Your Disability Benefits

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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. 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.

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

Important Note

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

About This SPD

This book is the summary plan description (SPD) for the following Plans:

- Verizon Sickness and Accident Disability Benefit Plan for New York Associates

- Verizon Sickness and Accident Disability Benefit Plan for New England Associates

- Verizon Sickness and Accident Disability Benefit Plan for New York and New England Associates of Non-Regulated Companies

- Verizon Long-Term Disability Plan for New York and New England Associates.

The Plans are subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. This book meets ERISA's requirements for an SPD and is based on Plan provisions effective January 1, 2006. It updates and replaces all previous SPDs and other descriptions of the benefits provided by the Plans. This SPD is part 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" subsection, within the "Additional 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 absent from 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 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 due to sickness or an off-duty injury for more than 52 weeks.

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

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

Verizon Benefits Center

The Verizon Benefits Center offers a Web site called Your Benefits Resources™ (www.verizon.com/benefits) where you'll find tools to help you manage your benefits. The Web site makes finding information fast and easy as it guides you through your benefits transactions. In addition to enrolling on the site, you can:

- Hotlink to other Verizon benefit provider sites.

- Create and print personalized provider listings and maps to providers' offices for most options.

- Review details about your healthcare and insurance plans. For overview information, use the comparison charts. For more detailed information, use the Benefits Manual.

- Select and update your beneficiary designations.

- Change Your Benefits Resources password.

- Give yourself a helpful "hint" in case you forget your password.

Verizon Benefits Center representatives are available should you have questions about your benefits. To reach the Verizon Benefits Center via telephone, call 1-877-4VzBens. Via this toll-free telephone number, you also can connect with other Verizon benefit providers.

Your Benefits Resources™ is a registered trademark of Hewitt Associates LLC.

Changes to the Plans

While the Company expects to continue the Plans indefinitely, Verizon 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 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 or part-time associate.

- A full-time associate is an employee who is regularly scheduled to work 25 or more hours per week. In addition, the definition of a full-time associate includes job sharing employees who are regularly scheduled to work at least 40 percent of a regular full-time employee's hours.
- A part-time associate is an employee who is regularly scheduled to work less than 25 hours per week.
- A temporary employee's eligibility is governed by the applicable collective bargaining agreements.

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 and your Sickness Disability benefits end.

Notes:

- "Service" is based on net credited service provisions of the Verizon Pension Plan for New York and New England Associates. 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 are a temporary associate employee of a participating company, you may be eligible for disability benefit coverage based on your net credited service and the terms of an applicable collective bargaining agreement.
- 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 Verizon Pension Plan for New York and New England Associates. However, if immediately prior to your reemployment 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 reemployment.

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.

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

State Disability Law and Your Verizon Benefits

If you are employed in New York or Rhode Island, you may be eligible for state-mandated sickness disability benefits if:

- You are not eligible to participate in the Verizon Plans.
- You are not eligible for benefits under the Verizon Plans because you have not yet reached the service requirement.
- You are not eligible for benefits under the Verizon 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 a Verizon Plan at the same time. However, any Verizon 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 the Verizon Benefits Center. (see your Important Benefits Contacts insert for the telephone number).

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

Your Sickness and Accident Disability benefit coverage ends when your employment terminates (including retirement) or when you receive the maximum benefit payable under the Plan. However, if your employment terminates prior to your reaching the maximum benefit 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 Long-Term Disability benefit coverage ends when you receive the maximum benefit payable under the 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% of pay or a combination of both, depending on your length of service as of your eighth consecutive calendar day of absence	If you have at least 6 months of service and you continue to be disabled after seven consecutive calendar days, Sickness Disability benefits may begin	The earlier of the date you no longer are disabled or you receive the maximum benefits payable (52 weeks)
Accident Disability	Full pay for at least 13 weeks (longer if you have 15 years of net credited service); 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 disabled or, if earlier, when you retire with a service pension or terminate employment with a deferred vested pension
Long-Term Disability	50% of your monthly pay (including 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 end, your employment is terminated and Long Term Disability benefits may begin	The earlier of the date you no longer are disabled or you turn age 65 (or, if you were over age 60 when you became disabled, you receive the maximum benefits payable, see "When Benefits End" for more information

Sickness Disability Benefits

Applying for a Benefit

To apply for Sickness Disability benefits, you need to:

- Call the Absence Reporting Center (ARC) on the first day you are absent. (See your Important Benefits Contacts insert for the telephone number.)

