Your Dental Coverage

Contents

Your Dental Benefits

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

- Freedom to use any dentist you choose
- Discounted rates for services when you use participating dental providers
- 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 New York and New England Associates, including the Other Plan Provisions of Verizon Covering New York and New England Associates. The Plan is subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. This document meets ERISA's requirements for an SPD and is based on Plan provisions and bargained-for changes effective January 1, 2009. It updates and replaces all previous SPDs and other descriptions of the benefits provided by the Plan. This SPD is a summary of this Plan.

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

This SPD is divided into the following major sections:

- **Participating in the Plan.** This section explains your eligibility, eligibility for your dependents and when eligibility ends.
- **Overview of Your Options.** This section describes the dental options available to you. Refer to it when deciding which option to choose and when you need information about your coverage and benefits.
  - **Dental Expense Plan Option.** This section provides details of how the Dental Expense Option Works.
  - **United Concordia Dental Preferred Provider Organization (PPO) Option.** This section provides details of how the United Concordia Dental PPO option works. (**Note:** This option is offered only to New England IBEW-represented associates.)
- **Continuing Coverage.** In some cases, you and/or your dependents can continue coverage even after eligibility for the Plan ends.
- **What Is Not Covered.** This section lists services and supplies not covered under the Plan.

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

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

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

Important Note:

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

Verizon Benefits Center

The Verizon Benefits Center offers a Web site called Your Benefits Resources™ where you'll find tools to help you manage your benefits. You can access Your Benefits Resources on the About You page on the Verizon eWeb or on the internet at www.verizon.com/benefits.

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

- Hotlink to other provider sites.

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

- Review details about your healthcare and insurance plans.

- Select and update your beneficiary designations.

- Change Your Benefits Resources password.

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

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

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

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 after you have completed three months of net credited service if you are employed by a Verizon participating company (see the "Additional Information" section) and are a regular full-time, part-time or eligible temporary New York or New England associate whose employment is covered by a collective bargaining agreement that provides for participation in the Plan.

A temporary employee's eligibility is governed by the applicable collective bargaining agreements.

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

"Service" means net credited service as defined by the Verizon Pension Plan for New York and New England Associates.

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.

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

Eligible Dependents

Dependents must be enrolled through Your Benefits Resources Web site or the Verizon Benefits Center to have coverage. You can enroll only your eligible Class I Dependents who meet the Plan definition for eligibility.

Dependent Eligibility Requirements

Dependent Class	Who They Are	Relationship
Class I Dependents	• Your legal spouse (whether or not legally separated)	• Spouse
	• 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 who live in your home and children who live in your home and for whom you or your spouse is the legal guardian	• Child
	• Your unmarried children (as defined above) from age 19 through the end of the calendar year in which they reach age 25 and are full-time students at an accredited educational institution, provided they receive more than 50% of their support from you. Coverage lasts until the end of the month they no longer qualify as full-time students or, if earlier, the end of the calendar year in which they reach age 25	• Full-Time Student
	• Your unmarried children (as defined above) of any age who are incapable of self-support and dependent on you for support due to physical or mental disability (if the disability began before age 19 or before age 25 while a full-time student and they 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 Your Benefits Resources Web site 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

Note: Class II Dependents and Sponsored Children are not eligible for coverage under the Plan.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a judgment from a state court or an order issued through an administrative process under state law that requires you to provide coverage for a dependent child under Verizon's healthcare plans, 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.

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 must be covered as an employee under this Plan and cannot be covered as a dependent of your spouses' or same-sex domestic partner's Verizon plan. However, if you are a part-time employee or have not completed the waiting period for eligibility, you may be covered as a dependent of your spouse or same-sex domestic partner under his or her Verizon Plan, provided you waive coverage under this Plan.

- Your spouse or same-sex domestic partner is not permitted to be covered as a dependent under this Plan. However, if he or she is a part-time employee or has not completed the waiting period for eligibility, he or she may be covered as a dependent under this Plan, provided he or she waives coverage under his or her own Verizon 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, you automatically are enrolled for dental coverage when you become eligible. Your coverage begins 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 is scheduled to work less than 25 hours a week who has been employed continuously by the Company since December 31, 1980, you automatically were enrolled for dental coverage when you became eligible. Your coverage began on the first day of the month in which you attained three months of net credited service.

- If you are a part-time associate scheduled to work less than 25 hours a week and have not been employed continuously by the Company since December 31, 1980 and you want dental coverage, you must enroll for it by accessing Your Benefits Resources Web site or through the Verizon Benefits Center after you complete three months of net credited service and agree to pay the required cost by payroll deduction; otherwise, you will not have coverage. If you enroll before the deadline shown on your Enrollment Worksheet, your coverage takes effect on the first day of the month in which you attain three months of net credited service. For example, if your hire date is June 20, your coverage is effective September 1. Otherwise, your coverage begins the first day of the month after you enroll.

- If you are changing from a management position to a full-time associate position, your coverage begins automatically 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 associate position for which you're scheduled to work less than 25 hours a week, you must enroll for coverage (as described in the "Changing Your Elections" section).

- 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 are a retired participant covered under retiree dental benefits who is rehired by the Company, you automatically are enrolled for dental coverage on the first day of the month after your date of rehire.

Regardless of your employment status, you must call the Verizon Benefits Center to enroll any Class I Dependent you want included under your coverage. You can choose coverage for yourself plus one dependent or for yourself plus two or more dependents. You will 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 call the Verizon Benefits Center and enroll them.

How Do I Enroll or Make Changes?

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

Enrollment Materials

As a newly hired associate or if you change from a management position to an associate position, the Verizon Benefits Center will send enrollment materials with your dental coverage options listed.

Changing Your Elections

Regular Elections

Starting in November 2009, you'll have the flexibility to make changes in your healthcare benefits once every 12 months, if you don't have a qualified change in status.

