WE'VE GOT YOU COVERED

Your Verizon Benefits

ANNUAL ENROLLMENT 2015

November 6 to November 20, 2014

BenefitsConnection

www.verizon.com/benefitsconnection

ANNUAL ENROLLMENT IS NOVEMBER 6 THROUGH NOVEMBER 20, 2014

Annual Enrollment is your opportunity to review your Verizon retiree coverage and make choices for the upcoming year. Be sure to review your options for 2015 and make any changes before the enrollment deadline.

Verifying Your Dependents

If you add a dependent to your coverage during Annual Enrollment, or at any time during the year, you will need to provide documentation to verify eligibility. Instructions for completing dependent verification will be sent to your home address on file after you have enrolled your dependent. If you have questions about eligibility, please refer to your Summary Plan Description (SPD), available in the Library Section of BenefitsConnection.

Dependent Children Enrolled in Dental Coverage

In order for a dependent child to be eligible for dental coverage after the end of the calendar year in which they reach age 19, he/she must be a full-time student at an accredited institution, or meet the conditions of being disabled. Coverage can continue through the end of the calendar year in which they reach age 25 as long as they maintain full-time student status.

Similar to last year, a dependent between the ages of 19 and 25 who has been identified as a full-time student with dental coverage under a Verizon plan will be automatically verified through the National Student Clearinghouse. If full-time student status cannot be verified, you'll receive instructions mailed to your home address on file after Annual Enrollment about what you need to do. Otherwise, you won't need to do anything further.

Rising Health Care Costs

It is important for you to review this material as there are changes to the medical plan provisions and increases in medical plan contributions as a result of the 2012 labor contract. Please read this material carefully to ensure you are aware of what is changing beginning January 1, 2015.

If your child is age 19 or over, is not a full-time student, and does not meet the conditions of being disabled, you must remove them from dental coverage during Annual Enrollment. If you would like to continue coverage for your dependent(s) through COBRA, please contact the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367) by December 31, 2014.

ACCESS TO HEALTH CARE: YOU HAVE OPTIONS

You may have different medical plan options available to you. Annual Enrollment is a good time to consider enrolling in a less expensive plan if it meets your needs. Information about these other medical plan options can be found on BenefitsConnection.

Not Eligible for Medicare? The Health Insurance Marketplace

There may be options available to you through the Health Insurance Marketplace established by the Affordable Care Act. The best place to get information and answers to any questions about Marketplace options is www.healthcare.gov, where you can view videos, search for health plans and learn more.

The Marketplace is intended to increase access to affordable health care for individuals who do not have access to affordable health care benefits from another source, such as their employer. As you consider forgoing your Verizon retiree medical coverage and enrolling in a Marketplace option instead, you need to understand the following potential implications:

- If you purchase health insurance through the Marketplace, Verizon will not contribute toward your cost of coverage or help you remit your payment.
- If you enroll in Verizon retiree medical coverage instead of a Marketplace option, you are not eligible for any government subsidy to pay for that coverage (i.e., a premium tax credit).
- Individuals are required to have "minimum essential coverage," or they must pay a tax. Both the Marketplace options and Verizon retiree medical coverage meet this definition, so if you are enrolled in either option, you will not be subject to a tax in 2015.
- If you are not enrolled in Verizon retiree medical coverage, you may be eligible for a government subsidy depending on your household income level and whether you are eligible for minimum essential coverage elsewhere.

Eligible for Medicare?

If you or a family member is eligible for Medicare, there may be Medicare options available through the individual market (and outside the plans that Verizon offers) that provide a lower cost for Medicare-eligible retirees based on medical needs.

MEDICAL PLAN CHANGES

There are some changes to the provisions of the MEP HCP and HCN medical plan options for 2015 as a result of the 2012 labor contract which are outlined below.

Two regional HMO options — HIP Health Plan of New York and Independent Health of Buffalo — will no longer be offered in 2015 to pre-Medicare retirees.

