Your benefits.

Investing together for a healthier you.

2017 Annual Enrollment
November 7 – November 18

New York/New England
Active CWA/IBEW

verizon

Investing together for a healthier you.

This guide reflects the terms that were agreed upon in the 2016 labor contracts. Read it carefully to ensure you are aware of what is changing on January 1, 2017.

2017 Annual Enrollment

Annual Enrollment opens November 7 and closes November 18 at midnight Eastern time.

This is your opportunity to review and update coverage elections to ensure the health and insurance coverages you have are what you and your family need for the upcoming year. Please make this a priority, and take advantage of the decision tools we provide to select the options that best meet your needs.

Enrollment is simple

If you're keeping the same coverages, then you're good to go. Your current medical (including prescription drug), dental, vision, life insurance, accidental death and dismemberment, and disability coverage will automatically continue for 2017. Also, your tobacco user status, Health Assessment credit, and spending account contributions will automatically carry over into 2017. If you wish to make any changes, then you must complete an active election on BenefitsConnection as part of Annual Enrollment. If you have questions or need assistance, you can call the Verizon Benefits Center at 855.4VzBens (855.489.2367). Representatives are available 9 AM to 5 PM, Eastern time.

Review this guide to be sure you understand your coverage options, contributions, and any plan changes for 2017.

Start here

Take the next step to review or update your coverage:

Log on to BenefitsConnection through About You or at verizon.com/BenefitsConnection

Review your current elections From the home page, under My benefits > Health & Insurance, select View This Year's Coverage

Review your 2017 options From the home page, under My benefits > Health & Insurance, select View Next Year's Coverage

Estimate your health care costs From the home page, under I want to, select See Next Year's Health Plan Comparison Charts

Visit the Library page for more information about your benefit plans From the home page, select Library

Take or update the Health Assessment
From the home page, under I want to, select Take My Health Assessment

Make election changes, update tobacco user status, add or drop dependents and verify your beneficiaries
From the home page, in the Annual Enrollment section under Suggestions for you, select Enroll Now

BenefitsConnection

We provide you 24/7 access to information and tools for managing your Verizon benefits.

Using any mobile device or computer, it's easy to find and easy to use, accessible through About You or at verizon.com/BenefitsConnection.

Learn more about it

To estimate your health care costs and compare plan options, from the BenefitsConnection home page, under I want to, select See Next Year's Health Plan Comparison Charts. From there, as an active employee you can also use the My Spending Account Calculators feature to estimate how much money to contribute to your Health Care Spending Account. From the BenefitsConnection home page, under I want to, select See Next Year's Health Plan Comparison Charts > My Spending Account Calculators.

To compare your dental plan options, from the BenefitsConnection home page, under I want to, select See Next Year's Health Plan Comparison Charts, then select My 2017 Dental Plan Options.

For more detailed information on your benefit plans, including Summary Plan Descriptions (SPDs) and vendor contact information, visit the Library page on BenefitsConnection.

Qualified life events prior to 2017

If you have a qualified life event (QLE) between now and the end of the year, you will need to make any necessary changes on BenefitsConnection for both 2016 and 2017.

Remember:

Annual Enrollment is generally the only time during the year when changes can be made to coverage, unless you have a qualified life event such as the birth of a child or marriage. For information on what constitutes a qualified life event, please refer to your SPD.

Adding a dependent to coverage

When adding a dependent to coverage during Annual Enrollment, or at any time during the year, you will need to provide documentation to verify eligibility. Instructions for completing the dependent verification will be sent to your work e-mail and home address on file after you have enrolled your dependent.

To enroll a spouse of any gender into coverage during Annual Enrollment, or as a result of a qualified life event, follow the prompts to add a new dependent and select spouse as the dependent relationship.

If appropriate documentation is not submitted in a timely manner, your dependent will be dropped from coverage.

If you have questions about eligibility, please refer to your SPD.

Having an ineligible dependent enrolled on your Verizon coverage may result in disciplinary action.

Dependent coverage age limit

Medical

A dependent child is eligible for medical coverage (including prescription drug) through the end of the month in which he/she attains age 26 regardless of student status. Coverage may be extended beyond age 26 for a dependent child who meets the conditions of being disabled.

