Dental Benefits
Summary Plan Description for
Mid-Atlantic Associates

V-B-AA-S-D-987-1/13

Contents

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:

- Options that allow you to choose the most appropriate coverage for you and your family, as well as the option to elect no coverage if you are covered as a dependent under another Verizon-sponsored dental plan or if you are a part-time associate who does not receive the full Company subsidy for dental coverage.

- Preventive care coverage that encourages regular checkups.

- Coverage for corrective care and orthodontia services.

About This SPD

This document is the summary plan description (SPD) for the Verizon Dental Expense Plan for Mid-Atlantic Associates (including eligible CWA and IBEW associates of Verizon). The Verizon Dental Expense Plan for Mid-Atlantic Associates is a component plan of Verizon Plan 550. Plan 550 provides other benefits to eligible associates, as described under the "Administrative Information" section. This SPD describes Plan benefits for Verizon Mid-Atlantic CWA and IBEW associates. Plan 550 also provides benefits for Connected Solutions Inc. technicians. These benefits are described in another SPD.

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, 2013, unless specifically noted otherwise. It updates and replaces all previous SPDs and other descriptions of the benefits provided by the Plan. This SPD is a summary of the Plan.

References in this SPD to the Plan or Dental Plan refer to the Verizon Dental Expense Plan for Mid-Atlantic Associates as a component of Verizon Plan 550.

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

This SPD is divided into the following major sections:

- **Participating in the Plan.** This section explains your eligibility, which of your dependents are eligible to be covered and when eligibility ends.

- **Overview of Your Dental 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.

- **Preferred Dentist Program (PDP) Option.** With this option, you have the freedom to use any dentist, but you benefit from discounted rates and a higher level of benefit coverage when you use a participating dentist.

- **Out-of-Area Option**. This is an option if you live outside the PDP's participating provider network area.

- **Standard Option.** This option works like a traditional dental plan. You may use any dentist you choose.

- **Dental Maintenance Organization (DMO) Option.** With this option, you can receive a high level of coverage but you must use a DMO dentist.

- **No Coverage Option.** If you do not want Verizon-sponsored dental coverage, you can choose this option, but only if you are covered as a dependent under another Verizon-sponsored plan or are a part-time associate.

- **Continuing Coverage If Eligibility Ends.** 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 Plan.

- **Administrative Information**. This section provides information about 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 website called BenefitsConnection where you'll find tools to help you manage your benefits. You can access BenefitsConnection on the "About You" page on the Verizon eWeb or on the Internet at www.verizon.com/benefitsconnection.

The website makes finding information fast and easy as it guides you through your benefits transactions, including annual enrollment. In addition to enrolling on the site, you can:

- Link to other Verizon benefit provider sites.

  Obtain a list of participating providers for the options under the Dental Plan. This list can be obtained free of charge via the BenefitsConnection website or by calling the Verizon Benefits

Center at 1-855-4VzBens (1-855-489-2367). You can also obtain a list of participating dentists, free of charge, by calling Aetna or MetLife. In addition, Aetna and MetLife have websites where you can get information about participating dentists online. For contact and website information, refer to the “Administrative Information” section

- Review details about your health care and insurance plans.
- Select and update your beneficiary designations.
- Verify your Verizon elections that are on file at the Verizon Benefits Center.
- Change your BenefitsConnection password.
- Give yourself a helpful “hint” in case you forget your password.

Verizon Benefits Center representatives are available should you have questions about your benefits. To reach the Verizon Benefits Center via telephone, call 1-855-4VzBens (1-855-489-2367).Using 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.

Participating in the Plan

Eligibility

You are eligible for Plan coverage on the first day of the month in which you attain three months of net credited service if you are employed by a Verizon participating company (see the "Additional Information" section) and are a regular or term full-time or part-time CWA-represented or IBEW-represented Mid-Atlantic associate. A term associate is an associate whose employment is covered by a collective bargaining agreement that provides for participation in the Plan.

"Associate," as used throughout this SPD includes any non-management employee.

"Service" is based on net credited service provisions of the Verizon Pension Plan for Mid-Atlantic and South Associates (to the extent that it covers Mid-Atlantic Associates, including the GTE South Incorporated [Southeast] Plan for Hourly-Paid Employees) (the "Verizon Pension Plan for Mid-Atlantic Associates").

Note: You are not eligible to participate in the Plan if any one of the following applies:

- You are paid by a temporary staffing or placement agency or other vendor or third party.
- You are employed under the terms of a written agreement with the Company as an independent contractor or consultant.
- You are paid through accounts payable instead of the payroll system.
- You are an occasional employee.

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

Eligible Dependents

Dependents must be enrolled through the BenefitsConnection website or the Verizon Benefits Center to have coverage. You can enroll only your eligible dependents who meet the Plan's definition for eligibility, and include your:

- Class I Dependents.

- Sponsored Children: Sponsored Children are eligible for coverage only if currently covered as of the Effective Date of the 2012 Memorandum of Understanding (October 19, 2012) and remain continuously eligible and enrolled; new Sponsored Children cannot be added to coverage after October 19, 2012.

Dependent Class	Who They Are	Relationship
Class I Dependents	• Your legal spouse (a legally separated spouse is not eligible). Spouse – the associate's legal partner in marriage by civil ceremony, religious ceremony or common law (to the extent common law is recognized under state law). As of January 1, 2014, your legal spouse includes a person of the same sex to whom you are married under state law (see the definition of "spouse" in the Glossary for details). Coverage for a spouse will end at the end of the month in which the spouse becomes legally separated or divorced from you. Any spouse by common-law marriage recognized by the state will be treated as a rightful spouse unless you show proof of legal divorce or relevant court documents from the spouse or the spouse waives his or her rights in writing. Under Verizon's definition, legal separation occurs when an associate and his/her spouse generally are living in separate dwellings and a legal proceeding or court order pertaining, but not limited to divorce, support, custody, property division or the like, where the couple has signed an agreement to that extent. The Plan's definition of legal separation is applicable in all states, including those which do not recognize legal separation under state law. A spouse who is considered separated under the terms of one Company benefit plan will be considered separated for all plans. If you are separated or divorced, you will be considered separated or divorced for purposes of all plans sponsored by Verizon. In such case, the dependent spouse would cease to be eligible for coverage under the bargained-for Plan. The spouse no longer eligible would be able to purchase continued dental coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), based upon the separation date as specified in the court order.	• Spouse

Dependent Class	Who They Are	Relationship
Class I Dependents (cont'd)	• Your unmarried children until the end of the calendar year in which they reach age 19, provided they receive more than 50% of their support from you. Children means children by birth, as well as legally adopted children (or children placed for adoption), stepchildren and children 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% of their support from you). Coverage lasts until the end of the calendar year in which 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
	• 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 the BenefitsConnection website or call the Verizon Benefits Center and speak with a representative.	• Domestic Partner • Domestic Partner's Child
	• Your unmarried children (as defined above and including any age requirements) who are alternate recipients under an approved qualified medical child support order (QMCSO).	• Child
Sponsored Children ***Note:*** *You cannot add new Sponsored Children after October 19, 2012. Once dropped from coverage, Sponsored Children cannot be reinstated*	• 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: Grandfathered Class II Dependents and Sponsored Parents are not eligible for coverage under the Plan.

Verifying Dependent Eligibility

At the time you enroll your dependent or at any time, upon request, you may be asked to provide proof of dependent status, such as:

- A marriage certificate.
- A birth certificate.
- Guardianship/adoption papers.
- Information to verify domestic partnership, such as the completion of an Affidavit of Domestic Partnership or evidence of cohabitation.

If you are unable to provide the required documentation, your dependent will not be covered. In addition, you may be required to reimburse Verizon for any costs associated with covering an individual who is not an eligible dependent and your, as well as your dependents', coverage may be terminated.