AT A GLANCE — MEP HCP BENEFITS[1]

PLAN PROVISION	2014	2015
Deductible: In-Network	$450 Individual/$1,125 Family	$475 Individual/$1,187.50 Family
Deductible: Out-of-Network	$700 Individual/$1,750 Family	$725 Individual/$1,812.50 Family
Out-of-Pocket Maximum: In-Network[2]	$1,100 Individual/$2,750 Family	$1,150 Individual/$2,875 Family
Out-of-Pocket Maximum: Out-of-Network	$2,000 Individual/$5,000 Family	$2,050 Individual/$5,125 Family
Prescription Drugs: Retail (In-Network)	PRE-MEDICARE **Generic:** Lower of $8 copay or discounted network price **Brand (Single-Source and Multi-Source):** 30% of discounted network price up to $25 maximum copay[3]	PRE-MEDICARE **Generic:** Lower of $9 copay or discounted network price **Brand (Single-Source and Multi-Source):** 30% of discounted network price up to $26.50 maximum copay[3]
	MEDICARE-ELIGIBLE **Generic:** Lower of $8 copay or discounted network price **Brand (Single-Source):** 30% of discounted network price up to $25 maximum copay **Brand (Multi-Source):** 40% of discounted network price up to $30 maximum copay	MEDICARE-ELIGIBLE **Generic:** Lower of $9 copay or discounted network price **Brand (Single-Source):** 30% of discounted network price up to $26.50 maximum copay **Brand (Multi-Source):** 40% of discounted network price up to $30 maximum copay
Prescription Drugs: Mail Order	PRE-MEDICARE **Generic:** Lower of $16 copay or discounted network price **Brand (Single-Source and Multi-Source):** 30% of discounted network price up to $50 maximum copay[3]	PRE-MEDICARE **Generic:** Lower of $18 copay or discounted network price **Brand (Single-Source and Multi-Source):** 30% of discounted network price up to $53 maximum copay[3]
	MEDICARE-ELIGIBLE **Generic:** Lower of $16 copay or discounted network price **Brand (Single-Source):** 30% of discounted network price up to $50 maximum copay **Brand (Multi-Source):** 40% of discounted network price up to $60 maximum copay	MEDICARE-ELIGIBLE **Generic:** Lower of $18 copay or discounted network price **Brand (Single-Source):** 30% of discounted network price up to $53 maximum copay **Brand (Multi-Source):** 40% of discounted network price up to $60 maximum copay
Prescription Drugs: Mail Order Out-of-Pocket Maximum	$700 per person	$742 per person

AT A GLANCE — HCN BENEFITS

PLAN PROVISION	2014	2015
Deductible: In-Network	$0 Individual/$0 Family	$0 Individual/$0 Family
Deductible: Out-of-Network	$700 Individual/$1,750 Family	$725 Individual/ $1,812.50 Family
Out-of-Pocket Maximum: In-Network[2]	$1,000 Individual/$2,500 Family	$1,050 Individual/$2,625 Family
Out-of-Pocket Maximum: Out-of-Network	$1,800 Individual/$4,500 Family	$1,850 Individual/$4,625 Family
Prescription Drugs: Retail (In-Network)	**PRE-MEDICARE** **Generic:** Lower of $8 copay or discounted network price **Brand (Single-Source and Multi-Source):** 30% of discounted network price up to $25 maximum copay[3]	**PRE-MEDICARE** **Generic:** Lower of $9 copay or discounted network price **Brand (Single-Source and Multi-Source):** 30% of discounted network price up to $26.50 maximum copay[3]
	MEDICARE-ELIGIBLE **Generic:** Lower of $8 copay or discounted network price **Brand (Single-Source):** 30% of discounted network price up to $25 maximum copay **Brand (Multi-Source):** 40% of discounted network price up to $30 maximum copay	**MEDICARE-ELIGIBLE** **Generic:** Lower of $9 copay or discounted network price **Brand (Single-Source):** 30% of discounted network price up to $26.50 maximum copay **Brand (Multi-Source):** 40% of discounted network price up to $30 maximum copay
Prescription Drugs: Mail Order	**PRE-MEDICARE** **Generic:** Lower of $16 copay or discounted network price **Brand (Single-Source and Multi-Source):** 30% of discounted network price up to $50 maximum copay[3]	**PRE-MEDICARE** **Generic:** Lower of $18 copay or discounted network price **Brand (Single-Source and Multi-Source):** 30% of discounted network price up to $53 maximum copay[3]
	MEDICARE-ELIGIBLE **Generic:** Lower of $16 copay or discounted network price **Brand (Single-Source):** 30% of discounted network price up to $50 maximum copay **Brand (Multi-Source):** 40% of discounted network price up to $60 maximum copay	**MEDICARE-ELIGIBLE** **Generic:** Lower of $18 copay or discounted network price **Brand (Single-Source):** 30% of discounted network price up to $53 maximum copay **Brand (Multi-Source):** 40% of discounted network price up to $60 maximum copay