Dental and vision

In order for a dependent child to be eligible for dental and vision after the end of the calendar year in which he/she reaches age 19, he/she must be a full-time student at an accredited institution, or meet the conditions of being disabled.

Dental and vision coverage can continue through the end of the calendar year in which a dependent child reaches age 25 as long as the child maintains full-time student status. If the child is between the ages of 19-25 and is not a full-time student, and does not meet the conditions of being disabled, you must remove him/her from dental and vision coverage during Annual Enrollment. If you would like to continue coverage for your dependent(s) through COBRA, please contact the Verizon Benefits Center at 855.4VzBens (855.489.2367) by December 30, 2016.

Similar to last year, Verizon will work with the National Student Clearinghouse in early 2017 to confirm student eligibility for dependents between the ages of 19 and 25 that are enrolled in dental and/or vision coverage. If full-time student status cannot be verified, instructions will be sent to your work e-mail and home address on file. If you do not comply with the instructions provided, your dependent will be dropped from dental and/or vision coverage.

Child life insurance and AD&D insurance

Effective January 1, 2017, you may cover a dependent child for child life insurance up to the end of the month in which the child attains age 26 regardless of student status. Coverage may be extended beyond age 26 for a dependent child who meets the conditions of being disabled.

The child life insurance and AD&D insurance plans cover all of your eligible dependent children. You are responsible for updating your election if your previously eligible dependents no longer meet these eligibility requirements.

Medical coverage

For 2017, you will continue to have a choice of the MEP HCP and HCN medical plan options. There are some changes to your deductibles, out-of-pocket maximums, and emergency room copay amounts. Please refer to the following charts for details. The EPO medical plan option will continue to be available to those currently enrolled in it.

If an HMO is currently available to you, it will continue to be available to you in 2017 as long as you live in a zip code where the HMO is offered. See the **Important changes to your plan** section of this guide for details. If you have a change in address, please review the options available to you on BenefitsConnection.

If you participate in an HMO or the EPO medical plan option, your emergency room copay amount will be $110 in 2017 (waived if admitted).

At a glance – MEP HCP

Plan provision	As of August 1, 2016	2017
Deductible	**Individual:** $525 in-network and out-of-network combined, plus an additional $250 out-of-network	**Individual:** $575 in-network and out-of-network combined, plus an additional $250 out-of-network
	Employee + 1 or More: 2.5 times the individual deductible amount; an individual will never need to exceed his or her own individual amount	**Employee + 1 or More:** 2.5 times the individual deductible amount; an individual will never need to exceed his or her own individual amount
Out-of-pocket maximum: In-network and out-of-network	**Individual:** $1,400 in-network and out-of-network combined, plus an additional $900 out-of-network	**Individual:** $1,550 in-network and out-of-network combined, plus an additional $1,050 out-of-network
	Employee + 1 or More: 2.5 times the individual out-of-pocket maximum amount; an individual will never need to exceed his or her own individual amount	**Employee + 1 or More:** 2.5 times the individual out-of-pocket maximum amount; an individual will never need to exceed his or her own individual amount
Emergency room	$100 copay (waived if admitted)	$110 copay (waived if admitted)

At a glance – HCN

Plan provision	As of August 1, 2016	2017
Deductible	**Individual:** $250 in-network and out-of-network combined, plus an additional $525 out-of-network	**Individual:** $275 in-network and out-of-network combined, plus an additional $550 out-of-network
	Employee + 1 or More: 2.5 times the individual deductible amount; an individual will never need to exceed his or her own individual amount	**Employee + 1 or More:** 2.5 times the individual deductible amount; an individual will never need to exceed his or her own individual amount
Out-of-pocket maximum: In-network and out-of-network	**Individual:** $1,400 in-network and out-of-network combined, plus an additional $900 out-of-network	**Individual:** $1,550 in-network and out-of-network combined, plus an additional $1,050 out-of-network
	Employee + 1 or More: 2.5 times the individual out-of-pocket maximum amount; an individual will never need to exceed his or her own individual amount	**Employee + 1 or More:** 2.5 times the individual out-of-pocket maximum amount; an individual will never need to exceed his or her own individual amount
Emergency room	$100 copay (waived if admitted)	$110 copay (waived if admitted)

Amounts paid toward the deductible apply toward the out-of-pocket maximum. Under the Affordable Care Act, additional out-of-pocket cost protection applies to your medical, including prescription drug, in-network out-of-pocket maximum. See the **Important changes to your plan** section of this guide for details.