If you make a change to your medical and/or dental benefits in November 2009, your benefits will take effect January 1, 2010.

You can change your medical and dental elections at the same time, or change only one of your elections. Once you make a change, whether to one or both benefit types, you will not be able to change to different medical and dental options for 12 months following the date of your change, unless you have a qualified change in status.

Example

On May 15, 2010 you change your medical election. Your new medical plan election will take effect July 1, 2010 and remain in effect for the next 12 months.

If you change only your medical election, your current dental election will also be effective through June 30, 2011.

You will not be eligible to make another change to your medical and/or dental benefits (outside of a qualified change in status) for another 12 months.

Qualified Change in Status

If you have a qualified change in status, you can make changes to your healthcare benefits within 90 days of the qualified event. Your new benefits take effect as of the date of the qualified event and will remain in effect as follows:

- If you change your medical and/or dental plan option, you will need to participate in those plan options for 12 months from the date of your qualified change in status, unless you have another qualified change in status.

  ### *Example*

  On April 15, 2009, you move and change your medical option from a local HMO to the HCP. Your new election will be effective the date of your move, April 15, 2009. Your election will remain in effect for the next 12 months. You will not be eligible to make another change to your medical and/or dental benefits (outside of a qualified change in status) for another 12 months.

- If you only make a change to your coverage category, for example from "You + Spouse" to "You + Family," and keep the same medical and dental plan options, you will not need to wait 12 months from the date of the qualified change in status before you can elect a new medical or dental plan option. You can elect a new plan option as early as November 2009 and your new plan option will be effective on or after January 1, 2010 of the next year.

Example

On April 15, 2009, you have a new baby and you change your medical coverage from "You + Spouse" to "You + Family." Your new election will be effective the date of birth, April 15, 2009. Your next enrollment opportunity will be November 2009 for elections effective January 1, 2010.

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 is covered under your dental coverage option on the date you gain the new dependent as long as you call the Verizon Benefits Center within 90 days of the event. Otherwise, coverage begins the first day of the month after you call the Verizon Benefits Center to enroll them.

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 day of the month following your election.

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

If you lose a dependent through death, divorce or termination of a same-sex domestic partnership, coverage for that dependent ends at the end of the month in which the event occurs. However, you must notify the Company by calling the Verizon Benefits Center to remove that dependent from your coverage. If you fail to remove your ineligible dependent, any premiums paid by you after the event will not be reimbursed and you will be responsible for any claims paid by the Plan. Further, your former dependent may lose his or her COBRA rights. For more information on COBRA, see the "Continuing Coverage" section.

If you and your spouse become legally separated, coverage for your spouse continues, unless you call the Verizon Benefits Center to remove him or her from your coverage.

A Dependent Loses Eligibility

If a dependent loses eligibility for 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 at the end of the month in which he or she loses full-time student status. If you are enrolled in a Dental Managed Care Organization (DMCO), check with your DMCO regarding eligibility rules since DMCO 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, 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 they become ineligible, they will lose their rights to purchase continued healthcare coverage under COBRA. For more information on COBRA, see the "Continuing Coverage" section.

You Move or Your Dentist Stops Participation

If you move, you must notify your supervisor of your address change. You will remain in your current option unless the move is to a location outside of your current option's service area, in which case you will receive information from the Verizon Benefits Center describing the remaining options available to you.

If you are a part-time associate you cannot elect the "no coverage" option at the time of your move. To make this change you must wait for your individualized enrollment opportunity or until you experience a qualified change in status.

If your dentist stops participating in the Plan during the Plan year, you cannot change your Plan option. You must wait until your next individualized enrollment opportunity or until you experience a qualified change in status.

Special Enrollment Rules

If you are a part-time associate who waived dental coverage for yourself and/or you are a part-time or full-time associate who did not cover your spouse or same-sex domestic partner and eligible dependents 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 if you are a part-time associate; if you are a full-time or part-time associate, you may be able to enroll your dependents. If you enroll:

- Within 90 days of the event, your coverage will be effective retroactive to the date of the event

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

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 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 December 31, 1980 and you work at least 17 but less than 25 hours a week, the Company contributes 50 percent of the amount it contributes for full-time employees. In order to have coverage, you must enroll and agree to pay the other 50 percent of the cost by payroll deduction.

If you have not been employed continuously by the Company since December 31, 1980 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.

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

Most dependents are considered Internal Revenue Service (IRS) tax dependents. You do not pay 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. 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.

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. For information on continuing coverage and COBRA, see the "Continuing Coverage" 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.
Anticipated Disability Leaves of Absence, Care of Newborn Children (CNC) Leaves of Absence, Enhanced Educational Leaves of Absence, Family Care Leaves of Absence and Union Leaves of Absence (Maximum Benefit Period Leave of Absence for New England associates only)	Under an Anticipated Disability, CNC, Enhanced Educational or Family Care Leave 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. Under a Union Leave of Absence, coverage can be continued according to your collective bargaining agreement.
Education Leaves of Absence or Personal Leaves of Absence	Under an Education or Personal Leave 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 manager 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 your employment ends due to long-term disability.
Cancellation of Coverage	If you are a part-time associate enrolled for dental coverage and 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 a part-time associate enrolled for dental coverage and you are required to make a payment, and it is not received on time, coverage will end on the first day of the month for which payment is not received.
End of Employment	Coverage under the Plan will end on the last day of the month in which your employment ends for any reason not specified in this section. **Note:** If you retire from the Company and meet eligibility requirements, you may qualify to elect retiree coverage under the Plan.
Plan Termination	Although the Company does not intend to terminate the Plan, were the Plan to be terminated, all coverage would end on the date of termination.

