Your survivor benefits

Contents

Your survivor benefits program

When you retire or if you become a long-term disability (LTD) benefit recipient, the Verizon survivor benefits program provides basic life insurance coverage at no cost to you. In addition, retirees and LTD benefit recipients have the option to continue supplemental life insurance coverage if the option is exercised prior to retirement. If you are a retiree, during the election period prior to your retirement, you also have the option to purchase dependent life insurance for your spouse (or same-sex domestic partner, if applicable) and your eligible children.

Plans for associate and management retirees

The plans that make up the survivor benefits program as applicable to eligible associate retirees are:

- The Verizon Group Life Insurance Plan for New York and New England Associates, which is a component plan of Verizon Plan 501 and

- The Verizon Dependent Group Life Insurance Plan for New York and New England Associates, which is a component plan of Verizon Plan 526.

For eligible management retirees, benefits are part of The Plan for Group Insurance, Verizon Plan 580.

Important note

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

About this SPD

This document is the summary plan description (SPD) for the survivor benefits program for New York and New England associate retirees and LTD benefit recipients, as well as New York and New England management retirees who retired before July 2, 1985. The plans described in this SPD are subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. This document meets ERISA's requirements for an SPD and is based on plan provisions and bargained-for changes effective January 1, 2009. It updates and replaces all previous SPDs and other descriptions of the benefits provided by these plans. This SPD is a summary of and 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 "Additional information" section.

This SPD is divided into the following major sections:

- **Participating in the plans**. This section explains your eligibility, which of your dependents are eligible to be covered, when you can make changes and when eligibility ends.

- **Your basic life insurance.** This section describes the company-provided basic life insurance coverage.

- **Your supplemental life insurance.** This section describes the supplemental life insurance coverage.

- **Your dependent life insurance.** This section describes the dependent life insurance coverage available to retirees.

- **How to receive a benefit.** This section provides information on receiving benefits.

- **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™ where you'll find tools to help you manage your benefits. You can access Your Benefits Resources on the Internet at www.verizon.com/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 provider sites.

- Review details about your health care and insurance plans.

- 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.

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 (as applicable). The plans may be amended by publication of any SPD, summary of material modification, enrollment materials or other communication relating to the plans, as approved by Verizon.

Decisions regarding changes to, or terminations of, benefits are made at the highest levels of management. Verizon employees below those levels and retirees 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 are formally adopted and are officially 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 the plans described in this summary plan description (SPD) if you were employed by one of the participating companies listed in the "Additional information" section and:

- You were a management employee who retired before July 2, 1985 with a service or disability pension under the NYNEX Management Pension Plan.

- You were an associate who retired:

  — With a service pension under the terms of the Verizon Pension Plan for New York and New England Associates (previously known as the NYNEX Pension Plan).

  — With a disability pension under the Verizon Pension Plan for New York and New England Associates (previously known as the NYNEX Pension Plan).

- You are a long-term disability (LTD) benefit recipient who meets all of the following conditions:

  — You were formerly an eligible employee,

  — You terminated employment because of a continuing disability within the meaning of the applicable disability benefit plan,

  — You were eligible at the time of the termination of employment and continue to receive LTD benefits under the applicable company-sponsored LTD plan and

  — You continue to receive LTD benefits under the applicable company-sponsored LTD plan.

Eligible dependents

In order to receive coverage, dependents must be enrolled before you retire. For purposes of electing dependent life insurance, you can enroll your eligible class I dependents who meet the plan definitions described in the chart that follows.

Class I dependent eligibility requirements

Who they are	Relationship
• Your legal spouse (whether or not separated) • Your ex-spouse (in Massachusetts, New Hampshire and Rhode Island only)	• Spouse
• Your unmarried children from at least 15 days old until the end of the calendar year in which they reach age 19 provided they receive more than 50% of their support from you. Children means children by birth, as well as legally adopted children or children placed for legal adoption, stepchildren who live in your home, and children who live in your home and for whom you or your spouse is the legal guardian	• Child
• Your unmarried children (as defined above) from age 19 through the end of the calendar year in which they reach age 25 and are full-time students at an accredited educational institution, provided they receive more than 50% of their support from you. Coverage lasts until the end of the month they no longer qualify as full-time students, or, if earlier, the end of the calendar year in which they reach age 25	• Full-time student
• Your unmarried children (as defined above) of any age who are incapable of self-support and dependent on you for support due to physical or mental disability if the disability began before age 19 or before age 25 while a full-time student and they are covered continuously under the Verizon Medical Expense Plan for New York and New England Associates or the Verizon Medical Expense Plan for Pre 8/10/1986 Associate Retirees and Pre 7/2/1985 Management Retirees; and, for dependent child life insurance, they were enrolled for coverage before exceeding the age limits and have been covered continuously	• Disabled child
• **For post-1986 associate retirees:** Your same-sex domestic partner, as defined below, and his or her unmarried children, as of the date your employment with Verizon ended. You generally cannot cover a new domestic partner or the child of a new domestic partner after retirement. However, if you marry a person of the same sex in a state that permits same-sex marriage, you will be eligible to add that person (or his or her child if also eligible) after retirement as a domestic partner. For more information on eligibility requirements, access Your Benefits Resources Web site or call the Verizon Benefits Center and speak with a representative	• Domestic partner • Domestic partner's child