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 health care plans, including dental. 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, 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, you and your dependents will have Standard option coverage.

State Eligibility Laws and the Employee Retirement Income Security Act of 1974 (ERISA)

States sometimes pass laws that require employee benefit plans to provide benefits and/or coverage to individuals who otherwise are not eligible. For example, a state might require an employer to provide coverage to an ex-spouse, a civil union spouse who does not otherwise meet the definition of domestic partner, or a child who exceeds the Plan age requirements who is not eligible for benefits under the Company dental plan.

The federal law known as ERISA supersedes state law. As a result, the Company generally only covers the individuals outlined in this SPD.

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 affiliates, the following rules apply:

- Children can be covered by one Verizon parent or the other, but not by both.
- You can be covered as an employee or retiree or as a dependent under a Verizon-sponsored dental plan, but not as both. To be covered as a dependent under another plan, you must choose the no coverage option under this Plan.
- Your spouse or same-sex domestic partner can be covered as an employee or retiree or as a dependent under a Verizon-sponsored dental plan, but not as both. To be covered as your dependent under this Plan, your spouse or same-sex domestic partner must be eligible for and must choose no coverage under his or her dental 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 by Newly Hired Associates

The following enrollment rules apply based on your work schedule:

- If you are a full-time associate or a part-time associate who is scheduled to work 25 or more hours a week, your dental coverage begins automatically on the first day of the month in which you attain three months of net credited service.
- If you are a part-time associate, scheduled to work less than 25 hours a week who has been employed continuously by the Company since before January 1, 1981, your dental coverage begins automatically on the first day of the month in which you attain three months of net credited service.If you are a part-time associate who has not been employed continuously by the Company since before January 1, 1981, you must enroll through the BenefitsConnection website or call the Verizon Benefits Center to have dental coverage. You can enroll after you complete three months of net credited service and agree to pay the required cost by payroll deductions; otherwise, you will not have coverage. If you enroll on or before the deadline shown on your Enrollment Worksheet, your coverage takes effect on the first day of the month in which you reach three months of net credited service. For example, if your hire date is June 20, your coverage is effective September 1. If you do not enroll by the deadline, you must wait until the annual enrollment period or, if sooner, when you have a life event (as described in the "Changing Your Elections" section).
- If you are a retired participant covered under retiree dental benefits who is rehired by the Company and you are not a working retiree, you automatically are enrolled for dental coverage on the first day of the month after your date of rehire.
- If you are changing from a management position to a full-time associate position or a part-time position in which you're scheduled to work 25 or more hours a week, your dental coverage begins automatically on the first day of the month following the date your payroll changes for the change in position. If you are changing to a part-time position in which you are scheduled to work less than 25 hours a week, you must enroll to have coverage.

- If you change from a full-time associate to a part-time associate position, your coverage continues and any applicable payroll deductions automatically begin as soon as administratively possible. You also can drop dental coverage, due to your change in status, by calling the Verizon Benefits Center. See the “Changing Your Elections” section for more information.

If you want to choose coverage under an option available to you, you must access the BenefitsConnection website or call the Verizon Benefits Center by the deadline shown in your enrollment information for that coverage to begin the first day of the month in which you attain three months of net credited service. If you are eligible for automatic coverage (as described above) and do not enroll, you will have coverage for yourself only under the applicable automatic coverage option (see "If You Do Not Enroll," below). This coverage will continue until the next annual enrollment period or until you have a qualified life event for which a change in coverage is allowed.

You have a right to elect “no coverage” and your enrollment is independent from your Medical Plan election.

If you want to choose coverage under another option available to you, you must access the BenefitsConnection website or call the Verizon Benefits Center. Available options include:

- For CWA-represented associates: Preferred Dentist Program (PDP) option
- For CWA-represented associates whose home ZIP code is outside the PDP service area: Out-of-Area option.
- For IBEW-represented associates: Standard option.
- For both IBEW- and CWA-represented associates: DMO option.
- For both IBEW- and CWA-represented associates who are covered as dependents under another Verizon-sponsored dental plan or who are part-time associates who do not receive the full Company subsidy for dental coverage: “No Coverage” option.

You also must access the BenefitsConnection website or call the Verizon Benefits Center to enroll any eligible dependent you want included under your coverage. You can choose coverage for yourself plus one dependent or for yourself plus two or more dependents. However, Sponsored Children are enrolled in a separate category. You'll need to provide each dependent's name, date of birth and Social Security number. If you enroll eligible dependents before the deadline shown on your Enrollment Worksheet, their coverage begins on the same date as your coverage. Otherwise, coverage begins the first day of the month after you enroll them.

Enrollment Worksheet

Before your three-month enrollment date or if you change from a management position to an associate position, the Verizon Benefits Center will send you an Enrollment Worksheet with your dental coverage options listed.

To Enroll or Make Changes

Log on to the BenefitsConnection website or call the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367). The BenefitsConnection website is available 24 hours a day, seven days a week,

If You Do Not Enroll

If you automatically are eligible for coverage based on your work schedule (see above), the option in which you are enrolled if you do not choose another option by your enrollment deadline depends on the bargaining agreement that covers you:

- **If you are a CWA-represented associate,** your automatic coverage option is the PDP or Out-of-Area option, depending on your home ZIP code.

- **If you are an IBEW-represented associate,** your automatic coverage option is the Standard option.

Changing Your Elections

Annual Enrollment

Each year during the annual enrollment period, you will have an opportunity to change your elections. Elections made during the annual enrollment period take effect on the following January 1 and remain in effect through December 31 of that year, unless you change the election during the year due to a change in status.

The DMO may have additional rules concerning enrollment. Call Member Services for details.

Qualified Life Events

Between annual enrollment periods, you may be able to change your Dental Plan option and covered dependents if you or a dependent has a qualified life event that affects eligibility for coverage. An election change can be made due to a qualified life event if the election change is on account of and corresponds with a qualified life event that affects eligibility for coverage under an employer's plan. (The change in elections must be consistent with the qualified life event.) Elections made due to qualified life events remain in effect until you make a change during an annual enrollment period or due to another qualified life event.

You Gain a New Dependent

- **If you gain a new, eligible dependent through marriage, acquisition of a same sex domestic partner, birth, adoption or placement for adoption**, that person automatically is covered under your dental coverage 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 the new dependent on the first day of the month following your election, if you make your election more than 90 days after the event.

Note: If you disenroll a same-sex domestic partner, you must wait 60 days before you can enroll a new same-sex domestic partner.

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–for example, a dependent child age 23 starts attending school full-time after a period of ineligibility due to age–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.

Upon request, you will be required to provide proof of dependent eligibility.

You Lose a Dependent Through Death, Legal Separation, Divorce or Termination of a Same-Sex Domestic Partnership

If you lose a dependent through death, legal separation, divorce or termination of a same-sex domestic partnership, coverage for that dependent ends on the last day of the month in which the event occurs. However, you must call 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 or ceases to be a dependent 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 a 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 on the last day of the calendar year (December 31) in which he or she loses full-time student status. If you are enrolled in a DMO, check with your DMO regarding eligibility rules since DMO rules may be different.

When a dependent loses eligibility, you must notify the Company by calling the Verizon Benefits Center before the dependent's coverage ends.

If you do not notify Verizon by calling the Verizon Benefits Center, any claims incurred by your ineligible dependent will become your financial responsibility and furthermore, if you do not disenroll your dependent within 60 days of when he or she becomes ineligible he or she will lose the right to purchase continued health care coverage under COBRA. For more information on COBRA, see the "Continuing Coverage If Eligibility Ends" section.