To ensure you have the medical coverage that best meets your needs, we provide some useful tools on BenefitsConnection to help you make those important choices, such as Health Plan Comparison Charts to estimate your health care costs and compare plan options.

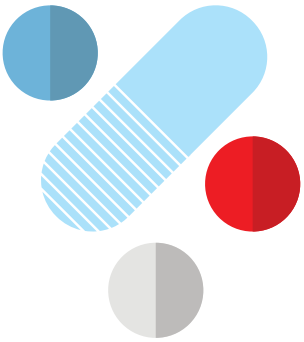
As an active employee, you may also want to consider enrolling in or increasing contributions to the Health Care Spending Account to take advantage of pre-tax savings. Please refer to the **Spending accounts** section of this guide for more details.

For more information about the medical plan, please refer to your SPD.

Take ten minutes

If you are an active employee and haven't already taken the Health Assessment in the past, take ten minutes of your time now and you can save $100 in medical coverage contributions for the upcoming year (pro-rated if you take after Annual Enrollment). Plus, you'll receive a detailed report about your personal health risk factors and a plan to reduce or eliminate them. If you took the Health Assessment prior to 2016, we encourage you to update it annually to receive valuable information about your current health status, as your health risks can change at any time. To access the Health Assessment, from the BenefitsConnection home page, under I want to, select Take My Health Assessment. See the Important legal notices section of this guide for information that applies to the Health Assessment.

Prescription drug coverage



The medical plan options discussed above continue to include prescription drug coverage through Express Scripts. There are no changes to the cost sharing features of your prescription drug coverage in 2017.

Under the Affordable Care Act, additional out-of-pocket cost protection applies to your medical, including prescription drug, in-network out-of-pocket maximum. There are also some changes in service coverage you may want to review. See the **Important changes to your plan** section of this guide for further details.

Be in the know about how you can save.

Save time and money by taking a few small steps when it comes to your prescriptions.

Choose generic drugs over brand-name when available. They are typically less expensive and have the same active ingredients as brand-name drugs. Also, if you have long-term prescriptions that you fill regularly, sign up for mail order, saving you both time and money.

You can access Express Scripts information directly on BenefitsConnection. From the home page, select Library. Under Prescription (Rx), select Access Express Scripts.

For more information about your prescription plan, log on to express-scripts.com or scan the QR code below. Here, you can research lower cost alternatives for prescriptions you take regularly using MyRXChoices, transfer long-term prescriptions from a retail pharmacy to mail order (home delivery), and compare the cost of medications at retail versus mail order using the "price a medication" tool.

Access the Express Scripts mobile app by scanning the QR code.

2017 medical plan costs

Your medical plan option contributions are changing. Below are the monthly medical plan contribution amounts effective for 2017.

Contribution amounts for other medical plan options, including COBRA continuation coverage, that may be available to you can be viewed on BenefitsConnection.

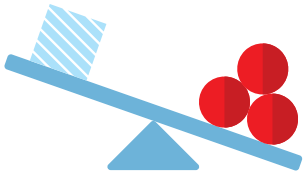
MEP HCP and HCN[1]

Non-tobacco user credit?	Yes	Yes	No	No
Completed Health Assessment?	Yes	No	Yes	No
Employee Only (monthly)	$88.00	$96.33	$138.00	$146.33
Employee + 1 or More (monthly)	$176.00	$184.33	$226.00	$234.33

EPO and HMOs (HMOs will be no greater than the amounts in the chart)[1]

Non-tobacco user credit?	Yes	Yes	No	No
Completed Health Assessment?	Yes	No	Yes	No
Employee Only (monthly)	$132.00	$140.33	$182.00	$190.33
Employee + 1 or More (monthly)	$264.00	$272.33	$314.00	$322.33

[1] *Contributions are based on employees scheduled to work 25 or more hours per week. If you are scheduled to work less than 25 hours per week, please visit BenefitsConnection for your contribution amounts. If you have not already done so, you can reduce your medical plan option contributions by completing an online Health Assessment and certifying that you and your covered dependents do not use tobacco products. See* ***Other important information*** *for more details about the non-tobacco user credit.*



Emergency room alternatives

If you need emergency care, be sure to go to the emergency room or dial 911.

