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Your Dental Coverage
CWA WV

January 1, 2019

Contents

Your Dental Benefits

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

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

- Preventive care coverage that encourages regular checkups.

- Coverage for corrective care and orthodontia services.

About This SPD

This document is the summary plan description (SPD) for the Frontier Communications Corporate Services Inc. Dental Expense Plan for Mid-Atlantic Associates, a component plan of the Frontier Communications Corporate Services Inc. Plan 550. Plan 550 provides other benefits to eligible associates, as described under “Administrative Information, Plan Identification” in the “Additional Information” section. Other benefits are described in separate SPDs.

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, 2019, including legislative and administrative updates. It updates and replaces all previous SPDs and other descriptions of the benefits provided by the Plan. This SPD is part of this Plan.

Most health plans are required to comply with the provisions of the new federal health care reform law, known as the “Affordable Care Act.” Certain health plans, including certain types of dental and vision plans, are exempt from this law. The dental benefit options described in this SPD qualify for that exemption. This means, for example, that these benefits do not have to offer dependent coverage to adult children who are under age 26, may rescind coverage in certain circumstances and may impose annual and lifetime limits on some or all benefits.

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, which of your dependents are eligible to be covered 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.

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

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

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

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

- **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:

Frontier 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.

Frontier Benefits Service Center

The Frontier Benefits Service Center offers a Web site at www.frontierbenefitscenter.com, where you'll find tools to help you manage your benefits.

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

- Hotlink to other Frontier benefit provider sites.

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

- Review details about your healthcare and insurance plans.
- Select and update your beneficiary designations.
- Change your password.
- Give yourself a helpful “hint” in case you forget your password.

Frontier Benefits Service Center representatives are available should you have questions about your benefits. To reach the Frontier Benefits Service Center via telephone, call 1-855-FTR-2887. Via this toll-free telephone number, you also can connect with other Frontier benefit providers.

Changes to the Plan

While Frontier Communications Corporation (Frontier) expects to continue the Plan indefinitely, Frontier 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, by action of its Board of Directors or its delegate or by publication of any SPD, summary of material modification, enrollment materials or other communication relating to the Plan, as approved by Frontier.

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

Participating in the Plan

Eligibility

You are eligible for Plan coverage on your date of hire, if you are employed by a Frontier participating company (see the "Additional Information" section) and are a regular or term full-time or part-time CWA WV (Mid-Atlantic) associate whose employment is covered by a collective bargaining agreement that provides for participation in the Plan. Also, to be eligible, you must be employed at a unit, subsidiary, division, entity or working group acquired as part of the merger with Verizon.

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

"Service" means net credited service as defined by the Frontier Pension Plan for Mid-Atlantic 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.
- You are a retiree

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 www.frontierbenefitscenter.com or the Frontier Benefits Service Center to have coverage. You can enroll only your eligible dependents who meet the Plan definition for eligibility, as described below.

Important Note: You will note that a new federal law, known as the Affordable Care Act, allows coverage of certain dependent children regardless of marriage or employment status up to the age of 26. This new requirement only applies to medical coverage and does not apply to dental coverage. If your dependent child ceases to satisfy the age and full-time student requirements described in this SPD, his/her dental coverage will terminate, but he/she may be eligible for COBRA continuation coverage if you contact the COBRA administrator within the required time period. Please see the COBRA continuation coverage section in this SPD for further information.

Dependent Class	Who They Are	Relationship
Class I Dependents	• Your legal opposite sex and same sex spouse (a legally separated spouse is not eligible) • 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 or has legal custody • 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 • 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) • Your unmarried children (as defined above and including any age requirements) who are alternate recipients under an approved qualified medical child support order (QMCSO)	• Spouse • Child • Full-Time Student • Disabled Child • Child
Sponsored Children	Your unmarried children from age 19 through the end of the calendar year in which they reach age 25 who are not full-time students or incapacitated and otherwise meet the definition of child, as described above	Sponsored Child

Note:

- Effective 1/1/2019, Domestic Partners (Same-sex or Opposite sex) and their children are not eligible for coverage under the Plan.
- Effective 1/1/2019, children in the category of “Sponsored Child” are no longer eligible for coverage.
- Grandfathered Class II Dependents and Sponsored Parents 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 Frontier’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 Frontier Benefits Service Center. In any case, if subject to an order, you and each child will be notified about further procedures.

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

- You and your dependents will have Preferred Dentist Program (PDP) or Out-of-Area coverage, depending on your home ZIP code.

If Your Spouse Is a Frontier Employee or Retiree

For dental coverage, if your spouse is employed by or retired from Frontier or affiliates, the following rules apply:

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

- You can be covered as an employee or retiree or as a dependent under a Frontier-sponsored dental plan, but not as both. To be covered as a dependent under another plan, you must choose the no coverage option under this Plan. However, anyone employed by Frontier cannot be covered under the retiree dental plan.

- Your spouse can be covered as an employee or retiree or as a dependent under a Frontier-sponsored dental plan, but not as both. To be covered as your dependent under this Plan, your spouse must be eligible for and must choose the no coverage option under his or her plan. If he or she is not eligible to choose the no coverage option under his or her plan, your spouse cannot be covered under your Plan.

Enrolling in the Plan

Initial Enrollment by Newly Hired Associates

The following enrollment rules apply based on your work schedule:

- **Hired on or after June 1, 2018:**
  - If you are a full-time associate or a part-time associate who is scheduled to work 25 or more hours a week, your vision coverage begins automatically on your date of hire.

  - If you are a part-time associate scheduled to work less than 25 hours a week you are eligible for coverage on your date of employment, if you actively enroll for vision coverage. Otherwise, you will not have coverage.

- **Hired prior to June 1, 2018:**
  - If you are a full-time associate or a part-time associate who is scheduled to work 25 or more hours a week, your dental coverage begins automatically on the first day of the month in which you attain three months of net credited service.

  - If you are a part-time associate, scheduled to work less than 25 hours a week who has been employed continuously by Verizon and then Frontier since before January 1, 1981, your dental coverage begins automatically on the first day of the month in which you attain three months of net credited service.

  - If you are a part-time associate who has not been employed continuously by Verizon and then Frontier since before January 1, 1981, you must enroll through the Frontier benefits Web site or call the Frontier Benefits Service Center to have dental coverage. You can enroll after you complete three months of net credited service and agree to pay the required cost by payroll deductions; otherwise, you will not have coverage. If you enroll on or before the deadline shown on your Enrollment Worksheet, your

coverage takes effect on the first day of the month in which you reach three months of net credited service. For example, if your hire date is June 20, your coverage is effective September 1. If you do not enroll by the deadline, you must wait until the benefits renewal period or, if sooner, when you have a status change (as described in the “Changing Your Elections” section).

- If you are changing from a management position to a full-time associate position or a part-time position in which you’re scheduled to work 25 or more hours a week, your dental coverage begins automatically on the first day of the month following the date your payroll changes for the change in position. If you are changing to a part-time position in which you are scheduled to work less than 25 hours a week, you must enroll to have coverage.