[1] *The MEP HCP individual and family annual deductibles listed in the MEP HCP chart applies to retirees whose retirement date is on or after January 1, 2013. If you retired before January 1, 2013, then your individual and family annual deductible continues to be based on your retirement date.*

[2] *An additional layer of out-of-pocket cost protection was added to the MEP HCP and HCN plans in 2014; this additional protection also will apply to your prescription drug benefit in 2015. See the Important Changes to Your Plan section of this document for more details.*

[3] *If you choose a brand-name medication when a generic equivalent is available, you will pay the generic copay/coinsurance plus 100% of the difference in cost between the brand-name and generic. The maximum copay will not apply. This additional cost will apply unless your doctor certifies that you are medically unable to take the generic medication and the exception is approved by Express Scripts.*

IMPORTANT PRESCRIPTION DRUG INFORMATION

HMO Prescription Drug Coverage

For 2015, participants enrolled in the following HMOs that currently receive prescription drug coverage directly with the HMO will now receive their prescription drug coverage through Express Scripts: Capital District Physicians Health (CDPHP), UHC Passport/Harvard Pilgrim, BlueAlliance NY, Univera Healthcare (NY), and Aetna Inc HMO.

As a result of this change, you will receive a new prescription ID card.

In addition to the information below and on BenefitsConnection, you may also attain Express Scripts prescription plan information by logging onto www.express-scripts.com or by calling Express Scripts Member Services at 1-877-877-1878.

Below is the Express Scripts deductible and copay/coinsurance information:

AT A GLANCE — PRESCRIPTION DRUG COVERAGE

PRESCRIPTION AND DRUG TYPE	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Retail (up to a 30-day supply)	You Pay	You Pay
Annual Deductible	None	**PRE-MEDICARE:** $50
		MEDICARE-ELIGIBLE: None
Generic	Lower of $9 copay or discounted network price	**PRE-MEDICARE** After deductible, 30% of discounted network price plus 100% of the difference between the retail cost and the discounted network price
		MEDICARE-ELIGIBLE 30% of discounted network price plus 100% of the difference between the retail cost and the discounted network price
Brand (Single-Source and Multi-Source)	**PRE-MEDICARE** 30% of discounted network price up to $26.50 maximum copay[1]	**PRE-MEDICARE** After deductible, 40% of discounted network price plus 100% of the difference between the retail cost and the discounted network price[1]
	MEDICARE-ELIGIBLE **Single-Source:** 30% of discounted network price up to $26.50 maximum copay **Multi-Source:** 40% of discounted network price up to $30 maximum copay	**MEDICARE-ELIGIBLE** **Single-Source:** 40% of discounted network price plus 100% of the difference between the retail cost and the discounted network price **Multi-Source:** 50% of discounted network price plus 100% of the difference between the retail cost and the discounted network price

AT A GLANCE — PRESCRIPTION DRUG COVERAGE

PRESCRIPTION AND DRUG TYPE	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Mail Order (up to a 90-day supply)	You Pay	You Pay
Annual Deductible	None	N/A
Generic	Lower of $18 copay or discounted network price	N/A
Brand (Single-Source and Multi-Source)	**PRE-MEDICARE** 30% of discounted network price up to $53 maximum copay[1]	N/A
	MEDICARE-ELIGIBLE **Single Source:** 30% of the discounted network price up to $53 maximum copay **Multi-Source:** 40% of discounted network price up to $60 maximum copay	N/A

[1] *If you choose a brand-name medication when a generic equivalent is available, you pay the generic copay/coinsurance plus 100% of the difference in cost between the brand-name and generic. The maximum copay will not apply. This additional cost will apply unless your doctor certifies that you are medically unable to take the generic medication and the exception is approved by Express Scripts.*

Medicare Prescription Drug Coverage

For most Medicare-eligible retirees, if you or a covered family member is or becomes eligible for Medicare, your prescription drug coverage is provided through a Verizon-sponsored group Medicare Part D plan. This benefit consists of a standard Medicare Part D benefit, plus a supplemental "wrap-around" plan to preserve a comprehensive level of prescription drug benefits.

Medicare-eligible retirees who have moved to the Medicare Part D plan with the wrap-around will receive additional required information about the program each year. Retirees and family members who become eligible for Medicare will receive additional information at that time.