Enrolling in the plans

Initial enrollment

Before you retire or when you become eligible for LTD benefits, the Verizon Benefits Center provides an enrollment worksheet listing your basic life insurance, supplemental life insurance and dependent life insurance options and the deadline for enrolling. (**Note:** If you want to increase your supplemental life or dependent life insurance coverage, you have to do so before your retirement date):

- For basic life insurance, coverage is automatic and provided at no cost to you.

- For supplemental life insurance and dependent life insurance, you pay monthly premiums for coverage. Initially, any coverage you have in effect at the time you become eligible for the plans will continue. Supplemental life insurance is not available if you are age 65 or older and dependent life insurance is not available to LTD benefit recipients. If you want to increase supplemental life and dependent life coverage, you must do so before your retirement date. If you start or increase coverage, statement of health requirements apply (see below). You can decrease or stop the supplemental life and dependent life insurance coverage at any time. If you elect to decrease or stop coverage, or do not enroll for supplemental life or dependent life insurance coverage during the enrollment period prior to your retirement, you will not be permitted to increase, reinstate or enroll for coverage at a later date. (**Note:** Coverage for your spouse or same-sex domestic partner, if applicable, ends on the January 1 following the date in which he or she reaches age 65. Coverage for dependents ends at the end of the calendar year when they reach age 19 or age 25 as applicable.)

Generally, any changes you elect become effective on the first day of the month following the enrollment deadline (subject to statement of health form approvals, if applicable).

If you do not make an election during your initial enrollment period:

- For basic life insurance, you will continue to have coverage in the amount indicated on your enrollment worksheet, subject to reduction due to age as explained in the “Coverage reduction based on age” section.

- For supplemental life insurance, you will continue to have supplemental life insurance coverage under the plan in the same amount (if any) as was in effect immediately prior to your retirement date.

- For dependent life insurance, if you are a retiree, you will continue to have the same coverage based on the dependent life insurance you had as an active associate. If you are an LTD benefit recipient, any coverage you had as an active associate will end on the last day of the month in which you begin to receive LTD benefits.

Statement of health form requirements

If you start supplemental life or dependent life insurance, or increase your level of coverage before you retire, you are required to complete a statement of health form.

When a statement of health form is required for supplemental life insurance or dependent life insurance, your current election remains in effect until the insurance company approves your new election. Your coverage becomes effective on the first day of the month after the insurance company approves the statement of health form. If your statement of health form is not approved, coverage at your current level will remain in effect.

Beneficiary designation

A beneficiary is the person (or persons) you name to receive benefits when you die. You name a beneficiary when you first elect coverage. You must designate your beneficiaries separately for basic life insurance and, if applicable, supplemental life insurance.

You can designate one person or several individuals to receive benefits. If you want benefits to be shared, you need to indicate the percentage (instead of a dollar amount) of the total benefit for each beneficiary. For example, you can designate 60% of the benefit for one person and 40% for another for a total of 100%. Unless you choose otherwise, multiple beneficiaries will share equally in the benefit. For example, three beneficiaries would be allocated benefits at 34%, 33% and 33% for a total of 100%. **Note:** Fractions are not allowed.

When you name your beneficiaries, keep the following in mind:

- Remember to include your beneficiary's full name and relationship to you. For example:

  — "50% to Juan Gonzalez, my son; and 50% to Anna Gonzalez, my daughter."

- If you name more than one primary beneficiary and one of the primary beneficiaries dies before you, the death benefit that would have been paid to the deceased primary beneficiary will be paid to your remaining beneficiaries.

- Indicate whether beneficiaries are primary or contingent. A primary beneficiary is the first to receive plan benefits in the event of your death. If your primary beneficiary is no longer living when the plan pays benefits, your contingent beneficiary will receive plan benefits. A contingent beneficiary (or beneficiaries) receives benefits only if none of your primary beneficiaries are living when you die.

- If you want benefits to be paid to a trust, indicate the name, date and trustee of the trust. Copies of the trust document must be provided to the benefit administrator.

- If you want benefits to be paid to your estate, indicate that on the form.

- If you want to allow for the possibility that you will have additional children, you can include a clause like the following: "In equal shares to the children born of my marriage to Maria Gonzalez, or to the survivor or survivors."

