Your Dental Coverage

Contents

Intentionally left blank

- **Preferred dentist program (PDP) option (for CWA-represented associate retirees in the PDP service area).** With this option, you have the freedom to use any dentist, but you benefit from negotiated fees and a higher level of benefit coverage when you use a participating dentist.

- **Out-of-area option (for CWA-represented associate retirees not in the PDP service area).** This is an option if you live outside the PDP's participating provider network area.

- **Standard option (for IBEW-represented associate retirees).** This option works like a traditional indemnity dental plan. You may use any dentist you choose.

- **Dental maintenance organization (DMO) option (for IBEW- and CWA-represented associate retirees).** With this option, you can receive a high level of coverage but you must use a DMO dentist.

- **No coverage option (for IBEW- and CWA-represented associate retirees).** If you do not want Verizon-sponsored dental coverage, you can choose this option.

- **Continuing coverage.** In some cases, you and/or your dependents can continue coverage even after eligibility for the plan ends.

- **What is not covered.** This section lists services and supplies not covered under the plan.

- **How to file a claim.** This section provides information on when you need to file a claim to receive benefits.

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

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

Important Note:

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

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, including benefits renewal. 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.

Changes to the plan

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

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

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

Participating in the plan

Eligibility

You are eligible for plan coverage if:

- You retired from one of the Verizon participating companies listed on page 54 after December 31, 1989.
- At the time of your retirement, you were an associate employee and you were granted a service or disability pension under the Verizon Pension Plan for Mid-Atlantic Associates (formerly known as the Bell Atlantic Pension Plan).
- You are a working retiree (see page 58) or if you are a former GTE retiree covered by a collective bargaining agreement between the company and the union that provides for participation in this plan.

Note: You are not eligible for this plan if you receive or are eligible to receive a deferred vested pension based on the provisions of the Verizon Pension Plan for Mid-Atlantic Associates (formerly the Bell Atlantic Pension Plan).

Eligible Dependents

Dependents must be enrolled through Your Benefits Resources Web site or the Verizon Benefits Center to have coverage. You can enroll only your eligible dependents who meet the plan definition for eligibility, and include your:

Dependent class	Who they are	Relationship
Class I dependents	• Your legal spouse (a legally separated spouse is not eligible)	• Spouse
	• Your unmarried children until the end of the calendar year in which they reach age 19, provided they receive more than 50 percent of their support from you. Children means children by birth, as well as legally adopted children (or children placed for 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 or has legal custody	• 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 percent 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 were covered continuously)	• Disabled child

Dependent class	Who they are	Relationship
Class I dependents cont.	• Your same-sex domestic partner and his or her children who meet the plan requirements for a same-sex domestic partner (and children of a same-sex domestic partner) may be eligible for coverage. For more information on eligibility requirements and tax implications, access Your Benefits Resources Web site or call the Verizon Benefits Center and speak with a representative • Your unmarried children (as defined above and including any age requirements) who are alternate recipients under an approved qualified medical child support order (QMCSO)	• Domestic partner • Domestic partner's child • Child
Sponsored children	Your unmarried children from age 19 through the end of the calendar year in which they reach age 25 who are not full-time students or incapacitated and otherwise meet the definition of child, as described above	Sponsored child

Note: Only class I dependents and sponsored children are eligible for dental coverage.

Qualified medical child support order (QMCSO)

A QMCSO is a judgment from a state court or an order issued through an administrative process under state law that requires you to provide coverage for a dependent child under Verizon's healthcare plans. The order is served on Verizon or its agent for service of legal process and reviewed by the Verizon Benefits Center. You may obtain a copy of the QMCSO administrative procedures, free of charge, from the plan administrator in care of the Verizon Benefits Center. In any case, if subject to an order, you and each child will be notified about further procedures..

Note: If you (and your covered dependents) have Dental Maintenance Organization (DMO) coverage as of the effective date of an approved QMCSO and the recipient child does not live in a DMO service area, your coverage automatically will change as follows:

- If you are a CWA-represented associate retiree, you and your dependents will have preferred dentist program (PDP) or out-of-area coverage, depending on your home ZIP code.

- If you are an IBEW-represented associate retiree, you and your dependents will have standard option coverage.

If your spouse or same-sex domestic partner is a Verizon employee or retiree

For dental coverage, if your spouse or same-sex domestic partner is employed by or retired from Verizon or an affiliate, the following rules apply:

- Children can be covered by one Verizon parent or the other, but not by both.

- You can be covered as a retiree or as a dependent under a Verizon associate dental plan, but cannot be covered as both. To be covered as a dependent under another associate plan, you must be eligible for and choose the no coverage option under this plan. However, an exception occurs if your spouse or same-sex domestic partner is a management employee or retiree, in which case you may be covered as both a retiree under your associate plan and as a dependent under a Verizon management plan and do not need to waive coverage.

- Your spouse or same-sex domestic partner can be covered under a bargained-for associate dental plan as either an employee (or retiree) or as a dependent under a bargained-for associate dental plan, but not as both coverage categories. To be covered as your dependent under this plan, your spouse or same-sex domestic partner must be eligible for and must choose the no coverage option under his or her plan. If he or she is not eligible to choose the no coverage option under his or her plan, your spouse or same-sex domestic partner cannot be covered under your plan.

Enrolling in the plan

Initial enrollment

Retirees

When you retire, coverage for you and your enrolled eligible dependents will continue under your active employee plan until the end of the month in which you retire. Coverage for you and your enrolled eligible dependents under this plan will automatically begin on the first day of the month following your retirement.

Near the time you retire, you will receive enrollment information from Verizon. This information will explain your options, the enrollment process and enrollment deadlines.

Survivors

If you are a surviving eligible dependent of an eligible retiree and you had been covered under the plan prior to the retiree's death, you may choose to elect COBRA continuation coverage (see page 28).

How do I enroll or make changes?

Access Your Benefits Resources Web site or call the Verizon Benefits Center at the telephone number listed on your Important Benefits Contacts insert. Your Benefits Resources is available 24 hours a day, Monday through Saturday and from 1:00 p.m. to midnight, Eastern time on Sunday. Benefits Center Representatives are available to help you from 8:00 a.m. to 6:00 p.m. Eastern time, Monday through Friday (excluding holidays).

If you do not enroll

If you do not enroll by your enrollment deadline, you and your covered dependents will continue to have coverage under the option in effect for you at the time of your retirement.

Changing your elections

You can change your elections at any time, as many times as necessary, for any reason. Your new coverage takes effect the first of the month following a 31-day waiting period. Here are some examples:

- If you make your new selection January 25, coverage is effective March 1.
- If you make your new selection June 1, coverage is effective August 1
- If you make your new selection September 15, coverage is effective November 1.

Benefits renewal

You are not required to change your elections during a formal benefits renewal period. However, an exception **may** occur if your dental option will not be available to you in the following plan year. If this happens, you will be notified prior to the benefits renewal period that your dental option will not be available, and that your coverage will default to another option if you do not change your election during benefits renewal. You also will receive a benefits renewal kit that includes information about all your dental plan options. At that time you can:

- Take no action. Your default dental coverage will take effect January 1 of the following year.

- Select a new dental option during the traditional benefits renewal period. Your new coverage will take effect January 1 of the following year.

You also can select a new option at any time, and your change will be effective the first of the month following a 31-day waiting period.

You gain a new dependent

If you gain a new, eligible dependent through marriage, birth, adoption or placement for adoption, that person is automatically covered under your dental option for 90 days after the event. If you want dental coverage to continue for the new dependent, you must call the Verizon Benefits Center to enroll that dependent in the plan (otherwise, coverage will end for that dependent after 90 days):

- Your election will take effect on the date that you gained the new dependent, if you make your election within 90 days of gaining the new dependent.

- Coverage will begin again for new dependents on the date of your election, if you make your election more than 90 days after the event.

Note: You cannot add coverage for a new same-sex domestic partner or the child of a same-sex domestic partner.

If you and your domestic partner of the same or opposite sex have registered with a governmental entity, such as the state of California, your registered domestic partner (even if the individual is of the opposite sex) will be entitled to coverage, if coverage of domestic partnerships are part of Verizon's contractual arrangement with a particular municipality or state.

If you gain a new, eligible dependent as the result of a QMCSO, you can enroll that dependent in the plan by calling the Verizon Benefits Center. Your election will take effect on the date the QMCSO is approved by the Verizon Benefits Center.

If you gain a new, eligible dependent as the result of an event other than those listed above, you can enroll that dependent in the plan by calling the Verizon Benefits Center. Your election will take effect the first of the month following your election.

You lose a dependent through death, divorce, legal separation or termination of a same-sex domestic partnership

If you lose a dependent through death, divorce, legal separation or termination of a same-sex domestic partnership, coverage for that dependent ends on the date of the event. However, you must notify the company by calling the Verizon Benefits Center to remove that dependent from your coverage; otherwise, you will continue to pay any required premiums.

A dependent loses eligibility

If a dependent loses eligibility under the plan in situations other than those described above, the dependent's coverage will continue until the end of the month in which the event occurs that causes the dependent to lose eligibility. An exception occurs if the dependent is a child who loses eligibility because he or she reaches an age limit for coverage. In this case, the child's coverage will continue until December 31 of the year in which the age limit is reached. However, if the child reaches the age 25 limit and is a full-time student who graduates prior to December 31 of his or her 25th year or no longer maintains his or her full-time student status, his or her coverage will terminate at the end of the month in which he or she loses full-time student status.

When a dependent loses eligibility, you must notify the company by calling the Verizon Benefits Center before the dependent's coverage ends. Even if you do not notify the company, you are responsible for any claims and expenses incurred after the date the coverage should have ended. Also, if you do not notify the company, your dependent may lose the right to purchase continued dental care benefits under COBRA.