You Move

If you are enrolled in the DMO option or the PDP option and move to a location outside of the DMO or PDP option's service area, you must notify your department of your address change. After payroll registers your move, you automatically will receive a move package from the Verizon Benefits Center if you move to a location outside of your current option's service area and you will have the opportunity to choose a new option. If you notify Verizon (by calling the Verizon Benefits Center) and make your election within 90 days of the creation of your move package, your election will be effective on the date of your move. If you do not call within 90 days of the creation of your move package, you will be defaulted to a new option as follows:

- **If you are a CWA-represented associate,** your automatic coverage option is the Out-of-Area option, depending on your home ZIP code.

- **If you are an IBEW-represented associate,** your automatic coverage option is the Standard option.

Your Dentist Stops Participation

If your dentist stops participating in the Plan during the Plan year, you cannot change your option. You must wait until the next annual enrollment period or until you experience a life event to change your Dental Plan option.

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 (however, special enrollment is not available if loss of coverage was due to your or your dependents' failure to pay 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 or your dependents' coverage will be effective retroactive to the date of the event
- After 90 days of losing the other coverage, your or your dependents' 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, placement for adoption or acquisition of a same-sex domestic partner and his or her children, you may be able to enroll yourself and your dependents. If you enroll:

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

Note: While domestic partners are not subject to the same special enrollment rights as spouses, Verizon administers domestic partners as if they were "spouses" under the terms of the Dental Plan.

To request special enrollment or obtain more information, call the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

Cost of Coverage

The Company pays the full cost of dental coverage for you and your enrolled Class I Dependents if you have at least three months of net credited service and are as follows:

- A regular or term full-time associate working at least 25 hours a week.

- A part-time associate hired before January 1, 1981 and continuously employed by the Company since that date.

If you have not been employed continuously by the Company since before January 1, 1981 and you work at least 17 but less than 25 hours a week, the Company contributes 50 percent of the full cost of coverage applicable to the dental option that you elect under the Plan. In order to have coverage, you must enroll and agree to pay the other 50 percent of the cost of coverage by payroll deduction.

If you have not been employed continuously by the Company since before January 1, 1981 and you work less than 17 hours a week, you can enroll for coverage if you call the Verizon Benefits Center and agree to pay the full cost.

You pay the full cost of coverage for any Sponsored Children whom you choose to cover.

Note that all associate contributions are paid on an after-tax basis.

Tax Status of Dependents (Imputed Income)

Most dependents are considered Internal Revenue Service (IRS) tax dependents. You are not taxed on imputed income for IRS tax dependents.

If you cover a same-sex domestic partner, a domestic partner's child or another person who is not considered an IRS tax dependent, Verizon is required to report income for you that reflects the value of the coverage for tax-reporting purposes. This is known as imputed income. Your annual IRS Form W-2 will reflect the value of coverage for any dependent who is not an IRS tax dependent.

Verizon assumes all dependents are IRS tax dependents, except same-sex domestic partners and their children. You must contact the Verizon Benefits Center if your same-sex domestic partner and his or her children are your IRS tax dependents or if you cover other dependents who are not IRS tax dependents.

When Participation Ends

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

Associate Coverage An associate's coverage will end on the earliest date described below. You may be able to continue coverage under COBRA. See the “Continuing Coverage If Eligibility Ends” section.	
Leaves of Absence	In general, if you go on a leave of absence, your coverage continues in accordance with Company guidelines and as collectively bargained.
Leaves of Absence Under the Family and Medical Leave Act	The Company complies with the Family and Medical Leave Act of 1993 (FMLA). All leaves of absence qualifying under the FMLA will be administered in accordance with the terms of the FMLA. Coverage may be continued during approved leaves, as provided in Company policy and as collectively bargained. Call the Verizon Benefits Center for details.
Leaves of Absence Under the Uniformed Services Employment and Reemployment Rights Act	All military leaves of absence qualifying under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) will be administered in accordance with the terms of USERRA.
Union Leaves of Absence	Coverage can be continued according to your collective bargaining agreement.
Anticipated Disability Leaves of Absence, Care of Newborn Child (CNC) Leaves of Absence and Dependent Care Leaves of Absence	Verizon will pay the amount it normally does for your coverage. If you contribute to the cost of your dental coverage, however, you must continue making contributions during your leave. The Company will bill you monthly for these charges.
Education Leaves of Absence or Personal Leaves of Absence	Coverage for you and eligible dependents will end on the last day of the month in which your leave begins.
Change in Employment Status	If your employment status changes from associate to management status, coverage under the Plan will end on the last day of the month in which you become a management employee of Verizon or an affiliate of Verizon. You will have an opportunity to make an election into another plan.
Long-Term Disability (LTD)	If you are receiving long-term disability benefits, coverage under the Plan will end on the last day of the month in which you qualify to begin long-term disability.
Cancellation of Coverage	If you cancel coverage due to a change in status, 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 it is not received.
Plan Termination	Although Verizon does not intend to terminate the Plan, were the Plan to be terminated, all coverage would end on the date of termination.

Associate Coverage An associate's coverage will end on the earliest date described below. You may be able to continue coverage under COBRA. See the “Continuing Coverage If Eligibility Ends” section.	
Other Termination of Employment	If your employment is terminated for any reason not specified above, coverage under the Plan will end on the last day of the month in which your employment is terminated..

Dependent Coverage A dependent's coverage will end on the earliest date described below. Your dependent may be able to continue coverage under COBRA. See the “Continuing Coverage If Eligibility Ends” section.	
Associate's Coverage Ends	If the associate's coverage ends for any reason except when the associate dies, coverage for all dependents also will end at the same time.
Associate Dies	When the associate dies, coverage for all dependents will end on the last day of the month in which the associate 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 in which 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 in which 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 otherwise fails to meet the definition of eligible dependent. • 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 calendar year in which he or she no longer qualifies as a full-time student. • Coverage for a disabled child ends on the last day of the month in which he or she no longer meets the definition of a disabled child. • Coverage for a Sponsored Child ends on the earlier of the last day of the calendar year in which he or she 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 no longer is required to provide coverage for this child or, if earlier, the date the child no longer would be eligible for coverage • 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 partner (or the partner no longer meets the definition of a same-sex domestic partner as defined in the “Glossary”).

Extended Benefits

Your dental coverage will continue while you receive benefits from the Verizon Sickness and Accident Disability Benefit Plan for Mid-Atlantic Associates if you pay the required contributions, if any.

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

- A prosthesis, including bridgework, if the impressions were taken and the abutment teeth were prepared fully before coverage otherwise would end
- A crown, if the tooth was prepared before coverage otherwise would end
- Root canal therapy, if the tooth was opened before coverage otherwise would end.

Notify the Verizon Benefits Center If a Dependent Is Ineligible

It is your responsibility to notify the Verizon Benefits Center within 90 days if your dependents no longer meet eligibility requirements. Otherwise, any claims incurred by an ineligible dependent become your financial responsibility. Furthermore, if you do not disenroll your dependents within 60 days of when they become ineligible, they will lose the right to purchase continued health care coverage 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 as of the date determined by the Plan administrator. The Company may require that you reimburse the amount of any claims paid by the Plan on behalf of an ineligible dependent.

Certificate of Creditable Coverage

When any person’s coverage under the Plan ends for any reason, including the end of COBRA continuation coverage, the Verizon Benefits Center 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 the BenefitsConnection website or call the Verizon Benefits Center.

Continuation of Coverage Under COBRA

In some instances, a person whose eligibility for 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. See the “Continuing Coverage If Eligibility Ends” section for more information.

