 days of confinement services and 45 days of non-confinement services before long-term care benefits can begin. Under the enhanced option, you can choose a shorter waiting period. (See “Special Plan Features” in the “Your Coverage” section for more information.)

During the waiting period, you or a family member must notify Mutual of Omaha that the covered person is unable to perform the minimum ADLs and is receiving care. If the covered person is determined to need long-term care after he or she satisfies the waiting period, long-term care benefits begin.

When Benefits Begin

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

Premium Waiver

Your benefit period begins on the first day you receive covered services (including your waiting period) and ends when you go for 180 consecutive days without receiving services. You continue to pay your long-term care insurance premium for the first 90 days of the benefit period. After you receive covered services for 90 days, your premium is waived until your benefit period ends.

Important

If you assign your benefits to the hospital, physician or other provider who performs long-term care services, the provider is paid directly. If benefits are not assigned, Mutual of Omaha determines whether you or the provider will receive payment.

Coordination of Benefits

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

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

When the Plan is secondary, the claims administrator subtracts the primary plan’s payment from the allowable expenses. The Plan’s secondary payment (if any), when added to the benefit payable by the primary plan, never will exceed 100 percent of the total covered expenses incurred.

Priority of Payment

Under the Plan’s COB provisions, if you are covered under another group plan and that other plan does not have a COB clause, that other plan will be considered the primary plan. If your other group plan does have a COB clause, the plan which covers the insured person as an employee will be considered the primary plan. When the previous rules do not establish an order of benefit determination, the plan that has covered the person for the longer period of time is the primary plan and the plan that has covered the person for a shorter period of time is the secondary plan.

Coordination With Medicare

If you are eligible for Medicare Parts A and B, the Plan coordinates benefits with Medicare as either the primary or secondary plan, depending on your age and employment status. This COB provision applies whether or not you are enrolled for Medicare and before any other benefit coordination under the Plan.

The Plan is the primary plan and Medicare is the secondary plan for the following covered persons entitled to Medicare coverage:

- For Medicare entitlement due to age: Active employees and their spouses.
- For Medicare entitlement due to disability: Employees with coverage under this Plan due to current employment status and their family members.
- For Medicare entitlement due to end-stage renal disease: All covered persons during the first 18 months of such Medicare entitlement.

For all other covered persons, the Plan is the secondary plan.

Important

- You should submit any eligible claims to your medical or disability plan before you apply for long-term care benefits.
- Claims for less than $50 are not subject to the Plan's COB rules.

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 your Important Benefits Contacts insert 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 don't, any amounts which could have been recovered through subrogation may be deducted from future Plan payments. In any case, Verizon will require payment from you only for amounts recovered that are net of your legal costs related to the action.

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

The Plan is not responsible for your legal costs.

Right of Recovery

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

Additional Information

Claims and Appeals Procedures

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

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

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

Claims Regarding Eligibility to Participate in the Plan

At this time, for eligibility-related claims, the claims and appeals administrator is the VCRC. Eligibility claims should be directed to the Verizon Claims Review Unit at::

Verizon Claims Review Committee
P.O. Box 1438
Lincolnshire, IL 60069 1438

Claims should be directed to the Verizon Claims Review Unit, whereas appeals should be directed to the Verizon Claims Review Committee c/o the Verizon Claims Review Unit. In either case, the P.O. Box is 1438.

Claims Regarding Scope/Amount of Benefits Under the Plan

At this time, for benefit related claims, the VCRC has delegated its authority to finally determine claims to ***Mutual of Omaha***, which has discretionary authority to determine claims and appeals for your Long-Term Care Insurance Plan benefits.

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

The claims and appeals administrators have discretionary authority to:

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

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

If a claim is denied

Disagreements about benefit eligibility or benefit amounts can arise. If the Verizon Benefits Center is unable to resolve the disagreement, Verizon has formal appeal procedures in place for Employee Retirement Income Security Act of 1974 (ERISA)-covered plans.

This section explains the steps you or your authorized representative is required to take to file an ERISA claim or appeal. The procedure is slightly different, depending on whether you have an "**eligibility**" claim or a "**benefit**" claim.

An **eligibility** claim is a claim to participate in a plan or plan option or to change an election to participate during the year. A **benefit** claim is a claim for a particular benefit under a plan. It typically will include your initial request for benefits.