A dependent changes eligibility class

If a dependent loses eligibility as a class I dependent but would be eligible for coverage as a sponsored child, you must notify Verizon by calling the Verizon Benefits Center within 90 days of the change in eligibility to ensure your dependent's coverage will continue without interruption. Likewise, if a child's eligibility class changes from a sponsored child to a class I dependent due to enrollment as a full-time student, you must call the Verizon Benefits Center and certify the child's full-time student status. If you do not notify the Verizon Benefits Center of the change within 90 days, the dependent's coverage will cease until notification is received. When notification is received, coverage will be reinstated on the first day of the month following notification.

You move

If you move to a new residence during the plan year and that move affects your coverage (e.g., if you are covered by the DMO option and you move out of the DMO service area), you can change your dental plan option. You must call the Verizon Benefits Center to make a change.

You may elect coverage under the standard option, the PDP option or the out-of-area option, as applicable, effective the first day of the month after you make the election. If you do not make a new election when you move, you will automatically be covered under the standard option, the PDP option or the out-of-area option, based on your home zip code, through December 31 of the year in which you moved or until you make a change, if earlier.

Special enrollment rules

If you or your dependents (including your spouse or same-sex domestic partner) waived dental coverage because of other dental insurance coverage, you may be able to enroll yourself or your dependents in the plan if you later lose that other insurance due to:

- Loss of eligibility.
- Termination of employer contributions for such coverage.
- Exhaustion of COBRA coverage.

If you enroll yourself or your dependents in the plan:

- Within 90 days of losing the other coverage, your coverage will be effective retroactive to the date of the event.
- After 90 days of losing the other coverage, your coverage will be effective the first day of the month following your enrollment.

In addition, if you gain a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. If you enroll:

- Within 90 days of the event, your coverage will be effective retroactive to the date of the event.
- After 90 days following the event, your coverage will be effective the first day of the month following your enrollment.

Note: You cannot add coverage for a same-sex domestic partner or a child of that same-sex partner acquired after you become covered under the plan.

Cost of coverage

Verizon pays the full cost of coverage for you and your eligible, enrolled class I dependents. You pay the full cost of coverage for sponsored children.

Special note for same-sex domestic partner coverage

If you cover a same-sex domestic partner and his or her dependents whom you do not claim as dependents for federal income tax purposes, Verizon is required by tax law to impute income to you based on the fair market value of the coverage provided to your same-sex domestic partner and his or her dependents.

When participation ends

This section explains when participation in the plan ends for you and your dependents.

Retiree coverage

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

Reemployment
Coverage under the plan ends on the last day of the month in which you are reemployed by the company or an affiliate in a position that is other than occasional or temporary.

When you subsequently retire:

- If you had been retired for 90 days or less before being rehired, you will be treated as a newly retired participant under the applicable retiree dental plan.

- If you had been retired for more than 90 days before being rehired, you will be covered again under the plan, subject to the terms and conditions that apply to individuals who retired on your initial retirement date.

Cancellation of coverage
If you cancel coverage, your coverage will end on the last day of the month in which you elect to cancel coverage.

Failure to submit payment (if required)
If you are required to make a payment and it is not received on time, 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 plan, were the plan 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 in the following section. Your dependent may be able to continue coverage under COBRA (see page 28).

Retiree's coverage ends
If the retiree's coverage ends for any reason except when the retiree dies, 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.

Dependent ceases to meet the eligibility requirements
A dependent's coverage will end on the earlier of either the date the dependent is covered as an employee or retiree under any company-sponsored dental plan or the last day of the month in which the dependent no longer qualifies as a dependent under the plan, subject to the following:

- Coverage for your spouse ends on the last day of the month he or she becomes legally separated or divorced from you.

- Coverage for a same-sex domestic partner ends on the last day of the month 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 (if not 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 the date the stepchild otherwise becomes an ineligible dependent, if earlier.

- 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 because he or she reduces his or her course load to a level below full-time as defined by the educational institution, graduates or otherwise leaves school for reasons other than illness, injury or school vacations.

- 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 sponsored child ends on the earlier of the last day of the calendar year in which the child reaches age 25 or the last day of the month for which a required contribution is not received.

- Coverage for a child under a QMCSO ends on the date the associate is no longer required to provide coverage for this child or, if earlier, the date the child would no longer be eligible for coverage, as defined on page 4.

- 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 on page 57.

Continuing coverage when a dependent is ineligible

It is your responsibility to notify the Verizon Benefits Center within 60 days if your dependents no longer meet eligibility requirements. Otherwise, any claims incurred by an ineligible dependent become your financial responsibility and your dependent may lose the right to purchase continued dental care benefits under COBRA.

Periodically, you may be asked to provide proof of your dependents' eligibility. If such proof is not provided, those dependents will lose their eligibility for the plan, effective retroactively as of the date determined by the plan administrator.

Extended benefits

The plan will pay benefits for the following services, supplies and treatment received after your coverage would otherwise end, as long as the service, supply or treatment is installed or delivered within two months following the date coverage would otherwise end:

- A prosthesis, including bridgework, if the impressions were taken and the abutment teeth were prepared fully before coverage would otherwise end,

- A crown, if the tooth was prepared before coverage would otherwise end, and

- Root canal therapy, if the tooth was opened before coverage would otherwise end.

Continuation of coverage under COBRA

In some instances, a person whose coverage under this plan ends still may be able to continue coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments. Continuation of coverage under COBRA is described on page 28 of this summary plan description (SPD).

Certificate of Creditable Coverage

When any person's coverage ends for any reason, including the end of COBRA continuation coverage, the company will send that person a Certificate of Creditable Coverage, free of charge, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This certificate may help the person receive coverage under another plan. Specifically, this certificate may help reduce or eliminate exclusionary periods of coverage for pre-existing conditions under the plan. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. You also will be provided with a certificate, free of charge, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. To request a certificate, access Your Benefits Resources Web site or call the Verizon Benefits Center.

Overview of your options

Dental plan options

the plan includes a range of options to help you meet your dental needs. the options available to you depend on the bargaining agreement that covers you:

- For CWA-represented associate retirees in the service area: preferred dentist program (PDP) option (see page 14).
- For CWA-represented associate retirees whose home zip code is outside the PDP service area: out-of-area option (see page 20).
- For IBEW-represented associate retirees: standard option (see page 22).
- For both IBEW- and CWA-represented associate retirees: dental maintenance organization (DMO) option (see page 25).
- For both IBEW- and CWA-represented associate retirees: no coverage option (see page 27).

Alternative procedures

Regardless of the coverage option you choose, if there are two or more ways of effectively treating your dental condition, benefits will be payable based on the cost of the least expensive treatment that's appropriate, as determined by the claims administrator. You will be responsible for all charges above the amount considered for the least expensive treatment. Your dentist provides all dental recommendations related to your treatment.

Predetermination of benefits

Regardless of the coverage option you choose, if dental treatment is expected to cost more than $300, you should request that your dentist complete a Course of Treatment Form, available from the claims administrator, to indicate the intended treatment and estimated fees to the claims administrator. The claims administrator considers the dentist's recommended treatment as well as alternative treatments, and then notifies you and your dentist of the benefits payable under the plan.

If you do not get a predetermination of benefits, the claims administrator will make the determination of what the plan will pay when the claim is received.

Important note

If you already have been approved for treatment and there is a slight change in your course of treatment, you do not have to refile for predetermination of benefits. However, for major changes in treatment, you must refile.

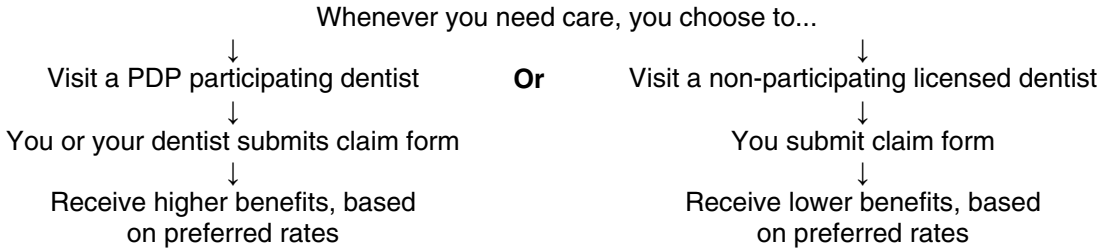
Preferred dentist program option (for CWA- represented associate retirees in the PDP service area)

The preferred dentist program (PDP) option is available to retirees who are former CWA-represented associates and whose home ZIP code is in a PDP service area.

Under the PDP, when you need care, you can visit any dentist. The same expenses are covered whether or not you use a participating provider. However, when you use a dentist in the PDP network, you are charged preferred rates, which are negotiated fees. In addition, you receive the highest benefits available under the option and you do not have to meet a deductible.

If you receive covered services outside the network, you must meet an annual deductible before the option pays benefits for basic restorative or major restorative services; the option pays a lower percentage of covered services; and you are responsible for any amount charged over the preferred rate.

The chart below describes how the PDP works.



A list of participating dentists can be obtained, free of charge, by calling MetLife at the telephone number listed on your Important Benefits Contacts insert. MetLife also has a Web site where you can get information about participating dentists online.

You can access MetLife's Web site via Your Benefits Resources Web site or via the address shown on your Important Benefits Contacts insert.

Important note

Your eligibility for the PDP is based on your home ZIP code. If the PDP is not shown as an option on your Enrollment Worksheet because you do not live in a PDP service area, you may be able to opt-in to the PDP. (Speak with a Verizon Benefits Center representative for details.)

Annual deductible

When you use nonparticipating dentists, you must pay an annual $50 deductible per person before the option pays benefits for basic restorative, major restorative or orthodontic services. There is no deductible required for preventive and diagnostic care. There is no family limit. Expenses for non-covered services or supplies do not count toward the deductible.

Benefit maximums

The annual benefit maximum the option will pay is $1,500 per person, per calendar year. No more than $1,000 per person will be paid when nonparticipating providers are used for covered services and supplies. This applies to all covered dental benefits combined, except orthodontia.

Orthodontic services are subject to a separate lifetime benefit limit of $2,000 per person. No more than $1,000 per person will be paid when nonparticipating providers are used for covered services and supplies.