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

If you want to choose coverage under an option available to you, you must access www.frontierbenefitscenter.com or call the Frontier Benefits Service Center by the deadline shown on your Enrollment Worksheet for that coverage to begin the first day of the month in which you attain three months of net credited service. If you are eligible for automatic coverage (as described above) and do not enroll, you will have coverage for yourself only under the applicable automatic coverage option (see "If You Do Not Enroll," below). This coverage will continue until the next benefits renewal period or until you have a change in status for which a change in coverage is allowed. If you want to choose coverage under another option available to you, you must access the Frontier Benefits Web site or call the Frontier Benefits Service Center. Available options include:

- PDP

- For CWA-represented associates whose home ZIP code is outside the PDP service area: Out-of-Area option

- For CWA-represented associates who are covered as dependents under another Frontier-sponsored dental plan or who are part-time associates who do not receive the full Company subsidy for dental coverage: No dental coverage

You also must access the Frontier Benefits Web site or call the Frontier Benefits Service Center to enroll any eligible dependent you want included under your coverage. You can choose coverage for yourself plus one dependent or for yourself plus two or more dependents. You'll need to provide each dependent's name, date of birth and Social Security number. If you enroll eligible dependents before the deadline shown on your Enrollment Worksheet, their coverage begins on the same date as your coverage. Otherwise, coverage begins the first day of the month after you enroll them.

How Do I Enroll or Make Changes?

Access the Frontier Benefits Web site or call the Frontier Benefits Service Center at the telephone number listed on your Important Benefits Contacts insert. Benefits Center

Representatives are available to help you from 9:00 a.m. to 6:00 p.m. Eastern time, Monday through Friday (excluding holidays).

If You Do Not Enroll

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

- Your automatic coverage option is the PDP or Out-of-Area option, depending on your home ZIP code.

Changing Your Elections

Benefits Renewal

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

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

Status Changes

Between benefits renewal periods, you may be able to change your Dental Plan option and covered dependents if you or a dependent has a change in status that affects eligibility for coverage. An election change can be made due to a change in status if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan. Elections made due to status changes remain in effect until you make a change during a benefits renewal period or due to another status change.

You Gain a New Dependent

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

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

- Coverage will begin again for the new dependent on the first day of the month following your election, if you make your election more than 90 days after the event.

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

Benefits Service Center. Your election will take effect the first of the month following your election.

You Lose a Dependent Through Death, Legal Separation, or Divorce

If you lose a dependent through death, legal separation, or divorce, coverage for that dependent ends on the last day of the month in which
the event occurs. However, you must notify the Company by calling the Frontier Benefits Service Center to remove that dependent from your coverage; otherwise, you will continue to pay any required premiums even though that individual will be ineligible for benefits.

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 on the last day of the month in which he or she loses full-time student status. If you are enrolled in a DMO, check with your DMO regarding eligibility rules since DMO rules may be different.

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

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

A Dependent Changes Eligibility Class

If a dependent loses eligibility as a Class I Dependentd, you must notify the Company by calling the Frontier Benefits Service Center within 90 days of the change in eligibility to ensure your dependent's coverage will continue without interruption. If you do not notify the Frontier Benefits Service Center of the change within 90 days, the dependent's coverage will cease until notification is received. When notification is received, coverage will be reinstated on the first day of the month following notification.

If you do not notify Frontier, 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

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

Your Dentist Stops Participation

If your dentist stops participating in the Plan during the Plan year, you cannot change your option. You must wait until the next benefits renewal period or until you experience a status change to change your Dental Plan option.

Special Enrollment Rules

If you or your dependents waived dental coverage because of other dental insurance coverage, you may be able to enroll yourself or your dependents in the Plan if you later lose that other insurance due to:

- Loss of eligibility
- Termination of employer contributions for such coverage (however, special enrollment is not available if loss of coverage was due to your or your dependents failure to pay for such coverage)
- Exhaustion of COBRA coverage.

If you enroll yourself or your dependents in the Plan:

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

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

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

Cost of Coverage

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

- A regular or term full-time associate working at least 25 hours a week
- A part-time associate hired before January 1, 1981 and continuously employed by Verizon and then Frontier since that date.

If you have not been employed continuously since before January 1, 1981 and you work at least 17 but less than 25 hours a week, the Company contributes 50 percent of the 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 Verizon and then Frontier since before January 1, 1981 and you work less than 17 hours a week, you can enroll for coverage if you call the Frontier Benefits Service Center and agree to pay the full cost.

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 Frontier Benefits Service Center for details.
Leaves of Absence Under the Uniformed Services Employment and Reemployment Rights Act	All military leaves of absence qualifying under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) will be administered in accordance with the terms of USERRA.
Union Leaves of Absence	Under a Union Leave of Absence, coverage can be continued according to your collective bargaining agreement.
Anticipated Disability Leaves of Absence, Care of Newborn Child (CNC) Leaves of Absence and Dependent Care Leaves of Absence	• Under an Anticipated Disability Leave of Absence, a Care of Newborn Child Leave of Absence or a Dependent Care Leave of Absence, Frontier 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. • **If You Receive Short-Term Disability Benefits:** Your dental coverage will continue while you receive benefits from the Frontier Sickness and Accident Disability Benefit Plan for Mid-Atlantic Associates if you pay any required contributions.
Education Leaves of Absence or Personal Leaves of Absence	If you take an Education Leave of Absence 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 Frontier or an affiliate of Frontier. You will have an opportunity to make an election into another plan.
Long-Term Disability (LTD)	If you are receiving long-term disability benefits, coverage under the Plan will end on the last day of the month in which you qualify to begin long-term disability.
Cancellation of Coverage	If you cancel coverage due to a change in status, your coverage will end on the last day of the month in which you elect to cancel coverage.
Failure to Submit Payment (if Required)	If you are required to make a payment, and it is not received on time, coverage will end on the first day of the month for which it is not received.
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. If you retire from the Company and meet eligibility requirements, you may qualify to elect retiree coverage.
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.
Strike	Coverage will terminate for all Covered Employees who stop working because of the strike as of the last day of the month in which the strike commences. The Covered Employees' share of premiums, if any, must continue to be paid through the end of the month at which time coverage terminates due to the strike. For purposes of this SPD, "strike" also includes a lockout or other general work stoppage.