Overview of Your Dental 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 associates: Preferred Dentist Program (PDP) option
- For CWA-represented associates whose home ZIP code is outside the PDP service area: Out-of-Area option
- For IBEW-represented associates: Standard option
- For both IBEW- and CWA-represented associates: Dental Maintenance Organization (DMO) option
- For both IBEW- and CWA-represented associates who are covered as dependents under another Verizon-sponsored Dental Plan or who are part-time associates who do not receive the full Company subsidy for dental coverage: No dental coverage.

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 Predetermination of Benefits 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

The Preferred Dentist Program (PDP) option is available to CWA-represented associates 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 discounted 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.

Whenever you need care, you choose to...

↓		↓
Visit a PDP participating dentist	**Or**	Visit a non-participating licensed dentist
↓		↓
PDP dentist submits claim form		You submit claim form
↓		↓
Receive higher benefits, based on discounted fees		Receive lower benefits, based on non-discounted fees

A list of participating dentists can be obtained, free of charge, by calling MetLife at 1-800-988-8331. MetLife also has a website where you can get information about participating dentists online at www.metlife.com/dental.

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, per calendar year 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 annual deductible.

Benefit Maximums

The annual maximum benefit 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, 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 Participating Dentists	Using 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 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 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 Participating Dentists	Using Nonparticipating Dentists
Preventive and Diagnostic Care (Frequency limits are per person) Routine oral exam: Two 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	Option pays 100% of preferred rate	Option pays 100% of preferred rate
Basic Restorative Care Oral surgery, including: • Incision and draining of abscess • Simple extractions • Surgical removal of soft tissue impactions • Removal of partial or complete bony impactions • 30 minutes of intravenous sedation or general anesthesia, in connection with oral surgery Fillings made from amalgam, composite acrylic resin. Multiple fillings in one 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	Option pays 80% of preferred rate	Option pays 70% of preferred rate

Option Feature	Using Participating Dentists	Using Nonparticipating Dentists
Periodontics, including: • Gingivectomy • Osseous surgery • Periodontal surgery • Scaling and root planing: Limited to one full mouth procedure every 24 months If more than one 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 Feature	Using Participating Dentists	Using 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 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% of preferred rate	Option pays 50% of preferred rate
Orthodontic Care Services for the detection, prevention and correction of malocclusion of teeth in relation to the jaw	Option pays 60% of preferred rate	Option pays 50% 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

The Out-of-Area option is available to 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. 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, 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 maximum benefit 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

The Standard option is available to 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 maximum benefit 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, 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 at 1-800-843-3088 .Also, you can view and print the Standard option schedule of benefits from the BenefitsConnection website.

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 the Verizon Benefits Center. Also, you can view and print the Standard option schedule of benefits from the Benefits Connection website.

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. 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.

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: Two 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 or prematurely lost or extracted teeth regardless of when the teeth were lost or extracted	Option pays 100% of R&C

Option Feature	Benefit
Tooth sealants to permanent non-restored molars; for dependents under age 19 only: Once every 5 calendar years	

[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.

Option Feature	Benefit
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: • Gingivectomy • Osseous surgery • Scaling and root planing Orthodontics, including: • Interceptive orthodontic treatment • Limited orthodontic treatment • Comprehensive orthodontic treatment of adolescent dentition • Comprehensive orthodontic treatment of adult dentition • Post-treatment stabilization Additions to partial dentures to replace extracted teeth Initial installation of dental implants and related services, including any separate charges for restorative crowns Repair or re-cementing of crowns, inlays, bridgework or dentures Diagnosis and non-surgical treatment of temporomandibular joint 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	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

Option Feature	Benefit
Basic Major and Orthodontic Care (cont.) 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 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 Option

The Dental Maintenance Organization (DMO) option is available to both CWA- and 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 the “Administrative Information” section for the telephone number).

If your personal dentist leaves the DMO, you must select another DMO personal dentist. You cannot change your dental option for this reason.

A list of personal dentists can be obtained free of charge by calling Aetna at 1-877-238-6200. Aetna also has a website where you can get information about personal dentists online. You can access Aetna’s website at www.aetna.com or via the BenefitsConnection website.

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%
Basic care (for example, fillings, most oral surgery and root canals)	Option pays 100% (certain services covered at 60%)[1]
Major care (for example, crowns, bridgework and dentures)	Option pays 60%
Orthodontia Note: 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	Option pays 50%
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 any individual you cover meets the benefit maximum for orthodontia, 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 at 1-877-238-6200. Aetna also has a website where you can get information about covered procedures and features. You can access Aetna's website .

No Coverage Option

The “No Coverage” option is available to full-time CWA- and IBEW-represented associates who are covered as dependents under another Verizon-sponsored dental plan.

Part-time CWA- and IBEW-represented associates who do not receive the full Company subsidy for dental coverage can waive coverage for any reason. Part-time associates who receive the full Company subsidy can waive coverage only if they are covered as dependents under another Verizon-sponsored Dental Plan.

When you waive coverage for a calendar year, your election will remain in effect for each subsequent year unless you enroll in a dental coverage option during the annual enrollment period or if you have a change in status that allows you to elect coverage before the annual enrollment period.

Continuing Coverage If Eligibility Ends

Generally, your coverage or a dependent's coverage will end when your eligibility or a dependent's eligibility for the Plan ends. In some circumstances, however, coverage can be continued for a period of time if you agree to pay the cost.

Family and Medical Leave Act of 1993 (FMLA)

Assuming you have met the applicable service requirements, FMLA allows you to:

- Take up to 12 work weeks of leave each calendar year for specified family and medical reasons.
- Be restored to your former position or an equivalent position and pay when you return to work.

Benefits Coverage While on FMLA Leave

Dental coverage remains in effect while you are on FMLA leave. Verizon reserves the right to require you to pay for these benefits and to change its FMLA policy in the future.

A newly acquired dependent is eligible for coverage while your coverage is continued during FMLA leave.

State Family and Medical Leave Laws

Verizon's FMLA policy must comply with any state law that provides greater family or medical leave rights than those provided under its FMLA policy. If your leave qualifies under FMLA and under a state law, you will receive the greater benefit.

If Verizon Changes Benefits

If Verizon offers new benefits or changes its benefits while you are on leave, you are eligible for the new or changed benefits but your contributions – or payroll deductions – for these benefits may increase.

Coverage Continuation Rights Under COBRA

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

- **Employees.** You are eligible for COBRA continuation if you lose your coverage under the Dental Plan because of one of the following qualifying events:

  — Your hours of employment are reduced.

  — Your employment ends for any reason other than your gross misconduct.

- **Spouse of employee.** 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.

  — Your hours of employment are reduced.

  — Your employment ends for any reason other than gross misconduct.

  — You become divorced.

- **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:

  — The parent-employee dies.

  — The parent-employee's hours of employment are reduced.

  — The parent-employee's employment ends for any reason other than his or her gross misconduct.

  — The parents become divorced.

  — 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 an employee.

[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.

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 the "Administrative Information" section for contact information.)

Notification of Qualifying Events

When the qualifying event is the end of employment, reduction in hours of employment or death of the employee, **Verizon will notify** the Verizon Benefits Center (the COBRA administrator) of the qualifying event.

For other qualifying events (divorce of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child), **you or the qualified beneficiary must notify** the Verizon Benefits Center within 60 days after the qualifying event. If you or the qualified beneficiary fails to notify the Verizon Benefits Center within 60 days after the qualifying event, your dependent will not be entitled to elect COBRA continuation coverage.

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 employees 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.

You and your qualified beneficiaries 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. If you fail to elect continued coverage within the 60-day time frame, you will lose the opportunity to continue coverage under COBRA.

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.

COBRA continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of employment or reduction of the employee's hours of employment. This 18-month period of COBRA continuation coverage can be extended in two ways:

- **Disability extension of 18-month period of continuation coverage.** If a qualified beneficiary covered under the Dental Plan is determined by the Social Security Administration to be disabled and you notify the Verizon Benefits Center in a timely fashion, you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months, if all of the following conditions are met:

  — Your COBRA qualifying event was a termination of employment or reduction in hours.