Important note

The lifetime orthodontic benefit maximum is a single lifetime maximum for all Verizon coverage. If you or any individual you cover meets the benefit maximum for orthodontia, your or that individual does not gain a new lifetime orthodontic benefit maximum if you change options.

How benefits are determined

The same expenses are covered regardless of the dentist you use. However, when you use PDP participating dentists, your share of expenses generally will be less because you are charged preferred rates. Preferred rates are negotiated by the administrator and usually are less than fees charged by nonparticipating dentists. In addition, the option pays a higher percentage of covered expenses and you do not have to meet a deductible.

Preventive and diagnostic care

In general, the option pays 100 percent of covered preventive and diagnostic care services based on the preferred rate, whether you use a participating dentist or a nonparticipating dentist. If you use a nonparticipating dentist, there is no deductible, but you must pay any amount that is over the preferred rate. (See the "Overview of Benefits" section for covered services and supplies.)

Basic restorative care

If you receive basic restorative care from a participating dentist, the option pays 80 percent of the preferred rate.

If you receive basic restorative care from a nonparticipating dentist, the option pays 70 percent of the preferred rate after you meet the deductible. If your dentist charges more than the preferred rate, you also must pay the amount above the preferred rate. (See "Basic Restorative Care" under the "Overview of Benefits" section for covered services and supplies.)

Major restorative care

If you receive major restorative care from a participating dentist, the option pays 65 percent of the preferred rate.

If you receive major restorative care from a nonparticipating dentist, the option pays 50 percent of the preferred rate after you meet the deductible. If your dentist charges more than the preferred rate, you also must pay the amount above the preferred rate. (See "Major Restorative Care" under the "Overview of Benefits" section for covered services and supplies.)

Dental implants

The option covers services for dental implants, with reimbursement consistent with plan coverage for other major restorative services such as dental bridges. This benefit is limited to $1,000 per implant.

In addition to the implant procedure, the option covers any separate charge related to a restorative crown.

Due to the extensive cost of this service, predetermination is recommended. See the "Predetermination of benefits" section for more information.

Orthodontic care

If you receive orthodontic care from a participating dentist, the option pays 60 percent of the preferred rate.

If you receive orthodontic care from a nonparticipating dentist, the option pays 50 percent of the preferred rate after you meet the deductible. If your dentist charges more than the preferred rate, you also must pay the amount above the preferred rate. However, if the Verizon Employee Benefits Committee (VEBC) determines that there is an insufficient number of participating orthodontists in your service area, the option will pay 60 percent of your orthodontist's charge, and the deductible does not apply. (See "Orthodontic care" under the "Overview of benefits" section for covered services and supplies.)

Important note

Even if you visit a participating dentist for a service or supply that is **not** covered by the PDP option, your expenses still will be lower than using a nonparticipating dentist because you will be charged the preferred rate.

Overview of benefits

Option feature	Using PDP participating dentists	Using PDP nonparticipating dentists
Annual deductible–does not apply to preventive and diagnostic care	Not applicable	$50 per person; no family limit
Annual benefit maximum, excluding orthodontia	$1,500 per person[1]	$1,000 per person[1]
Orthodontic lifetime benefit maximum	$2,000 per person[2,3]	$1,000 per person[2,3]

[1]Note that the $1,000 annual benefit maximum when using nonparticipating dentists counts toward the $1,500 maximum when using participating providers (so if you receive $1,000 in benefits using nonparticipating dentists, you are eligible to receive an additional $500 in benefits from participating providers).

[2]Note that the $1,000 lifetime orthodontic benefit maximum when using nonparticipating dentists counts toward the $2,000 maximum when using participating providers (so if you receive $1,000 in benefits using nonparticipating dentists, you are eligible to receive an additional $1,000 in benefits from participating providers).

[3]The lifetime orthodontic benefit maximum is a single lifetime maximum for all Verizon coverage and is in addition to the separate annual benefit maximum.

Option feature	Using PDP participating dentists	Using PDP nonparticipating dentists
Preventive and diagnostic care (Frequency limits are per person) Routine oral exam: 2 per calendar year. Additional exams are covered as needed specifically for emergency confirmation of diagnosis of suspected disease or injury, as long as no other covered services or supplies are rendered on the same day Cleaning and scaling of teeth: twice per calendar year Single film X rays: as needed to diagnose a specific condition, except for orthodontia Complete X-ray series, including panoramic film and bitewing X rays or a single panoramic film: once every 3 calendar years if ordered by a dentist Supplementary bitewing X rays: twice each calendar year if ordered by a dentist Topical fluoride treatment: once per calendar year for covered persons over age 13 Panoramic X ray, including maxillary and mandibular: once every 3 calendar years Fabrication, insertion and adjustment of a non-orthodontic space maintainer for patients under age 19 only: as needed for replacement of congenitally missing teeth and prematurely lost or extracted teeth, regardless of when the teeth were lost or extracted	Option pays 100 percent of preferred rate	Option pays 100 percent of preferred rate

Option feature	Using PDP participating dentists	Using PDP nonparticipating dentists
Basic restorative care Oral surgery, including: • Incision and draining of abscess • Simple extractions • Surgical removal of soft tissue impactions; exception: If you live in Pennsylvania, New Jersey or Delaware, you must submit these expenses to your medical plan first • Removal of partial or complete bony impactions 30 minutes of intravenous sedation or general anesthesia, in connection with oral surgery Fillings made from amalgam, silicate, acrylic or plastic, composite acrylic resin. Multiple fillings in 1 surface are considered a single filling Root canal therapy (including X rays, tests, lab exams and follow-up care) for devitalized teeth only, including X rays and cultures in conjunction with a surgical procedure Periodontics, including: • Gingival curettage • Gingivectomy • Osseous surgery • Periodontal surgery • Scaling and root planing: limited to 1 full mouth procedure every 24 months If more than 1 surgery is performed at the same time, the more comprehensive procedure is covered by the option Additions to partial dentures to replace extracted teeth Tooth sealants to permanent non-restored molars; for covered individuals who are under age 19 only: once per tooth every 5 calendar years	Option pays 80 percent of preferred rate	Option pays 70 percent of preferred rate

Option feature	Using PDP participating dentists	Using PDP nonparticipating dentists
Major restorative care Inlay restorations, if the tooth cannot be restored by other means because of extensive caries or traumatic injury Crowns (single restorations), if the tooth cannot be restored by other means because of extensive caries or traumatic injury: once every 5 calendar years Initial installation of fixed bridges, bridge pontics or crowns to form abutments Repair or re-cementing of crowns, inlays, bridgework or dentures Initial installation of partial or full removable dentures, including adjustments to such dentures within 6 months of initial installation Initial installation of a permanent full denture that replaces a temporary denture if it is installed within 12 months of the temporary denture Initial installation of dental implants and related services, including any separate charges for restorative crowns Replacement or modification of an existing full removable or partial denture or fixed bridge if it was installed at least 5 years prior to its replacement or additional extractions required the replacement Lab costs for relining complete upper or lower dentures, excluding relining within 6 months of insertion Replacement of congenitally missing teeth Diagnosis and non-surgical treatment of temporomandibular joint (TMJ) dysfunction, if the treatment is not otherwise excluded from coverage Occlusal devices for teeth grinding (bruxism): necessity determined by the plan administrator	Option pays 65 percent of preferred rate	Option pays 50 percent of preferred rate
Orthodontic care Services for the detection, prevention and correction of malocclusion of teeth in relation to the jaw	Option pays 60 percent of preferred rate	Option pays 50 percent of preferred rate[4]

[4]Option pays 60 percent of your orthodontist's charges if the VEBC determines there is a limited number of participating orthodontists in your service area. The deductible does not apply.

Out-of-area option (for CWA-represented associate retirees not in the PDP service area)

The out-of-area option is available to retirees who are former CWA-represented associates whose home ZIP code is outside the preferred dentist program (PDP) service area.

The out-of-area option covers the same services and supplies as the PDP option (see pages 14 through 19). However, the out-of-area option pays the same percentage of benefits based on reasonable and customary (R&C) amounts regardless of the dentist you choose. If your dentist charges more than the R&C amount, you are responsible for the portion above the R&C amount. You do not have to meet a deductible before the option pays benefits for covered services and supplies.

Important notes

- You cannot opt-in to the out-of-area option.

- The lifetime orthodontic benefit maximum is a single lifetime maximum for all Verizon coverage. If you or any individual you cover meets the benefit maximum for orthodontia, you or that individual does not gain a new lifetime orthodontic benefit maximum if you change options.

- Even if you enroll in the out-of-area option, you can visit a dentist who participates in the PDP network. If you do, your expenses will be lower because you will be charged the preferred rate.

Benefit maximums

The annual benefit maximum the option will pay is $1,500 per person, per calendar year. This applies to all covered dental benefits combined, except orthodontia.

Orthodontic services are subject to a separate lifetime benefit limit of $2,000 per person.

How benefits are determined

The out-of-area option pays benefits based on the type of covered service or supply you receive. You can use any dentist you choose.

Preventive and diagnostic care

In general, the option pays 100 percent of R&C for covered preventive and diagnostic care. If your dentist charges more than the R&C amount, you are responsible for the portion above the R&C amount.

Basic restorative care

The option pays 80 percent of R&C for covered basic restorative care. If your dentist charges more than the R&C amount, you are responsible for the portion above the R&C amount.

Major restorative care

The option pays 65 percent of R&C for covered major restorative care. If your dentist charges more than the R&C amount, you are responsible for the portion above the R&C amount.

Dental implants

The option covers services for dental implants, with reimbursement consistent with plan coverage for other major restorative services such as dental bridges. This benefit is limited to $1,000 per implant.

In addition to the implant procedure, the option covers any separate charge related to a restorative crown.

Due to the extensive cost of this service, predetermination is recommended. See the "Predetermination of benefits" section for more information.

Orthodontic care

The option pays 60 percent of R&C for covered orthodontic care. If your dentist charges more than the R&C amount, you are responsible for the portion above the R&C amount.

