Annual Enrollment 2013: November 7 through 21

Your Benefits — **Connected**

It's Time to Review
Your Verizon Benefit Options

BenefitsConnection
www.verizon.com/benefitsconnection

Annual Enrollment for 2013 will begin November 7, 2012 and will continue through November 21, 2012. Enclosed is important information about how your benefits will change for 2013 and what you can expect for Annual Enrollment. Additionally, you will soon receive a separate **Annual Enrollment Confirmation Statement/Enrollment Worksheet** in the mail that shows your current elections as well as your 2013 options.

Under the new East labor contracts, there are a number of changes to health care benefits. It's important that you consider these changes so you can make the best decisions when selecting your 2013 health care coverage in the upcoming Annual Enrollment period.

Your plans continue to offer affordable, quality health care for you and your family, including access to important preventive care and valuable prescription drug coverage, and Verizon will continue to pay for the majority of the cost of your group health care coverage. We will continue to manage your benefit programs to keep costs down and quality coverage up. A good example of this is the recent Dependent Verification Process and we thank you for your participation.

If you are retired with a net credited service date before August 3, 2008, you will not be required to contribute premiums during 2013, 2014 and 2015 if you enroll in the MEP HCP or HCN plan options. If you elect coverage under the EPO or an HMO option, a monthly premium contribution will apply. This amount will generally be no more than $67.50 per month for retiree only coverage and $135.00 per month for family coverage. Medicare-eligible retirees will pay no more than half this amount. The value of these options is significantly higher than the monthly premium contribution.

As in the past, if you are happy with your current health plan option and wish to continue it, there is nothing you need to do during Annual Enrollment unless you have a change to your covered dependents.

Please review the enclosed information thoroughly and then select the health care option that best meets the needs of you and your family.

Sincerely,

DC Chiffriller

Donna Chiffriller
Vice President, Benefits

Annual Enrollment is November 7 through 21, 2012

Choosing Your 2013 Coverage

During Annual Enrollment, you have the opportunity to decide which coverage you want for 2013. If you don't make any changes, your current 2012 elections will continue for medical, dental, and supplemental life insurance.

Getting Registered

The first time you log on to BenefitsConnection, you will need to register. Just follow the simple on-screen instructions to get started.

To make your 2013 benefit choices during Annual Enrollment, please log on to the new BenefitsConnection website (www.verizon.com/benefitsconnection) or call the new Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367) by November 21. Representatives are available Monday through Friday, 8 a.m. to 6 p.m. ET. During Annual Enrollment, Benefits Center hours are extended to 8 p.m. ET.

As part of the transition to Xerox HR Solutions, we are pleased to bring you new resources to keep you connected with your Verizon benefits.

Online Tools

BenefitsConnection (Access online at www.verizon.com/benefitsconnection)

On this site you can learn about your plan options, review your coverage, make any changes and enroll. With this new portal, you'll be able to view your coverage elections virtually anywhere, anytime, on any web-enabled device or smartphone.

WellConnect (Access through BenefitsConnection)

This is your personalized wellness resource center to help you and your family live healthier. You'll have confidential access to all your Verizon wellness benefits as well as access to online tools to help you eat well, stay active and maintain a well-balanced lifestyle.

Your Eligible Dependents

You can choose to cover your spouse, domestic partner and/or children under your Verizon benefits.

Change! If you are currently covering an eligible Class II Dependent or Sponsored Child, his or her coverage can continue. **However, no new Class II Dependents or Sponsored Children can be added to Verizon coverage. If you drop a Class II Dependent or Sponsored Child from your coverage, he or she cannot be added back to coverage.**

When Dependents Need to be Verified

If you add a new dependent to your Verizon coverage, you will be required to verify his or her eligibility.

WellConnect Feature:

Access to Verizon HealthZone, powered by WebMD

The Verizon HealthZone is an online health portal that provides personalized and confidential health care tools and resources that can help you set health goals and make the best health and health care decisions. Online tools include:

- A search feature that provides access to information such as symptoms, diagnoses, potential risks, and treatment options for more than 350 of the most common health topics
- Online lifestyle management centers, which provide 24/7 access to information about healthy eating, stress reduction, exercise, and weight management
- A confidential Personal Health Record which allows you to keep track of your medical information in one place
- A Symptom Checker, which allows you to select parts of the body (computer-generated) where you are experiencing symptoms, to help you determine if and when you should seek medical attention

Medical Plan Options

There are changes to all medical plans under the new labor contracts, including changes to deductibles, copays, coinsurance and out-of-pocket maximums.