  — The disability started at some time before the 60th day of COBRA continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.

  — A copy of the Notice of Award from the Social Security Administration is provided to the Verizon Benefits Center within 60 days of receipt of the notice and before the end of the initial 18 months of COBRA coverage.

  — An increased premium of 150 percent of the monthly cost of coverage is paid, beginning with the 19th month of coverage.

- **Second qualifying event extension of 18-month period of continuation coverage.** If another qualifying event occurs during the first 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Dental Plan.

  This extension may be available to your spouse and any dependent children receiving continuation coverage if you die or get divorced, or if your dependent child no longer is eligible under the Dental Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

COBRA Qualifying Events

	Maximum Continuation Period (months) for:		
Qualifying Event	**You**	**Spouse**	**Covered Child**
You lose coverage because of reduced work hours or taking unpaid leave, other than leave under the FMLA	18	18	18
You terminate employment for any reason (except gross misconduct)	18	18	18
You or your dependent is disabled – as defined by the Social Security Act – at the time of the qualifying event or during the first 60 days of COBRA continuation coverage	29 (Initial 18 months, plus additional 11 months)	29 (Initial 18 months, plus additional 11 months)	29 (Initial 18 months, plus additional 11 months)
Your covered child no longer qualifies	N/A	N/A	36

	Maximum Continuation Period (months) for:		
Qualifying Event	**You**	**Spouse**	**Covered Child**
as a dependent			
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. If you fail to elect continued coverage within the 60-day time frame, you will lose the opportunity to continue coverage under COBRA.

What COBRA Coverage Costs

COBRA participants must pay monthly premiums for coverage. This premium is independent of and separate from any premium that you (or your qualified beneficiary) pays for Medical Plan COBRA continuation coverage.

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

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).

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 annual enrollment period.
  - If you have a qualified life event.
  - 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 employee.

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 website at www.dol.gov/ebsa.

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

What Is Not Covered

The Plan does not cover the following dental expenses for you or a covered dependent:

- 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 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 temporomandibular joint dysfunction

- 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

- For the 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 Associates 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.

- 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 will file claims for you. 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 (Aetna or MetLife, as applicable based on your option). See the "Administrative Information" section for contact information).

- 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 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 the "Administrative Information" section for contact information).

The subrogation and reimbursement provisions also mean that if you make a liability claim against a third party after you have received benefits from the Plan, you must include the amount of those benefits as part of the damages you claim. If the claim proceeds to a settlement or judgment in your favor, you must reimburse the Plan for the benefits you received. You and your dependents must grant a lien to the Plan and you and your dependents must assign to the Plan any benefits received under any insurance policies or other coverages. As a condition of eligibility for benefits, you and your dependents must agree to cooperate with the claims administrator's subrogation vendor in carrying out the Plan's subrogation and reimbursement rights. Cooperation means you must respond promptly and fully with inquiries from the claims administrator's subrogation vendor and take what action the claims administrator's subrogation vendor requests to help recover the value of benefits provided under the Plan. If you 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 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 Unit
P.O. Box 8998
Norfolk, VA 23501-8998

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

Verizon Benefits Center
Attn: Verizon Claims Review Committee
PO Box 8998
Norfolk, VA 23501-8998

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

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 Plan. The following Dental Plan option 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
DMO Option	Aetna

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.

The following information applies to the Dental Plan options. The steps that you or your authorized representative is required to take to file a Dental Plan 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 Dental Plan.
- ***Concurrent care.*** A claim for ongoing treatment over a period of time or a number of additional treatments that have been approved.
- ***Urgent care***. A claim for dental care or treatment that, if the longer time frames for nonurgent care were applied, the delay (1) could 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. Benefit claims and appeals are divided into the four categories of claims described above.

<table>
<tr><th>General procedures</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 1-855-4VzBens (1-855-489-2367). You (or your authorized representative) must return the form to the Verizon Claims Review Unit at the address on the form.

To file a benefit claim, you (or your authorized representative) should write to your Dental Plan option claims and appeals administrator (referred to as the “claims administrator”). To obtain contact information for your plan, you should refer to the telephone number and/or website shown on the back of your ID card or refer to the “Claims and Appeals Administrators” section for claims administrator contact information.

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 1-855-4VzBens(1-855-489-2367) or your Dental Plan option claims and appeals administrator (the “claims administrator”). 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>

General procedures	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 claims administrator'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. If the Verizon Claims Unit or claims administrator decides to request additional information before deciding the claim, you will be notified 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

General procedures	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
If the claims administrator does not deny the claim based on lack of sufficient information, you will have **(see columns to the right)** from receipt of the notice to provide the additional information. Otherwise, the claim will be decided based on information originally provided.	45 days	45 days	45 days	45 days
If you provide additional information, you will be notified of the decision by the Verizon Claims Review Unit or the claims 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

How you will be notified of the claim decision
If your claim is approved, the Verizon Claims Review Unit or the claims administrator generally will notify you in writing. For benefit claims, if this notification is provided in writing, it is commonly referred to as an explanation of benefits or EOB.

If your claim is **denied (adverse benefit determination)**, in whole or in part, the Claims Review Unit or the claims administrator 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 claims administrator 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, including the Dental Plan options, for benefit claims to the Dental Plan option claims administrators. The Dental Plan options have accepted the responsibility of being the claims fiduciary.

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.

General procedures	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 claims administrator as explained at Step 1), write to the contact identified by your claims 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 claims administrator will consult with a health care professional who has appropriate relevant experience.	180 days	180 days	180 days	180 days You may orally file your appeal with the Verizon Claims Review Unit or the contact identified by your claims administrator. At the time your claim is denied, the Verizon Claims Review Unit or your claims administrator will give you instructions about how to file your appeal. You must identify that you are appealing an urgent care claim.

General procedures	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
Upon request: • You are entitled to learn the identity of such an expert. • You are entitled to copies of any health care professional's report. • You will be provided with any documents used by the Plan to come to the determination of your case.				
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 claims administrator's receipt of your appeal	**Eligibility appeals:** 60 days **Benefit appeals:**[1] • 60 days, if claims administrator provides 1 level of mandatory appeal • 30 days, if claims administrator provides 2 levels of mandatory appeal	**Eligibility appeals:** 30 days **Benefit appeals:**[1] • 30 days, if claims administrator provides 1 level of mandatory appeal • 15 days, if claims administrator 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 claims administrator will notify you in writing

If your appeal is **denied**, in whole or in part, the Claims Review Committee or the claims administrator 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."

General procedures	Post-service claim	Pre-service claim	Concurrent care claim	Urgent care claim
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 Dental Plan option claims and appeals administrator that offers 1 mandatory level of appeal, the claims 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 claims administrator that offers 2 mandatory levels of appeal, you may appeal to the Dental Plan option 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 claims administrator will provide you with an independent medical review, upon request, in conjunction with this second and final appeal.				
The following provision applies if the Dental Plan option 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 claims administrator's receipt of your second and final appeal. If this appeal is denied, the claims 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.

[1]If your claims administrator 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 Dental Plan option provides two mandatory appeals, both appeals must occur within the 72-hour time frame.

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

- 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 Plan administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your spouse or your 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 SPD 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 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 information provided in the notice that follows is required under the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA Privacy Notice

NOTICE OF PRIVACY PRACTICES FOR THE VERIZON COMMUNICATIONS INC. HEALTH PLANS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

I. Background Information and Effective Date

The Department of Health and Human Services published a final regulation addressing the privacy of Protected Health Information (as defined in section III below) in August of 2002 (the "Privacy Rule"). As a result, the Verizon Communications Inc. ("Verizon") health plans listed in section II below will have to comply with the Privacy Rule, effective April 14, 2003 (the "Effective Date"). This Notice, which is required by the Privacy Rule, is effective on the Effective Date.