Dependent Coverage A dependent's coverage will end on the earliest date described below. Your dependent may be able to continue coverage under COBRA. For information on continuing coverage and COBRA, see the "Continuing Coverage" 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 Class I 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 divorced from you. Coverage for a legally separated spouse will end on the last day of the month following the date you elect coverage to end. • Coverage for a same-sex domestic partner ends on the day he or she fails to meet the definition of a same-sex domestic partner. • Coverage for a child ends on the last day of the calendar year in which he or she reaches age 19 (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 an 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 month in which he or she no longer qualifies as a full-time student because he or she reduces his or her course load to a level below full time as defined by the educational institution, graduates or otherwise leaves school for reasons other than illness, injury or school vacations. • Coverage for a disabled child ends on the last day of the month in which he or she no longer meets the definition of a disabled child. • Coverage for a 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 (Plan 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

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 healthcare 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 retroactively 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.

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" section for more information.

Certificate of Creditable Coverage

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

Overview of Your Options

Plan Options

As a participant in the Dental Plan, you have one or both of these options available:

- **Dental Expense Plan Option.** This option is offered to all Dental Plan participants. It provides comprehensive coverage to meet your dental care needs. The coverage includes a voluntary preferred provider organization (PPO) – a network of participating dental providers who have agreed to charge a negotiated fee for certain services.

- **United Concordia Dental Preferred Provider Organization (PPO) Option.** If you are a New England IBEW-represented associate, you may elect this Dental PPO option (if available in your home zip code) as an alternative to the Dental Expense Plan. This option offers associates in New England (Maine, Vermont, Rhode Island, Connecticut, New Hampshire, Massachusetts, New York) greater access to dentists who participate in the Plan's PPO network.

Comparing Your Dental Plan Options

Highlights	Dental Expense Plan Coverage	Dental PPO Plan coverage (if available in your home ZIP code)
Annual deductible	None	None
Lifetime deductible	$50 individual; $150 family (does not apply to preventive and diagnostic care services)	None
Preventive and diagnostic care services[1] (for example, cleanings, exams and X rays)	Plan pays 100% of negotiated, discounted fees (in network) or R&C charges (out-of-network)	Plan pays 100% of negotiated, discounted fees (in network) or R&C charges (out-of-network)
Basic restorative services[1] (for example, fillings, most oral surgery, anterior and bicuspid root canals)	Covered according to a schedule of benefits	Plan pays 90% of negotiated, discounted fees (in network) or R&C charges (out-of-network)
Major services[1] (for example, crowns, bridgework and dentures)	Covered according to a schedule of benefits	Plan pays 80% of negotiated, discounted fees (in network) or R&C charges (out-of-network)
Annual benefit maximum (excluding orthodontia)	$1,500 per person	$1,000 per person
Orthodontia	Covered according to a schedule of benefits, up to the per person lifetime maximum of $2,000	Covered up to the per person lifetime maximum of $2,000

[1] Subject to Plan limits.

If You Are Enrolled in an HMO

If you are enrolled in a Health Maintenance Organization (HMO) that offers dental care services, you must receive services through your HMO first. If there are unpaid charges that are covered charges under the Plan, you or your dentist then may submit claims to this Plan, and they will be paid according to Plan provisions.

The Dental Expense Plan Option

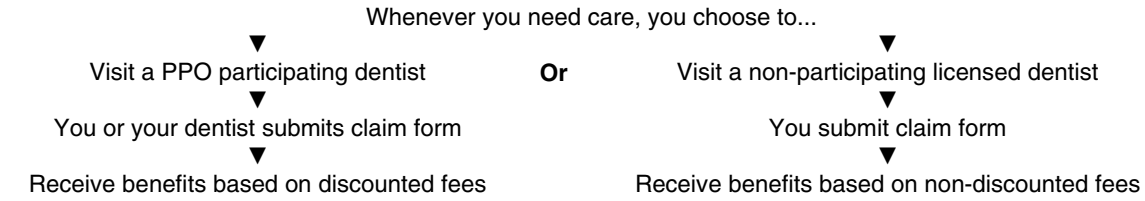
The Dental Expense Plan option provides comprehensive coverage to meet your dental care needs. The coverage includes a voluntary Preferred Provider Organization (PPO) – a network of participating dental providers who have agreed to charge a negotiated fee for certain services.

How Coverage Works

When you need care, you can visit any dentist. The same expenses are covered whether or not you use a participating provider. However, because PPO network charges are based on the discounted rate, which generally is lower than the reasonable and customary (R&C) charge, your out-of-pocket costs typically are less. To receive PPO benefits, you must receive care from a participating network provider.

If you receive covered services outside the network, benefits will be based on non-negotiated fees, which means your share, after the option pays a benefit, could be higher.

The chart below describes how the PPO works.



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

Lifetime Deductible

You must pay a lifetime $50 deductible per person, $150 family deductible, before the option pays benefits for corrective care.

Benefit Maximums

Whether you use PPO dentists or nonparticipating dentists, 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

You will receive coverage for the same expenses regardless of the dentist you use. However, your share of expenses generally will be less when you use PPO dentists because you will be charged discounted fees. These fees are negotiated by the PPO administrator and usually are less than fees charged by nonparticipating dentists.

Preventive and Diagnostic Care

In general, the Dental Expense Plan option pays 100 percent of covered preventive and diagnostic care services, no deductible, based on the discounted fees or R&C charges, depending on whether you receive care from a PPO dentist or a nonparticipating dentist. If you receive care from a nonparticipating dentist who charges more than the R&C amount, you are responsible for the portion above the R&C amount.

Corrective Care

For corrective care services, whether you use a PPO dentist or a nonparticipating dentist, you must pay a lifetime $50 deductible, $150 family maximum, before the Dental Expense Plan option pays benefits for corrective care. If you receive care from a PPO dentist, after you meet the deductible, the option pays the lesser of the negotiated discounted fees or benefits based on the scheduled benefit amount, but not more than the actual charge.