- By your eighth consecutive calendar day of absence, your supervisor will file a form with MetLife Insurance Company to initiate your disability absence.

When Benefits Begin

You may be eligible to receive Sickness Disability benefits after you have been absent for more than seven consecutive calendar days due to sickness or an off-duty injury. For information on disability benefits for an on-duty injury, see the “Accident Disability Benefits” section.

In addition, you must:

- Be under a qualified physician’s care.

- Receive proper medical treatment.

- Take proper care of yourself.

- 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.

- Obtain permission from the claims administrator if you plan to recuperate away from home at any time during your absence.

Verizon’s Workers’ Compensation department determines when an injury is considered on-duty or off-duty and when benefits are paid.

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 chart below 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 6 months but less than 2 years	–	52 weeks
2 years but less than 5 years	4 weeks	48 weeks
5 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: If you are eligible for any Workers' Compensation or other state-mandated disability payments, your benefit may be reduced by these amounts.

How Pay Is Determined

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

If your compensation is ordinarily computed on other than a time basis, your average compensation (not including compensation for overtime) for the preceding three months, or other period of time provided in an applicable collective bargaining agreement, may be used as your the rate of pay – provided that the resulting rate is not less than your time rate.

Overpayments

In the unlikely event of a benefit overpayment, both you and your Supervisor will be notified by Payroll of the overpayment and given the opportunity to repay it to the Plan.

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 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.

Recurrences and Successive Disabilities

If you return to work after being disabled and you 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, 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 = 42 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 chart below 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 2 weeks	On the first scheduled work day of your absence
More than 2 weeks but less than 13 weeks	On the eighth consecutive calendar day of your absence[1]
More than 13 weeks	On the eighth consecutive calendar day of your absence, with eligibility for a new 52-week benefit period[1]

[1]You may be eligible for Incidental Absence payments during the seven-day period before Sickness Disability benefits begin.

Applying for Social Security

After you have received Sickness or Accident Disability benefits for more than six months, you must apply for Social Security disability benefits. You can begin the application process for Social Security disability benefits after five months of short-term disability. During your fifth month of disability, you will receive information from MetLife on how to apply.

Third Medical Opinion

If you are a CWA-represented associate, you may be eligible for a third medical opinion in the following situations.

Dispute Over Medical Condition

When there is a disagreement between the Company and you or your Union over your medical condition, which your Union claims will affect your wages or Sickness or Accident Disability benefits, you will be examined by a third doctor who is acceptable to both the Union and the Company. The Company will pay for your examination. The doctor's opinion will be limited to your clinical condition and will determine whether you are eligible for wages or Sickness or Accident Disability benefits.

Dispute Over Ability to Return to Work

The Company will provide your Union with a weekly report of employees who are not being paid for absences. When there is a disagreement between the Company and your doctor regarding your condition or your ability to return to work, your Union must notify the Company in writing within 21 days of receipt of its first weekly notice that it wishes to submit the dispute to a third doctor. A medical vendor that is jointly selected by the Company and your Union Association will designate the third doctor. Until a medical vendor is jointly selected, the current medical vendor will select the third doctor. This designation and your examination must take place within 30 days of the Company's receipt of your Union's written notice. The Union and the Company will share equally the cost of your examination. The third doctor's conclusion is binding on the Company and the Union. However, if the doctor determines you can return to work, the Company will determine whether it can provide work for you within any restrictions imposed by the third doctor's conclusion. If the Company determines it cannot provide such work for you, you will receive disability benefits.

Important Note

A copy of the third doctor's opinion will be supplied to the Union upon its request and the submission of your signed release.

A copy of your medical records will be supplied to the Union as soon as possible after its request and the submission of your signed release.