II. Plans on Behalf of Which this Notice is Being Provided

For purposes of this Notice, the term "Verizon Health Plans" has special meaning. This Notice applies to the following Verizon plans, which collectively are referred to in this Notice as the "Verizon Health Plans:"

- Verizon Plan 550 (EIN: 23-2259884, PIN: 550)
- Verizon Plan 552 (EIN: 23-2259884, PIN: 552)

Note: Verizon Plan 550 and Verizon Plan 552 are hybrid entities under the Privacy Rule. In that case, this Notice shall only apply and be interpreted to apply to that portion of these plans that are subject to the Privacy Rule as a group health plan.

In addition, in the event you are covered by an insured health plan, your insurer will be providing you with a separate notice that describes the insurer's use and disclosure of your Protected Health Information.

III. Health Information to Which this Notice Applies

This Notice 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 health care 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 health care to you;

  — Your past, present, or future physical or mental condition; or

  — The past, present, or future payment for your health care.

This includes any of the following documentation, if the documentation reveals your identity and your health status or payment issues: medical records (such as hospital charts or doctor's notes); medical bills (such as bills for hospital or doctor's services); claims data (such as data on claims payments made by one of the Verizon Health Plans on your behalf); and insurance payment information (such as an Explanation of Benefits).

IV. Uses and Disclosures of Protected Health Information by the Verizon Health Plans

The Verizon Health Plans may use or disclose your Protected Health Information for purposes of making or obtaining payment for your health care, for purposes of conducting health care operations, or for certain other specified purposes. The Verizon Health Plans have established a policy to guard against unnecessary uses and disclosures of your Protected Health Information.

The purposes for which your Protected Health Information may be used and disclosed by the Verizon Health Plans may be summarized as follows:

A. To Make or Obtain Payment for Health Care

The Verizon Health Plans may use or disclose your Protected Health Information to make payment for, or to obtain or facilitate payment of, your health care claims. Payment for health care includes such activities as: making eligibility or coverage determinations; claims management or adjudication; claims appeals determinations; coordination of benefits with another health plan; medical necessity determinations; concurrent or retrospective review of services; utilization review of services; pre-certification or pre-authorization of services; subrogation of claims; billing; determination of cost sharing amounts; risk adjusting based on enrollee health status and demographics; disclosure to consumer reporting agencies; obtaining payment under a contract of reinsurance; and collection activities.

For example, a Verizon Health Plan may provide Protected Health Information regarding your coverage or treatment to other health plans to coordinate the payment of benefits between or among the other plans and the Verizon Health Plan.

B. To Conduct Health Care Operations

The Verizon Health Plans may use or disclose your Protected Health Information to facilitate the administration and operation of the Verizon Health Plans. Health care operations include such activities as: case management and care coordination; conducting or arranging for medical review, auditing, or legal services; population-based activities to improve health or reduce health care costs; contacting providers or patients with information regarding treatment alternatives; clinical guideline and protocol development; reviewing the competence or qualifications of health care professionals and evaluating health plan performance; underwriting and premium rating; fraud and abuse detection; and activities relating to the creation, renewal, or replacement of a health care contract. Pursuant to the provisions of the Genetic Information Nondiscrimination Act of 2008, the Verizon Health Plans do not use or disclose Protected Health Information that is "genetic information" for underwriting purposes as defined under such Act.

For example, a Verizon Health Plan may use Protected Health Information regarding your coverage or treatment for case management to help ensure that appropriate treatment is being provided for your condition.

C. For Treatment Alternatives or Distribution of Health-Related Benefits and Services

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.

D. To Assist Verizon as Plan Sponsor

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.

E. When Legally Required

The Verizon Health Plans may disclose your Protected Health Information when required to do so by any federal, state, or local law.

F. In Connection With Judicial and Administrative Proceedings

The Verizon Health Plans may disclose your Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by the order. The Verizon Health Plans also may disclose your Protected Health Information in the course of any judicial or administrative proceeding in response to a subpoena, discovery request, or other lawful process, but only when the Verizon Health Plan involved receives satisfactory assurance from the party seeking the Protected Health Information that that party made reasonable efforts to either notify you about the request or to obtain an order protecting your Protected Health Information.

G. For Law Enforcement Purposes

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.

H. For Health Oversight Activities

The Verizon Health Plans may disclose your Protected Health Information to a health oversight agency for health oversight activities authorized by law, including: audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of the health care system, certain government benefit programs, certain entities subject to government regulatory programs, or certain entities subject to civil rights laws. The Verizon Health Plans may not disclose your Protected Health Information if you are the subject of an investigation and the investigation does not arise out of and is not directly related to your receipt of health care or public benefits.

I. In the Event of a Serious Threat to Health or Safety

Under certain circumstances, the Verizon Health Plans may, consistent with applicable law and standards of ethical conduct, use or disclose your Protected Health Information if the Verizon Health Plans, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or to the health or safety of the public.

J. For Specified Government Functions

Under certain circumstances, the Verizon Health Plans may use or disclose your Protected Health Information to facilitate specified government functions related to: the military and veterans; national security and intelligence activities; protective services for the President of the United States and others; or correctional institutions and inmates.

K. For Public Health Activities

The Verizon Health Plans may disclose your Protected Health Information for public health activities, such as to assist public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other public health activities as specified in the Privacy Rule.

L. For Disaster Relief Purposes

Under certain circumstances, the Verizon Health Plans may use or disclose your Protected Health Information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

M. In Connection with Decedents

The Verizon Health Plans may disclose your Protected Health Information to funeral directors or coroners to enable them to carry out their lawful duties.

N. For Workers' Compensation Purposes

The Verizon Health Plans may disclose your Protected Health Information to the extent necessary to comply with laws related to Workers' Compensation or similar programs established by law that provide benefits for work-related injuries or illnesses without regard to fault.

O. For Involvement In, and Notification Of, Your Care

The Verizon Health Plans may use or disclose your Protected Health Information to your relatives or other persons you identify who are involved in your care or payment for your care, or to notify family members or others responsible for your care of your condition or location. In these situations, when you are present and not incapacitated, the Verizon Health Plans will either: (1) provide you with an opportunity to disagree to the use or disclosure and, if you do not disagree, your Protected Health Information may be used or disclosed; or (2) obtain your agreement to the use or disclosure.

P. To Assist Victims of Abuse, Neglect, or Domestic Violence

The Verizon Health Plans may, under certain circumstances, disclose Protected Health Information about individuals who are reasonably believed to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive such reports.

Q. For Cadaveric Organ, Eye, or Tissue Donation

The Verizon Health Plans may use or disclose Protected Health Information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye, or tissue donation and transplantation.

R. For Certain Government-Approved Research Activities

The Verizon Health Plans may use or disclose Protected Health Information about you for research as provided under the Privacy Rule.

S. To Other Covered Entities

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

T. With an Authorization

Other than as stated above, 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 will no longer 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 has already made prior to the date the Verizon Health Plan receives notice of the revocation.

V. Your Rights Regarding Your Protected Health Information

You have the following rights regarding the Protected Health Information retained by a Verizon Health Plan:

A. Right to Request Restrictions

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 health care operations.

- Certain uses and disclosures for disaster relief and other notification purposes and for involvement in your care.

If you make a request to a Verizon Health Plan for a restriction as described above, the Verizon Health Plan is not required to agree to such a restriction in certain situations. However, the Verizon Health Plan must comply with your requested restriction if: (1) except as otherwise required by law, you request a restriction on the disclosure to a health plan of your Protected Health Information for payment or health care operations; and (2) the Protected Health Information relates solely to a health care item or service for which a health care provider has been paid out of pocket in full.