Dependent Coverage A dependent's coverage will end on the earliest date described below. Your dependent may be able to continue coverage under COBRA. See the “Continuing Coverage” section.	
Associate's Coverage Ends	If the associate's coverage ends for any reason except when the associate dies, coverage for all dependents also will end at the same time.
Associate Dies	When the associate dies, coverage for all dependents will end on the last day of the month in which the associate dies.
Dependent Ceases to Meet the Eligibility Requirements	A dependent's coverage will end on the earlier of either the date the dependent is covered as an employee or retiree under any Company-sponsored dental plan or the last day of the month in which the dependent no longer qualifies as a dependent under the Plan, subject to the following: • Coverage for your spouse ends on the last day of the month in which he or she becomes legally separated or divorced from you. • Coverage for a child ends on the last day of the calendar year in which he or she reaches age 19 (if not a full-time student), or the last day of the month in which the child is married, if earlier. • Coverage for a stepchild ends on the last day of the month in which he or she no longer lives with you or otherwise fails to meet the definition of eligible dependent. • Coverage for a full-time student ends on the earlier of the last day of the calendar year in which the student reaches age 25 or the last day of the month in which he or she no longer qualifies as a full-time student. • Coverage for a disabled child ends on the last day of the month in which he or she no longer meets the definition of a disabled child. • Coverage for a child 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

Extended Benefits

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

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

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

Notify the Frontier Benefits Service Center If a Dependent Is Ineligible

It is your responsibility to notify the Frontier Benefits Service Center within 90 days if your dependents no longer meet eligibility requirements. Otherwise, any claims incurred by an ineligible dependent become your financial responsibility. Furthermore, if you do not disenroll

your dependents within 60 days of when they become ineligible, they will lose the right to purchase continued health care benedicts under COBRA.

Audits of Enrollment Status and Proof of Dependents

Frontier reserves the right to audit at any time any enrollment election or other information you have provided in connection with your enrollment. This right to audit includes auditing the status of your enrolled spouse/partner, and dependent children to determine if they meet the eligibility criteria. During an audit, you may be required to provide proof of your marriage and for your enrolled dependent children. If you cannot provide sufficient proof that an enrolled individual meets the eligibility criteria, he/she will be disenrolled from Frontier benefits, possibly retroactively.

This right to audit also includes whether the correct premium or contribution is being charged for your coverage, including any premium surcharge or additional premium. The application of the correct premium or contribution is always and completely subject to audit. Frontier may apply the correct premium or contribution retroactively (due to an audit or otherwise).

Providing Frontier false or misleading information regarding your enrollment, a spouse/partner or dependent child, enrolling an individual who does not satisfy the eligibility criteria, or failing to drop an enrolled individual in a timely manner when he/she no longer satisfies the eligibility criteria may constitute fraud or misrepresentation. If Frontier determines that fraud or misrepresentation has occurred, Frontier may also terminate or suspend the employee's plan coverage, require repayment of an ineligible individual's prior claims, require payment of the total value of an ineligible individual's coverage or take other corrective action (retroactively or otherwise).

Cooperation

In order to participate in the Plan, you and your enrolled Dependents are required to cooperate with the Plan and Claims Administrators and provide the Plan and Claims Administrators with information that is needed to administer your benefits. This includes providing the Plan and Claims Administrators with your and your Dependents' correct Social Security numbers, correct legal names and birthdates. You must also respond to reasonable requests of the Plan and Claims Administrators for additional information, and assist the Plan and Claims Administrators in correcting any claims paid in error or for the wrong amount. Failure to cooperate with the Plan and Claims Administrators as set forth above may result in the termination or suspension of your and your Dependents' coverage under the Plan.

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. Additional information is provided below.

Overview of Your Options

Dental Plan Options

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

- Preferred Dentist Program (PDP) option

- For CWA-represented associates whose home ZIP code is outside the PDP service area: Out-of-Area option

- Dental Maintenance Organization (DMO) option

- For CWA-represented associates who are covered as dependents under another Frontier-sponsored Dental Plan or who are part-time associates who do not receive the full Company subsidy for dental coverage: No dental coverage.

Alternative Procedures

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

Predetermination of Benefits

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

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

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

Preferred Dentist Program Option

The Preferred Dentist Program (PDP) option is available to CWA-represented associates whose home ZIP code is in a PDP service area.

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

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

The chart below describes how the PDP works.

Whenever you need care, you choose to...		
↓	Or	↓
Visit a PDP participating dentist		Visit a non-participating licensed dentist
↓		↓
Dentist submits claim form		You submit claim form
↓		↓
Receive higher benefits, based on discounted fees		Receive lower benefits, based on non-discounted fees

A list of participating dentists can be obtained, free of charge, by calling MetLife at 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.

Important Note

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

Annual Deductible

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

Benefit Maximums

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

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

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

How Benefits Are Determined

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

Preventive and Diagnostic Care

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

Basic Restorative Care

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

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

Major Restorative Care

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

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

Dental Implants

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

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

Due to the extensive cost of this service, predetermination is recommended. See the “Predetermination of Benefits” section for more information.

Orthodontic Care

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

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

Important Note:

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

Overview of Benefits

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

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

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

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

Preventive and Diagnostic Care (Frequency limits are per person) Routine oral exam: Two per calendar year. Additional exams are covered as needed specifically for emergency confirmation of diagnosis of suspected disease or injury, as long as no other covered services or supplies are rendered on the same day Cleaning and scaling of teeth: Twice per calendar year Single film X rays: As needed to diagnose a specific condition, except for orthodontia Complete x-ray series, including panoramic film and bitewing X rays or a single panoramic film: Once every 3 calendar years if ordered by a dentist Supplementary bitewing X rays: Twice each calendar year if ordered by a dentist Topical fluoride treatment: Once per calendar year Panoramic survey, including maxillary and mandibular: Once every 3 calendar years Fabrication, insertion and adjustment of a non-orthodontic space maintainer for patients under age 19 only: As needed for replacement of congenitally missing teeth and prematurely lost or extracted teeth regardless of when the teeth were lost or extracted	Option pays 100% of preferred rate	Option pays 100% of preferred rate
Basic Restorative Care Oral surgery, including: • Incision and draining of abscess • Simple extractions • Surgical removal of soft tissue impactions; exception: if you live in Pennsylvania, New Jersey or Delaware, you must submit these expenses to your medical plan first • Removal of partial or complete bony impactions 30 minutes of intravenous sedation or general anesthesia, in connection with oral surgery Fillings made from amalgam, silicate, acrylic or plastic, composite acrylic resin. Multiple fillings in one surface are considered a single filling Root canal therapy (including X rays, tests, lab exams and follow-up care) for devitalized teeth only, including X rays and cultures in conjunction with a surgical procedure Periodontics, including: • Gingival curettage • Gingivectomy • Osseous surgery • Periodontal surgery • Scaling and root planing: Limited to one full mouth procedure every 24 months	Option pays 80% of preferred rate	Option pays 70% of preferred rate

If more than one surgery is performed at the same time, the more comprehensive procedure is covered by the option Additions to partial dentures to replace extracted teeth Tooth sealants to permanent non-restored molars; for covered individuals who are under age 19 only: Once per tooth every 5 calendar years		

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

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

Out-of-Area Option

The Out-of-Area option is available to CWA-represented associates whose home ZIP code is outside the Preferred Dentist Program (PDP) service area.

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

Important Notes:

- You cannot opt-in to the Out-of-Area option.
- The lifetime orthodontic benefit maximum is a single lifetime maximum for all Frontier coverage. If you or any individual you cover meets the benefit maximum for orthodontia, that individual does not gain a new lifetime orthodontic benefit maximum if you change options.
- Even if you enroll in the Out-of-Area option, you can visit a dentist who participates in the PDP network. If you do, your expenses will be lower because you will be charged the preferred rate.