Accident Disability Benefits

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 accidental injury arising out of and in the course of employment. The length of your Company service is used to determine the duration of your full–pay benefit period.

Accidental injuries are considered as arising out of and in the course of employment only where the injury has resulted solely from an accident that occurs during and in direct connection with the performance of duties to which you are assigned in the service of the employing company, or which you are directed to perform by a proper authority, or in voluntarily protecting the employing company's property or interests.

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.

Verizon reserves the right to require periodic recertification of your disability.

When Benefits Are Paid

If you are disabled in an on-duty accident and unable to 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 above).

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.

Important Note

Verizon determines whether you are unable to work due to an on-duty accidental injury arising out of and in the course of employment.

Benefits for Total Disability

Under the Plan, total disability means you are unable to work at **any** Company 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. Under the Plan, your benefit is based on your basic pay rate plus shift differentials, commissions and temporary increases. It does not include overtime, awards, incentives or allowances.

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[1] Up To...	And Then, Half Pay[1]
Less than 15 years	13 weeks	You can receive half pay for as long as you remain totally disabled or, if earlier, until you retire with 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	

[1]Full- and half-pay benefits are offset by any Workers' Compensation payments you are eligible to receive.

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.

Applying for Social Security

After you have received Sickness or Accident Disability benefits or more than six months, you must apply for Social Security disability benefits. You can begin the application process for Social Security disability benefits after five months of short-term disability. During your fifth month of disability, you will receive information from MetLife on how to apply.

Overpayments

In the unlikely event of a benefit overpayment, both you and your Supervisor will be notified by Payroll of the overpayment and given the opportunity to repay it to the Plan.

Third Medical Opinion

If you are a CWA-represented associate, you may be eligible for a third medical opinion in the following situations.

Dispute Over Medical Condition

When there is a disagreement between the Company and you or your Union over your medical condition, which your Union claims will affect your wages or Sickness or Accident Disability benefits, you will be examined by a third doctor who is acceptable to both the Union and the Company. The Company will pay for your examination. The doctor's opinion will be limited to your clinical condition and will determine whether you are eligible for wages or Sickness or Accident Disability benefits.

Dispute Over Ability to Return to Work

The Company will provide your Union with a weekly report of employees who are not being paid for absences. When there is a disagreement between the Company and your doctor regarding your condition or your ability to return to work, your Union must notify the Company in writing within 21 days of receipt of its first weekly notice that it wishes to submit the dispute to a third doctor. A medical vendor that is jointly selected by the Company and your Union Association will designate the third doctor. Until a medical vendor is jointly selected, the current medical vendor will select the third doctor. This designation and your examination must take place within 30 days of the Company's receipt of your Union's written notice. The Union and the Company will share equally the cost of your examination. The third doctor's conclusion is binding on the Company and the Union. However, if the doctor determines you can return to work, the Company will determine whether it can provide work for you within any restrictions imposed by the third doctor's conclusion. If the Company determines it cannot provide such work for you, you will receive disability benefits.

Important Note

A copy of the third doctor's opinion will be supplied to the Union upon its request and the submission of your signed release.

A copy of your medical records will be supplied to the Union as soon as possible after its request and the submission of your signed release.

If You Partially Recover From a Total Disability

Your injury is reclassified as a partial disability if you are totally disabled and you recover sufficiently to be able to work, but you are not able to return to your pre-disability job. In this case, you will receive Accident Disability benefits according to the partial disability provisions described below.

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

Benefits for Partial Disability

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 Verizon Employee Benefits Committee (VEBC).

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.

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 6 years.

Recurrences and Successive Disabilities

You still can 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 again are absent due to the original injury or due to a successive 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 your on-duty injury is unrelated to your prior injury or if a recurrence occurs after you are back at work more than 13 weeks, you will begin a new disability period.

Situations That May Affect Your Benefits

The following situations may affect your benefits under the Plan:

- You fail to report immediately 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

All other Verizon benefit coverage continues while you qualify for Accident Disability benefits.

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, 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 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.

You must be continuously certified as disabled for a 52-week period to be eligible for Long Term Disability (LTD). Your disability will be treated as continuous even if your disability stops for 13 weeks or less during the 52-week period. The days that you are not disabled (not receiving STD benefits) will not count toward this 52-week period.