Standard option
(for IBEW-represented associate retirees)

The standard option is available to retirees who are former IBEW-represented associates.

The standard option is a traditional “indemnity” option. You can choose any dentist and receive benefits for covered services from the option. There is no deductible.

Benefit maximums

The annual benefit maximum the option will pay is $1,500 per person per calendar year. This applies to all covered dental benefits combined, except orthodontia.

Orthodontic services are subject to a separate lifetime benefit limit of $2,000 per person.

Important note

The lifetime orthodontic benefit maximum is a single lifetime maximum for all Verizon coverage. If you or any individual you cover meets the benefit maximum for orthodontia, you or that individual does not gain a new lifetime orthodontic benefit maximum if you change options.

How benefits are determined

The standard option pays benefits based on the type of covered service or supply you receive. You can use any dentist you choose.

Preventive and diagnostic care

In general, the option pays 100 percent of reasonable and customary (R&C) amounts for covered preventive and diagnostic care. If your dentist charges more than the R&C amount, you are responsible for the portion above the R&C amount.

Basic care

The option pays benefits for covered basic care according to a schedule of benefits. If your dentist charges more than the scheduled amount, you are responsible for the portion above the scheduled amount.

For the scheduled benefit for a specific service or to obtain a copy of the schedule of benefits, free of charge, call Aetna member services (see your Important Benefits Contacts insert for the telephone number).

Major care

The option pays benefits for covered major care according to a schedule of benefits. If your dentist charges more than the scheduled amount, you are responsible for the portion above the scheduled amount.

For the scheduled benefit for a particular procedure or to obtain a copy of the schedule of benefits, free of charge, call Aetna member services (see your Important Benefits Contacts insert for the telephone number).

Dental implants
The option covers services for dental implants, with reimbursement consistent with plan coverage for other major restorative services such as dental bridges. This benefit is limited to $1,000 per implant.

In addition to the implant procedure, the option covers any separate charge related to a restorative crown.

Due to the extensive cost of this service, predetermination is recommended. See the "Predetermination of benefits" section for more information.

Orthodontic care
The option pays benefits for covered orthodontic care according to a schedule of benefits. If your dentist charges more than the scheduled amount, you are responsible for the portion above the scheduled amount.

For the scheduled benefit for a specific orthodontic service or to obtain a copy of the schedule of benefits, free of charge, call Aetna member services (see your Important Benefits Contacts insert for the telephone number).

Overview of benefits

Option feature	Benefit
Annual benefit maximum, excluding orthodontia	$1,500 per person
Orthodontic lifetime benefit maximum	$2,000 per person[1]
Preventive and diagnostic care (Frequency limits are per person) Routine oral exam: 2 per calendar year; additional exams are covered as needed specifically for emergency confirmation of diagnosis of suspected disease or injury, as long as no other covered services or supplies are rendered on the same day Cleaning and scaling of teeth: twice per calendar year Single film X rays: as needed to diagnose a specific condition, except for orthodontia Complete X ray series, including panoramic film and bitewing X rays or a single panoramic film: once every 3 calendar years if ordered by a dentist Supplementary bitewing X rays: twice each calendar year if ordered by a dentist Topical fluoride treatment: once per calendar year Panoramic survey, including maxillary and mandibular: once every 3 calendar years Fabrication, insertion and adjustment of a non-orthodontic space maintainer for patients under age 19 only: as needed for replacement of congenitally missing teeth and prematurely lost or extracted teeth regardless of when the teeth were lost or extracted Tooth sealants to permanent non-restored molars; for dependents under age 19 only: once every 5 calendar years	Option pays 100 percent of R&C

[1]The lifetime orthodontic benefit maximum is a single lifetime maximum for all Verizon coverage and is in addition to the separate annual benefit maximum.

Basic, major and orthodontic Care Oral surgery, including: • Incision and draining of abscess • Simple extractions • Surgical removal of soft tissue impactions • Removal of partial or complete bony impactions General anesthesia in connection with oral surgery Fillings made from amalgam, acrylic or plastic, composite acrylic resin Root canal therapy (including X rays, tests, lab exams and follow-up care) for devitalized teeth only, including X rays and cultures Periodontics, including: • Gingival curettage • Gingivectomy • Osseous surgery • Scaling and root planing If more than 1 surgery is performed at the same time, the more comprehensive procedure is covered by the option Additions to partial dentures to replace extracted teeth Repair or re-cementing of crowns, inlays, bridgework or dentures Diagnosis and non-surgical treatment of temporomandibular joint (TMJ) dysfunction, if the treatment is not otherwise excluded from coverage Inlay restorations, if the tooth cannot be restored by other means because of extensive caries or traumatic injury Crowns (single restorations), if the tooth cannot be restored by other means because of extensive caries or traumatic injury Initial installation of fixed bridges, bridge pontics or crowns to form abutments Initial installation of partial or full removable dentures, including adjustments to such dentures within 6 months of initial installation Initial installation of a permanent full denture that replaces a temporary denture if it is installed within 12 months of the temporary denture Replacement or modification of an existing full removable or partial denture or fixed bridge if it was installed at least 5 years prior to its replacement or additional extractions required the replacement Initial installation of dental implants (up to $1,000 per implant) and related services, including any separate charges for restorative crowns Lab costs for relining complete upper or lower dentures: excluding relining within 6 months of insertion Occlusal devices for teeth grinding (bruxism): necessity determined by the plan administrator Replacement of congenitally missing teeth Services for the detection, prevention and correction of malocclusion of teeth in relation to the jaw	Option pays according to a schedule of benefits. Call Aetna member services to request benefit information for a particular procedure or to obtain a copy of the schedule free of charge

Dental maintenance organization (DMO) option
(for IBEW- and CWA-represented associate retirees)

The DMO option is available to retirees who are former CWA- or IBEW-represented associates.

Important note
The DMO is offered to you regardless of where you live and where DMO dentists are located. Before you enroll, make sure providers conveniently are located to you.

How the DMO works
With the DMO option, you receive a high level of coverage for your dental expenses. In addition, most benefits are not subject to annual or lifetime limits on coverage, except for orthodontia, which is limited to one full course of treatment per lifetime for each covered member. You must use a DMO personal dentist; otherwise, you will receive no coverage for your dental expenses because there is no out-of-network benefit with the DMO. However, some states require certain minimum benefit payments when you use a nonparticipating dentist.

Personal dentists
When you join a DMO, you will need to choose a personal dentist from the DMO network. Your personal dentist will be your primary dentist who coordinates care if you need to see a dental specialist. In general, if you don't receive care from or you are not referred by your personal dentist, you will receive no coverage for your dental expenses.

You may select a different personal dentist for each family member. You can change your personal dentist up to once a month by calling the DMO administrator (see your Important Benefits Contacts insert for the telephone number).

If your personal dentist leaves the DMO, you must select another DMO personal dentist, or change your dental option. If you change your dental option, your election will be effective the first of the month following 31 days from the date of your election.

A list of personal dentists can be obtained free of charge by calling Aetna at the telephone number listed on your Important Benefits Contacts insert. Aetna also has a Web site where you can get information about personal dentists online. You can access Aetna’s Web site via Your Benefits Resources Web site or via the address shown on your Important Benefits Contacts insert.

Emergencies
The DMO does require you to contact your personal dentist first when you need emergency dental care. If for any reason you are unable to contact your personal dentist, contact Member Services. You should check with the claims administrator for details on emergency coverage.

Overview of benefits

Covered procedure/feature	Benefits using DMO personal dentist (otherwise, generally no coverage)
Annual deductible	None
Preventive and diagnostic care (for example, cleanings and X rays)	Option pays 100 percent
Basic care (for example, fillings, most oral surgery and root canals)	Option pays 100 percent (certain services covered at 60 percent)[1]
Major care (for example, crowns, bridgework and dentures)	Option pays 60 percent
Orthodontia	Option pays 50 percent
Annual benefit maximum (excluding orthodontia)	None
Orthodontic lifetime benefit maximum[2]	Limited to one full course of treatment per lifetime per covered person

[1]Certain restorative services, molar root canals, osseous surgery, removal of full or partial bony impacted teeth and general anesthesia are covered at 60 percent.

[2]The lifetime orthodontic benefit maximum is a single lifetime maximum for all Verizon coverage and is in addition to the separate annual benefit maximum. If your or any individual you cover meets the benefit maximum for orthodontia, you or that individual does not gain a new lifetime orthodontic benefit maximum if you change options.

It is Aetna's responsibility to provide, free of charge, a detailed document about the covered procedures and features of the DMO. This material is available, upon request, by contacting Aetna directly via the telephone number shown on your Important Benefits Contacts insert. Aetna also has a Web site where you can get information about covered procedures and features. You can access Aetna's Web site via Your Benefits Resources Web site or via the address shown on your Important Benefits Contacts insert.

No coverage option (for IBEW- and CWA-represented associate retirees)

The no coverage option is available to retirees who are former CWA- and IBEW-represented associates.

If you elect no coverage, you will be able to re-enroll at any time. See page 6 for information on Anytime Enrollment.

Coverage continuation rights under the Consolidated Omnibus Budget Reconciliation Act of 1985

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), offers you the opportunity to continue coverage.

For additional information about your rights and obligations under the dental plan and under federal law, contact the Verizon Benefits Center.

What is COBRA continuation coverage?

COBRA coverage is a temporary continuation of dental plan coverage when it otherwise would end because of a life event, known as a "COBRA qualifying event." (Specific qualifying events are listed later in this section.)

After a qualifying event, COBRA continuation coverage is offered to each "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the dental plan is lost because of the qualifying event. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period.

Qualified beneficiaries who elect COBRA continuation coverage must pay for it.

COBRA qualified beneficiaries

- **Retirees.** If you, your covered spouse or dependent child lose coverage under the plan, or if there is a substantial reduction in coverage under the plan because of Verizon's bankruptcy, special rules may allow coverage to be continued for a certain period.