MEDICAL PLAN PREMIUM CONTRIBUTIONS

Your premium contributions depend on your retirement date, your net credited service date, and the medical plan option you select.

If You Retired Before January 1, 2013
With a Net Credited Service Date Before August 3, 2008

You will not be required to contribute premiums through 2015 if you enroll in the MEP HCP or HCN medical plan options. If you elect coverage under the EPO or an HMO medical plan option, the monthly premium contributions in Table 2 below will apply.

If You Retired January 1, 2013 or Later
With a Net Credited Service Date Before August 3, 2008

For 2015, you will only be required to pay the applicable monthly premium contribution amount, as noted in Table 1 or 2, for retiree medical coverage. However, beginning in 2016 and later plan years, as provided for in your 2012 labor contract, your annual contribution toward retiree medical coverage will equal the greater of (a) the excess, if any, of the cost of coverage for the coverage category and medical plan option you elect over the retiree medical cap described in the Retiree Medical Caps section or (b) the annual premium contribution amounts, based on the applicable monthly premium contribution amount for that plan year.

TABLE 1

MEP HCP AND HCN	MONTHLY CONTRIBUTION	
COVERAGE CATEGORY	PRE-MEDICARE RETIREE	MEDICARE-ELIGIBLE RETIREE
Retiree Only	$37.10	$18.55
Retiree + 1	$63.60	$31.80
Retiree + Family	$63.60	$31.80

TABLE 2

EPO AND HMOs	MONTHLY CONTRIBUTION *(No greater than the following rates)*[1]
COVERAGE CATEGORY	PRE-MEDICARE RETIREE
Retiree Only	$82.50
Retiree + 1	$125.00
Retiree + Family	$165.00

[1] *Medicare-eligible retirees will pay no more than half this amount.*

RETIREE MEDICAL CAPS

As you are aware, your benefit plans specify limits on the amount the Company will contribute toward retiree medical coverage that were agreed to in prior labor contracts. These limits are referred to as retiree medical caps. The retiree medical caps under the current labor contracts that apply beginning in 2016 will be based on the greater of:

- The COBRA contribution rates established in December 2014 for the 2015 plan year for pre-Medicare and Medicare-eligible retirees for the MEP HCP and HCN and, for the EPO and HMOs, no greater than the COBRA contribution rate for the HCN, or
- The retiree medical cap amounts in the 2008 labor contracts (see the following chart).

2008 LABOR CONTRACT RETIREE MEDICAL CAPS

COVERAGE CATEGORY	ANNUAL PRE-MEDICARE COMPANY CONTRIBUTION CAP	ANNUAL MEDICARE-ELIGIBLE COMPANY CONTRIBUTION CAP
Retiree Only	$12,580	$6,330
Retiree + 1	$25,160	$12,660
Retiree + Family	$31,450	$18,990

If your net credited service date is August 3, 2008 or later

The Company will provide the following annual contributions toward the cost of retiree medical coverage:

- **Not Eligible for Medicare:** $480 for each full year of net credited service, up to a maximum of 30 years.
- **Medicare-Eligible:** A reduced amount that is not less than half of the amount provided for pre-Medicare retirees with the same net credited service.

OTHER IMPORTANT INFORMATION

To Print a Confirmation Statement

A confirmation statement will no longer be automatically sent to your home address on file after Annual Enrollment. If you would like a paper confirmation statement of your 2015 coverage, simply log on to BenefitsConnection (www.verizon.com/benefitsconnection). From the Home Page, under My Benefits > Health and Insurance, click on *View Next Year's Coverage*, then select the Print icon in the upper-right corner.

Your enrollment information will continue to be available to you online 24/7. You can also request a confirmation statement be mailed to you by calling the Verizon Benefits Center.

Need to Make Changes or Have Questions?

If you want to make any changes to your Verizon benefits or covered dependents for 2015, you need to take action **between November 6 and November 20.** Just log on to BenefitsConnection (www.verizon.com/benefitsconnection) to find all the information you need and make your elections.

If you have questions and need help, you can call the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367). Representatives are available 8 a.m. to 6 p.m., Eastern time. During Annual Enrollment, Benefits Center hours are extended until 8 p.m., Eastern time.

IMPORTANT NOTE ABOUT SUPPLEMENTAL LIFE INSURANCE

The rates for supplemental life insurance are based on age ranges. This means you may see an increase in the amount you are paying if your age as of December 31, 2015 will be in the next age bracket.