Important Note

To be eligible for LTD benefits, your employment must have ended due to your disability, with no guarantee of re-employment. 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 certain forms, including a disability income questionnaire, a reimbursement agreement and certain medical information concerning your medical condition from your physician. You will receive this information in the mail when you reach the 44th week of Sickness Disability benefits, and you must submit these forms within 20 days of receiving them.

It is possible that Verizon or the LTD claims 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. 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

Your LTD benefit – in combination with certain other sources of income – provides you with income equal to 50 percent of your monthly base pay at the time you are disabled.

For purposes of the Plan, your monthly base pay is your basic pay rate as determined by payroll records, including shift differentials, commissions and temporary increases. It does not include any overtime, awards, incentives or allowances.

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 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 Verizon Pension Plan for New York and New England Associates.

Example: Determining an LTD Benefit

Assume that:

- You are age 50 when you begin receiving benefits.
- Your monthly base pay is $3,000.
- The only other income you are receiving is a monthly Social Security benefit of $900.

Step 1: Calculate 50 percent of your monthly base pay.

$3,000 × .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 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 must apply for Social Security benefits. You can begin the application process for Social Security disability benefits after five months of disability. During your fifth month of disability, you will receive information from Verizon on how to apply. 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 will stop receiving LTD benefits when you no longer are disabled or you turn age 65 (unless you are older than age 60 when Sickness Disability benefits begin – see the following chart).

If you are over age 60 when you become disabled, your benefits may continue past age 65:

Age When You Are Disabled	Duration of Benefits
At age 60 or younger	Age 65
Over age 60	5 years[1]

[1]Includes 52 weeks of Sickness Disability benefits.

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 or a participating company 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 less than 13 weeks when your disability recurs or a successive disability occurs, you may receive LTD benefits beginning with the first day you are disabled.

- If you have been back at work 13 weeks or more when your disability recurs or a successive disability occurs, for purposes of LTD Plan eligibility, you will be treated as a new hire on the date you return to work. 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. **Note:** Once you have been entitled to Social Security disability benefits for 24 consecutive months, Medicare becomes primary and Verizon medical coverage is secondary.

- Your dental and vision coverage end, unless you choose to continue coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments or, for dental coverage, you also are receiving a service or disability pension (see Your Dental Benefits SPD and Your Vision Benefits SPD).

- Survivor benefit coverage may continue for a period of time (see Your Survivor Benefits Program SPD).

- If you participate in the Savings Plan, you can receive a final distribution of your vested account (see Your Savings Plan SPD).

- You may be eligible to retire with a service or disability pension (see Your Pension Plan SPD).

When Benefits Are Not Paid

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

- Your commission of a felony

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

- Military service

- War, whether declared or undeclared, or any act or hazard of war occurring after you become covered under the Plan

- 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 away from home to recuperate or for vacation, you must attain approval from the claims administrator prior to commencement of the travel. This requirement covers all travel away from home while receiving Sickness and Accident Disability benefits.

If you do not attain approval for travel, 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 those benefits from the negligent person or by obtaining a reimbursement from that person's insurance company – or from you if settlement amounts have been paid to you by the negligent person or his or her insurer.

You can contact the claims administrator 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 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 pays 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.

Disability Claims and Appeals Procedures

The claims and appeals procedure is slightly different, depending on whether you have an "eligibility" claim or a "benefit" claim. An eligibility claim is a claim for eligibility to have coverage in a plan. A benefit claim is any claim that is not a claim for eligibility. An example of a benefit claim is a claim for disability benefits due to alleged failure to satisfy the definition of "disabled" under the Verizon Long-Term Disability Plan for New York and New England 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're 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 1438
Lincolnshire, IL 60069-1438

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

If you have a claim or appeal, you should contact the appropriate claims and appeals administrator for the type of claim or appeal you have.