If there is no in-network provider for a specific service within 40 miles of your home zip code, you and your eligible dependents will be eligible to receive in-network benefits for that service that apply to the medical option you are enrolled in.

HCN Highlights

- Provides in-network coverage through Anthem's Blue Card PPO Network; out-of-network services are also covered.
- No annual deductible for in-network services—you save money by using in-network providers!
- Preventive care services are covered at 100% (in-network) without a copay.

At a Glance 2013 HCN Benefits

Plan Provisions	In-Network*	Out-of-Network**
Preventive Care (Coverage, age, and frequency provisions of the Affordable Care Act apply)	The plan pays 100%	The plan pays 80%, no deductible
Doctor's Office Visits	**Pre-Medicare:** $20 copay for PCP and $25 copay for specialist **Medicare-Eligible:** $10 copay for PCP and $15 for specialist	After meeting your deductible, the plan pays 70%
Outpatient Lab and X-Ray	**Pre-Medicare:** $20 copay **Medicare-Eligible:** $10 copay	After meeting your deductible, the plan pays 70%
Other Covered Services	Generally, the plan pays 90%	Generally, after meeting your deductible, the plan pays 70%
Chiropractic Services	**Pre-Medicare:** $20 copay **Medicare-Eligible:** $10 copay Limited to $750 per calendar year per individual; limit combined in-network and out-of-network	After meeting your deductible, the plan pays 70%
Deductible	None	**Individual:** $700 **Family:** 2.5 times the individual deductible amount
Out-of-Pocket Maximum	**Individual:** $1,000 in-network and out-of-network combined, plus an additional $800 out-of-network **Family:** 2.5 times the individual out-of-pocket maximum amount; an individual will never need to exceed his or her own individual amount. *Note:* Amounts paid toward the deductible will now apply toward the out-of-pocket maximum.	
Emergency Room	**Pre-Medicare:** $75 copay (copay waived if admitted) **Medicare-Eligible:** $25 copay (copay waived if admitted)	
Urgent Care	**Pre-Medicare:** $20 copay **Medicare-Eligible:** $10 copay	

**The coinsurance is based on Network Negotiated Fee (NNF) as negotiated by Anthem.*

***The coinsurance is based on Maximum Allowed Amount (MAA), which is 315% of the national Medicare schedule.*

MEP HCP Highlights

- In-network coverage through Anthem's Blue Card PPO Network; out-of-network services are also covered. (You save money by using in-network providers!)
- Preventive care services (in-network and out-of-network) covered at 100%
- Coinsurance for most services 90%/70% (in-network/out-of-network)

At a Glance 2013 MEP HCP Benefits

Plan Provisions	In-Network*	Out-of-Network**
Preventive Care (Coverage, age, and frequency provisions of the Affordable Care Act apply)	The plan pays 100%, no deductible	
Doctor's Office Visits	**Pre-Medicare:** $20 copay, no deductible **Medicare-Eligible:** $10 copay, no deductible	After meeting your deductible, the plan pays 70%
Outpatient Lab and X-Ray	**Pre-Medicare:** $20 copay, no deductible **Medicare-Eligible:** $10 copay, no deductible	After meeting your deductible, the plan pays 70%
Other Covered Services	After meeting your deductible, the plan pays 80% or 90% depending upon the service	Generally, after meeting your deductible, the plan pays 70%
Chiropractic Services	After meeting your deductible, the plan pays 80% Limited to 60 visits per calendar year (not to exceed 1 visit per day); limit combined in-network and out-of-network	$20 copay plus difference between $92 flat fee and cost of service
Deductible	**Individual:** ***If your retirement date is prior to August 3, 2003:*** Your annual deductible is equal to 1% of your annual pension benefit in effect on December 31 of the previous calendar year (minimum of $25; maximum of $150) ***If your retirement date is after August 2, 2003 and before January 1, 2013:*** Your annual deductible is equal to the deductible you had as an active employee as of the date of your retirement. 8/3/2003 - 12/31/2005: $150 1/1/2006 - 12/31/2007: $200 1/1/2008 - 12/31/2012: $250 **Family:** 2.5 times the individual deductible	
Carryover Deductible	Expenses applied during October, November and December also apply to the next year's deductible	
Out-of-Pocket Maximum	**Individual:** $1,050 in-network and out-of-network combined, plus an additional $950 out-of-network **Family:** 2.5 times the individual out-of-pocket maximum amount; an individual will never need to exceed his or her own individual amount *Note:* Amounts paid toward the deductible will now apply toward the out-of-pocket maximum.	
Emergency Room	**Pre-Medicare:** $75 copay (copay waived if admitted) **Medicare-Eligible:** $25 copay (copay waived if admitted)	
Urgent Care	**Pre-Medicare:** $20 copay **Medicare-Eligible:** $10 copay	