	***Eligibility* claims procedure**	***Benefit* claims procedure**
Step 1:		
How to file a claim	To file an **eligibility** claim, request a Claim Initiation Form from the Verizon Benefits Center at 1-877-4VzBens. 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. See your Important Benefits Contacts insert for contact information.	To file a **benefit** claim, you (or your authorized representative) should write to Mutual of Omaha. You must include: • A description of the benefits for which you are applying. • The reason(s) for the request. • Relevant documentation. See your Important Benefits Contacts insert for contact information.
When you will be notified of the claims decision	You will be notified of the decision within 90 days of the Claims Review Unit's receipt of your Claim Initiation Form (180 days, when special circumstances apply).	You will be notified of the decision within 90 days of Mutual of Omaha's receipt of your written claim (180 days, when special circumstances apply).
Failure to provide sufficient information	The Claims Review Unit will notify you of the deadline to submit additional information, if applicable.	Mutual of Omaha will notify you of the deadline to submit additional information, if applicable.

	***Eligibility* claims procedure**	***Benefit* claims procedure**
How you will be notified of the claim decision	If your claim is **approved**, the Claims Review Unit will notify you in writing. If your claim is **denied**, in whole or in part, your written denial notice will contain: • The specific reason(s) for the denial. • The plan provisions on which the denial was based. • Any additional material or information you may need to submit to complete the claim. • The plan's appeal procedures.	If your claim is **approved**, Mutual of Omaha will notify you in writing. If your claim is **denied**, in whole or in part, your written denial notice will contain: • The specific reason(s) for the denial. • The plan provisions on which the denial was based. • Any additional material or information you may need to submit to complete the claim. • The plan's appeal procedures.
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 Mutual of Omaha. The Claims Review Committee has delegated its authority to finally determine claims to Mutual of Omaha. As such, Mutual of Omaha 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 Mutual of Omaha are final and binding on all parties.
How to file an appeal	If your claim is denied and you want to appeal it, you must file your appeal within 60 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.	If your claim is denied and you want to appeal it, you must file your appeal within 60 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 Mutual of Omaha and include: • A copy of your claim denial notice. • The reason(s) for the appeal. • Relevant documentation.

	***Eligibility* claims procedure**	***Benefit* claims procedure**
When you will be notified of the appeal decision	You will be notified of the decision with 60 days of the Claims Review Committee's receipt of your appeal (120 days, when special circumstances apply). If your appeal is **approved**, the Claims Review Committee will notify you in writing. If your appeal is **denied**, in whole or in part, your written denial notice will contain: • The specific reason(s) for denial. • A statement regarding the documents that you are entitled to. • The plan provisions on which the denial was based.	You will be notified of the decision with 60 days of Mutual of Omaha's receipt of your appeal (120 days, when special circumstances apply). If your appeal is **approved**, Mutual of Omaha will notify you in writing. If your appeal is **denied**, in whole or in part, your written denial notice will contain: • The specific reason(s) for denial. • A statement regarding the documents that you are entitled to. • The plan provisions on which the denial was based.
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.	The decision on your appeal is final. As a result, Mutual of Omaha will not review your matter again, unless new facts are presented. You have a right to bring a civil action.

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

Assistance With Your Questions

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

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

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

Administrative Information

Administrative information about the Plan is provided in this section.

Important Telephone Numbers

You can connect to the Verizon Benefits Center and other Verizon benefit providers by calling 1-877-4VzBens. If you prefer, you can call the benefit providers directly via the telephone numbers shown on your Important Benefits Contacts insert.

Plan Sponsor/Employer

The Plan sponsor/employer is:

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

Plan Administrator

The Plan administrator is:

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

Telephone number: 1-877-4VzBens and follow the instructions to reach the Verizon Benefits Center.

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

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

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

Benefits Administrator

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

Claims and Appeals Administrators

The claims administrators have the authority to make final determinations regarding claims for benefits. The claims administrators are authorized to determine eligibility for benefits and interpret the terms of the Plan in its sole discretion, and all decisions by the claims administrators are final and binding on all parties.

There are two claims and appeals administrators for the Plan.

Verizon Claims Review Committee (VCRC)

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

Verizon Claims Review Committee
c/o Verizon Benefits Center
100 Half Day Road
P.O. Box 1438
Lincolnshire, IL 60069-1438

See your Important Benefits Contacts insert for the telephone number.