The claims and appeals administrators, as the claims fiduciaries, have discretionary authority to:

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

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

The 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 1-877-4VzBens. 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 you're applying for • The reason(s) for the request and • Relevant documentation	To file a claim, write to the disability administrator for the plan (MetLife) and include: • A description of the benefits you're applying for • The reason(s) for the request and • 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)

<table>
<tr><th></th><th>Disability plan eligibility
claims procedure</th><th>Disability plan benefit
claims procedure</th></tr>
<tr><td>Failure to provide sufficient information</td><td>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 the 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</td><td>If you fail to provide sufficient information, the claim may be decided based on the information provided. However, the disability administrator may notify you within either 75- or 105-day extension period that additional information is needed. In some cases, you may be required to have an independent medical examination.

You will have 45 days to provide the additional information. Otherwise, the claim will be decided based on the 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</td></tr>
<tr><td>How you will be notified of the claim decision</td><td>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 and
• The plan’s appeal procedures</td><td>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) and
• The plan’s appeal procedures</td></tr>
</table>

	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 at 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 at 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 and • 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 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 and • 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 healthcare professional who has appropriate relevant experience. You are entitled to the identity of such an expert, upon request.
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)

	Disability plan *eligibility* claims procedure	**Disability plan *benefit* claims procedure**
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 denial • The plan provisions on which the denial was based • Any internal procedures on which the denial was based • A statement regarding the documents that you are entitled to and • 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 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 that you are entitled to • The plan's voluntary appeal procedures and • 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 benefit appeals:** If you had a benefit appeal that was denied at Step 2, you may submit a voluntary appeal to the disability administrator. You must file your voluntary appeal within 60 days from the date you receive written notice of your denied appeal. To file your voluntary appeal, write to the disability administrator at the address provided to you in your Step 2 denial letter and include: • A copy of your appeal denial notice • The reason(s) for the appeal and • Relevant documentation This appeal is voluntary. You have a right to bring a 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 summary plan description. 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 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 a 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 administrator.

If you have a claim for benefits which 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 the 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 publications 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

See your Important Benefits Contacts insert for information.

Plan Sponsor
The Plan sponsor 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

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 legal department. Instead, submit them to the claims administrator for the Plans (see "Claims and Appeals Procedures").

Benefits Administrator
Metropolitan Life Insurance Company (MetLife) is the benefits administrator for Plans. As the benefits administrators, MetLife has the authority and responsibility to perform daily administration of benefits under the Plans. (See below for the addresses and your Important Benefits Contacts insert for the telephone numbers for the benefits administrators.)

MetLife Insurance Company
MetLife is the benefits administrator responsible for exercising the discretion to determine benefit payments under the Sickness and Accident Disability Benefit Plan and the Long-Term Disability Plan. MetLife also is the claims administrator for claims relating to the scope or amount of benefits under the Long-Term Disability Plan. MetLife can be reached at the following address:

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

See your Important Benefits Contacts insert for the telephone number.

Plan Funding

The Plans is 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 operating expenses of the Company.

Plan Identification

Disability coverage is provided through the following welfare plans, which are listed with the Department of Labor under two numbers: The Employer Identification Number (EIN) is 23-2259884 and the Plan Numbers (PNs) are listed below.

- Verizon Sickness and Accident Disability Plan for New York Associates: PN 560

- Verizon Sickness and Accident Disability Plan for New England Associates: PN 559

- Verizon Sickness and Accident Disability Plan for New York and New England Associates of Non-Regulated Companies: PN 566

- Verizon Long-Term Disability Plan for New York and New England Associates: PN 569

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.
1095 Avenue of the Americas
37th Floor
New York, NY 10036

Official Plan Document

This SPD is part of the official Plan documents.

Participating Companies

The following is a list of participating companies as of January 1, 2006. The list may change from time to time.

Verizon Sickness and Accident Disability Benefit Plan for New York Associates

- Verizon New York Inc.
- Empire City Subway Co. Ltd.

Verizon Sickness and Accident Disability Benefit Plan for New England Associates

- Verizon New England Inc.

Verizon Sickness and Accident Disability Benefit Plan for New York and New England Associates of Non-Regulated Companies

- Telesector Resources Group Inc.

Long-Term Disability Plan for New York and New England Associates

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