Benefit Maximums

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

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

How Benefits Are Determined

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

Preventive and Diagnostic Care

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

Basic Restorative Care

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

Major Restorative Care

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

Dental Implants

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

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

Due to the extensive cost of this service, predetermination is recommended. See the “Predetermination of Benefits” section for more information.

Orthodontic Care

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

Dental Maintenance Organization Option

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

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

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

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

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

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

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

Overview of Benefits

Covered Procedure/Feature	Benefits Using DMO Personal Dentist (otherwise, generally no coverage)
Annual deductible	None
Preventive and diagnostic care (for example, cleanings and X rays)	Option pays 100%
Basic care (for example, fillings, most oral surgery and root canals)	Option pays 100% (certain services covered at 60%)[5]
Major care (for example, crowns, bridgework and dentures)	Option pays 60%
Orthodontia	Option pays 50%
Annual benefit maximum (excluding orthodontia)	None
Orthodontic lifetime benefit maximum[6]	Limited to one full course of treatment per lifetime per covered person

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

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

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

No Coverage Option

The no coverage option is available to full-time CWA WV associates who are covered as dependents under another Frontier-sponsored dental plan.

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

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

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 (or up to 26 weeks to care for a covered military service member, to the extent required under FMLA).

- 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. Frontier 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

Frontier'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 Frontier Changes Benefits

If Frontier 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 Frontier Benefits Service Center.

What is COBRA Continuation Coverage?

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

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

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

COBRA qualified beneficiaries

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

  — Your hours of employment are reduced.

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

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

  — You die.

  — Your hours of employment are reduced.

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

  — You become divorced.

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

  — The parent-employee dies.

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

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

  — The parents become divorced.

  — The child loses eligibility for coverage as a “dependent child” under the Dental Plan.

When COBRA Coverage is Available

The Dental Plan offers COBRA continuation coverage to qualified beneficiaries only after the Frontier Benefits Service 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, **Frontier will notify** the Frontier Benefits Service 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 Frontier Benefits Service Center within 60 days after the qualifying event.

How COBRA Coverage is Offered

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

The Frontier Benefits Service 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 Frontier Benefits Service 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.

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

- **Disability extension of 18-month period of continuation coverage.** If a qualified beneficiary covered under the Dental Plan is determined by the Social Security Administration to be disabled and you notify the Frontier Benefits Service 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 Frontier Benefits Service 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 Dental Plan.

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

- **Special Medicare Rule**. A special rule applies in certain situations where you, the employee, become entitled to Medicare benefits less than 18 months before your termination or reduction in hours of employment. In this situation, COBRA continuation coverage for your spouse and dependent children may last until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before your employment terminates, COBRA continuation coverage for your spouse and dependent children may last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

In addition to COBRA continuation coverage, you may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

When making the decision of whether to elect COBRA continuation coverage, you should keep in mind that you may have other options. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov or by calling 1-800-318-2596.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you

may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible. When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

Additional information is provided below.

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 (but only if you provide timely notice of this determination)	29 (Initial 18 months, plus additional 11 months)	29 (Initial 18 months, plus additional 11 months)	29 (Initial 18 months, plus additional 11 months)
Your covered child no longer qualifies as a dependent	N/A	N/A	36
You die	N/A	36	36
You and your spouse divorce	N/A	36	36

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

What COBRA Coverage Costs

COBRA participants must pay monthly premiums for coverage.

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

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

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

If you or your dependent elects COBRA continuation coverage:

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

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

- You or your dependent may change your coverage:

  — During your benefits renewal period.

  — If you have a qualified change in status.

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

- 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 Frontier, provided the plan does not have a legally valid pre-existing condition exclusion or limitation affecting the qualified beneficiary. If it does, Frontier 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.

- Frontier 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).

Health Insurance Marketplace

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you will also learn if you qualify for free or low-cost coverage from

Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.healthcare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days, your special enrollment period will end and you may not be able to enroll until annual enrollment, so you should take action right away if you think you may want Marketplace coverage. In addition, you may also enroll in Marketplace coverage annually during what is called an "open enrollment" period. The open enrollment period is the time during which anyone can purchase coverage through the Marketplace. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.healthcare.gov.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." If, however, you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if you enroll outside of the Marketplace open enrollment.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you will have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

When considering your options for health coverage, you may want to think about:

- *Premiums*: You can be charged up to 102% of total plan premiums for COBRA coverage (more if you qualify for an extension of coverage on account of a disability). Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

- *Provider Networks*: If you are currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.

- *Drug Formularies*: If you are currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

- *Service Areas*: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

- *Other Cost-Sharing*: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If you have questions about your right to coverage, contact the COBRA Administrator.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.healthcare.gov.

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.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

In addition, if your coverage ends due to certain military leaves, you may be able to continue coverage under the provisions of the Uniformed Services Employment and Reemployment Rights Act (USERRA). Contact the Frontier Benefits Service Center for more information.

To be entitled to USERRA rights, you must give advance notice of your service unless it is impossible or unreasonable under the circumstances to give such notice or giving such notice is precluded by military necessity. Service in the uniformed services includes performance of duty on a voluntary or involuntary basis in the Armed Forces (including the Coast Guard and the Reserves), the Army National Guard, the Air National Guard, and the commissioned corps of the Public Health Service.

Your right to continued coverage under USERRA is very similar, but not identical, to your right to continued health coverage under COBRA. In those instances where your rights under COBRA and USERRA are not the same, whichever law gives you the greater benefit will apply. The administrative policies and procedures, which govern your right to COBRA continuation coverage, also apply to your right to USERRA continuation coverage, with a few limited exceptions.

Any election that you make under COBRA will also be an election to continue your coverage under USERRA. If, however, you are unable to elect COBRA within the required period because of military necessity or because it is impossible or unreasonable for you to do so, the period for electing USERRA coverage will be tolled until the military necessity is abated or it is no longer impossible or unreasonable for you to make the required election. The period for electing COBRA coverage, however, will not be tolled in this situation.

You are the only one that has the right to make an election under USERRA to continue health coverage for yourself and any covered dependents. Your covered dependents do not have an independent right to make an election for USERRA continuation coverage. As a result, if you do not elect USERRA / COBRA coverage on behalf of your covered dependents, your covered dependents will still have a right to elect to continue their health coverage under COBRA, but they will not be entitled to receive any additional benefits provided under USERRA.

If you elect to continue health coverage for yourself (or your covered dependents) under USERRA, you must pay 102% of the full premium elected (the same rate as COBRA) at the same time as the premium for COBRA coverage is due. However, if your uniformed service period is less than 31 days, you are not required to pay more for health coverage than you would be required to pay as an active employee.

USERRA continuation coverage will generally continue for up to 24 months following the date your leave of absence begins. However, this coverage will terminate earlier if any one of the following events occurs:

- A premium payment is not made within the required time;
- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Although COBRA coverage and USERRA coverage begin at the same time, they do not end at the same time. COBRA coverage continues for up to 18 months (although, if certain events occur, it can be extended), while USERRA coverage continues for up to 24 months as described above. On the other hand, there are certain events, like your failure to return to work at the end of your service or a dishonorable discharge, which cause your USERRA coverage to terminate early but which do not cause COBRA coverage to terminate. In that situation, even if your USERRA coverage terminates, you may still be entitled to continued health coverage under COBRA.