If you receive care from a nonparticipating dentist, after you meet the deductible, the Dental Expense Plan option pays benefits up to the scheduled benefit amount, but not more than the actual charge. If your dentist charges more than the scheduled benefit amount, you are responsible for the portion above the scheduled benefit amount.

Sample procedures from the benefit schedule follow for frequently performed corrective care. Call MetLife Member Services (see your Important Benefits Contacts insert for the telephone number) if you have a question regarding a particular procedure or if you would like to request a copy of the complete benefit schedule.

Corrective Care	American Dental Association Code	Scheduled Benefit
Amalgam permanent – 1 surface filling	2140	$28
Amalgam permanent – 2 surface filling	2150	$42
Amalgam permanent – 3 surface filling	2160	$65
Composite resin – 1 surface – anterior filling	2330	$36
Composite resin – 2 surface – anterior filling	2331	$59
Composite resin – 3 surface – anterior filling	2332	$79
Composite resin – 4+ surface – anterior filling	2335	$89
Composite resin – 1 surface – posterior filling	2391	$36
Composite resin – 2 surface – posterior filling	2392	$59
Composite resin – 3 surface – posterior filling	2393	$79
Porcelain fused to gold crown	2750	$439
Porcelain fused to semiprecious crown	2752	$362
Re-cement crown	2920	$27
Crown buildup	2950	$82
Prefabricated post and core	2954	$87
Root canal – bicuspid therapy	3320	$320

Corrective Care	American Dental Association Code	Scheduled Benefit
Root canal – molar therapy	3330	$401
Periodontal scaling per quadrant	4341	$61
Periodontal prophylaxis	4910	$50
Extraction, erupted tooth or exposed root	7140	$37
Extraction of erupted tooth	7210	$61
Removal of impacted tooth bony	7240	$177
Palliative treatment of pain	9110	$27

Dental Implants

The option covers services for dental implants, including amounts incurred for services related to a finishing crown.

This benefit is limited to $1,000 per implant, subject to the $1,500 annual maximum and consistent with plan coverage for other major restorative services.

Alternative Procedures

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 is 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 decisions related to your treatment.

Predetermination of Benefits

If dental treatment is expected to cost more than $200, you should request that your dentist submit an outline of 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 Dental Expense Plan option will pay when the claim is received.

You or your dentist can request a Course of Treatment form from the claims administrator at the telephone number provided on your Important Benefits Contacts insert.

Accidental Injury Dental Treatment

If you receive accidental injury dental treatment that is not performed by a dentist, you first must file a claim for benefits under your medical plan; you then can file a claim for benefits under this Plan.

Overview of Benefits

Option Feature	Using Participating Dentists	Using Nonparticipating Dentists
Lifetime deductible: Applies to corrective care only	$50 per person, $150 family limit	$50 per person, $150 family limit
Annual benefit maximum, excluding orthodontia	$1,500 per person[1]	$1,500 per person[1]
Orthodontic lifetime benefit maximum	$2,000 per person[2]	$2,000 per person[2]
Preventive and Diagnostic Services: (Frequency limits are per person) Routine oral exam: 2 per calendar year Cleaning and scaling of teeth: Twice per calendar year Full mouth or panorex X rays: Once every 3 calendar years Supplementary bitewing X rays: Twice each calendar year X rays required to diagnose a specific condition: As necessary, except X rays for orthodontia or temporomandibular joint dysfunction Fluoride treatment: 1 per calendar year Sealant applied to permanent molars only for dependents under age 14: As necessary; charges for replacement of the sealant within 36 months of treatment are not covered Fabrication, insertion and adjustment of a fixed or removable space maintainer: As needed for replacement of congenitally missing teeth and prematurely lost or extracted teeth, regardless of when the teeth were lost or extracted —for covered individuals who are under age 19 only	100% of discounted fees	100% of R&C charges

[1]The annual maximum is a combined maximum totaling $1,500 for participating and nonparticipating dentists.
[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.

Option Feature	Using Participating Dentists	Using Nonparticipating Dentists
Corrective Care Restorations necessary to restore or replace the structure of a tooth, such as fillings, inlays, onlays and crowns Oral surgery in and around the mouth, excluding charges covered by any Company-sponsored Medical Plan[3] Endodontic procedures to prevent or treat diseases of the dental pulp, such as root canal therapy Periodontic procedures to treat the supporting area around the teeth Prosthodontic procedures to replace 1 or more teeth, except wisdom teeth, extracted while the patient is covered under the Plan, including: • Initial installation of fixed bridgework or full or partial dentures. A fixed bridgework is covered when front anterior teeth are missing, abutment teeth do not have a poor periodontal status, double cantilevers do not exist or the mouth does not have 2 missing posterior teeth on 1 side and 1 or more missing posterior teeth on the other side • Adjustments to full or partial dentures • Replacement of existing denture or bridgework if it was installed at least 5 years prior to its replacement or additional extractions required the replacement • Addition of teeth to an existing denture or bridgework • Installation of a permanent 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 • Repair or re-cementing of crowns, inlays, bridgework or dentures • Relining of dentures 6 or more months after insertion • General anesthesia in connection with covered oral surgery Orthodontic procedures, except for cosmetic purposes Non-surgical treatment of temporomandibular joint dysfunction to relieve pain in the joint connecting the lower jaw and the skull	Benefit based on the scheduled amount after you pay the $50 lifetime deductible per person, $150 family limit. Since participating dentists charge negotiated fees, your remaining share of expenses is likely to be lower	Benefit based on the scheduled amount after you pay the $50 lifetime deductible per person, $150 family limit. Since nonparticipating dentists do not charge negotiated fees, your remaining share of expenses is likely to be higher

[3]You should submit a predetermination of benefits for any oral surgery since certain procedures may be covered by the Medical Plan.