- To include stepchildren, foster children or other informally adopted children, specify them by name. Otherwise, they are not legally included if you designate "my children."

- To ensure that your beneficiary instructions are followed, corrected forms cannot be accepted. If you make a mistake or need to make a change, be sure to complete and sign a new form.

- If you die and do not leave a surviving beneficiary, your insurance benefits will be paid as follows:

  — Your surviving spouse, if any,

  — Your surviving children equally, if there is no surviving spouse,

  — Your surviving parents equally, if there is no surviving spouse or child and

  — Your estate.

Managing beneficiary information

You can manage your beneficiary information online or by calling the Verizon Benefits Center. Once you have entered your information online, you can sign on to the Web site at any time after that to review or update your beneficiary information.

Online, go to Your Benefits Resources Web site on the Internet (see your Important Benefits Contacts insert for contact information), then:

- From the “Find it Fast” menu, select “Beneficiaries.”

- Choose Basic Life Insurance and follow the instructions.

Once you input your beneficiary designation, your election is effective immediately and the Verizon Benefits Center will send you a confirmation in the mail.

To designate a beneficiary via the Verizon Benefits Center, contact a Verizon Benefits Center representative. The representative will process your designation. Your election is effective immediately and the Verizon Benefits Center will send you a confirmation in the mail.

You also can verify or change your beneficiary designation at any time by accessing Your Benefits Resources Web site or calling the Verizon Benefits Center.

If you previously completed a beneficiary designation form, your beneficiary will be the person you designated on the paper form until you input your beneficiary information via Your Benefits Resources. After you enter your beneficiary information, your online designation will replace your paper designation as your current beneficiary designation.

You are not required to use the online beneficiary management features on the Web site, but doing so is convenient and an efficient way to keep your beneficiary information current.

Assignment of benefits

If you make an assignment, you transfer your ownership rights in the insurance to an assignee. The assignee can either be a person or a trust. The assignment becomes effective on the date you sign the transfer but only after it is approved by the insurance carrier. After your assignment becomes effective, you can no longer make any changes, including changing your beneficiaries, changing your coverage amount or converting coverage. Those rights belong to the assignee.

To request additional information and an assignment form, call the Verizon Benefits Center via the telephone number shown on your Important Benefits Contacts insert.

Because of the various legal and tax implications involved, you may wish to consult with a lawyer or tax advisor before assigning your benefits.

Changing your elections

After you retire, you may stop or decrease supplemental life insurance and dependent life insurance coverage at any time. If you elect to stop or decrease your coverage, you may not reinstate or increase coverage at a later date.

To make changes online, go to Your Benefits Resources Web site (see your Important Benefits Contacts insert for contact information), then:

- From the "What To Do When" menu, select "Enroll or Change Long Term Disability, Supplemental Life and AD&D Coverage."

- Follow the instructions.

You also can make changes by calling the Verizon Benefits Center via the telephone number shown on your Important Benefits Contacts insert. The Verizon Benefits Center will provide information about the options available to you.

Any change becomes effective the first day of the month following the election.

Cost of coverage

The company pays the full cost of basic life insurance for you. If you elect supplemental life insurance and/or dependent life insurance, you will be responsible for the cost of that coverage. Your cost for coverage will be deducted from your monthly pension check, or debited from your bank account or billed to you directly if you chose a lump-sum payment during a pension cashout trial period. For more information about supplemental life insurance and dependent life insurance payment options, call the Verizon Benefits Center.

The cost for supplemental life insurance is determined by your age as of December 31 of the previous year and the amount of your coverage, which is based on your benefit bearing wage (BBW) at the time your active employment ended. Note that the cost of dependent child life insurance is the same regardless of the number of eligible children you cover.

If you are a retiree, the cost for life insurance for your spouse or same-sex domestic partner (if applicable) is based on his or her age.

Imputed income

Under federal tax law, the value of basic life insurance coverage over $50,000 is subject to federal income tax. This value is called imputed income. If you have imputed income, it will be shown on your taxable income form prepared by Verizon.

Have your premiums deducted from your bank account

Pay your premiums automatically, safely and securely via direct bank debit.

To enroll in direct debit, log on to Your Benefits Resources Web site or call the Verizon Benefits Center. Be sure to have a check or deposit slip handy to get the correct account and nine-digit ABA routing numbers.

When participation ends

Retiree or LTD benefit recipient coverage

A retiree's or LTD benefit recipient's coverage will end on the earliest date described below.

You are receiving LTD benefits

If you are receiving LTD benefits, but you are not eligible for a service or disability pension, your basic life insurance will continue for a period of time. You may also continue to participate in supplemental life insurance for the same period of time.