What Is Not Covered

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

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

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

- Procedures determined by the claims administrator to be experimental

- Services rendered by an immediate family or household member

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

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

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

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

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

- Treatment resulting from insurrection or participation in a riot

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

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

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

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

  However, for the DMO option, if orthodontia treatment started prior to the coverage effective date, treatment provided after the coverage effective date may be covered as determined by the claims administrator.

- For the PDP option and the Out-of-Area option, orthodontia treatment started prior to the coverage effective date

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

- Implants (not covered under the DMO only)

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

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

- Drugs and their administration

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

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

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

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

- Services or supplies covered under the Frontier Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates or any other Plan of Frontier or an affiliate; charges for treatment of accidental injury to natural teeth while covered under the Plan that total $250 or less are covered under the Plan

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

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

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

  The Plan has the right to recover or place a lien on any benefits paid or payable if Workers’ Compensation provides benefits for the same condition.

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

How to File a Claim

When you choose coverage under the Out-of-Area Option, you must file claim forms. An advantage of the Preferred Dentist Program (PDP) and the Dental Maintenance Organization (DMO) is that you normally will not have to file claims.

When Claims Are Required

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

When you participate in the Out-of-Area Option or if you use a nonparticipating dentist, you will have to file claim forms to be reimbursed. To file a claim:

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

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

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

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

  — Certify the employee/patient information is correct

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

- Send the form to the claims administrator.

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

Coordination of Benefits

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

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

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

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

Priority of Payment

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

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

- For a dependent child, Frontier 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 Frontier plan) pays benefits first.

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

Note: If both parents elect coverage under a Frontier-sponsored Dental Plan, their child can be covered under only one parent's Plan.

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

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

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

For active associates and covered persons eligible for Medicare, the Plan is typically the primary plan over Medicare.

Special Rules

Even if the Plan is your normal primary or secondary health plan, in all events any worker's compensation coverage, the medical or other compensation component of a personal umbrella insurance policy or contract, the medical or other compensation component of any homeowner's/renter's insurance policy or contract, and any group or individual automobile insurance policy or contract (including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, and no-fault automobile insurance coverage) will be the primary plan for accidents and injuries that are covered by, reimbursable by or for which compensation is otherwise payable by the applicable policy or

contract. This Plan will then pay secondary. In addition, for participants and dependents covered by no-fault automobile insurance all medical expenses related to an automobile accident should be submitted to the automobile insurance carrier first. The Plan will pay covered expenses only according to the coordination of benefit rules discussed above.

Reimbursement

If you or one of your dependents suffers a loss or injury caused by the actions or omissions of a third party, that third party may be responsible for paying your dental expenses. For this purpose, a "party" means any individual, entity, person or other party responsible for causing your loss or injury or responsible for making any payment to you or your dependents due to you or your dependents accident, injury or illness, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, homeowner's/renter's insurance, personal umbrella coverage, Workers' Compensation coverage and any first-party insurance coverage. However, a party does not include any individual or supplementary insurance policy or coverage classified as an individual cancer, individual specific disease or individual hospital indemnity policy (e.g., individual policies sold by AFLAC). For purposes of any applicable coordination of benefits rules, a third party shall pay primary and the plan shall pay secondary.

For example, if you are injured in a car accident, the person who caused the accident (and the person's insurer) are the third parties and may be responsible for paying for your injury-related expenses. You and your dependent will be required to provide the plan or its agents information concerning any claim or lawsuit you or your dependents may have against a third party for injury caused by that party. You or your dependent must also provide the plan or its agents any documents or information relevant to the protection of the plan's rights of reimbursement. You may be asked to sign a repayment agreement as a condition for receiving benefits under the plan. If the agreement is not signed or you fail to cooperate with the claims administrator, you will lose your benefits related to the accident/injury/illness. If you do not cooperate, the claims administrator may terminate your injury-related benefits from and after a certain date even if your injury-related benefits were approved before that date.

If you decide to sue the person who caused the accident/injury/illness, you must inform the Frontier Benefits Service Center. If you receive any type of payment, reimbursement or legal recovery from the third party or an insurer, you are obligated to reimburse the plan for any expenses that the plan paid (and will pay in the future) for the accident/injury/illness and for any related legal and collection costs the plan incurred. Any amounts recovered in excess of the foregoing shall be paid to you, but any excess portion shall be first applied to reduce the liability of the plan for future payments of benefits with respect to the accident/injury/illness that is the subject of the right of reimbursement. The plan may initiate legal action against you or your dependent (or anyone else holding the proceeds, such as a legal representative or trust) to collect the payment, reimbursement or legal recovery, and may take any other actions allowed by applicable law to protect the plan's right of reimbursement.

In the above example, if the plan paid for the dental expenses you incurred as a result of the accident, and you later received money from the person who caused the accident or such person's insurer, you must pay back the plan from the money paid by the person who caused the accident or such person's insurer.

Your obligation to reimburse the plan exists for any legal recovery that relates to an accident, injury or illness for which the plan paid benefits (including any amounts used to pay your legal fees), even if you recover less than initially claimed (or less than your full loss) and even if the legal recovery is designated as not for medical or dental expenses. In addition, the right of full and unreduced reimbursement also apply even if the rights of the plan are separated and treated as not resolved in the judgment, settlement, verdict or insurance

proceeds (but in this case the plan's rights shall be assigned to you to the extent reimbursement is actually received out of the recovery). The plan's right to receive any payment, reimbursement or recovery discussed in this section supersedes and has priority over you and your dependent's right to receive any payment, reimbursement and recovery.

Your obligation to reimburse the plan will not be reduced to reflect any fees, expenses or costs, including attorneys' fees, incurred by your or your dependents in obtaining a recovery unless separately agreed to, in writing, by the Plan Administrator. The plan expressly rejects the "common-fund doctrine" and any other similar rule which would require the plan to share in the recovery costs.

The plan's right of reimbursement, as described in this SPD and the Plan document, applies without regard to any equitable defenses that you or your dependents assert or may be entitled to assert, including without limitation any defense of unjust enrichment. ERISA preempts any State or local law, or any regulation issued thereunder, which prohibits or attempts to limit the plan's right of reimbursement.

In order to recover any reimbursement, payment, overpayment or excess payment to which the plan has a right of reimbursement as provided above, you and your dependents, as a condition of receiving benefits under the plan, grant to the plan the following rights:

- A first priority equitable lien against the proceeds of any settlement, verdict, insurance proceeds or other amounts received by you or your dependents from or on behalf of any third party that may be responsible for an illness, injury or condition for which the plan incurred expenses. The amount of the lien is equal to the amount of prior and future benefits paid by the plan

- The right to impose a constructive trust on the proceeds from any settlement, verdict, insurance or other amounts awarded, transferred or paid by or on behalf of a third party to you or your dependents and any other person or entity holding the proceeds, including a legal representative or trust

- The right to bring any legal action or proceeding to enforce the above rights in any court of competent jurisdiction as the plan may elect, and upon receiving benefits under the plan you and your dependents hereby submit to each jurisdiction regardless of your current or future residence

Anti-Assignment Rules

Your rights and benefits under the Plan cannot be assigned, sold or transferred to any person, including your healthcare provider. The only exception is under a qualified medical child support order. Any purported assignments of benefits or rights under the Plan that a healthcare provider or any other person or entity requests that you execute (and/or has you execute) shall be void and shall not apply to the Plan.