**The coinsurance is based on Network Negotiated Fee (NNF) negotiated by Anthem.*

***The coinsurance is based on Maximum Allowed Amount (MAA), which is 315% of the national Medicare schedule.*

EPO Highlights (Not Available if You are Medicare-Eligible)

- Provides in-network coverage only through Anthem's Blue Card PPO Network; no out-of-network benefits
- No annual deductible

Change! The EPO is not available to new enrollees. If you are currently in the EPO and choose another option for 2013, you and your eligible dependents will not be able to enroll in the EPO in the future.

At a Glance 2013 EPO Benefits

Plan Provisions	In-Network
Preventive Care	The plan pays 100%
Doctor's Office Visits	$20 copay for PCP and $25 copay for specialist
Outpatient Lab and X-Ray	The plan pays 100%
Hospital Admissions	$150 copay per admission
Other Covered Services	Generally, the plan pays 100%
Deductible	None
Out-of-Pocket Maximum	None
Emergency Room	$75 copay (copay waived if admitted)
Urgent Care	$25 copay

Local HMOs

HMOs are available in select geographic areas.
Most HMOs feature:

- In-network coverage only with no annual deductible
- Your choice of primary care physician
- A copay of not more than $20 for a primary care physician office visit
- A copay of not more than $25 for a specialist office visit (referral may be required)
- A copay of not more than $75 for an emergency room visit
- Coverage for prescription drugs

To see if there is an HMO available in your area, check your 2013 options on BenefitsConnection or your worksheet.

The maximum copays described above do not apply to Medicare Advantage Plans that are filed and approved by the Federal Government.

Change! Medical Plan Administrator

Effective January 1, 2013, Anthem Blue Cross Blue Shield (Anthem) will administer Verizon's HCN, MEP HCP and EPO plan options, as well as the mental health and substance abuse benefits for these options. The Blue Card PPO Network is the same network that is currently used for the MEP HCP and the EPO plan options.

Anthem is one of the nation's leading providers of health care plans. Nationwide, more than 96% of hospitals and 91% of professional providers contract directly with Blue Cross Blue Shield companies, so there's a good likelihood that the doctors you use today are in the Anthem network. If you want to check to see if your provider is in the network, go to www.anthem.com/verizon.

IMPORTANT NOTE: If you or a family member are currently undergoing treatment with a doctor or other provider not in the Anthem network, you may be eligible to receive in-network benefits for up to three months in 2013 to allow you to complete your treatment or transition to a provider in the Anthem network. Please contact Anthem at 1-855-869-8139 if you need to take advantage of this transition of care.

2013 Medical Plan Premium Contributions for Post-December 31, 1991 Retirees

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 during 2013, 2014 and 2015 if you enroll in the MEP HCP or HCN options.

If you elect coverage under the EPO or an HMO option, a monthly premium contribution will apply. This amount will be no more than:

- $67.50 per month for retiree only coverage
- $105.00 per month for retiree + 1 coverage
- $135.00 per month for family coverage

Medicare-eligible retirees will pay no more than half this amount.

You will soon receive a separate ***Annual Enrollment Confirmation Statement/Enrollment Worksheet*** in the mail that shows your current elections as well as your 2013 options and costs.