Basic and supplemental life insurance continuation	
If you have this much net credited service at the time your employment ends…	**Your coverage will continue for…**
Under 5 years	1 year from the date you are approved to receive LTD benefits
5, but less than 10 years	2 years from the date you are approved to receive LTD benefits
10, but less than 15 years	3 years from the date you are approved to receive LTD benefits
15 years or more	3 years from the date you are approved to receive LTD benefits, if you are *not* eligible for a service or disability pension

If you are eligible for a disability or service pension benefit, your basic life insurance coverage continues, at no cost to you, until the time of your death. However, if you were an associate who retired before August 3, 2008, beginning at age 66, the amount of your basic life insurance is reduced by 10% each year until you reach age 70 (see the "Coverage reduction based on age" section for details.).

Attainment of age 65

Supplemental life insurance coverage will stop on the January 1 following the month in which you reach age 65.

Failure to make required payment for supplemental life insurance and/or dependent life insurance

If your required payment is not received on time, your coverage will end on the first day of the month for which payment is not received.

Plan termination

Although the company does not intend to terminate the plans, were the plans to be terminated, all coverage would end on the date of termination.

Dependent coverage

A dependent's coverage will end on the earliest date described below.

Retiree's plan eligibility ends

If the retiree's eligibility for the plans ends for any reason, coverage for all dependents will also end at the same time.

Retiree dies

When the retiree dies, coverage for all dependents will end on the last day of the month in which the retiree dies. A dependent may have the option to convert to an individual policy (see "Conversion to an individual policy" below).

Dependent ceases to meet the class I eligibility requirements

- A dependent's coverage will continue until the end of the month in which the event occurs that causes the dependent to lose eligibility. A spouse's coverage ends at the end of the month in which he or she becomes divorced from you. Coverage for a legally separated spouse continues, unless you call the Verizon Benefits Center to remove him or her from your coverage.

- Coverage for a same-sex domestic partner (if applicable) ends on the day he or she fails to meet the definition of a same-sex domestic partner.

- Coverage for a child ends on the last day of the calendar year in which he or she reaches age 19 (unless the child is a full-time student) or the last day of the month in which the child is married, if earlier.

- Coverage for a stepchild ends on the last day of the month in which he or she no longer lives with you or, if earlier, when he or she no longer qualifies as a dependent as stated under "Class 1 dependent eligibility requirements" in the "Participating in the plans" section.

- Coverage for a full-time student ends on the earlier of the last day of the calendar year in which the student reaches age 25 or the last day of the month in which he or she no longer qualifies as a full-time student.

- Coverage for a disabled child ends on the last day of the month in which he or she no longer meets the definition of a disabled child.

- Coverage for a child of a same-sex domestic partner ends on the last day of the calendar year in which the child reaches age 19 or age 25 (if a full-time student), as applicable, or the last day of the month in which the child otherwise fails to meet the definition of a child of a same-sex domestic partner (or the same-sex domestic partner no longer meets the definition of a same-sex domestic partner) as defined in the "Glossary."

Conversion to an individual policy

When your coverage under the survivor benefits program ends for any reason other than due to your election to stop coverage, you may be eligible to convert all or part of your basic life insurance, supplemental life insurance and dependent life insurance to individual policies. Converting your insurance under the survivor benefits program means that you have the opportunity to purchase an individual policy from the insurance company at regular rates (not group rates) without taking a medical examination.

Also, if your basic life insurance is reduced after you reach age 65, you may convert all or part of the amount of the reduction to an individual policy every time the reduction equals 20% of the original coverage. For example, if the basic life insurance annual reduction each year between ages 66 and 70 is 10%, every other year you may convert the past and current year's reduction to an individual policy. However, the amount of any policy issued will not be more than the amount of the reduction.

To take advantage of this conversion feature, you must apply to the insurance company within 31 days after:

- The date your coverage ends, should the survivor benefits program end.

- The date the program is amended, should the survivor benefits program be amended to terminate your eligibility for coverage.

- The date your coverage ends because you are no longer in a class which remains eligible for the plan.

During this 31-day conversion period, your basic life insurance and supplemental life insurance coverage will continue.

The individual policy to which you may convert your basic life insurance and supplemental life insurance will meet the following requirements:

- It must be a form of insurance other than the term insurance customarily provided by the insurance company,

- The premium will be calculated based on your class of risk, the form and amount of the individual policy and your age on your birthday nearest to the date of the policy's issue and

- The amount will be equal to (or less than, if you choose) the amount of your life insurance under this program as of the date your 31-day conversion period begins.

There are two exceptions to this last point:

- If your coverage ends because this program ends, the amount of your individual policy will not be more than the amount of your coverage under this program as of the date it ends minus the amount of any coverage for which you are eligible – or for which you may become eligible – under any group policy issued or reinstated by the insurance company within 45 days after the program ends, and

- If your coverage ends because the program is amended and you are no longer eligible for coverage, the amount of your individual policy will not exceed the amount of coverage you are eligible for if the program ends, as described above.