Dental Preferred Provider Organization (PPO) Plan Option (for New England IBEW-represented associates only)

As an alternative to the Dental Expense Plan option, you may elect the United Concordia Dental PPO Plan option, if available in your home ZIP code. This option offers associates in New England (Maine, Vermont, Rhode Island, Connecticut, New Hampshire, Massachusetts, New York) greater access to dentists who participate in the Plan's PPO network. Using PPO dentists could lower your out-of-pocket expenses for covered dental care.

The Dental PPO Plan option works much like the Dental Expense Plan option. Preventive care is covered at 100 percent. However, benefits for covered corrective care, including fillings, crowns and oral surgery, are based on a percentage of negotiated, discounted fees (in network) or R&C charges (out-of-network). Unlike the Dental Expense Plan option, there are no annual or lifetime deductibles.

How Coverage Works

When you need care, you can visit any dentist. The same expenses are covered whether or not you use a participating provider. However, because PPO network charges are based on the negotiated rate, which is generally lower than the reasonable and customary (R&C) charge, your out-of-pocket costs are typically less. To receive PPO benefits, you must receive care from a participating network provider.

If you receive covered services outside the network, benefits will be based on non-negotiated fees, which means your share, after the option pays a benefit, could be higher.

The chart below illustrates your choices under the option.

Whenever you need care, you choose to...

▼		▼
Visit a PPO participating dentist	**Or**	Visit a nonparticipating licensed dentist
▼		▼
You or your dentist submits claim form		You submit claim form
▼		▼
Receive benefits based on discounted fees		Receive benefits based on non-discounted fees

A list of participating dentists can be obtained, free of charge, by calling United Concordia via the telephone number shown on your Important Benefits Contacts insert. United Concordia also has an Web site where you can get information about participating dentists online. You can access United Concordia's Web site via Your Benefits Resources Web site or via the address shown on your Important Benefits Contacts insert.

Benefit Maximums

Whether you use PPO dentists or nonparticipating dentists, the annual benefit maximum the option will pay is $1,000 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. The lifetime orthodontic benefit maximum includes amounts applied to the orthodontic benefit maximum when you were an active employee.

How Benefits Are Determined

You will receive coverage for the same expenses regardless of the dentist you use. However, your share of expenses will generally be less when you use PPO dentists because you will be charged negotiated fees. These fees are negotiated by the PPO administrator and are usually less than fees charged by nonparticipating dentists.

Preventive and Diagnostic Care

In general, the PPO Plan option pays 100 percent of covered preventive and diagnostic care services based on the negotiated fees or R&C charges, depending on whether you receive care from a PPO dentist or a nonparticipating dentist. If you receive care from a nonparticipating dentist who charges more than the R&C amount, you are responsible for the portion above the R&C amount.

Corrective Services

In general, the PPO Plan option pays 90 percent of covered basic corrective services, and 80 percent of covered major corrective services, based on the negotiated fees or R&C charges, depending on whether you receive care from a PPO dentist or a nonparticipating dentist. If you receive care from a nonparticipating dentist who charges more than the R&C amount, you are responsible for the portion above the R&C amount.

Dental Implants

The PPO option covers services for dental implants, including amounts incurred for services related to a finishing crown.

This benefit is limited to $1,000 per implant, subject to the $1,500 annual maximum and consistent with Plan coverage for other major restorative services.

Alternative Procedures

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 is 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 decisions related to your treatment.

Predetermination of Benefits

If dental treatment is expected to cost more than $200, you should request that your dentist submit an outline of 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 will then notify you and your dentist of the benefits payable.

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

You or your dentist can request a Course of Treatment Form from the claims administrator via the telephone number shown on your Important Benefits Contacts insert.

Accidental Injury Dental Treatment

If you receive accidental injury dental treatment that is not performed by a dentist, you must first file a claim for benefits under your medical plan; you can then file a claim for benefits under this Plan.

Overview of Benefits

Option Feature	Using Participating Dentists	Using Nonparticipating Dentists
Annual deductible	None	None
Annual benefit maximum, excluding orthodontia	$1,000 per person[1]	$1,000 per person[1]
Lifetime orthodontic benefit maximum	$2,000 per person[2]	$2,000 per person[2]
Preventive and Diagnostic Services: (Frequency limits are per person) Routine oral exam: 2 per calendar year Cleaning and scaling of teeth: 2 per calendar year Full mouth or panorex X rays: 1 every 3 calendar years Supplementary bitewing X rays: 2 each calendar year X rays required to diagnose a specific condition: As necessary, except X rays for orthodontia or temporomandibular joint dysfunction Fluoride treatment: 1 per calendar year Sealant applied to permanent molars only for dependents under age 14: As necessary; charges for replacement of the sealant within 36 months of treatment are not covered Fabrication, insertion and adjustment of a fixed or removable space maintainer: As needed for replacement of congenitally missing teeth and prematurely lost or extracted teeth, regardless of when the teeth were lost or extracted—for covered individuals who are under age 19 only	100% of negotiated fee	100% of R&C charges

[1]The annual maximum is a combined maximum totaling $1,000 for participating and nonparticipating dentists.
[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).

Option Feature	Using Participating Dentists	Using Nonparticipating Dentists
Corrective Care – Basic Services Restorations necessary to restore or replace the structure of a tooth, such as fillings Endodontic procedures to prevent or treat diseases of the dental pulp, such as root canal therapy Periodontic procedures to treat the supporting area around the teeth	90% of negotiated fee	90% of R&C charges
Corrective Care – Major Services Restorations necessary to restore or replace the structure of a tooth, such as inlays, onlays and crowns Oral surgery in and around the mouth, excluding charges covered by any Company-sponsored Medical Plan[3] Prosthodontic procedures to replace 1 or more teeth, except wisdom teeth, extracted while the patient is covered under the Plan, including: • Initial installation of fixed bridgework or full or partial dentures. A fixed bridgework is covered when front anterior teeth are missing, abutment teeth do not have a poor periodontal status, double cantilevers do not exist or the mouth does not have 2 missing posterior teeth on 1 side and 1 or more missing posterior teeth on the other side • Adjustments to full or partial dentures • Replacement of existing denture or bridgework if it was installed at least 5 years prior to its replacement or additional extractions required the replacement • Addition of teeth to an existing denture or bridgework • Installation of a permanent 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 • Repair or re-cementing of crowns, inlays, bridgework or dentures • Relining of dentures 6 or more months after insertion • General anesthesia in connection with covered oral surgery Orthodontic procedures, except for cosmetic purposes Non-surgical treatment of temporomandibular joint dysfunction to relieve pain in the joint connecting the lower jaw and the skull	80% of negotiated fee	80% of R&C charges

[3]You should submit a predetermination of benefits for any oral surgery since certain procedures may be covered by the Medical Plan.