IMPORTANT CHANGES TO YOUR PLAN

Out-of-Pocket Maximum Changes

As required by the Affordable Care Act, your total in-network out-of-pocket costs in 2015 under the medical plan options available to you will not exceed $6,600 for individual coverage and $13,200 for family coverage. The maximum imposed by the Affordable Care Act does not change your bargained for out-of-pocket maximum, but creates a separate legally required limit on in-network out-of pocket costs which requires that additional costs, such as copays and prescription drug expenses, count toward these limits even if they do not apply toward your bargained for out-of-pocket maximum. Costs that apply toward your total in-network out-of-pocket maximum include, for example, deductibles, copays, coinsurance, and in 2015, eligible prescription drug expenses. Out-of-pocket expenses that do **not** apply toward your out-of-pocket maximums include, for example, contributions, spending for non-covered items and services, out-of-network items and services, and the additional cost if you purchase a brand name prescription drug in a situation where a generic drug was available and medically appropriate as determined by your physician. Please refer to your Health Plan Comparison Charts on BenefitsConnection for more details.

Preventive Care Updates Required by the Affordable Care Act

As previously communicated to you, the Verizon medical plan options available to you are not grandfathered and accordingly, these medical plan options must offer certain preventive care benefits to you in-network without cost sharing. Under the Affordable Care Act, the medical plans generally may use reasonable medical management techniques to determine frequency, method, treatment, or setting for a recommended preventive care service.

For 2015, an additional update has been made to the preventive care benefits that must be offered without cost sharing. Specifically, if you are a woman who is at increased risk for breast cancer and at low risk for adverse medication effects, you may be eligible to receive risk-reducing medications, such as tamoxifen or raloxifene, in-network without cost sharing under the Verizon medical/prescription drug plan options. If your physician prescribes this type of medication to reduce your risk of breast cancer, contact Express Scripts (or your medical/prescription drug plan administrator) to ensure that you satisfy the administrative requirements necessary to receive this important benefit. You may be required to meet requirements beyond just submitting the prescription – for example, you and/or your physician may need to demonstrate that you are at an increased risk for breast cancer. Again, contact the Verizon medical plan option or prescription drug administrator, such as Express Scripts, for more details.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Affordable Care Act

Due to recent guidance under the MHPAEA, Verizon has made additional adjustments to mental health and substance use disorder benefits under its group health plan options. Contact your Verizon medical plan option or prescription drug administrator for details on all changes.

IMPORTANT LEGAL NOTICES

Notice of Privacy Practices for the Verizon Communications Inc. Health Plans

The Notice of Privacy Practices for the Verizon Communications Inc. Health Plans ("HIPAA Privacy Notice") explains the uses and disclosures the Verizon Health Plans may make of your protected health information, your rights with respect to your protected health information, and the Plans' duties and obligations with respect to your protected health information.

The HIPAA Privacy Notice can be found on BenefitsConnection. You may view the notice and/or print a paper copy from the website; or you also may request a paper copy by calling the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

Summary Health Information Required by the Patient Protection and Affordable Care Act

Summaries of Benefits and Coverage (SBCs) required by the Affordable Care Act are available on BenefitsConnection at www.verizon.com/benefitsconnection. If you would like a paper copy of the SBCs (free of charge), you may contact the Verizon Benefits Center at 1-855-4Vz-Bens (1-855-489-2367).

Verizon is required to make SBCs, which summarize important information about health benefit plan options in a standard format, available to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family in the case of illness or injury and choosing a health benefit option is an important decision. SBCs are being made available in addition to other information regarding your health benefits including Health Plan Comparison Charts which also can be found on BenefitsConnection.

Actual plan provisions for Company benefits are contained in the appropriate plan documents or applicable Company policies. This Annual Enrollment guide provides updates to your existing Summary Plan Description (SPD) as of January 1, 2015. Please keep this guide and any additional Summary of Material Modification (SMM) with your SPDs until Verizon provides you with SPDs that have been updated to reflect the changes to your benefits. As always, the official plan documents determine what benefits are provided to Verizon employees, retirees, and their dependents. Your SPDs are available at www.verizon.com/benefitsconnection, or you can call the Verizon Benefits Center and request a printed copy. As explained in your SPD, Verizon reserves the right to amend or terminate any of its plans or policies at any time with or without notice or cause, subject to applicable law.