If you wish to make a request for a restriction, please make a request in writing to the privacy contact identified in paragraph IX below. Your request should include the following: (1) what uses and/or disclosures you want to limit; and (2) to whom you want the restriction to apply (for example, disclosures to your spouse).

B. Right to Receive Confidential Communications

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. For example, you may ask that a Verizon Health Plan only communicate with you at a certain telephone number. If you wish to receive confidential communications, please make your request in writing to the privacy contact identified in paragraph IX below. Your request must be reasonable and should include the following: (1) an alternative address or other means of contacting you; and (2) a statement that the disclosure of all or part of the Protected Health Information to which the request pertains could endanger you. The Verizon Health Plan(s) will attempt to accommodate these requests for confidential communications.

C. Right to Inspect and Copy

In general, you have the right to inspect and obtain a copy of your Protected Health Information. If a Verizon Health Plan uses or maintains an electronic health record with respect to your Protected Health Information, you have the right to request and obtain a copy of this information in an electronic format. A request to inspect or obtain a copy of your Protected Health Information must be made in writing to the privacy contact identified in paragraph IX below and must include: (1) the desired form or format of access; (2) a description of the Protected Health Information to which the request applies; and (3) appropriate contact information. If you request a copy of your Protected Health Information, you may be charged a reasonable fee for the costs of copying, postage, and other supplies associated with your request. Under very limited circumstances, your request to inspect or obtain a copy of your Protected Health Information may be denied. In most cases, if your request is denied, you may request a review of the denial in accordance with the privacy complaint procedure, a copy of which can be obtained from the privacy officer in care of the Verizon HIPAA Unit at the address in paragraph IX below.

D. Right to Amend

If you believe that Protected Health Information a Verizon Health Plan has about you is inaccurate or incomplete, you may ask that Verizon Health Plan to amend that Protected Health Information. You have the right to request an amendment for as long as the Protected Health Information is kept by the Verizon Health Plan.

A request to amend your Protected Health Information must be made in writing to the privacy contact identified in paragraph IX below. The request to amend must include the name of the Verizon Health Plan(s) to which the request applies, a description of the amendment requested, and a reason to support the request.

Your request for an amendment may be denied if you request an amendment of Protected Health Information that the Verizon Health Plan determines: (1) was not created by the Verizon Health Plan, unless the originator of the Protected Health Information is no longer available to make the amendment; (2) is not part of the Verizon Health Plan's records; (3) is not Protected Health Information that you would be permitted to inspect or copy; or (4) is accurate and complete.

If your request is denied, you may request a review of the denial in accordance with the privacy complaint procedure, a copy of which can be obtained from the privacy officer in care of the Verizon HIPAA Unit at the address in paragraph IX below.

E. Right to an Accounting of Disclosures

You have a right to request a list of the disclosures made by a Verizon Health Plan of your Protected Health Information. The list will not include the following types of disclosures: (1) disclosures to you of your own Protected Health Information; (2) disclosures for purposes of payment and health care operations; (3) disclosures you authorize; (4) disclosures to persons involved in your care or for disaster relief or other notification purposes; (5) disclosures for national security, intelligence, or law enforcement purposes; (6) disclosures that are part of a limited data set, as defined in the Privacy Rule; or (7) disclosures that are incident to a use or disclosure otherwise permitted or required by the Privacy Rule.

A request for an accounting must be made in writing to the privacy contact identified in paragraph IX below. The request must specify the name of the Verizon Health Plan(s) to which the request applies, as well as the time period for which you are requesting the accounting. The time period for which you request an accounting may not start earlier than the April 14, 2003 Effective Date of the Privacy Rule and may not be for a period of time going back more than six years. The first accounting you request within a 12-month period will be free of charge. For additional accountings within that same 12-month period, you may be charged a reasonable fee for the costs of providing the accounting. You will be notified in advance of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

F. Right to Receive a Paper Copy of this Notice

You have the right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously or agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

VI. Other Obligations of the Verizon Health Plans

In addition to the other obligations set forth in this Notice, the Verizon Health Plans are required to:

- Maintain the privacy of your Protected Health Information in a manner consistent with the Privacy Rule.
- Provide you with this Notice of their legal duties and privacy practices with respect to your Protected Health Information.
- Abide by the terms of this Notice.

When and as required, the Verizon Health Plans will notify you in the event of an impermissible or unauthorized acquisition, access, use, or disclosure of your Protected Health Information, that compromises the security or privacy of such Protected Health Information, under the Privacy Rule.

VII. Changes to this Notice

The Verizon Health Plans reserve the right to change this Notice and to make the revised or changed Notice effective for Protected Health Information the Verizon Health Plans already have about you, as well as for any such information received in the future. If the Verizon Health Plans change any of their privacy policies and procedures, the Verizon Health Plans will revise the Notice as appropriate and will provide a copy of the revised Notice to you by mail within 60 days of the change. You may also obtain a paper copy of this Notice from the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

VIII. Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the privacy officer in care of the Verizon HIPAA Unit identified in paragraph IX below or with the Secretary of the United States Department of Health and Human Services. All complaints must be submitted in writing. You will not be retaliated against in any way for filing a complaint.

IX. Contact Information

In some cases, your Protected Health Information may be held internally at Verizon by members of the Verizon workforce who perform functions on behalf of the Verizon Health Plans. In most cases, however, your Protected Health Information will be held by privacy contacts, such as the health insurers or health plan option administrators, who pay claims on behalf of one or more of the Verizon Health Plans.

Contact your health insurer or health plan option administrator:

If you have a question, concern, complaint, or request regarding Protected Health Information held by a **health insurer or health plan option administrator**, contact your health insurer or health plan option administrator directly. Contact information for your health insurer or health plan option administrator can be found in your summary plan description, your insurance cards, on the BenefitsConnection website at www.verizon.com/benefitsconnection or by calling the Verizon Benefits Center toll free at 1-855-4VzBens (1-855-489-2367).

Contact the Privacy Officer for the Verizon Health Plans:

If you have a question, concern, complaint, or request regarding Protected Health Information held internally at Verizon, contact the privacy officer for the Verizon Health Plans as follows:

HIPAA Privacy Officer
c/o Verizon HIPAA Unit
P.O. Box 1483
Lincolnshire, IL 60069-1483
1-908-559-3628

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT THE PRIVACY OFFICER DESIGNATED IN PARAGRAPH IX ABOVE.

The Notice of Privacy Practices for the Verizon Communications Inc. Health Plans is available on the BenefitsConnection website at www.verizon.com/benefitsconnection. Generally, the Notice of Privacy Practices for the Verizon Communications Inc. Health Plans available on BenefitsConnection is the most up to date. Once you have logged on to BenefitsConnection, select the Library link from the home page and then “HIPAA Privacy Policy” under “Benefit Forms” in order to view the Notice. You may view the Notice on the website and/or print a paper copy from the website. You may also request a paper copy of the Notice at any time by calling the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

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 1-855-4VzBens (1-855-489-2367).

Plan Sponsor/Employer/Company

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
P.O. Box 8998
Norfolk, VA 23501-8998

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

You may communicate to the Plan administrator in writing at the address above. 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 Verizon 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.)