Continuing Coverage

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 the Consolidated Omnibus Budget Reconciliation Act of 1985

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

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

What Is COBRA Continuation Coverage?

COBRA coverage is a temporary continuation of 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 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 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 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 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 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.

When COBRA Coverage Is Available

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

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.

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.

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:

- The death of the employee.

- Your divorce.

- A dependent child losing eligibility as a dependent child.

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

COBRA 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 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% 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 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 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)

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

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

If you are eligible for Trade Adjustment Assistance (TAA) or Alternative Trade Adjustment Assistance (ATAA) and did not elect COBRA continuation coverage during the COBRA election period that applied to your loss of dental coverage due to your separation from employment, then you may have an additional COBRA election period. You may elect COBRA continuation coverage during the 60-day period that starts on the first day of the month that you become a TAA- or ATAA-eligible individual. Your election for COBRA continuation coverage must not be made later than six months after the date of the TAA/ATAA-related loss of coverage (the date that you lost dental coverage due to your separation from employment that gives rise to you being a TAA- or ATAA-eligible individual).

What COBRA Coverage Costs

COBRA participants must pay monthly premiums for coverage.

Premiums are based on the full cost per covered person set at the beginning of the year, plus 2% 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).

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

If you or your dependent elects COBRA continuation coverage:

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

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

- You or your dependent may change your coverage:

  — During an individualized enrollment opportunity.

  — If you have a qualified change in status.

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

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

When COBRA Coverage Ends

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

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

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

- Verizon stops providing any dental benefits to any 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 Web site at www.dol.gov/ebsa.

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

What Is Not Covered

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

- Services or supplies provided prior to the date coverage becomes effective
- Cosmetic dental treatment
- Services or supplies that are provided after the covered person's coverage under the Plan has ended, except as described under "Continuing Coverage," "Extended Benefits"
- Replacement of teeth removed prior to the date coverage becomes effective
- Amounts above the reasonable and customary (R&C) charge, the scheduled benefit or a Plan maximum
- Extra sets of dentures or other appliances
- Dental work done free of charge
- Services or supplies for which no charges would have been made if dental coverage had not existed
- Dental work covered by any armed forces or government benefits
- 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 medically necessary
- Charges for missed appointments
- Charges for completion or filing of claim forms
- Educational training programs, dietary instructions or plaque control programs

- Treatment resulting from war, insurrection, participation in a riot or service in the armed forces of any government after the date coverage becomes effective
- Periodontal splinting
- Appliances, restorations and procedures to alter vertical dimension
- Services covered under another Plan maintained by Verizon or an affiliate
- Anesthesia, except general anesthesia that is medically necessary and provided in connection with oral surgery
- Drugs or the administration of drugs
- Procedures determined by the claims administrator to be experimental
- Replacement of a lost or stolen prosthesis
- Hospital charges
- Services rendered by an immediate family member
- Treatment of bruxism and harmful habits
- Rebasing of dentures

How to File a Claim

If you want to receive benefits, you or your dentist will need to submit a claim form to the claims administrator.

Filing a Claim

When you incur a dental expense, you should file a claim for benefits as soon as possible and no later than 15 months after the claim is incurred.

You can obtain a claim form from the dental claims administrator. (See your Important Benefits Contacts insert for the telephone number.) Complete the patient information section and sign the form, authorizing your dentist to release the necessary information to the claims administrator. If you want your dentist to be paid directly, sign the appropriate space on the form; otherwise, the dental claims administrator will reimburse you directly.

Your dentist must fill out the appropriate section of the form when your treatment is completed, and you or your dentist should submit the form to the dental claims administrator at the address indicated on the form. If your dental expenses are for major services (for example, periodontal procedures, crowns or bridges), you or your dentist should submit your X rays and/or diagnostic materials along with the claim. (See “How Benefits Are Determined.”)

Your benefits are paid either to you, even if the service was for a dependent, or to the care provider, depending on what you indicated on your claim form. If there is a conflict as to whether you or your dentist should be paid by the Plan, the claims administrator may withhold payment until the conflict has been resolved.

Coordination of Benefits

How Coordination Works

If you or your eligible dependent is covered by more than one dental plan, special rules apply for determining who pays benefits first (the primary plan) and how benefits are determined when another plan is secondary (pays benefits after the primary plan). This section describes these rules.

The coordination of benefits (COB) feature eliminates 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 second (the secondary plan) and so on.

When the Plan is primary, it pays benefits up to the limits described in this summary plan description (SPD).

When the Plan is secondary, the claims administrator subtracts the primary plan’s payment from the allowable expense. The 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 applicable allowable expense.

If you have coverage through a prepaid dental plan (such as a Dental Managed Care Organization [DMCO]), 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 they 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 COB 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.

If you are a covered person under a self-insured plan option, you can contact the subrogation vendor directly with questions. If you are a covered person under an insured plan option, you can contact the claims administrator with questions. See your Important Benefits Contacts insert for contact information.

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

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

The Plan is not responsible for your legal costs.