Mutual of Omaha

Mutual of Omaha is the benefits administrator responsible for responsible for authorizing benefit payments, considering appeals, resolving questions, obtaining records, filing reports and the distribution of information to Plan participant and also is the claims administrator for claims relating to the scope or amount of benefits under the Plan. Mutual of Omaha can be reached at the following address:

Mutual of Omaha
S-1 GDMS/Group LTC Claims
Mutual of Omaha Plaza
Omaha, NE 68175-0001

See your Important Benefits Contacts insert for the telephone number.

Plan Funding

The Plan is insured fully through Mutual of Omaha. Employees pay premiums to the insurance company for coverage.

Plan Identification

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

Plan Year

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

Agent for Service of Legal Process

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

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

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

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, 2007. The list may change from time to time.

- Verizon Advanced Data Inc.
- Verizon Connected Solutions Inc. technicians
- Verizon Delaware Inc.
- Verizon Maryland Inc.
- Verizon New Jersey Inc.
- Verizon Pennsylvania Inc.
- Verizon Services Corp.
- Verizon Virginia Inc.
- Verizon Washington D.C. Inc.
- Verizon West Virginia Inc.
- Verizon Avenue, Inc.
- Verizon Corporate Services Corp.

Glossary

A

Adult Day Care

This usually is a supervised program for adults, including medical, personal and recreational services, but not providing overnight or residential services.

C

Confinement Services

Confinement services include various types of care, from custodial to skilled nursing care, that a patient admitted to a nursing home or hospice receives.

Custodial Care

Custodial care is assistance with personal care that can be provided by someone without professional skills or training.

F

Full-time Associate

A full-time associate is an employee who is regularly scheduled to work 25 or more hours a week.

H

Home Health Aide Services for Home Health Care and Home Hospice Care

Home health aide services include helping the patient with:

- Bathing and care of mouth, skin and hair.
- Bowel and bladder care.
- Getting in and out of bed and walking.
- Exercises, prescribed and taught by appropriate professionals.
- Medication ordered by a physician.
- Household services essential to the home health care (if such services would be performed if the patient were in a hospital or skilled nursing facility).
- Reporting changes in the patient's condition to the supervising nurse.

Home Health and Home Hospice Care Call
One home health and home hospice care call consists of one visit for nursing care and physical, occupational and speech therapy; or up to four consecutive hours for home health aide services.

Home Health Care
Provided at home, and may include personal care, skilled nursing care, speech therapy, physical therapy, social services or the services of a home health aide. Home health care also can include respite care.

I
Intermediate Care
Occasional nursing and rehabilitation care provided by skilled medical personnel for those not needing around-the-clock skilled nursing care.

L
Long-Term Care Facility
A state-licensed inpatient facility providing a program of nursing care and related services. In general, retirement homes, rest homes, mental institutions and sheltered living homes do not meet the requirements for state licensing.

N
Non-Confinement Services
These services include home health care, adult day care, respite care and hospice care.

P
Parent or Parent-in-Law
Your or your spouse's natural parent or legal adoptive parent, or any other person who was at one time married to your or your spouse's natural or legal adoptive parent.

Part-time Associate
A part-time associate is an employee who is regularly scheduled to work less than 25 hours a week.

Participating Company
Verizon or any corporation or partnership that is an affiliate of Verizon that has elected to participate in the Long Term Care Insurance Plan for Mid-Atlantic Associates..

Pre-Existing Condition
Any sickness or physical condition for which an expense was incurred or for which medical advice or treatment was recommended or received within six months prior to the date your coverage takes effect, that results in incurring long-term care expenses in the first six months of coverage after the effective date of coverage.

R

Respite Care

Respite care is a type of home health care designed to relieve the patient's caregiver. An aide comes to the home to provide relief for a few hours up to several days to give the caregiver a break.

S

Skilled Nursing Care

This 24-hour-a-day care, performed under the supervision of a licensed physician, consists of nursing and rehabilitation services administered by registered nurses, licensed practical nurses or physical therapists.

Spouse

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

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

Statement of Health Form

A Statement of Health Form may consist of a physician's statement, copies of your medical records and/or a physical examination. If an examination is required, Mutual of Omaha pays for it.

U

Unit of Service

The basic option pays benefits on a "unit of service" basis. Each calendar day of confinement for skilled, intermediate or inpatient hospice care is valued as one "unit of service." A half-unit is assigned for each calendar day of custodial care, home health care visit, adult day care and home hospice care.

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