However, if you want or need immediate care but don't have a true emergency, where can you go?

There are plenty of choices, including retail health clinics, local urgent care centers, or walk-in doctor's offices. With these options, you'll likely get quicker and less costly service than trying to schedule an appointment with your primary doctor.

Emergency room visits can cost 4-6 times more than a doctor's office, retail health clinic, or urgent care facility visit. For example, the copay for a primary care or specialist physician visit, or for an urgent care facility visit, is in the $25 to $30 range, whereas the copay for an emergency room visit will be $110 in 2017.

Let's explore the options.

Service choice	What they can do
Retail health clinic	Many major pharmacies and retail stores now offer walk-in clinics where you can get routine medical care like flu shots or tend to a bad cough, sore throat, or ear ache.
Walk-in doctor's office	Here, you don't have to be an existing patient and appointments are not required. This is great for quick medical attention for symptoms such as asthma, a sprain, or nausea.
Urgent care centers	Staff here can help with larger medical issues that need immediate attention but are not life-threatening, such as animal bites, stitches, sprains, and x-rays.

You can find more information through BenefitsConnection on WellConnect. From the BenefitsConnection home page, select **VISIT WellConnect > My Healthy Living > Wise Care.**

Make the right choice for you and your family to get the care you need, when you need it.

Dental coverage and plan costs

Verizon offers two dental options so you can choose the plan that meets your needs.

If you'd like to compare your dental plan options and related plan costs (including the cost for COBRA continuation coverage), from the BenefitsConnection home page, under I want to, select See Next Year's Health Plan Comparison Charts then select My 2017 Dental Plan Options. For more information about the dental plan, please refer to your SPD.

No medical, dental, and/or vision coverage

If you are currently an active employee in No Coverage for medical, dental and/or vision, and you make no changes during this Annual Enrollment, your No Coverage election for medical, dental and/or vision will carry over for 2017.

Please note: Verizon's medical coverage meets the definition of Minimum Essential Coverage (MEC), which is the type of coverage that can help you avoid a penalty under the Affordable Care Act's individual mandate. If you want to enroll in MEC and currently have No Coverage, you must make an affirmative election.

If you have coverage today and would like to waive coverage for 2017, you need to choose No Coverage during Annual Enrollment. If you choose No Coverage, you cannot enroll in coverage during the year unless you have a qualified life event or as otherwise required by law. Please refer to your SPD for guidelines on qualified life events.

Life and Accidental Death & Dismemberment (AD&D) Insurance

Take the time to assess your current life and AD&D needs. They can change from year to year, especially if your family dynamics or lifestyle has changed.

Verify your beneficiary information

It's important to verify that your beneficiary information on BenefitsConnection is both accurate and up to date. In the event of your death, the insurance plan administrator will pay proceeds based on your beneficiary information on record.

Supplemental life insurance rates

The rates for an active employee with supplemental life insurance and spouse life insurance are based on age ranges. As you and your spouse age and fall into a new age band, your costs could increase. Your costs for 2017 are based on age as of December 31, 2017.

Spending accounts

A spending account is a great way to save money by contributing pre-tax dollars to pay for out-of-pocket eligible health care and dependent day care expenses, and lower your taxable income.

You cannot modify your spending account election during the year unless you have certain qualified life events. So, be sure you've taken a close look at your 2017 needs to see if you should make any spending account election changes. Please refer to your SPD for guidelines on qualified life events.

For 2017, the annual maximum contribution amounts are as follows:

- Health Care Spending Account: $2,500
- Dependent Day Care Spending Account: $5,000

As an active employee, unless you make an active election to change your contributions, your 2016 elections will automatically carry over to 2017. If you are an active employee considering changing the amount you contribute, you may want to use the My Spending Account Calculators feature on BenefitsConnection. From the BenefitsConnection home page, under I want to, select See Next Year's Health Plan Comparison Charts > My Spending Account Calculators.