At its option, the Plan may accept claims filed by a healthcare provider and may make payments for covered services directly to a healthcare provider. However, these activities will not constitute an assignment of health benefits or rights under the Plan or a waiver of the Plan's anti-assignment rules. Further, a direct payment to a healthcare provider will not constitute an assignment of health benefits or rights under the Plan. Any purported assignments of benefits or rights under the Plan shall be void and shall not apply to the Plan.

In addition, during a visit to your healthcare provider, your provider may ask you to authorize him/her to receive payments directly for your healthcare services. Such authorizations are void and will not apply to the Plan. Payments will only be made directly to a healthcare provider if the Plan determines that such direct payments satisfy its requirements of the applicable time. Payments made directly to providers for covered services are not assignments of benefits.

The Plan may also make payments directly to you. Payments, as well as notice regarding the receipt and/or adjudication of claims, may also be made to an alternate recipient or that person's custodial parent or authorized representative under a qualified medical child support order.

If the Plan makes a payment, this will fulfill the Plan's obligation to pay for covered services. The Plan is not responsible for paying healthcare provider invoices that are balance-billed to you.

Authorized Representatives

You may appoint an authorized representative to act on your behalf for purposes of the Plan. Any appointment of an authorized representative must follow these requirements –

- The appointment must be in writing and dated, AND
- The appointment must clearly indicate the authorized representative, the scope of the appointment and any limitations on the authorized representative, AND
- The appointment must be signed by you, and must be notarized by a notary public, AND
- The appointment must satisfy any other legal requirement applicable to appointments under state or federal law, AND
- The appointment must be approved by the Plan Administrator in writing.

The Plan will also recognize a court order appointing a person as your authorized representative. The Plan Administrator or Claims Administrator may also provide different rules and procedures for an appointment of an authorized representative in emergency situations. You should contact the Plan Administrator or Claims Administrator with any questions or to qualify someone as your authorized representative.

Any purported appointment of an authorized representative that does not follow the above requirements will be void and will not apply to the Plan.

Right of Subrogation

When another party is legally responsible or agrees to compensate you or your dependent for an accident, illness or injury for which the plan has paid benefits, the plan has the same rights ("right of subrogation") that you and your dependent have against the party. For this purpose, a "party" means any individual, entity, person or other party responsible for causing your loss or injury or responsible for making any payment to you or your dependents due to you or your dependent's injury, illness or condition, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, homeowner's/renter's insurance, personal umbrella coverage, Workers' Compensation coverage and any first-party insurance coverage. However, a party does not include any individual or supplementary insurance policy or coverage classified as an individual cancer, individual specific disease or individual hospital indemnity policy (e.g., individual policies sold by AFLAC).

The plan expressly rejects and overrides any default rule that the plan does not have a right of subrogation until you or your dependent have been fully compensated. If you or your dependent enters into litigation or settlement with another party, the plan's right of subrogation will still apply.

The plan's right of subrogation, as described in this SPD and the Plan document, applies without regard to any equitable defenses that you or your dependents assert or may be entitled to assert, including without limitation any defense of unjust enrichment. ERISA preempts any State or local law, or any regulation issued thereunder, which prohibits or attempts to limit the plan's right of subrogation.

You and your dependent will need to provide the plan or its agents with any relevant information, assistance and documents that help the plan obtain its subrogation rights. Also, you could be required to sign and deliver to the plan or its agents documents to secure the plan's subrogation rights, and you and your dependent will be required to obtain the consent of the plan or its agents before releasing any party from liability for payment. If you fail to cooperate with the claims administrator, you will lose your benefits related to the accident/injury/illness. If you do not cooperate, the claims administrator may terminate your injury-related benefits from and after a certain date even if your injury-related benefits were approved before that date.

For the reimbursement and subrogation sections above, "you" means the covered Frontier employee, another covered person, a legal representative or the estate or heirs of a covered person (sometimes collectively referred to as "you").

Frontier's Right of Recovery

If, for some reason, a benefit is paid that is larger than the amount allowed by the plan, the plan has a right to recover the excess amount from the person or agency that received or holds this benefit. This excess amount is subject to a constructive trust in favor of the plan. The person receiving or holding plan benefits must produce any instruments or papers necessary to ensure this right of recovery.

Additional Information

Claims and Appeals Procedures

At the time of publication of this summary plan description (SPD), there are several claims and appeals administrators for the Plan.

This plan is exempt from the Affordable Care Act as a stand-alone dental plan, and therefore external review is not provided under this plan.

Claims Regarding Eligibility to Participate in the Plan

At this time, for eligibility-related claims and appeals, the claims fiduciary is the Plan Administrator (or its designee). Eligibility claims should be directed to the Plan Administrator at:

Plan Administrator
Frontier Benefits Service Center
Empyrean
P.O. Box 2607
Bellaire, TX 77402

1-855-FTR-2887

Claims Regarding Scope/Amount of Benefits Under the Plan

At this time, for benefit-related claims and appeals, the claims fiduciaries are the claims administrators who have discretionary authority to determine claims and appeals for Plan benefits:

Option	**Claims and Appeals Administrator**
PDP and Out-of-Area options	Metropolitan Life Insurance Company (MetLife)
DMO Option	Aetna

The addresses of the claims and appeals administrators for the Plan are listed under "Claims and Appeals Administrators" in the "Administrative Information" section. If you have a claim or appeal, you should contact the appropriate claims and appeals administrator for the type of claim or appeal you have.

The claims and appeals administrators have discretionary authority to:

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

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

If a Benefit Is Denied

Disagreements about benefit eligibility or benefit amounts can arise. The steps that you or your authorized representative is required to take to file a dental 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 an implant

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

	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 Frontier Benefits Service Center at 1-855-FTR-2887. You (or your authorized representative) must return the form to the Plan Administrator at the address on the form. To file a **benefit** claim, you (or your authorized representative) must write to the claims 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 Frontier Benefits-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 Frontier Benefits Service Center at 1-855-FTR-2887 or your claims administrator. 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 Frontier 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 Frontier Benefits Service Center's receipt of your properly submitted 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	72 hours

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
			of coverage); otherwise, within 72 hours	
Failure to provide sufficient information procedure If you fail to provide sufficient information, the claim may be decided based on the information provided. However, the Plan Administrator or claims administrator 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 Plan Administrator or claims administrator within **(see columns to the right)**	The time period **remaining** for the initial claim	The time period **remaining** for the initial claim		48 hours

How you will be notified of the claim decision
If your claim is approved, the Plan Administrator or claims administrator generally will notify you by telephone

If your claim is **denied**, in whole or in part, the Plan Administrator or claims administrator will notify you in writing, except for urgent care. Your denial notice will contain:

- The specific reason(s) for the denial,
- The plan provisions on which the denial was based,
- Any additional material or information you may need to submit to complete the claim,
- Any internal procedures or clinical information on which the denial was based, and
- The plan's appeal procedures and your right to bring legal action under ERISA once the appeals are exhausted.