Any individual policy issued to you will become effective at the end of the 31-day conversion period. However, if you die during this period, the plan will pay your beneficiary the maximum amount of life insurance for which an individual policy could have been issued under this provision, whether or not you have applied for an individual policy.

If your coverage ends or is reduced by a cumulative 20%, the insurance company will automatically send you a notice of your right to convert your coverage.

Important note

For more information or if you have questions about converting coverage, call the Verizon Benefits Center (see your Important Benefits Contacts insert for the telephone number).

Your basic life insurance

If you are a retiree or a long-term disability (LTD) benefit recipient, Verizon provides a degree of financial security for your family members in the event of your death by automatically providing basic life insurance for you.

Basic life insurance before age adjustment

Generally, your basic life insurance coverage at the time your coverage in this plan begins equals:

- **If you were an associate who retired on or before August 2, 2008:** your benefit bearing wage (BBW) as of your retirement date,

- **If you were hired before August 3, 2008 and retire on or after August 3, 2008:** your BBW as of August 2, 2008. The minimum coverage amount will be $20,000 or

- **If you are hired on or after August 3, 2008:** $20,000.

BBW includes your annual base pay at the time you retire or become disabled plus any bonus, incentive, and merit awards or commissions received in the 12 months before your retirement or disability, rounded up to the nearest $1,000 (subject to the reduction for age described below.) **Note:** BBW for associate retirees does not include pay for overtime, tour or other temporary differentials.

Basic life insurance coverage at the time your coverage in this plan begins does not equal your BBW if you:

- Were hired on or after August 3, 2008 or

- Are an associate retiree who retired before August 10, 1986 or a management retiree who retired before July 2, 1985. In this case, your basic life insurance coverage continues under the same level in effect when you retired.

Coverage reduction based on age

If you were an associate who retired before August 3, 2008, beginning at age 66, the amount of your basic life insurance is reduced by 10% each year, until you reach age 70. At age 70, your coverage amount will be equal to half of your BBW at retirement or when you became disabled. This reduced amount stays in effect for the rest of your life or if you are an LTD benefit recipient, as long as you continue to receive LTD benefits.

Age	Percentage of basic life insurance
66	90%
67	80%
68	70%
69	60%
70 and older	50%

Accelerated benefits option

If you were an associate who became a participant after August 9, 1986, and you are diagnosed with a terminal illness, up to 50% of your basic life insurance may be payable to you under the accelerated benefits option (ABO) to provide additional financial assistance to you and your family. (See the “How to receive a benefit” section for information.)

If you were a manager who retired before July 2, 1985, up to 80% of your basic life insurance may be payable to you under the ABO.

Your supplemental life insurance

You are given the opportunity to have supplemental life insurance coverage if you want to provide additional income protection for your family during retirement or while you are receiving long-term disability (LTD) benefits. Note, however, that if you decrease, stop or do not enroll for supplemental life insurance coverage during the enrollment period prior to your retirement, you will not be permitted to increase, reinstate or enroll for coverage under this plan at a future date. Supplemental life insurance coverage terminates on the January 1 following the month in which you reach age 65.

Supplemental life insurance options

You can purchase supplemental life insurance coverage up to four times your benefit bearing wage (BBW) when you become an eligible retiree or an LTD benefit recipient. (See the “Your basic life insurance” section for an explanation of BBW.) The option you have in effect is subject to enrollment rules described in the “Eligibility” section.

Supplemental life insurance options
No supplemental coverage
Additional 1 × your BBW
Additional 2 × your BBW
Additional 3 × your BBW
Additional 4 × your BBW
Additional 5 × your BBW

Supplemental life insurance coverage terminates on the January 1 following the month in which you reach age 65.

Accelerated benefits option

If you were an associate who became a participant after August 9, 1986 and you are diagnosed with a terminal illness, up to 50% of your supplemental life insurance may be payable to you under the accelerated benefits option (ABO) to provide additional financial assistance to you and your family. (See the “How to receive a benefit” section for information.)

If you were a manager who retired before July 2, 1985, up to 80% of your supplemental life insurance may be payable to you under the ABO.

Your dependent life insurance

You may want protection from financial burdens that could accompany the unexpected death of a spouse or child. If you retired after November 1, 1991 you can choose from several levels of coverage for dependent life insurance.

Long-term disability (LTD) benefit recipients are not eligible for dependent life insurance coverage.

If you are retired, your spouse dependent life insurance coverage terminates on the January 1 following the month in which your spouse or same-sex domestic partner reaches age 65. Coverage for dependent children ends at the end of the calendar year when they reach age 19 or age 25 as applicable.