Important note: According to IRS regulations, you must use all the money in your account each plan year for eligible expenses or it will be forfeited. Verizon offers a 2-1/2 month grace period that allows you to incur expenses until March 15 of the following plan year. You have until May 31 of the current plan year to submit claims from the prior plan year. Please see your SPD for details.

COBRA Health Care Spending Account (HCSA)

If you are currently contributing to a COBRA HCSA, you can continue to contribute through the end of the calendar year (December 31, 2016) of your COBRA qualifying event. However, you cannot elect a COBRA HCSA for the 2017 plan year. Remember, you must submit all claims by the claim filing deadline of May 31, 2017 or it will be forfeited.

Confirmation statement

You can confirm your current election information online at any time, 24/7, on BenefitsConnection from any mobile device or computer, so you can go green and stay green.

Still want a paper confirmation statement? Simply log on to BenefitsConnection from About You or at verizon.com/BenefitsConnection. From the home page, under My benefits > Health & Insurance, select View Next Year's Coverage, then select Print in the upper-right corner.

You can also request a confirmation statement be mailed to you by calling the Verizon Benefits Center.

Retiree medical contributions

Medical plan contributions

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

For all retirees who retired after January 1, 1992 with a net credited service date before August 3, 2008

The 2012 labor contracts provide for limits on the amount the Company will contribute toward retiree medical coverage in 2016 and later plan years. These limits are referred to as retiree medical caps which are listed below. The retiree medical caps limits were not changed by the 2016 labor contracts.

Retiree medical caps

Coverage category	MEP HCP (pre-Medicare)	MEP HCP (Medicare)	All other plan options (pre-Medicare)	All other plan options (Medicare)
Retiree Only	$15,447	$6,330	$12,580	$6,330
Retiree + 1	$30,893	$12,660	$25,160	$12,660
Retiree + Family	$38,639	$18,990	$31,450	$18,990

In the 2017 plan year, the cost of coverage of each of the Medicare plan options is less than the applicable retiree medical caps.

In the 2017 plan year, the cost of coverage of the following pre-Medicare plan options will exceed the applicable retiree medical caps, and this excess amount over the retiree medical caps is greater than the annual minimum contribution for at least some retirees:

- UHC Passport/ Harvard Pilgrim
- MEP HCP (greater than the minimum contribution for those who retired before January 1, 2013)

In addition, the cost of coverage of certain out-of-area HMOs exceeds the applicable retiree medical caps in 2017.

Consistent with the labor contracts and the previously described provisions, the 2017 retiree medical contributions that are payable each month for post-1/1/1992 retirees are as follows:

2017 pre-Medicare MEP HCP and HCN monthly retiree contributions

Coverage category	MEP HCP		HCN	
	Retired before 1/1/13	Retired on or after 1/1/13	Retired before 1/1/13	Retired on or after 1/1/13
Retiree Only	$13.00	$39.33	$0	$39.33
Retiree + 1	$26.08	$67.42	$0	$67.42
Retiree + Family	$30.75	$67.42	$0	$67.42

2017 pre-Medicare EPO and HMO monthly retiree contributions

Coverage category (Retired before, on, or after 1/1/13)	EPO	UHC Passport/ Harvard Pilgrim	Other NYNE HMOs (Varies by plan option)
Retiree Only	$132.00	$133.00	$110.00 - $123.20
Retiree + 1	$200.00	$266.00	$166.67 - $186.67
Retiree + Family	$264.00	$332.50	$220.00 - $246.40

2017 Medicare-eligible monthly retiree contributions

Coverage category	MEP HCP and HCN Advantage Plan options[1]	HMOs
Retiree Only	$0	$20.00 - $40.00
Retiree + 1	$0	$34.00 - $64.00
Retiree + Family	$0	$34.00 - $64.00

[1] *Effective January 1, 2017, the MEP HCP Advantage Plan option replaces the MEP HCP plan option and the HCN Advantage Plan option replaces the HCN plan option.*

In plan years after 2017, additional plan options may exceed the applicable retiree medical caps and require contributions pursuant to the caps. If you would like more information about the retiree caps and how they affect retiree contributions, visit the Library page on BenefitsConnection. From there, under Documents for all retirees > Medical/Prescription within the SPD section, select the **Retiree Medical Contributions Supplemental Guide.**

For retirees with a net credited service date of August 3, 2008 or later (and did not previously qualify for Company-provided retiree medical benefits)

For the 2017 plan year, the Company will provide the following contributions toward the cost of retiree medical coverage for eligible retirees:

- **Not eligible for Medicare:** $480 for each full year of net credited service that commences on or after August 3, 2008, 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.