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

Step 2

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

The Plan Administrator is the claims fiduciary for all eligibility claims. The claims administrator is the claims fiduciary and has discretionary authority to finally determine benefit claims.

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. Benefits are payable only to the extent determined by the claims fiduciary.

	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 Plan Administrator at Step 1), write to the address specified on your claim denial notice. If you have an appeal for **benefits** (i.e., you wrote to your claims administrator as explained at Step 1), write to the contact identified by your 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 Plan Administrator or the claims 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 Plan Administrator or the contact identified by your claims administrator. At the time your claim is denied, the Plan Administrator or your claims administrator will give you instructions about how to file your appeal. You must identify that you are appealing an urgent care claim.
When you will be notified of the appeal decision You will be notified of the decision within **(see columns to the right)** of the Plan Administrator's or the claim administrator's receipt of your appeal	**Eligibility appeals:** 60 days	**Eligibility appeals:** 30 days **Benefit appeals:**[8] • 30 days, if plan provides 1 level	**Eligibility and benefit appeals:** • Before a reduction or termination of	**Eligibility and benefit appeals:** 72 hours[9]

	Special rules			
	Post-service claim	**Pre-service claim**	**Concurrent care claim**	**Urgent care claim**
	Benefit appeals:[7] • 60 days, if plan provides 1 level of mandatory appeal • 30 days, if plan provides 2 levels of mandatory appeal	of mandatory appeal • 15 days, if plan provides 2 levels of mandatory appeal	benefits would occur • If the concurrent claim involves urgent care, 72 hours[8]	

How you will be notified of the appeal decision
If your appeal is approved, the Plan Administrator or claims administrator will notify you in writing

If your appeal is **denied**, in whole or in part, the Plan Administrator or claims administrator will notify you in writing. Your denial notice will contain:

- The specific reason(s) for the denial,
- A statement regarding the documents to which you are entitled,
- An explanation of the voluntary appeal procedures, if any,
- Any internal procedures or clinical information on which the denial was based,
- The plan provisions on which the denial was based, and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
- Your right to bring a civil action under ERISA Section 502.

Step 3

How to proceed if necessary
If you had an **eligibility** appeal that was denied by the Plan Administrator, Frontier will not review your matter again, unless new facts are presented. You have a right to bring a civil action under ERISA Section 502.

If you had a **benefit** appeal that was denied by a claim administrator that offers 1 mandatory level of appeal, it will not review your matter again, unless new facts are presented. You have a right to bring a civil action under ERISA Section 502.

If you had a **benefit** appeal that was denied by a claims administrator that offers 2 mandatory levels of appeal, you may appeal 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, the claims administrator will provide you with an independent medical review, upon request, in conjunction with this second and final appeal.

[7] If your plan provides more than one level of appeal, the response time frame is shorter, as noted above. A few Frontier plans offer a voluntary level of appeal. You are not required to file this voluntary appeal before filing a civil action under ERISA; however, you may find it helpful. The claims administrator 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.

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

The following provision applies if the 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 claims administrator's receipt of your second and final appeal. If this appeal is denied, the claims administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action under ERISA Section 502.	30 days	15 days	Time period remaining from your first appeal. Of course, the clock stops while you are preparing your second appeal.	Time period remaining from your first appeal. Of course, the clock stops while you are preparing your second appeal.

Peer Review

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

Proof of Loss

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

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

Exhaustion of Administrative Remedies

Before filing any claim or action in court or in another tribunal with respect to this Plan, you must first fully exhaust all of your actual or potential rights under the claims procedures provided above by filing an initial claim and then seeking a timely appeal of any denial, (other than a voluntary appeal level). This relates to claims for benefits, eligibility and to any other issue, matter or dispute with respect to the plan (including any plan interpretation or amendment issue).

This exhaustion requirement shall apply even if the Plan Administrator has not previously defined or established specific claims procedures that directly apply to the submission and consideration of a particular issue, matter or dispute. After you have filed your initial claim, the Plan Administrator will inform you of any specific claims procedures that will apply to your particular issue, matter or dispute, or it will apply the claims procedures noted above.

Limitations on Actions

Any claim or action that is filed in a court or other tribunal against or with respect to the plan and/or the Claims or Plan Administrators of the Plan must be brought within the following timeframes:

- For any claim or action relating to health benefits, the claim or action must be brought within three years of the date the supply was furnished or the service was rendered

- For all other claims (including eligibility claims), the claim or action must be brought within two years of the date when you know or should know of the actions or events that gave rise to your claim

Any claim or action brought after the above timeframes will be void. Any claim or action filed in a court or any other tribunal against or with respect to the Plan can only be brought or filed in the United States District Court for the District of Connecticut.

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.

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you
are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim
to be frivolous).

Assistance With Your Questions

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

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

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

HIPAA Privacy Rights

The 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 Frontier health plan or Frontier.
- 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 Frontier 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 Notice of Privacy Practices is located in the Required Health Coverage Notices document. You may view this document on the Benefits Website or contact the Frontier Benefits Service Center to obtain a copy.

If you have a complaint about the way that your personal health information is handled by Frontier or the Claims Administrator, you are encouraged to share your complaint with Frontier by contacting the Frontier Benefits Service Center. Frontier is committed to trying to resolve your concerns about the privacy of your personal information. Additional rights that you may have are described in the Privacy Notice.

Disclaimer

Your eligibility for benefits is determined by the Plan Administrator. Frontier Communications Corporation (Frontier) has full discretionary authority to interpret the terms of the plans summarized in this document and determine your eligibility for benefits under the Plan's terms.

If you are covered by an option not described in this SPD, material for that plan option is provided to you separately by the administrator or the Frontier Benefits Service Center. The material is hereby incorporated into this document by reference. That material, together with this document, comprise your SPD.

Although Frontier presently intends to continue the Plan outlined in this SPD, it reserves the right to amend, modify, suspend or terminate the Plan, in whole or in part, at any time, at its discretion, with or without advance notice to participants, for any reason, subject to applicable law and any duty to bargain collectively.

Accordingly, Frontier has the discretion to offer or terminate any benefit option and may change the benefits design, administrators and network providers of any option. Changes generally correspond with the Benefits Annual Open Enrollment period. Review the information you receive during Benefits Annual Open Enrollment for any plan changes.

Frontier also reserves the right to change the amount of required participant contributions for coverage under the Plan at any time, with or without advance notice to participants, subject to any duty to bargain collectively.

All terms of the plans are legally enforceable. However, this statement of benefits does not constitute a contract of employment or guarantee of any particular benefit.