Right of Recovery

If, for any reason, the 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 Claims Review Committee (VCRC), and to the individuals who chair each of these committees. At the time of publication of this summary plan description (SPD), there are several claims and appeals administrators for the Plan.

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 1438
Lincolnshire, IL 60069 1438

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

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

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 Metropolitan Life Insurance Company (MetLife) and United Concordia, which have discretionary authority to decide claims and appeals for your Dental Plan benefits.

The addresses of the claims and appeals administrators for the Dental Plan are listed 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 a beneficiary later proves that a claims or appeals administrator's decision was an abuse of administrator discretion.

If a Benefit Is Denied

Disagreements about benefit eligibility or benefit amounts can arise. If the Verizon Benefits Center is unable to resolve the disagreement, Verizon has formal appeal procedures in place for the Dental Plan.

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

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

- ***Post-service.*** A claim for reimbursement of medical services already received. This is the most common type of claim.

- ***Pre-service.*** A claim for a benefit for which coverage review is required by the plan.

- ***Concurrent care***. A claim for ongoing treatment over a period of time or a number of treatments. For example, if you have been authorized to receive seven treatments from a therapist and during the treatment your therapist suggests 10 treatments, your claim is a concurrent care claim. Some concurrent care claims also are urgent care claims.

- ***Urgent care.*** A claim for dental care or treatment that, if the longer time frames for nonurgent care were applied, the delay could: (1) seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or (2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be managed without the care or treatment that is the subject of the claim.

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

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

The following chart applies to **dental** claims. Benefit claims and appeals are divided into the four categories of claims described above.

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
Step 1				
How to file a claim To file an **eligibility** claim, request a Claim Initiation Form from the Verizon Benefits Center at 1-877-4VzBens. You (or your authorized representative) must return the form to the Verizon Claims Review Unit at the address on the form. To file a **benefit** claim, you (or your authorized representative) should write to your group health plan administrator. To obtain contact information for your plan, you should refer to the telephone number and/or Web site shown on the back of your ID card or the health plan comparison charts available on *Your Benefits Resources* Web site. You must include: • A description of the benefits for which you're applying, • The reason(s) for the request, and • Relevant documentation. To file an urgent care claim, you should call the Verizon Benefits Center at 1-877-4VzBens or your health plan. In addition, you must state that you're filing an urgent care claim.				
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.	Not applicable. Response time frame does not begin until claim is properly filed.	5 days	Not applicable. Response time frame does not begin until the claim is properly filed. If the claim involves urgent care, 24 hours.	24 hours
When you will be notified of the claim decision You will be notified of the decision within **(see columns to the right)** of the Verizon Benefits Center's receipt of your Claim Initiation Form or the health plan's receipt of your claim.	30 days This period may be extended for 15 days. You will be notified within the initial 30-day period.	15 days This period may be extended for an additional 15 days. You will be notified within the initial 15-day period.	A time period sufficiently in advance of the reduction or termination of coverage to allow you to appeal and obtain a response to that appeal before your coverage is reduced or terminated For concurrent care that is urgent, within 24 hours (provided that you submitted a claim at least 24 hours in advance of the reduction or termination of coverage); otherwise, within 72 hours	72 hours

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
Failure to provide sufficient information procedure If you fail to provide sufficient information, the claim may be decided based on the information provided. However, the Verizon Claims Review Unit or health plan may notify you within **(see columns to the right)** that additional information is needed.	30 days	15 days	Decision will be based on information provided, unless the concurrent care claim involves urgent care; see urgent care time frame	24 hours
You will have to provide the additional information within **(see columns to the right)**. Otherwise, the claim will be decided based on information originally provided.	45 days	45 days		48 hours
If you provide additional information, you will be notified of the decision by the Verizon Claims Review Unit or the health plan administrator within **(see columns to the right)**	The time period **remaining** for the initial claim	The time period **remaining** for the initial claim		48 hours

How you will be notified of the claim decision
If your claim is approved, the Verizon Claims Review Unit or health plan generally will notify you by telephone

If your claim is **denied**, in whole or in part, the Claims Review Unit or the health plan will notify you in writing, except for urgent care. Your denial notice will contain:

- The specific reason(s) for the denial,
- The plan provisions on which the denial was based,
- Any additional material or information you may need to submit to complete the claim,
- Any internal procedures or clinical information on which the denial was based, and
- The plan's appeal procedures.

If your urgent care claim is denied, the health plan will notify you via telephone. Within 3 days of this oral denial, you will receive a written denial notice, as explained under the general procedure. The denial notice also will explain the expedited review process.

Step 2

About appeals and the claims fiduciary
Before you can bring **any** action at law or at equity to recover plan benefits, you **must** exhaust this process. Specifically, you must file an appeal or appeals, as explained in this Step 2, and the appeal(s) must be finally decided by the claims fiduciary.

The Claims Review Committee is the claims fiduciary for all eligibility claims. The Claims Review Committee has delegated its authority to finally determine claims to the health plans for benefit claims. The vast majority of health plans have accepted the responsibility of being the claims fiduciary. If your health plan has not accepted this responsibility, you will be notified in your claim denial notice, which will indicate that you should appeal to the Claims Review Committee.

The claims fiduciary is authorized to finally determine appeals and interpret the terms of the plan in its sole discretion. All decisions by the claims fiduciary are final and binding on all parties.