- **Spouse of retiree.** Your spouse is eligible for COBRA continuation if he or she loses coverage under the dental plan because of one of the following qualifying events:

  — You die.

  — You become divorced or legally separated.

- **Dependent children.** Dependent children are eligible for COBRA continuation if they lose coverage under the dental plan because of one of the following qualifying events:

  — You die.

  — You become divorced or legally separated

  — The child loses eligibility for coverage as a "dependent child" under the dental plan.

Although not entitled to legal rights under COBRA, Verizon offers same-sex domestic partners and children of same-sex domestic partners continuation coverage, as outlined in this section[1]. For this purpose, a same-sex domestic partner will be offered coverage "like" a spouse's coverage, and a child of a same-sex domestic partner will be offered coverage "like" a child of a retiree.

When COBRA coverage is available

The dental plan offers COBRA continuation coverage to qualified beneficiaries only after the Verizon Benefits Center has been notified that a qualifying event has occurred. (See your Important Benefits Contacts insert for contact information.)

You or the qualified beneficiary must notify the Verizon Benefits Center within 60 days after the qualifying event.

How COBRA coverage is offered

After the Verizon Benefits Center receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each qualified beneficiary.

The Verizon Benefits Center provides a COBRA enrollment notice by mail within 14 days after receiving notice of the qualifying event and each qualified beneficiary has an independent right to elect COBRA continuation coverage.

Covered retirees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. It is critical that you (or anyone who may become a qualified beneficiary) maintain a current address with the Verizon Benefits Center to ensure that you receive a COBRA enrollment notice following a qualifying event.

How long COBRA coverage lasts

COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- Your death.
- Your divorce.
- A dependent child losing eligibility as a dependent child.

[1] A child of a same-sex domestic partner can be a qualified beneficiary if he or she also is an Internal Revenue Service (IRS) tax dependent of the employee.

COBRA qualifying events

	Maximum continuation period (months) for:		
Qualifying event	**You**	**Spouse**	**Covered child**
Your covered child no longer qualifies as a dependent	N/A	N/A	36
You die	N/A	36	36
You and your spouse divorce	N/A	36	36

You and your eligible dependents have 60 days from the date coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect continued participation under COBRA.

What COBRA coverage costs

COBRA participants must pay monthly premiums for coverage.

Premiums are based on the full cost per covered person set at the beginning of the year, plus 2 percent for administrative costs. Dependents making separate elections are charged the same rate as a single retiree.

Payment is due at enrollment, but there is a 45-day grace period from the date you mail your enrollment form to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s).

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act also is available at www.doleta.gov/tradeact.

If you or your dependent elects COBRA continuation coverage:

- You or your dependent can keep the same level of coverage you had as an active employee or choose a lower level of coverage.

- Your or your dependent’s coverage is effective as of the date of the qualifying event. However, if you waive COBRA coverage and then revoke the waiver within the 60-day election period, your elected coverage begins on the date you revoke your waiver.

- You or your dependent may change your coverage:

  — During your benefits renewal period.

  — If you have a qualified change in status.

  — If you have a change in circumstance recognized by the Internal Revenue Service (IRS) and Verizon.

- You may enroll any newly eligible spouse or child under the plan rules.

When COBRA coverage ends

COBRA coverage ends before the maximum continuation period if one of the following occurs:

- You or any of your covered dependents become covered under another dental plan not offered by Verizon, provided the plan does not have a legally valid pre-existing condition exclusion or limitation affecting the qualified beneficiary. If it does, Verizon COBRA coverage for that pre-existing condition continues as long as you pay the premium.

- You or your covered dependent fails to make contributions by the due date as required.

- Verizon stops providing any dental benefits to any retiree.

Continuation coverage also may be terminated for any reason the dental plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If you have questions

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa.

Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's Web site.

What is not covered

The following dental expenses for you or a covered dependent are not covered:

- Charges for broken or missed appointments;
- Charges for completion or filing of claim forms;
- Services or supplies that primarily are for cosmetic or aesthetic purposes, including personalization or characterization of dentures, facings on crowns and pontics posterior to the second bicuspid and the crowning of a tooth that has no decay but is out of line with other teeth;
- Educational or training programs, such as oral hygiene and dietary instruction, or plaque control programs;
- Replacement of teeth missing before the effective date of coverage, except:
  - Replacement of an existing partial denture, full removable denture or fixed bridge if the device is installed at least five years prior to its replacement.
  - Replacement of a denture or bridge, while covered, if due to an additional extraction.
- Topical application of fluoride to a prepared portion of a tooth prior to its final restoration;
- Anesthesia, except intravenous sedation and general anesthesia when medically necessary in connection with oral surgery as determined by the claims administrator;
- Additional units of general anesthesia or intravenous sedation;
- Temporary appliances or restorations;
- Replacement of missing, lost or stolen devices (including space maintainers) or extra sets of dentures or other appliances;
- Services or supplies in connection with any duplicate prosthesis or other appliance; if you purchase a replacement for a missing, lost or stolen prosthesis, the rebasing, relining or repair of the prosthesis is a covered expense;
- Treatment of problems of the jaw joint, including temporomandibular joint (TMJ) dysfunction, craniomandibular disorders and other conditions of the jaw joint and the complex of muscles, nerves and other tissues related to the jaw joint, except as otherwise provided;
- Supplies used for the home application of fluoride;

- Appliances to control the grinding of teeth, except when necessary as determined by the claims administrator; athletic mouthguards; and occlusal guards, except for treatment of TMJ;

- A restoration or crown, except for treatment of decay or traumatic injury that cannot be repaired with a filling material or for a tooth that is an abutment to a covered partial denture or fixed bridge;

- Procedures determined by the claims administrator to be experimental;

- Services rendered by an immediate family or household member;

- Services not furnished by a dentist, except those performed by a dental hygienist under the direction of a dentist;

- Charges in excess of the reasonable and customary (R&C) amount, preferred rate or scheduled amount, as applicable, or in excess of the applicable annual or lifetime maximum, as determined by the claims administrator;

- Services or supplies for which there is no legal obligation to pay;

- Services or supplies for which no charges would have been made if dental coverage had not existed;

- Services or supplies provided as the result of disease, defect or injury caused by declared or undeclared war while covered by the plan;

- Treatment resulting from insurrection or participation in a riot;

- Services and supplies provided before the coverage effective date, including:

  — Any appliance or modification of an appliance if an impression was made prior to the coverage effective date.

  — A crown, bridge or gold restoration if the tooth was prepared prior to the coverage effective date.

  — Root canal therapy if the pulp chamber was opened prior to the coverage effective date.

  However, for the standard option and the dental maintenance organization (DMO) option, if orthodontia treatment started prior to the coverage effective date, treatment provided after the coverage effective date may be covered as determined by the claims administrator.

- For the preferred dentist program (PDP) option and the out-of-area option, orthodontia treatment started prior to the coverage effective date;

- Services or supplies provided after the coverage end date, except as otherwise provided;

- Implants (not covered under the DMO only);

- Services or supplies provided in connection with surgical periodontics, including periodontal splinting;

- Appliances, restorations and procedures to alter vertical dimension or restore occlusion, or to splint or correct attrition or abrasion;

- Drugs and their administration;

- Services or supplies covered under any federal or state "no-fault" motor vehicle insurance, regardless of whether you properly assert your rights under the motor vehicle insurance contract;

- Services or supplies for which you recover the cost by legal action, insurance proceeds or settlement from a third party whose negligent or wrongful actions have caused or are alleged to have caused your injury that needs dental treatment or from the third party's insurer;

- Services or supplies provided by any local, state or federal government agency, except as otherwise required by federal law;

- Services or supplies that are furnished, paid for or otherwise provided for treatment of a disability connected with military service or past or present service in the armed forces of a government, unless payment is required by law;

- Services or supplies covered under the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Retirees (or a health maintenance organization [HMO]) or any other plan of Verizon or an affiliate; charges for treatment of accidental injury to natural teeth while covered under the plan that total $250 or less are covered under the plan;

- Services or supplies for a condition covered under Workers' Compensation laws or for any other occupational condition, ailment, injury or disease occurring on the job for all employees and dependents if:

  — The covered person's employer provides reimbursement for such charges or makes a settlement for such charges.

  — The covered person fails to assert his or her rights to receive employer reimbursement.

  The plan has the right to recover or place a lien on any benefits paid or payable if Workers' Compensation provides benefits for the same condition; and

- Services or supplies that are not necessary for treatment of injury or disease or not rendered in accordance with accepted standards of dental practice as determined by the claims administrator.

How to file a claim

When you choose coverage under the standard option or the out-of-area option, you must file claim forms. an advantage of the preferred dentist program (PDP) and the Dental Maintenance Organization (DMO) is that you normally will not have to file claims.

When claims are required

If you participate in the PDP or the DMO, your participating dentist generally will file claims for you. In most cases, you will not have to file a claim form unless you go outside the network or receive emergency dental care when you are away from home.

When you participate in the standard option or the out-of-area option or if you use a nonparticipating dentist, you will have to file claim forms to be reimbursed. To file a claim:

- If you need a dental claim form, call the Verizon Benefits Center or the claims administrator to get one. (See your Important Benefits Contacts insert for the telephone number.)

- Ask your dentist to complete the balance of the claim form and return it to you. If he or she prefers to use another form, it should be attached to the claim form you provide.

- When dental work has been completed, sign the claim form to:

  — Authorize the dentist to release the information the claim administrator requires.

  — Certify the employee/patient information is correct.

  — Authorize payment directly to the dentist if the dentist does not require full payment from you.

- Send the form to the claims administrator.

- Claims must be filed within 15 months from the date services are rendered.

Coordination of benefits

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

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

When the plan is secondary, the claims administrator subtracts the primary plan's payment from the actual charge. The Verizon plan's secondary payment (if any) will never exceed the amount it would have paid if it were the primary plan. Also, the plan's secondary payment (if any) and the primary plan's payment, added together, never will exceed 100 percent of the actual charge.