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
P.O. Box 8998
Norfolk, VA 23501-8998

You also can call the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367)

Metropolitan Life Insurance Company (MetLife)

Under the PDP and Out-of-Area options, MetLife is the benefits administrator/claims administrator responsible for authorizing benefit payments, considering appeals, resolving questions, obtaining records, filing reports and the distribution of information to Dental Expense Plan participants. MetLife can be reached at the following address:

Metropolitan Life Insurance Company
MetLife Dental
P.O. Box 14093
Lexington, KY 40512-4093
1-800-988-8331
www.metlife.com/dental

Aetna

Under the Standard and DMO options, Aetna is the benefits administrator/claims administrator responsible for exercising the discretion to determine benefit payments, and also is the claims administrator for claims relating to the scope or amount of benefits under these options. Aetna can be reached at the following address:Aetna, Inc.
P.O. Box 14094
Lexington, KY 40512-4094
www.aetna.com

Standard Option Member Services
1-800-843-3088

DMO Option Member Services
1-877-238-6200

Qualified Medical Child Support Orders (QMCSOs)
The Verizon Benefits Center is responsible for the administration of QMCSOs. The Verizon Benefits Center can be reached at the following address:Verizon Benefits Center
P.O. Box 8998
Norfolk, VA 23501-8998

You also can call the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

Subrogation
Trover Solutions Inc. is responsible for insurance recoveries. Trover Solutions Inc. can be reached at:

Trover Solutions Inc.
Attention: Verizon Subrogation Unit
P.O. Box 36380
Louisville, KY 40232
1-800-395-5568

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 under the "Additional Information" section 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 currently are 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, 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 employees of Verizon (including Connected Solutions Inc. technicians) who will receive their own version of the SPD. Dental benefits for Connected Solutions Inc. technicians also are provided under the Verizon Dental Expense Plan for Mid-Atlantic Associates. Medical benefits are provided under the component plans referred to as the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates and the Connected Solutions Managed Care Health Plan. Vision benefits are provided under the component plans referred to as the Verizon Vision Care Plan for Mid-Atlantic Associates and the Connected Solutions Vision Care Plan. Medical and vision benefits are described in separate SPDs.

Plan Year

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

Agent for Service of Legal Process

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

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

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

Legal process also may be served on the trustee.

Official Plan Document

This SPD is a summary of the official Plan documents.

Collective Bargaining Agreements

The terms of your benefits are also 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, 2013. The list may change from time to time.

- Verizon Advanced Data Inc.
- Verizon Delaware Inc.
- Verizon Maryland Inc.
- Verizon New Jersey Inc.
- Verizon Pennsylvania Inc.

- Verizon Services Corp.
- Verizon South Inc. (Virginia).
- Verizon Virginia Inc.
- Verizon Washington D.C. Inc.
- Verizon Corporate Services Corp.

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Glossary

C

COBRA
A federal law (the 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 associate and his or her dependents 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.

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.

Discounted Fees
The negotiated fees that preferred provider organization (PPO) participating providers have agreed to charge for certain services.

F

Full-Time Associate
A full-time associate is an employee who is regularly scheduled to work 25 or more hours per week. Also, a part-time employee who is not a member of IBEW Local 1944 and who has been continuously employed since December 31, 1980 is considered a full-time associate.

I

Imputed Income
Most dependents are considered Internal Revenue Service (IRS) tax dependents. You are not taxed on imputed income for IRS tax dependents.

If you cover an individual who is not an IRS tax dependent, Verizon will report income for you that reflects the value of the coverage for that individual for tax reporting purposes. This is known as

imputed income. You will receive a W-2 annually for the value of coverage for any dependent who is not an IRS tax dependent.

Verizon assumes all dependents are IRS tax dependents, except same-sex domestic partners and their children. You must contact the Verizon Benefits Center if your same-sex domestic partner and his or her children are your IRS tax dependents or if you cover other dependents who are not IRS tax dependents.

IRS Tax Dependent

An IRS tax dependent for Dental Plan purposes changed under the Health Care and Education Reconciliation Act. While Verizon always recommends that you consult with a tax adviser, the definition provided here is a summary of these complex rules for **federal** tax purposes.

General Rule

Your spouse, including your same-sex spouse, is an IRS tax dependent as defined by federal (IRS) rules. In addition, your child who has not attained the age of 27 as of the end of the taxable year is an IRS tax dependent. This rule is more generous than the eligibility rule that applies to covering a child under the Plan. To meet this general rule, the child must be your (the associate's) son, daughter, stepson, stepdaughter or eligible foster child. [1] A son or daughter includes your legally adopted child or a child who is lawfully placed with you for adoption. This exclusion does **not** apply to the child of your domestic partner.

Other Categories

If you are covering an individual who is not an IRS tax dependent under the general rule, he or she may still be an IRS tax dependent if he or she is a U.S. citizen or resident who is a "qualifying child" or a "qualifying relative."

A "qualifying child" generally is a person who meets **all** of these requirements:

- Is younger than the associate covering the child.
- Is unmarried (i.e., has not filed a joint tax return during the calendar year at issue).
- Is under the age of 19 (or 24 in the case of a student) or is permanently and totally disabled.
- Is your child, grandchild, brother, sister, stepbrother or stepsister or niece or nephew.
- Does not provide over one-half of his or her own support for the calendar year.
- Lives with you for more than one-half of the calendar year.

If a person does not meet the definition of "qualifying child," he or she might be an IRS tax dependent by satisfying the "qualifying relative" requirements.

A "qualifying relative" generally is a person who meets **all** of these requirements:

- Is not your qualifying child or any other taxpayer's qualifying child during the calendar year.
- Receives over one-half of his or her support from you for the calendar year.
- Is "related to you" or "lives with you for the entire calendar year as a member of your household."

[1] An "eligible foster child" is an individual who is placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

Examples
Your domestic partner might be your IRS tax dependent if he or she is a U.S. citizen or resident, receives over one-half of his or her support from you and lives with you for the entire calendar year as a member of your household. Even though a domestic partner is not a “relative” in the traditional sense, he or she may meet the definition of “qualifying relative.”

Your domestic partner’s child typically will not be your IRS tax dependent, unless the domestic partner also is your tax dependent.

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
Medical Plan means Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates, which is a component of Verizon Plan 550.

P

Part-Time Associate
A part-time associate is an employee who is regularly scheduled to work fewer than 25 hours per week, other than an employee who has been continuously employed since December 31, 1980 and other than a job-sharing employee who is considered a full-time associate.

Participating Company
Verizon or any corporation or partnership which is an affiliate of Verizon that has elected to participate in the Verizon Dental Expense Plan for Mid-Atlantic Associates.

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 also are applicable to services obtained from a participating dentist under the Out-of-Area option.

R

Reasonable and Customary (R&C) 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

- 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

To qualify as a Class I Dependent, your same-sex domestic partner must meet all of the following criteria:

- Is an adult of the same sex as you

- Is not married to anyone else

- Is not the domestic partner of anyone else

- Is your only domestic partner and intends to remain so indefinitely

- Is not related to you by blood that would prevent marriage under the law

- Lives with you in the same permanent residence

- Is jointly responsible, along with you, for one another's welfare and for basic living expenses

- Is at least 18 years old and competent to contract under the law.

In addition, if you disenroll your partner, you must wait 60 days before enrolling a new partner.

You must agree to notify the Verizon Benefits Center if your partner no longer meets the criteria listed above.

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.

Spouse

Before January 1, 2014, Spouse is defined under the Plan as follows:

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

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

On and after January 1, 2014, Spouse is defined under the Plan as follows:

Your spouse is a person who is a husband or wife, pursuant to a legal union, under the laws of the state in which you live. The term spouse includes a person of the same-sex to whom you are married under “state” law. “State” means any domestic or foreign jurisdiction having the legal authority to sanction marriage.

T

Term Associate

A term associate is an associate whose employment is intended to last longer than 12 months but no longer than 36 months. A term associate’s employment ends upon completion of the specific project for which he or she is hired.

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 after 90 or more days of retirement.
- Whose reemployment lasts 120 or fewer days in a calendar year.