Dependent life insurance options

You can choose life insurance for your spouse or same-sex domestic partner (if applicable), and life insurance for your dependent children or children of your same-sex domestic partner (if applicable) who qualify as class I dependents (see the “Eligibility” section). You cannot elect dependent life insurance coverage for any covered dependent in an amount greater than the total of your basic life insurance and supplemental life insurance. You choose from the following options during the enrollment opportunity prior to your retirement:

Spouse life insurance options
No coverage
$5,000
$20,000
$50,000
$75,000
$100,000

Dependent child life insurance options
No coverage
$1,500
$5,000
$10,000
$15,000
$20,000

For information about filing a claim and payment options in the event a covered spouse, same-sex domestic partner (if applicable) or dependent child dies, see “How to receive a benefit.”

Accelerated benefits option

If you were an associate who became a participant after August 9, 1986, and your spouse or same-sex domestic partner (if applicable) is diagnosed with a terminal illness, up to 50% of dependent life insurance may be payable to you under the accelerated benefits option (ABO) to provide additional financial assistance to you and your family. (See the “How to receive a benefit” section for information.)

If you were a manager who retired before July 2, 1985, up to 80% of your dependent life insurance may be payable to you under the ABO.

How to receive a benefit

When a benefit is paid

Benefits from the plans can be paid to your beneficiary in different ways. You and your beneficiary should be aware of the differences in payment.

In general, basic life insurance and supplemental life insurance coverage pay a benefit to your beneficiary(ies) upon your death and dependent life insurance coverage pays a benefit to you upon the death of a covered dependent.

In addition, the accelerated benefits option (ABO) can provide payment of up to 50% of life insurance if you or a covered spouse or same-sex domestic partner (if applicable) is diagnosed as terminally ill (see below).

The accelerated benefit option (ABO)

The ABO is designed to provide you and your family with important financial assistance in the event you or a covered spouse or same-sex domestic partner (if applicable) is diagnosed with a terminal illness. “Terminal” is defined by the insurance company as an injury or illness that results in a life expectancy of six months or less with no reasonable prospect for recovery. You must have coverage of $10,000 or more.

You can receive payment of up to 50%, if you were an associate who became a retired participant after August 9, 1986, or 80%, if you were a manager who retired before July 2, 1985, of your life insurance coverage (basic and supplemental combined) with a payment minimum of $5,000 and a payment maximum of $250,000. Or, you can receive payment of up to 50% (or 80%) of coverage for a spouse or same-sex domestic partner (if applicable) who qualifies for an accelerated benefit under dependent life insurance.

To apply for an ABO payment, contact the Verizon Benefits Center (see your Important Benefits Contacts insert for the telephone number) to request an ABO package. You will need to complete the application form and provide verification from your attending physician that you or your spouse or same-sex domestic partner (if applicable) has been diagnosed with a terminal illness.

If applying for an ABO, you must return the completed application directly to the Verizon Benefits Center, and you will receive a letter from the insurance company notifying you of its decision.

Note the following about the ABO:

- You can receive an ABO payment only once under any one coverage,
- Any payment you receive will reduce your life insurance coverage amount otherwise available and
- Your share (if any) of the cost for the coverage you have in effect will be reduced because of the ABO payment.

You are not eligible to receive an ABO payment in these situations:

- Your coverage has been assigned,
- The life insurance payment will be made to a former spouse as part of a divorce agreement or
- You are required by a government agency to request an ABO payment in order to get or keep a government benefit or entitlement.

You should consult a tax advisor before making a decision to request an ABO payment.

How benefits are paid

In general, the benefits from the survivor benefits program are paid in one of two ways:

- **If the benefit is less than $5,000,** it will be paid in a lump sum or
- **If the benefit is $5,000 or more**, it will be placed in an interest-bearing money market account. Beneficiaries will have immediate checkbook access to this account.

Situations that can affect payment

The status of your beneficiary information can affect how payments are made. For example:

- **If you have more than one beneficiary,** benefits either are paid in a lump sum or deposited in a money market account for each beneficiary. Payments to an estate or trustee will be made in a lump sum.
- **If your beneficiary dies before you,** that person's estate or heirs have no rights to the benefits from your plans. Benefits will be paid first to your remaining beneficiaries. If your remaining beneficiaries are no longer living, benefits will be paid to your contingent beneficiaries. If your contingent beneficiaries are no longer living, all or part of your benefit then may be paid to your living spouse, living children (distributed equally), one living parent or living parents (distributed equally). If none of these family members are living, benefits will be paid to your estate.
- **If you didn't name a beneficiary,** benefits are paid to your living spouse, living children (distributed equally), one living parent or living parents (distributed equally). If none of these family members are living, benefits will be paid to your estate.