If you have coverage through a prepaid dental plan (such as a DMO), coordination will be based on the reasonable cash value of each service provided under the plan for purposes of determining if the plan will pay a benefit as the secondary plan.

Priority of payment

Under the plan's COB provisions, the order of payment is as follows:

- A plan that covers a patient as an active, inactive or former employee pays before a plan that covers the patient as a dependent.

- For a dependent child, Verizon uses the "birthday rule." This means that if a child is covered by both parents' group dental coverage, the plan of the parent whose birthday falls first during the calendar year pays benefits first. So, if the mother's birthday is April 27 and the father's birthday is October 23, the mother's plan pays benefits first. The parent's age has no effect on whose plan pays benefits first. If, however, the plan covering the parent who is not a plan participant does not use the birthday rule, that plan (not the Verizon plan) pays benefits first.

- In the case of a divorce or separation, the plan of the parent with court-ordered financial responsibility for the dependent child pays benefits for the child first. If there is no court order establishing financial responsibility or if both parents have joint legal custody, the plan of the parent with physical custody of the child pays first. If the court order provides that both parents have joint physical custody, the birthday rule applies.

Note: If both parents elect coverage under a Verizon-sponsored dental plan, their child can be covered under only one parent's plan.

When the previous rules do not establish an order of benefit determination, the plan that covers the person as an active employee is the primary plan and the plan that covers the person as an inactive or former employee is the secondary plan. If this rule does not establish an order of benefit determination, the plan that has covered the person for the longer period of time is the primary plan and the plan that has covered the person for the shorter period of time is the secondary plan.

A plan that does not have a COB feature is considered the primary plan.

For active associates and covered persons eligible for Medicare, the plan automatically still is the primary plan.

Subrogation and third-party reimbursement

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

You can contact the subrogation vendor directly with questions. See your Important Benefits Contacts insert for contact information.

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

The covered person must sign any 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 plan pays 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 Employee Benefits Committee (VEBC) and the Verizon Claims Review Committee (VCRC), and to the individuals who chair each of these committees.

At the time of publication of this summary plan description (SPD), there are several claims and appeals administrators for the plan. The VEBC or the VCRC may change these designations at any time.

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

Claims regarding eligibility to participate in the plan

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

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

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

Claims regarding scope/amount of benefits under the plan

At this time, for benefit-related claims, the VCRC has delegated its authority to finally determine claims to the dental plans. The following claims and appeals administrators have discretionary authority to determine claims and appeals for plan benefits:

Option	Claims and appeals administrator
PDP and out-of-area options	Metropolitan Life Insurance Company (MetLife)
Standard option	Aetna, Inc.
DMO option	Aetna, Inc.

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

The claims and appeals administrators have discretionary authority to:

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

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

If a 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 the dental plan.

The following information applies for "group health" or "health" claims. "Group health" or "health" refers to medical options – including mental health and substance abuse care, prescription drugs and vision care – and dental options. References to health plan option in this section mean dental plan option. The steps that you or your authorized representative is required to take to file a group health claim or appeal are outlined in the following chart. The steps vary slightly depending on the type of claim involved.

First, you must determine what type of claim you have:

- ***Post-service.*** A claim for reimbursement of dental services already received. This is the most common type of claim.
- ***Pre-service.*** A claim for a benefit for which coverage review is required by the plan.
- ***Concurrent care.*** A claim for ongoing treatment over a period of time or a number of treatments. For example, if you have been authorized to receive seven treatments from a dentist and during the treatment your dentist suggests 10 treatments, your claim is a concurrent care claim. Some concurrent care claims also are urgent care claims.
- ***Urgent care***. A claim for dental care or treatment that, if the longer time frames for nonurgent care were applied, the delay could: (1) seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or (2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be managed without the care or treatment that is the subject of the claim.

Second, you must determine whether you have an "eligibility" claim or a "benefit" claim.

An eligibility claim is a claim to participate in a plan or option or to change an election to participate during the year. An example of an eligibility claim is a claim to switch from an indemnity-type plan to a Dental Maintenance Organization (DMO) mid-year. A benefit claim is a claim for a particular benefit under a plan. It will typically include your initial request for benefits. An example of a benefits claim is a claim to receive coverage for a particular type of dental care, such as coverage for an implant.

The following chart applies to **dental** claims.

<table>
<tr><th></th><th colspan="4">Special rules</th></tr>
<tr><th></th><th>Post-service claim</th><th>Pre-service claim</th><th>Concurrent care claim</th><th>Urgent care claim</th></tr>
<tr><td colspan="5">Step 1</td></tr>
<tr><td colspan="5">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.

To file a benefit claim, you (or your authorized representative) should write to your group health plan administrator. To obtain contact information for your plan, you should refer to the telephone number and/or Web site shown on the back of your ID card or the health plan comparison charts available on Your Benefits Resources Web site.

You must include:

• A description of the benefits for which you're applying,
• The reason(s) for the request, and
• Relevant documentation.

To file an urgent care claim, you should call the Verizon Benefits Center at 1-877-4VzBens or your health plan. In addition, you must state that you're filing an urgent care claim.</td></tr>
<tr><td>What happens if you don't follow procedure
If you misdirect your claim, but provide sufficient information to an individual who is responsible for Verizon benefits administration, you will be notified of the proper procedure within (see columns to the right) of receipt of the claim.</td><td>Not applicable. Response time frame does not begin until claim is properly filed.</td><td>5 days</td><td>Not applicable. Response time frame does not begin until the claim is properly filed. If the claim involves urgent care, 24 hours.</td><td>24 hours</td></tr>
</table>

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
When you will be notified of the claim decision You will be notified of the decision within **(see columns to the right)** of the Verizon Benefits Center's receipt of your Claim Initiation Form or the health plan's receipt of your claim.	30 days This period may be extended for 15 days. You will be notified within the initial 30-day period.	15 days This period may be extended for an additional 15 days. You will be notified within the initial 15-day period.	A time period sufficiently in advance of the reduction or termination of coverage to allow you to appeal and obtain a response to that appeal before your coverage is reduced or terminated For concurrent care that is urgent, within 24 hours (provided that you submitted a claim at least 24 hours in advance of the reduction or termination of coverage); otherwise, within 72 hours	72 hours
Failure to provide sufficient information procedure If you fail to provide sufficient information, the claim may be decided based on the information provided. However, the Verizon Claims Review Unit or health plan may notify you within **(see columns to the right)** that additional information is needed.	30 days	15 days	Decision will be based on information provided, unless the concurrent care claim involves urgent care; see urgent care time frame	24 hours
You will have to provide the additional information within **(see columns to the right)**. Otherwise, the claim will be decided based on information originally provided.	45 days	45 days		48 hours
If you provide additional information, you will be notified of the decision by the Verizon Claims Review Unit or the health plan administrator within **(see columns to the right)**	The time period **remaining** for the initial claim	The time period **remaining** for the initial claim		48 hours

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
How you will be notified of the claim decision If your claim is approved, the Verizon Claims Review Unit or health plan generally will notify you by telephone If your claim is **denied**, in whole or in part, the Claims Review Unit or the health plan will notify you in writing, except for urgent care. 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, and • The plan's appeal procedures. If your urgent care claim is denied, the health plan will notify you via telephone. Within 3 days of this oral denial, you will receive a written denial notice, as explained under the general procedure. The denial notice also will explain the expedited review process.				
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 or appeals, as explained in this Step 2, and the appeal(s) must be finally decided by the claims fiduciary. The Claims Review Committee is the claims fiduciary for all eligibility claims. The Claims Review Committee has delegated its authority to finally determine claims to the health plans for benefit claims. The vast majority of health plans have accepted the responsibility of being the claims fiduciary. If your health plan has not accepted this responsibility, you will be notified in your claim denial notice, which will indicate that you should appeal to the Claims Review Committee. The claims fiduciary is authorized to finally determine appeals and interpret the terms of the plan in its sole discretion. All decisions by the claims fiduciary are final and binding on all parties.				

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
How to file an appeal If your claim is denied and you want to appeal it, you must file your appeal within **(see columns to the right)** from the date you receive notice of your denied claim. You may request access to all documents relating to your appeal. If you have an appeal for **eligibility** (i.e., you wrote to the Verizon Claims Review Unit at Step 1), write to the address specified on your claim denial notice. If you have an appeal for **benefits** (i.e., you wrote to your health plan as explained at Step 1), write to the contact identified by your health plan administrator in 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 (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 Claims Review Committee or the health plan administrator will consult with a healthcare professional who has appropriate relevant experience. Upon request: • You are entitled to learn the identity of such an expert. • You are entitled to copies of any healthcare professional's report. • You will be provided with any documents used by the plan to come to the determination of your case.	180 days	180 days	Within a reasonable period of time, considering the time period scheduled for reduction or termination of benefits	180 days You may orally file your appeal with the Verizon Claims Review Unit or the contact identified by your health plan administrator. At the time your claim is denied, the Verizon Claims Review Unit or your health plan administrator will give you instructions about how to file your appeal. You must identify that you are appealing an urgent care claim.

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
When you will be notified of the appeal decision You will be notified of the decision within **(see columns to the right)** of the Claims Review Committee's or the health plan's receipt of your appeal	**Eligibility appeals:** 60 days **Benefit appeals:**[1] • 60 days, if health plan provides 1 level of mandatory appeal • 30 days, if health plan provides 2 levels of mandatory appeal	**Eligibility appeals:** 30 days **Benefit appeals:**[1] • 30 days, if health plan provides 1 level of mandatory appeal • 15 days, if health plan provides 2 levels of mandatory appeal	**Eligibility and benefit appeals:** • Before a reduction or termination of benefits would occur • If the concurrent claim involves urgent care, 72 hours[2]	**Eligibility and benefit appeals:** 72 hours[2]

How you will be notified of the appeal decision
If your appeal is approved, the Claims Review Committee or the health plan will notify you in writing

If your appeal is **denied**, in whole or in part, the Claims Review Committee or the health plan will notify you in writing. Your denial notice will contain:

- The specific reason(s) for the denial,
- A statement regarding the documents to which you are entitled,
- An explanation of the voluntary appeal procedures, if any,
- Any internal procedures or clinical information on which the denial was based,
- The plan provisions on which the denial was based, and
- The following statement: "You and your plan may have other voluntary alternative 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."