Additional information

Please remember that to be eligible for retiree medical benefits, you must meet applicable retirement eligibility requirements (30 years of net credited service; 25 years at age 50; 20 years at age 55; 15 years at age 60 or 10 years at age 65). Please also remember that retiree medical benefits are subject to change in the future.

Wellness disclaimer

The Verizon group health plans are committed to helping you achieve your best health. Your Verizon group health plan offers the opportunity to qualify for lower contributions for non-tobacco users (a non-tobacco user credit), which is a wellness program. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Verizon Benefits Center at 855.4VzBens (855.489.2367) and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Important changes to your plan

Changes to the Affordable Care Act maximums

As required by the Affordable Care Act, your total in-network out-of-pocket costs in 2017, including copays and prescription drug expenses under the medical plan options available to you, will not exceed $7,150 for individual coverage and $14,300 for family coverage. The individual in-network out-of-pocket maximum required by the Affordable Care Act applies to expenses incurred by each individual covered by the plan, regardless of whether the individual is covered under self-only coverage or other-than-self-only coverage (for example, family coverage). Your underlying medical plan's out-of-pocket maximums are not affected by the change, and copays and prescription drug expenses will not apply toward such amounts.

Preventive care updates to the medical plan, including prescription drug options

Your medical 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.

Additional updates have been made to the preventive care benefits that must be offered without cost sharing, including (but not limited to) clarification on services related to lactation counseling, obesity screening for adults, additional details on colonoscopies (including a specialist consultation before the procedure, coverage for a pathology exam on a polyp biopsy, and bowel preparation medication), and additional details on coverage for breast cancer genetic counseling. Contact the Verizon medical plan option or prescription drug administrator, such as Express Scripts, for more details.

Important change to domestic-partner coverage

If you currently cover a same-sex domestic partner for one or more employee benefits in the 2016 plan year, you must be married and provide proof of marriage by December 31, 2016 in order to continue coverage of your domestic partner effective January 1, 2017. Proof of marriage in the form of a government issued marriage certificate must be sent by December 31, 2016 (postmark date) to:

Verizon Benefits Center
P.O. Box 8998
Norfolk, VA 23501-8998

If you do not act as noted above, your domestic partner will be dropped from your medical and/or dental coverage effective January 1, 2017. Your domestic partner will receive a COBRA Continuation Coverage Election Notice that includes the 2017 COBRA rates after January 1, 2017, explaining his/her entitlement to continued coverage under COBRA due to loss of dependent status.

If you have elected Domestic Partner Life Insurance and do not act as noted above regarding proof of marriage, your domestic partner will be dropped from Domestic Partner Life Insurance effective January 1, 2017. You will be eligible to convert coverage to an individual whole life or variable universal life insurance policy. After January 1, 2017, Prudential will send you a letter describing life insurance continuation options, along with an application and the applicable premium.

Coverage for medical, including prescription drug, emergency services out-of-network

Generally, the same cost sharing (copayments and coinsurance) applies for in-network and out-of-network emergency services. You have a right to determine how the plan calculates payment for out-of-network services, since nuances apply, under this Affordable Care Act requirement. Contact the Verizon medical plan option or prescription drug administrator, such as Express Scripts, for more details.

Clinical trials

If you are participating in a clinical trial and you are receiving chemotherapy through that clinical trial, your chemotherapy coverage will not be adversely impacted by that clinical trial.

HMO eligibility

Under the Affordable Care Act, if your child lives outside an HMO's service area (for example, s/he attends college in a zip code where the HMO is not offered), s/he will still be eligible for coverage under the HMO until the end of the month in which s/he attains age 26 and is not subject to the requirement to reside within a zip code where the HMO is offered.