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

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

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

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

- The specific reason(s) for the denial,
- A statement regarding the documents to which you are entitled,
- An explanation of the voluntary appeal procedures, if any,
- Any internal procedures or clinical information on which the denial was based,
- The plan provisions on which the denial was based, and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Step 3

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

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

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

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

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

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

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the 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 Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule applies to "Protected Health Information," which is defined as any written, oral or electronic health information that meets the following three requirements:

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

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

- The Verizon health plans may use or disclose your Protected Health Information for purposes of conducting healthcare operations or paying your healthcare claims.
- The Verizon health plans may use or disclose your Protected Health Information to tell you about treatment alternatives, or to provide you with information about other health-related benefits or services that may be of interest to you.
- The Verizon health plans may disclose your Protected Health Information to Verizon, as sponsor of the Verizon health plans, to assist Verizon in the performance of plan administrative functions. The Verizon health plans also may provide summary health information to Verizon, as plan sponsor, so that Verizon may obtain premium bids or modify, amend or terminate the Verizon health plans. Summary health information does not directly identify you, but summarizes claims history, claims expenses or types of claims experienced. Finally, the Verizon health plans may disclose your enrollment and disenrollment information to Verizon as plan sponsor.
- The Verizon health plans may disclose your Protected Health Information when required to do so by any federal, state or local law, and when permitted to do so under the circumstances set out in the Verizon Notice of Privacy Practices.
- The Verizon health plans may disclose your Protected Health Information to a law enforcement official for certain law enforcement purposes. For example, the Verizon health plans may disclose your Protected Health Information pursuant to a law requiring the reporting of certain types of wounds or other physical injuries.

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

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

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

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

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

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

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

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

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

For more information regarding these rights and the privacy policies of the Verizon health plans, please review the Notice of Privacy Practices for the Verizon health plans. The Notice of Privacy Practices for the Verizon health plans is available on Your Benefits Resources Web site at www.verizon.com/benefits. You may view the notice on the Web site and/or print a paper copy from the Web site.

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

Administrative Information

Administrative information about the Plan is provided in this section.

Important Telephone Numbers

You can connect to the Verizon Benefits Center and other benefit providers directly by calling the toll-free telephone numbers shown on your Important Benefits Contacts insert.

Plan Sponsor/Employer

The Plan sponsor/employer is:

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

Plan Administrator

The Plan administrator is:

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

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

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

The Plan administrator or a person designated by the administrator has the full and final discretionary authority to publish the Plan document and benefit Plan communications, to prepare reports and make filings for the Plan and to otherwise oversee the administration of the Plan. However, most of your day-to-day questions can be answered by the Plan’s benefits administrator or a 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 claims administrator for the Plan (see the “Additional Information” section for more information).

Benefits Administrators

Metropolitan Life Insurance Company (MetLife) is the benefits administrator for the Dental Expense Plan option and United Concordia is the benefits administrator for the Dental PPO option. As the benefits administrators, MetLife and United Concordia have the authority and responsibility to perform daily administration of benefits under the Plan. (See below for the address and your Important Benefits Contacts insert for the telephone number for the benefits administrators.)

Claims and Appeals Administrators

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

There are several claims and appeals administrators for the Plan.

Verizon Claims Review Committee (VCRC)

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

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

See your Important Benefits Contacts insert for the telephone number.

Metropolitan Life Insurance Company (MetLife)

MetLife is the benefits 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

See your Important Benefits Contacts insert for the telephone number.

United Concordia

United Concordia is the benefits administrator responsible for authorizing benefit payments, considering appeals, resolving questions, obtaining records, filing reports and the distribution of information to Dental PPO Plan participants. United Concordia can be reached at the following address:

United Concordia Companies, Inc.
4401 Deer Path Road
Northwoods Crossing Office Park
Harrisburg, PA 17110

See your Important Benefits Contacts insert for the telephone number.

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
100 Half Day Road
P.O. Box 1457
Lincolnshire, IL 60069-1457

You also can call the Verizon Benefits Center at 1-877-4VzBens.

Plan Funding

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.

Except for certain DMCO 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:

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

Plan Identification

Dental coverage is provided through the Verizon Dental Expense Plan for New York and New England Associates, including the Other Plan Provisions of Verizon Covering New York and New England Associates. 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 505.

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

Participating Companies

The following is a list of participating companies as of January 1, 2009. This list may change from time to time.

- Empire City Subway Company (Limited)
- Telesector Resources Group Inc.
- Verizon New England Inc.
- Verizon New York Inc.

Glossary

C

COBRA
A federal law (Consolidated Omnibus Budget Reconciliation Act of 1985 and its subsequent amendments) allowing continuation of health 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. Covered services must be medically necessary as determined by the claims administrator to be payable.

D

Deductible
Under the Dental Expense Plan option, the lifetime amount of covered expenses you pay before the option pays benefits for corrective care.

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

Discounted Fees
The negotiated discounted 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. In addition, the definition of a full-time associate includes job-sharing employees who are regularly scheduled to work at least 40 percent of a regular full-time employee's hours.

I

Imputed Income
Most dependents are considered Internal Revenue Service (IRS) tax dependents. You do not pay 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. 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 is a U.S. citizen or resident who is a "qualifying child" or a "qualifying relative."

A "qualifying child" generally is a person who:

- Is younger than the employee 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.[1]
- 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:

- 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."

Examples

Your 25-year-old child might be your IRS tax dependent if he or she is a U.S. citizen or resident and receives over one-half of his or her support from you. Even though your child does not meet the definition of "qualifying child," he or she meets the definition of "qualifying relative."

Your same-sex 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 same-sex domestic partner is not a "relative" in the traditional sense, he or she may meet the definition of "qualifying relative."

Your same-sex domestic partner's child typically will not be your IRS tax dependent, unless the same-sex domestic partner also is your tax dependent.

[1] If a parent does not claim a qualifying child, then a non-parent can claim the child, as long as the non-parent's adjusted gross income is higher than the highest adjusted gross income of any parent of the child.

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.

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 that is an affiliate of Verizon that has elected to participate in the Plan.

R

Reasonable and Customary Charge (R&C)

The reasonable and customary 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 amount payable under the Dental Expense Plan option for a specific covered corrective care service or supply based on coverage levels agreed to between Verizon and the claims administrator. You can call the claims administrator with specific questions about the scheduled benefit for a particular service or supply.

Spouse

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

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