Note: If you have assigned your life insurance (see "Assignment of benefits") and the assignee dies before you, any benefit payable as a result of your death will be made to the assignee's designated beneficiary(ies) or estate, unless the life insurance has been reassigned to you prior to the death of the assignee. Also, note that reassigning the policy may not result in a change in the beneficiary from the previous assignment. You will need to complete a new beneficiary designation form after the policy has been reassigned.

Applying for benefits

Verizon will assist you or your beneficiary in applying for a benefit.

If you or your beneficiary is entitled to life insurance benefits, call the Verizon Benefits Center (see your Important Benefits Contacts insert for the telephone number). The Verizon Benefits Center will provide the appropriate information, assistance for processing the form(s) and documents necessary for claiming benefits, as well as forward your claim to the insurance company and answer any questions while your claim is being processed.

If your benefits are denied

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

Right of recovery

If, for any reason, the Verizon plans pay a benefit that is larger than the amount allowed, 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 Claims Review Committee (VCRC), and to the individual who chairs this committee. The chairperson has the discretion to designate the claims and/or appeals administrator from time to time. Furthermore, the VCRC (and its chairperson) has the discretion to designate the VCRC as a "final appeals administrator," either in place of the existing appeals process under the plans, or as an additional level of appeal beyond the existing two-tier or three-tier claims and appeals process, depending on whether a final appeals administrator has been appointed. If a final appeals administrator has been designated, the final appeals administrator has sole authority to exercise discretion in review and resolution of a final appeal of a claim denied upon initial appeal under the plans.

Claims regarding eligibility to participate in the plans

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 Unit
P.O. Box 1438
Lincolnshire, IL 60069-1438

Eligibility appeals should be directed to the Verizon Claims Review Committee c/o the Verizon Claims Review Unit at:

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

The Verizon Benefits Center works at the direction of the VCRC, which has discretionary authority to determine claims and appeals related to eligibility and enrollment in the plans.

Claims regarding scope/amount of benefits under the plans

Metropolitan Life Insurance Company (MetLife) has discretionary authority to determine claims and appeals for plan benefits.

The addresses of the claims and appeals administrators for the plans are listed under "Claims and appeals administrators" later in this 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 plans based on their provisions and applicable law and make factual determinations about claims arising under the plans.

- Determine whether a claimant is eligible for benefits.

- Decide the amount, form and timing of benefits.

- Resolve any other matter under the plans that is raised by a participant or a beneficiary, or that is identified by either the claims or appeals administrator.

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

If a life insurance benefit 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 ERISA covered plans.

This section explains the steps that 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	**Benefits 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.	To file a benefit claim, you (or your authorized representative) should write to the claims administrator for the plan. You must include: • A description of the benefits for which you are applying. • The reason(s) for the request. • Relevant documentation.
When you will be notified of the 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 the claims administrator'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.	The claims administrator will notify you of the deadline to submit additional information, if applicable.

	Eligibility claims procedure	Benefits 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**, the claims administrator 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 the claims administrator. The Claims Review Committee has delegated its authority to finally determine claims to the claims administrator. As such, the claims administrator 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 claims administrator 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 the claims administrator for the plan and include: • A copy of your claim denial notice. • The reason(s) for the appeal. • Relevant documentation.

	Eligibility claims procedure	Benefits claims procedure
When you will be notified of the appeal decision	You will be notified of the decision within 60 days of the Claims Review Committee's receipt of your appeal (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 within 60 days of the claims administrator's receipt of your appeal (120 days, when special circumstances apply). If your appeal is **approved**, the claims administrator 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, the claims administrator will not review your matter again, unless new facts are presented. However, if you would like the Verizon Claims Review Committee to review the procedures of the claims administrator, you may complete step 2 a second time, but send your appeal to the Verizon Claims Review Committee. You have a right to bring a civil action.

Your rights under ERISA

As a participant in the plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

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 plan documents, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plans 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 plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plans' annual financial reports. 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 on the people responsible for the operation of a plan. The people who operate your plans, called "fiduciaries" of the plans, 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 keep you from obtaining a welfare benefit or exercising your ERISA rights.

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 plans 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 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 plans' fiduciaries misuse the plans' 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 questions about your plans, 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, DC 20210

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

Administrative information

Administrative information about the plans is provided in this section.

Important telephone numbers

You can connect to the Verizon Benefits Center and the Verizon benefit administrator by calling the toll-free number shown on your Important Benefits Contacts insert. If you prefer, you can call the benefit administrator 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:

Verizon
c/o Verizon Benefits Center
P.O. Box 1457
100 Half Day Road
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 or via the telephone number shown on your Important Benefits Contacts insert. But, for questions about plan benefits, you should contact the Verizon Benefits Center or the claims administrator. The Verizon Benefits Center administers enrollment and handles participant questions, requests and certain benefits claims, but is not the plan administrator. The benefit administrator performs the daily administration of benefits.