Step 3

How to proceed if necessary
If you had an **eligibility** appeal that was denied by the Claims Review Committee, Verizon will not review your matter again, unless new facts are presented. You have a right to bring a civil action.

If you had a **benefit** appeal that was denied by a group health plan administrator that offers 1 mandatory level of appeal, the group health plan administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action.

If you had a **benefit** appeal that was denied by a group health plan administrator that offers 2 mandatory levels of appeal, you may appeal to the health plan a second time. You must submit your second appeal within 180 days from the date that you received the denial of your first appeal. In addition, your health plan will provide you with an independent medical review, upon request, in conjunction with this second and final appeal.

[1]If your health plan provides more than one level of appeal, the response time frame is shorter, as noted above. A few Verizon health plans offer a voluntary level of appeal. You are not required to file this voluntary appeal before filing a civil action; however, you may find it helpful. The health plan will provide you with information regarding its voluntary appeal, if it applies. A voluntary appeal is not subject to the same time frames as mandatory appeals.

[2]If your health plan provides two mandatory appeals, both appeals must occur within the 72-hour time frame.

The following provision applies if the health plan provides 2 levels of mandatory appeal:				
When you will be notified of the second and final appeal decision You will receive a response within **(see columns to the right)** of the health plan administrator's receipt of your second and final appeal. If this appeal is denied, the health plan administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action.	30 days	15 days	Time period remaining from your first appeal. Of course, the clock stops while you are preparing your second appeal.	Time period remaining from your first appeal. Of course, the clock stops while you are preparing your second appeal.

Peer review

If you disagree with the claims administrator's resolution of a claim and did not previously agree to the charge, you can request a peer review. Peer review is a self-imposed professional discipline established at the local, regional or state level by the American Dental Association. Under peer review, independent committees are established to hear cases and resolve fee disputes. Contact the claims administrator for more information.

Proof of loss

The claims administrator has the right to require verification of any information supplied as part of a claim. This includes requesting itemized bills for treatment (such as course of treatment for orthodontia), as well as medical and dental records. Claims will not be considered for reimbursement until requested information is received by the claims administrator. The following are acceptable means of verification:

- Dentist's written certification–claim form, letter, etc.
- Receipt for payment from dentist, if dentist refuses to provide the written certification, and
- Employee's cancelled check, if dentist refuses to provide a receipt for payment.

Your rights under ERISA

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

Receive information about your plan and benefits

- Examine, without charge at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The administrator may make a reasonable charge for the copies.

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

Continue group health plan coverage

- Continue healthcare coverage for yourself, your spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review your summary plan description and the documents governing the plan on your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent actions by plan fiduciaries

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

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

Enforce your rights

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

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

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

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

Assistance with your questions

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

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

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

HIPAA privacy rights

The HIPAA Privacy Rule applies to "Protected Health Information," which is defined as any written, oral or electronic health information that meets the following three requirements:

- The information is created or received by a healthcare provider, a Verizon health plan or Verizon.
- The information includes specific identifiers that identify you or could be used to identify you.
- The information relates to one of the following:
  - — Providing healthcare to you.
  - — Your past, present or future physical or mental condition.
  - — The past, present or future payment for your healthcare.

The Notice of Privacy Practices for the Verizon health plans contains a complete explanation of your rights under the HIPAA Privacy Rule. The notice describes how Protected Health Information may be used and disclosed, and how you can get access to that information. The following is a summary of those uses and disclosures of Protected Health Information and your rights with respect to Protected Health Information:

- The Verizon health plans may use or disclose your Protected Health Information for purposes of conducting healthcare operations or paying your healthcare claims.
- The Verizon health plans may use or disclose your Protected Health Information to tell you about treatment alternatives, or to provide you with information about other health-related benefits or services that may be of interest to you.

- The Verizon health plans may disclose your Protected Health Information to Verizon, as sponsor of the Verizon health plans, to assist Verizon in the performance of plan administrative functions. The Verizon health plans also may provide summary health information to Verizon, as plan sponsor, so that Verizon may obtain premium bids or modify, amend or terminate the Verizon health plans. Summary health information does not directly identify you, but summarizes claims history, claims expenses or types of claims experienced. Finally, the Verizon health plans may disclose your enrollment and disenrollment information to Verizon as plan sponsor.

- The Verizon health plans may disclose your Protected Health Information when required to do so by any federal, state or local law, and when permitted to do so under the circumstances set out in the Verizon Notice of Privacy Practices.

- The Verizon health plans may disclose your Protected Health Information to a law enforcement official for certain law enforcement purposes. For example, the Verizon health plans may disclose your Protected Health Information pursuant to a law requiring the reporting of certain types of wounds or other physical injuries.

- The Verizon health plans may disclose your Protected Health Information to healthcare providers to assist them in connection with their treatment or payment activities. In addition, the Verizon health plans may disclose your Protected Health Information to other entities subject to the HIPAA Privacy Rule to assist them with their payment activities or certain of their healthcare operations. For example, the Verizon health plans might disclose your Protected Health Information to a healthcare provider when needed by the provider to render treatment to you.

- Other than as permitted or required by law, the Verizon health plans will not use or disclose your Protected Health Information without your written authorization. If you authorize a Verizon health plan to use or disclose your Protected Health Information, you may revoke that authorization in writing at any time. If you revoke the authorization, the Verizon health plan no longer will use or disclose your Protected Health Information for the reasons covered by your written authorization. Your revocation will not affect any uses or disclosures a Verizon health plan already has made prior to the date the Verizon health plan receives notice of the revocation.

In general, you have the following rights regarding the Protected Health Information retained by a Verizon health plan:

- You have the right to request that a Verizon health plan restrict uses and disclosures of your Protected Health Information to carry out payment or healthcare operations.

- You have the right to request that a Verizon health plan communicate with you in a certain way if you feel that the disclosure of your Protected Health Information could endanger you.

- You have the right to inspect and obtain a copy of your Protected Health Information.

- If you believe that Protected Health Information a Verizon health plan has about you is inaccurate or incomplete, you have the right to request a correction.

- You have a right to request a list of disclosures made by a Verizon health plan of your Protected Health Information, other than those disclosures for which an accounting is not required.

- You have a right to request and receive a paper copy of the Notice of Privacy Practices for the Verizon health plans, even if you have received this notice previously or agreed to receive this notice electronically.

For more information regarding these rights and the privacy policies of the Verizon health plans, please review the Notice of Privacy Practices for the Verizon health plans. The Notice of Privacy Practices for the Verizon health plans is available on Your Benefits Resources Web site at www.verizon.com/benefits. Select "View or Print HIPAA Privacy Notice" in the "Learn More" section on the Benefits Overview page of the Benefits Manual. You may view the notice on the Web site and/or print a paper copy from the Web site.

You also may request a paper copy of the notice by calling the Verizon Benefits Center at 1-877-4VzBens. Have your User ID and Benefits Center password available. Listen to the main menu to make your selection and then follow the prompts to reach a representative. Benefits Center representatives are available from 8:00 a.m. until 6:00 p.m., Eastern time, Monday through Friday.

Administrative information

Administrative information about the plan is provided in this section.

Important telephone numbers

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

Plan sponsor/employer

The plan sponsor/employer is:

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

Plan administrator

The plan administrator is:

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

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

You may communicate to the plan administrator in writing at the address above. But, for questions about plan benefits, you should contact the Verizon Benefits Center. The Verizon Benefits Center administers enrollment and handles participant questions, requests and certain benefits claims, but is not the plan administrator. Claims relating to the scope and amount of benefits under the plan are administered by the administrators listed under "Claims regarding scope/amount of benefits under the plan" in the "Additional information" section.

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

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

Benefits administrators

The benefits administrators have authority and responsibility to perform daily administration of benefits under the plan.

- Aetna is the benefits administrator for the standard option and the dental maintenance organization (DMO) option. (See below for the address for the benefits administrator.)

- Metropolitan Life Insurance Company (MetLife) is the benefits administrator for the preferred dentist program (PDP) option and the out-of-area option. (See below for the address for the benefits administrator.)

See your Important Benefits Contacts insert for the telephone numbers for the benefits administrators.

Claims and appeals administrators

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

There are several claims and appeals administrators for the plan.

Verizon Claims Review Committee (VCRC)

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

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

See your Important Benefits Contacts insert for the telephone number.

The administrators listed here are the benefits administrators responsible for authorizing benefit payments, considering appeals, resolving questions, obtaining records, filing reports and the distribution of information to plan participants. See your Important Benefits Contacts insert for the telephone numbers.

Coverage	Benefits administrators
Standard option and DMO option	Aetna, Inc. P.O. Box 14094 Lexington, KY 40512-4094
PDP option and out-of-area option	MetLife P.O. Box 14093 Lexington, KY 40512-4093

Qualified medical child support orders (QMCSOs)

The firm responsible for the administration of QMCSOs is Hewitt Management Company LLC. Hewitt Management Company LLC can be reached at the following address:

Hewitt Management Company LLC
c/o Verizon Benefits Center
P.O. Box 1457
100 Half Day Road
Lincolnshire, IL 60069-1457

You can contact Hewitt by calling the Verizon Benefits Center via the telephone number shown on your Important Benefits Contacts insert.

Plan funding

PDP, out-of-area and standard options

The plan is not financed by an insurance company, nor are plan benefits guaranteed under a contract of insurance. The claims and appeals administrators listed on page 51 do not insure or guarantee plan benefits.

The company has the discretion to pay claims out of the general assets of the company, and certain benefits are currently funded through a trust.

The trustee is:

Mellon Bank, N.A.
One Mellon Bank Center - Room 3346
Pittsburgh, PA 15258

DMO option

The DMO option is fully insured though Aetna. The company and employees pay premiums to the insurance company for coverage.