As a matter of prudent business planning, Frontier continually is reviewing and evaluating various proposals for changes in its benefit plans and programs. Because of the need for confidentiality, such proposals are not evaluated below high levels of management. Frontier employees below such levels do not know whether Frontier will or will not adopt any future changes and/or new benefit plans and programs. Unless and until Frontier formally announces such changes, no one is authorized to give assurances that such changes will or will not occur.

Any actions noted above may be taken by Frontier and any officer of Frontier who has the authority or who has been delegated the authority to take such action. Benefits for claims occurring after the effective date of a plan amendment or termination are payable in accordance with the terms of the plan as modified by the amendment or termination. All statements in this document and all representations by Frontier or its personnel are subject to this right of termination and amendment. This right applies without limitation, even after an individual's circumstances have changed by retirement, disability or otherwise.

Administrative Information

Administrative information about the Plan is provided in this section.

Important Telephone Numbers

You can connect to the Frontier Benefits Service Center and other Frontier benefit providers by calling 1-855-FTR-2887. If you prefer, you can call the benefit providers directly via the telephone numbers shown on your Important Benefits Contacts insert.

Plan Sponsor/Employer

The Plan sponsor/employer is:

Frontier Communications Corporation
EIN: 06-0619596

Merritt 7 Corporate Park
401 Merritt
Norwalk, CT 06851
(203) 614-5114

Plan Administrator

The Plan administrator is:

Frontier Communications Corporation
ATTN: Plan Administrator
Merritt 7 Corporate Park
401 Merritt
Norwalk, CT 06851

The Plan Administrator may be contacted by phone or in person through the Company's Benefits Department. Call 203-614-5600.

You may communicate to the Plan Administrator in writing at the address above. But, for questions about Plan benefits, you should contact the Frontier Benefits Service Center. The Frontier Benefits Service 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 benefit Plan communications, to prepare reports and make filings for the Plan and to otherwise oversee the administration of the Plan. However, most of your day-to-day questions can be answered by the Plan's benefits administrator or a Benefits Center Representative.

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

Benefits Administrators

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

- Aetna is the benefits administrator for the Standard Option and the Dental Maintenance Organization (DMO) option. (See below for the address for the benefits administrator.)

- Metropolitan Life Insurance Company (MetLife) is the benefits administrator for the Preferred Dentist Program (PDP) option and the Out-of-Area option. (See below for the address for the benefits administrator.)

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

Claims and Appeals Administrators

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

Metropolitan Life Insurance Company (MetLife)

Under the PDP and Out-of-Area options, MetLife is the claims and appeals 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

Tel: 1-800-942-0854

Aetna

Under the DMO options, Aetna is the claims and appeals administrator responsible for exercising the discretion to determine benefit payments, and also is the claims administrator for claims relating to the scope or amount of benefits under these options. Aetna can be reached at the following addresses:

DMO Option
Aetna
P.O. Box 15046
Albany, NY 12212-5046

Tel: 1-877-238-6200

Qualified Medical Child Support Orders (QMCSOs)

The Frontier Benefits Service Center is responsible for the administration of QMCSOs. The Frontier Benefits Service Center can be reached at the following address:

Frontier Benefits Service Center
Empyrean
P.O. Box 2607
Bellaire, TX 77402

Or you can call 1-855-FTR-2887

Plan Funding

PDP and Out-of-Area Options

The Plan is not financed by an insurance company, nor are Plan benefits guaranteed under a contract of insurance. The claims and appeals administrators listed under the "Additional Information" section do not insure or guarantee Plan benefits.

Benefits are paid from the Company's general assets.

DMO Option

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

Plan Identification

Dental coverage is provided through the Frontier Communications Corporate Services Inc. Dental Expense Plan for Mid-Atlantic Associates, which is a component plan of Frontier Plan 550. It is a welfare plan, that is a group health plan, listed with the Department of Labor under two numbers: The Employer Identification Number (EIN) is 06-0619596 and the Plan Number (PN) is 550.

In addition to the benefits described in this SPD, Frontier Plan 550 provides other benefits to Mid-Atlantic associate employees of Frontier who will receive their own version of the SPD. Medical benefits are provided under the component plans referred to as the Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates. Vision benefits are provided under the component plan referred to as the Vision Care Plan for Mid-Atlantic Associates. Medical and vision benefits are described in separate SPDs.

Plan Year

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

Agent for Service of Legal Process

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

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

Frontier Communications Corporation
ATTN: General Counsel
Merritt 7 Corporation Park
401 Merritt
Norwalk, CT 06851

Official Plan Document

This SPD is a summary, and part, of the official Plan documents.

Collective Bargaining Agreements

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

Participating Companies

The following is a list of current participating companies. The list may change from time to time: Frontier Communications Corporate Services Inc., Frontier Communications Corporation and each other affiliate of Frontier.

However, only individuals covered by a collective bargaining agreement providing for participation in the applicable benefit option and associated with the business group, entities, subsidiaries and locations acquired through the merger with Verizon (as identified by Frontier) are eligible to participate if they satisfy the requirements set forth above.

Glossary

C

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

Covered Person
Any employee 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
The amount of covered expenses you pay before certain options pay benefits for specific care.

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

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

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
If you cover an individual who is not an Internal Revenue Service (IRS) tax dependent for health plan purposes, Frontier will report income for you that reflects the value of the coverage for that individual for tax reporting purposes. This is known as imputed income.

IRS Tax Dependent
In general, a biological or adopted child (or child placed for legal adoption), stepchild or an eligible foster child under age 27 is an IRS tax dependent for health plan purposes. In addition, an IRS tax dependent for health plan purposes generally includes a U.S. citizen or

resident who is a “qualifying child” or a “qualifying relative,” with some modifications as follows:

A “qualifying child” includes a person who:

- Is under the age of 19 (or 24 in the case of a full-time student) or is permanently and totally disabled.
- Is your child, grandchild, brother, sister, stepbrother or stepsister or niece or nephew.
- Does not provide over one-half of his or her own support for the calendar year.
- Lives with you for more than one-half of the calendar year (or, generally, with the other parent, if you are divorced).

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.”

Please note, however, that not all IRS tax dependents are eligible dependents under this Plan. Specifically, your children over age 19 are eligible only if they are disabled or are full-time students.

Examples
Your 25-year-old grandchild 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 grandchild does not meet the definition of “qualifying child,” he or she meets the definition of “qualifying relative.”

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

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

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

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

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

- The fee most commonly charged by a majority of providers in a given geographic area where those providers have similar training in the performance of the procedures

- The fee normally charged by that provider for a similar service or supply

- The amount charged for unusual circumstances or complications requiring additional time, skill and experience in connection with that particular dental service, supply or procedure.

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

Spouse
Your legal spouse is eligible to be covered under the Plan, unless you are divorced. 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. Effective from and after September 16, 2013, the term “spouse” also includes a legal same sex spouse if the marriage was validly entered into in a state or foreign country whose laws authorize the marriage of two individuals of the same sex, even if the married couple reside in a state that does not recognize the validity of same-sex marriages.