Retiree Medical Caps

As you are aware, your benefit plans specify limits on the amount the company will contribute towards retiree medical coverage that were agreed to in prior labor contracts. These limits are referred to as retiree medical caps. The recently negotiated labor contracts ensure that you will not have to pay any amounts above these retiree medical caps if you are enrolled in the MEP HCP or HCN during the term of the new labor contracts, even though the cost of these plans is projected to exceed the retiree medical caps. The new labor contracts also increased the amount of the retiree medical caps that will apply beginning in 2016. The new retiree medical caps 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 chart below).

Coverage Category Elected by Retiree	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

For 2013, 2014, and 2015, you will only be required to pay the applicable monthly premium contribution amount, if any, for retiree medical coverage. However, beginning in 2016 and later plan years, your annual contribution toward retiree medical coverage will equal the greater of (1) the excess, if any, of the cost of coverage for the coverage category and medical option you elect over the retiree medical cap described above, or (2) the annual premium contribution amounts, calculated based on the applicable monthly premium contribution amount.

Prescription Drug Highlights

With the new labor contracts, there are changes to your cost for prescription drugs depending on the type of medication, where you fill the prescription and how long you'll be taking it. The chart shows the new copays and coinsurance amounts for prescription drugs.

At a Glance 2013 Prescription Drug Coverage

Prescription and Drug Type	In-Network Pharmacy	Out-of-Network Pharmacy
Retail (30-day Supply)	**You Pay** *(original prescription and each refill)*	**You Pay** *(original prescription and each refill)*
Annual Deductible	None	$50 combined for generic and brand drugs
Generic Drugs	Lower of $8 copay or discounted network price	After deductible, 30% of discounted network price plus 100% of the difference between the retail cost and the discounted network price
Brand Drugs (Single-Source and Multi-Source Brand Drugs)	**Pre-Medicare:** 30% of discounted network price, up to $25 maximum copay per prescription.* **Medicare-Eligible:** Single-Source - 30% of discounted network price, up to $25 maximum copay per prescription Multi-Source – 40% of discounted network price, up to $30 maximum copay per prescription	**Pre-Medicare:** After deductible, 40% of discounted network price plus 100% of the difference between the retail cost and the discounted network price.* **Medicare-Eligible:** Single-Source – After deductible, 40% of discounted network price plus 100% of the difference between the retail cost and the discounted network price. Multi-Source – After deductible, 50% of discounted network price plus 100% of the difference between the retail cost and the discounted network price
Maintenance Drugs (beyond three fills at a retail pharmacy)	50% of discounted network price, maximum copay does not apply	50% of discounted network price plus 100% of the difference between the retail cost and the discounted network price.
Mail Order Pharmacy (90-day Supply)**	**You Pay** *(original prescription and each refill)*	**You Pay** *(original prescription and each refill)*
Generic Drugs	Lower of $16 copay or discounted network price	N/A
Brand Drugs (Single-Source and Multi-Source Brand Drugs)	**Pre-Medicare:** 30% of discounted network price, up to $50 maximum copay per prescription.* **Medicare-Eligible:** Single-Source - 30% of discounted network price, up to $50 maximum copay per prescription Multi-Source – 40% of the discounted network price, up to $60 maximum copay per prescription	N/A

**Pre-Medicare only - 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. Maximum copays 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.*

***For MEP HCP enrollees, there is an annual out-of-pocket maximum of $600 per person for mail order pharmacy. The additional cost when a pre-Medicare retiree chooses a brand-name medication when a generic equivalent is available does not count against the out-of-pocket maximum.*

Save Money on Prescription Drugs

There are several ways you can save on the cost of prescription drugs. This includes choosing a generic drug when available and using the mail order pharmacy for long-term (maintenance) prescription medication.

Using Generics

Many brand medications, referred to as multi-source brand medications, have a generic equivalent available. Generics have the same active ingredient formula as brand-name drugs, but they are much less expensive, which can translate into savings for consumers Single-source brand medications do not have a generic equivalent, but there is often a generic alternative available that treats the same condition and will cost you less.

If your doctor prescribes a medication, make sure to ask if there is a generic version. For pre-Medicare retirees only — If you choose a brand-name medication when a generic equivalent is available, you will pay the generic copay/coinsurance plus the difference in cost between the brand-name and generic. 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.

Using the Mail Order Pharmacy (for Long-Term Maintenance Medications)

If you or a family member take maintenance medications—for example, for high blood pressure—you can save money by using the mail order pharmacy program.