Plan identification

Dental coverage is provided through the Verizon Dental Expense Plan for Mid-Atlantic Associates (as applicable to Post-1989 Associate Retirees), which is a component plan of Verizon Plan 550. It is a welfare plan, that is a group health plan, listed with the Department of Labor under two numbers: The employer identification number (EIN) is 23-2259884 and the plan number (PN) is 550.

In addition to the benefits described in this SPD, Verizon Plan 550 provides other benefits to Mid-Atlantic associate retirees of Verizon who will receive their own version of the SPD. Medical benefits are provided under the component plans referred to as the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Post-1989 Associate Retirees, the Verizon Prime Care Medical Plan for Mid-Atlantic IBEW Associate Retirees and Verizon's Bell Atlantic Medical Expense Plan. Life insurance benefits are provided under the component plan referred to as the Verizon Life Insurance Plan for Mid-Atlantic Associate Retirees. Medical and life insurance benefits are described in separate SPD.

Plan year

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

Agent for service of legal process

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

In addition, a copy of the legal process involving this plan should be delivered to:

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

Legal process also may be served on the trustee.

Official plan document

This SPD is a summary of the official plan documents.

Your eligibility for benefits (dental coverage) is determined by the Verizon Dental Expense Plan for Mid-Atlantic Associates (as applicable to Post-1989 Associate Retirees), including this SPD. The company has full discretionary authority to interpret the terms of the plans summarized in this document and determine your eligibility for benefits under the plans' terms. In some cases, Verizon has delegated this authority.

If you are covered by a DMO option, material for that plan option is provided to you separately by the administrator. The DMO material is hereby incorporated into this document by reference. The DMO material, together with this document, comprises your SPD.

Collective bargaining agreements

The terms of your benefits may also be governed by a collective bargaining agreement between Verizon and your union. You and your beneficiaries may review the collective bargaining agreement at your location you also can request a copy by writing to the plan administrator.

Participating companies

The following is a list of participating companies as of January 1, 2007. The list may change from time to time.

- Verizon Advanced Data Inc.
- Verizon Connected Solutions Inc. (the former Bell Atlantic Communications and Connection Services Inc. – BACCSI)[2]
- Verizon Delaware Inc.
- Verizon Maryland Inc.
- Verizon Network Services Inc.
- Verizon New Jersey Inc.
- Verizon Pennsylvania Inc.
- Verizon Services Corporation
- Verizon Virginia Inc.
- Verizon Washington, D.C. Inc.
- Verizon West Virginia Inc.

[2] This is not a participating company; however, the following grandfather rule applies to each individual who (a) prior to transferring directly to BACCSI was an employee of another former Bell Atlantic company that was then a participating company in this plan, and (b) subsequently separated from service from Verizon Connected Solutions Inc. between January 1, 1996 and December 31, 2001 with sufficient age and service to qualify for retirement benefits under this plan according to the age and service eligibility rule of this plan, which then apply to retirees of companies participating in the Verizon Pension Plan for Mid-Atlantic Associates. Upon retiring, such a retiree will be eligible to participate in the provisions of this plan, which then apply to retirees of one or more participating companies in the Verizon Pension Plan for Mid-Atlantic Associates, in accordance with the terms of this plan as it may be amended from time to time. Nothing in this grandfather rule is intended to prohibit the termination of any and all retiree dental benefit plans for retirees of all Verizon pension plans for Mid-Atlantic associates of participating companies, including any retirees of the former BACCSI described in this paragraph.

Glossary

C

COBRA

A federal law (Consolidated Omnibus Budget Reconciliation Act of 1985 and its subsequent amendments) allowing continuation of plan coverage for a period of time at the participant's expense if a participant loses plan coverage because of certain qualifying events.

Covered person

Any retired participant and any eligible dependents you have enrolled in the plan, or any eligible individual who has elected coverage under COBRA.

Covered services

The services, treatments or supplies identified as payable in the official plan document. Covered services must be medically necessary as determined by the claims administrator to be payable.

D

Deductible

The amount of covered expenses you pay before certain options pay benefits for specific care.

Dental hygienist

A person who is trained to remove calcium deposits and stains from the surfaces of the teeth and is licensed as required by the jurisdiction in which he or she practices.

Dentist

A person who is licensed to practice dentistry and administer treatment or perform dental surgery.

L

Legally separated

An employee and his or her spouse are legally separated if they do not live together and if they have a signed document or a legal proceeding, such as a separation agreement, that indicates that the employee or his or her spouse intends to live separately.

M
Medically necessary

A service or supply provided by a hospital, physician or other provider of healthcare services to diagnose or treat an illness or injury, which service or supply is consistent with the covered person's condition and which meets all of the following tests, as determined by the claims fiduciary:

- It must be ordered by a physician.

- It must be recognized throughout the provider's profession as safe, appropriate, effective and essential; it must be required for the diagnosis or treatment of the particular illness or injury; and it must be employed appropriately in a manner and setting consistent with generally accepted United States medical standards.

- It must be the most efficient and economical service or supply that can safely be provided.

- It must be neither educational or developmental nor experimental or investigational in nature.

Services or supplies that are provided only because an unnecessary service or supply is being provided shall not be considered medically necessary.

In the case of a hospital stay, in addition to meeting the above tests, the length of the stay and hospital services and supplies shall be considered medically necessary only to the extent that the claims fiduciary determines them to be not allocable to the scholastic education or vocational training of the covered person.

A service or supply furnished to a newborn child shall not be considered medically necessary for medical care of a diagnosed illness or injury, unless the service or supply meets either of these conditions:

- It is furnished for the medical care of a diagnosed illness (including a congenital defect or birth abnormality) or injury and meets all of the foregoing tests, or

- It is furnished immediately after the child's birth and is one of the following:

  — Hospital room and board, or

  — Other supplies and nonprofessional services furnished to newborns by the hospital for medical care in that hospital.

The foregoing definition shall be applied solely for purposes of determining plan benefits and not for determining what type of medical care should be provided; all decisions related to the type of medical care to be provided shall be made independently by the covered person and the covered person's physician.

P

Participating company

Verizon or any corporation or partnership which is an affiliate of Verizon that has elected to participate in the plan.

Preferred rate

The fee that participating dentists have agreed with the benefits administrator to accept as payment in full for covered services and supplies provided to preferred dentist program (PDP) participants. These rates are also applicable to services obtained from a participating dentist under the out-of-area option.

R

Reasonable and customary charge

The reasonable and customary (R&C) charge is the lesser of the actual charge or the maximum fee allowance for a covered service or supply. The benefits administrator determines the R&C charge.

The maximum fee allowance is determined by taking into consideration the following:

- The fee most commonly charged by a majority of providers in a given geographic area where those providers have similar training in the performance of the procedures;
- The fee normally charged by that provider for a similar service or supply; and
- The amount charged for unusual circumstances or complications requiring additional time, skill and experience in connection with that particular dental service, supply or procedure.

S

Same-sex domestic partner

You and your domestic partner must meet all of the following. You are:

- The same gender (sex).
- Each other's sole domestic partner.
- Not married to anyone else; i.e., neither of you is married to anyone else.
- Both at least 18 years old and mentally competent to enter into a marriage contract.
- Not related by blood to the degree of closeness that would prohibit your legal marriage in the state in which you reside.
- Living (and have lived) together in the same principal residence for at least six months and intend to do so indefinitely.
- Jointly responsible for each other's common well-being and financial obligations.

If at any time you do not meet all of the above criteria, you and/or your domestic partner must notify the Verizon Benefits Center of the change in status within 60 days.

You may be subject to taxes on imputed income for the coverage you choose for your domestic partner and his or her children.

Scheduled amount

The maximum benefit payable for a specific covered service or supply, as determined by the claims administrator. If the schedule does not indicate an amount for a specific covered service or supply, the scheduled amount is calculated as 75 percent of the applicable R&C amount.

W

Working retiree

A former associate employee of a participating company (other than Verizon Delaware Inc., Verizon Pennsylvania Inc., Verizon Directory Services or Verizon Connected Solutions Inc.) who was represented by CWA immediately prior to leaving the company and:

- Who retired on a service pension or who elected a service pension cashout under the Verizon Pension Plan for Mid-Atlantic Associates.

- Who is reemployed by a participating company 90 or more days after retirement.

- Whose reemployment lasts 120 or fewer days in a calendar year.

Your dental benefits

The Verizon Dental Expense Plan (the Plan) is designed to provide you and your family with comprehensive dental care coverage. The Plan includes:

- Freedom to use any dentist you choose.
- Negotiated fees for services when you use participating dental providers.
- Preventive care coverage that encourages regular checkups.
- Coverage for corrective care and orthodontia services.

Please keep this book handy and refer to it first whenever you have questions about your retiree dental benefits.

Verizon Dental Expense Plan for Mid-Atlantic Post-1989 Associate Retirees

The Verizon Dental Expense Plan for Mid-Atlantic Post-1989 Associate Retirees is one of several plans that together comprise Verizon Plan 550. General terms of Verizon Plan 550 are described in a separate plan document; those terms apply to the Verizon Dental Expense Plan for Mid-Atlantic Post-1989 Associate Retirees.

About this SPD

This document is the summary plan description (SPD) for the Verizon Dental Expense Plan for Mid-Atlantic Post-1989 Associate Retirees (the plan). The plan is subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. This document meets ERISA's requirements for an SPD and is based on Plan provisions and bargained-for changes effective January 1, 2004, including legislative and administrative updates through January 1, 2007. It updates and replaces all previous SPDs and other descriptions of the benefits provided by the Plan. This SPD is a summary of this Plan.

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

This SPD is divided into the following major sections:

- **Participating in the plan.** This section explains your eligibility, eligibility for your dependents and when eligibility ends.
- **Overview of your options.** This section describes the dental options available to you. Refer to it when deciding which option to choose and when you need information about your coverage and benefits.

Intentionally left blank

Intentionally left blank

Intentionally left blank