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' benefit administrator or a Verizon Benefits Center representative.

Claims and appeals administrators

Do not send any benefit claims to the plan administrator or to the Verizon legal department. Instead, submit them to the claims administrator for the plans (see below).

There are several claims administrators for the plans. The claims administrator has the authority to make final determinations regarding claims for benefits.

Verizon has delegated its authority to finally determine claims to the Verizon Claims Review Committee, except in cases where an authorized Verizon official delegates the authority to finally determine claims to the benefit administrator on behalf of Verizon. Benefits under these plans will be paid only if Verizon, or its delegate, decides in its discretion that the applicant is entitled to the benefits.

The claims administrator is authorized to determine eligibility for benefits and interpret the terms of the plans in its sole discretion, and all decisions by the claims administrator are final and binding on all parties.

Verizon Claims Review Committee (VCRC)

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

Verizon Benefits Center
P.O. Box 1438
100 Half Day Road
Lincolnshire, IL 60069-1438

You can call the Verizon Benefits Center via the telephone number shown on your Important Benefits Contacts insert.

Plan funding

Benefits are provided through an insured contract with MetLife. Also, certain benefits are currently funded in whole or in part through a trust. MetLife can be reached at the following address:

MetLife Insurance Company
One Airport Road
Oriskany, NY 13424

You can call MetLife via the telephone number shown on your Important Benefits Contacts insert. The VCRC is technically the claims administrator for these insured benefits (see above for details).

The trustee is:

Bank of New York Mellon
One Mellon Bank Center
Room 151-1335
Pittsburgh, PA 15258

Plan identification
Survivor benefits coverage is provided through several different plans.

The Verizon Group Life Insurance Plan for New York and New England Associates is one of several component plans that together comprise Verizon Plan 501. In addition to the life insurance benefits described in this SPD, Verizon Plan 501 provides other benefits to eligible associate retirees of Verizon, and those benefits are described in separate SPDs.

Verizon Plan 501 is a welfare plan that is a life insurance plan. The plan is listed with the U.S. Department of Labor under two numbers: The employer identification number (EIN) is 23-2259884 and the plan number (PN) is 501.

The Verizon Dependent Group Life Insurance Plan for New York and New England Associates is one of several component plans that together comprise Verizon Plan 526. In addition to the life insurance benefits described in this SPD, Verizon Plan 526 provides other benefits to eligible associate retirees of Verizon, and those benefits are described in separate SPDs.

Verizon Plan 526 is a welfare plan that is a life insurance plan. The plan is listed with the U.S. Department of Labor under two numbers: The employer identification number (EIN) is 23-2259884 and the plan number (PN) is 526.

The plan as applicable to former management employees is part of The Plan for Group Insurance. The plan is a welfare plan that is listed with the U.S. Department of Labor under two numbers: The employer identification number (EIN) is 23-2259884 and the plan number (PN) is 580.

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 earlier in this section.

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

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

Legal process may also be served on the trustee.

Collective bargaining agreements
These plans are maintained pursuant to one or more collective bargaining agreements, and a copy of the agreements may be obtained upon written request to the plan administrator. The collective bargaining agreements are also available for inspection at the office of the plan administrator.

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, 2009. This list may change from time to time.

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

Glossary

B

Benefit bearing wage (BBW)

BBW includes your annual base pay at the time you retire or become disabled plus any bonus, incentive, and merit awards or commissions received in the 12 months before your retirement or disability, rounded up to the nearest $1,000 (subject to the reduction for age). **Note:** BBW for associate retirees does not include pay for overtime, tour or other temporary differentials.

N

Net credited service

Your entire period of continuous employment with Verizon counted in years, months and days, subject to provisions of the applicable pension plan.

S

Same-sex domestic partner (if applicable)

Note: If you are a post-1986 associate retiree, your same-sex domestic partner (and his or her children) may be eligible for coverage. To qualify as a class I dependent, your same-sex domestic partner must meet all of the following criteria:

- Is an adult of the same sex as you,
- Is not married to anyone else,
- Is not the same-sex domestic partner of anyone else,
- Is your only same-sex domestic partner and intends to remain so indefinitely,
- Is not related to you by blood that would prevent marriage under the law,
- Lives with you in the same permanent residence and has for at least 60 days,
- Is, along with you, able to demonstrate interdependence and can provide evidence (e.g., common ownership of real property, common ownership of a vehicle, proof of joint bank account) and
- Is at least 18 years old and mentally competent to consent to contract.

You must agree to notify the Verizon Benefits Center within 31 days if your same-sex domestic partner no longer meets the criteria listed above.

Contact the Verizon Benefits Center to obtain an affidavit required to determine survivor benefit eligibility.