If you fill a maintenance prescription more than three times (initial prescription plus two refills) at a retail pharmacy, you will pay 50% of the cost of that drug beginning with the fourth fill and for all subsequent fills plus, if you use an out-of-network pharmacy, 100% of the difference between the retail cost and the discounted network price. Plan maximums will not apply. So, for maintenance prescriptions, mail order offers savings as well as the convenience of ordering a 90-day supply of your medication.

Express Scripts recently merged with Medco, and the new combined company is called Express Scripts. The HCN, MEP HCP and EPO plan options provide prescription drug coverage through Express Scripts. If you are enrolled in an HMO, check BenefitsConnection or with your plan for prescription drug coverage information.

Important Prescription Drug Information

In February 2011, we sent you a letter informing you that Verizon will sponsor a group Medicare Part D plan and that most Medicare-eligible retirees and family members will receive their prescription drug coverage through this program beginning in 2013. Because your current prescription drug benefits are more comprehensive than the standard Medicare Part D program, Verizon has designed a supplemental "wrap-around" plan to preserve the level of prescription drug benefits retirees currently receive. An overview guide is being sent to Medicare-eligible retirees who will be part of the group moving to the Medicare Part D plan with the supplemental "wrap around."

Dental Coverage

There are no changes to your dental coverage options.

Life Insurance

No changes have been made to your life insurance coverage options.

Important Note about Supplemental Life Insurance

If you are enrolled in Supplemental Life Insurance, the rates you pay are age-based, which means you may see an increase to the amount you are paying if you will age into the next rate tier during 2013.

Notes:

Notes:

Additional Changes under the Patient Protection and Affordable Care Act

In March of 2010, Congress passed health care reform, which is now known as the "Affordable Care Act." Although many retiree medical plans are not required to comply with the Affordable Care Act group market reforms, Verizon is applying the reforms to the health plans offered to individuals who retired after August 9, 1986 under the Verizon Post-1995 Collectively Bargained Retiree Health Plans. Verizon previously communicated some of the changes under the Affordable Care Act as part of the 2011 Annual Enrollment. Following is a general overview of some additional changes effective January 1, 2013.

- Certain preventive care goods and services, including women's preventive care will be covered with no cost sharing (copays, coinsurance, or deductibles) when delivered by an in-network provider.
- In addition to the existing claims and appeals rules, there can be an Independent Review Organization review with respect to denials involving medical judgment or a rescission of coverage.
- Most Verizon medical plan options do not require you to designate a primary care physician (PCP). However, for the options that do have such a requirement, specific consumer/patient protections will apply (for example, you have the right to designate a pediatrician as a PCP for your child and you are not required to obtain authorization from a PCP to obtain access to obstetrical or gynecological care).
- You can enroll your adult child up to age 26, even if he or she is eligible for other employer-sponsored coverage, including military coverage. Before January 1, 2013, an adult child up to age 26 was not eligible for Verizon coverage if he or she was eligible for employer-sponsored coverage (other than parental coverage).
- Summary Health Information Required by the Patient Protection and Affordable Care Act:

  Starting this year, Summaries of Benefits and Coverage (SBCs) required by the Affordable Care Act are available on the BenefitsConnection website 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 1-855-4VzBens (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 plan information on BenefitsConnection. Click on See My Medical Plan Provisions and select My Medical Plan Options.

This is a general overview of the changes under the Affordable Care Act. Additionally, Verizon will provide you with a separate communication that contains a summary of the changes for 2013 under the Affordable Care Act and how key elements of the Affordable Care Act may affect you.

This Annual Enrollment Guide includes the most recent collectively bargained provisions agreed to between Verizon and the CWA and IBEW that are effective January 1, 2013 and provides updates to your existing Summary Plan Description(s). This Guide does not describe other benefit changes that will become effective in 2014 and 2015 under the new labor contracts. Please keep this Guide along with updated SPDs that Verizon will provide you in the near future to reflect the changes to your benefits under the most recent collective bargaining agreement. 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; updated SPDs will be distributed to you in the near future. As explained in the SPDs, Verizon reserves the right to amend or terminate any of its plans or policies at any time and without notice or cause, subject to applicable law and any duty to bargain collectively.