Transgender and Autism Spectrum Disorder coverage

Verizon provides coverage for care related to gender dysphoria or gender transition services that are "medically necessary." If your benefit package previously excluded coverage for gender transition services, the exclusion has been removed. Contact the Verizon medical plan option or prescription drug administrator, such as Express Scripts, for more details on what gender transition services and benefits are available.

Verizon provides coverage for "medically necessary" Applied Behavior Analysis (ABA) Therapy for the treatment of Autism Spectrum Disorder. Contact your Verizon medical plan option for more details on what benefits are available.

Women's Health Cancer Rights Act

Under the Women's Health Cancer Rights Act (WHCRA), the Plan is required to provide coverage for all stages of reconstruction of the breast on which the mastectomy was performed (with consultation with the attending physician and patient), including as of January 1, 2017, details, such as re-pigmentation, to restore the physical appearance of the breast. As always, cost sharing (deductibles and coinsurance) for these benefits must be consistent with other benefits under the Plan. Contact the Verizon medical plan option for more details.

Form 1095-C

Form 1095-C, Employer-Provided Health Insurance Offer and Coverage, is a form that you may receive at the beginning of each year as part of the Affordable Care Act. The form includes information about the health insurance coverage offered to you by Verizon. Save it to file your taxes. It will assist you with completing the 'Health Care – Individual Responsibility' section on your Form 1040 tax filing (or other tax form as appropriate).

Important legal notices

Update to the 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. Verizon updated the HIPAA Privacy Notice, Contact Information section, to reflect changes to the contact information for the Verizon HIPAA Unit.

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 855.4VzBens (855.489.2367).

Summaries of Benefits and Coverage (SBCs) 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 verizon.com/BenefitsConnection. If you would like a paper copy of the SBCs (free of charge), you may contact the Verizon Benefits Center at 855.4VzBens (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.

Americans with Disabilities Act (ADA) notice regarding wellness program

The wellness program offered to you by Verizon is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary Health Assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the Health Assessment.

However, employees who choose to participate in the wellness program will receive an incentive of $100, which will be used to reduce your medical premiums. Although you are not required to complete the Health Assessment, only employees who do so will receive the $100 medical premium reduction.

The information from your Health Assessment will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as a voluntary health coaching program. You also are encouraged to share your results or concerns with your own doctor.

Other important information

Protections from disclosure of medical information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Verizon may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are a registered nurse, a doctor, or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. The confidentiality of medical information will be maintained in accordance with Verizon policies and procedures. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Verizon Benefits Center at 855.4VzBens (855.489.2367), and indicate that you have a question or concern regarding this notice.

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements with respect to Verizon's Group Health Plans that are "Covered Entities"

Discrimination is against the law.

Verizon's group health plans that are "covered entities" (referred to in this notice as "Verizon's group health plans") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Verizon's group health plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Verizon's group health plans[1]:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Verizon Benefits Center at 855.4VzBens (855.489.2367).

If you believe that Verizon's group health plans have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, Ralph Fader, Sr. Analyst Benefits, Verizon's Civil Rights Coordinator, is available to help you.

Civil Rights Coordinator address and contact information	Verizon Benefits Center Attn: Civil Rights Coordinator P.O. Box 8998 Norfolk VA 23501-8998	Fax: 908.630.2639 E-mail: ralph.p.fader@verizon.com Phone: 908.559.3620 TTY: 711

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855.489.2367 (TTY: 711).

注意 : 如果您使用繁體中文 , 您可以免費獲得語言援助服務。請致電 855.489.2367.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855.489.2367.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 855.489.2367.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 855.489.2367 (ATS: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855.489.2367 번으로 전화해 주십시오.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 855.489.2367.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 7632.984.558 (رقم هاتف الصم والبكم:.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855.489.2367.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 855.489.2367.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 855.489.2367.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 855.489.2367.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 855.489.2367.

注意事項 : 日本語を話される場合、無料の言語支援をご利用いただけます。855.489.2367 まで、お電話にてご連絡ください。.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 855.489.2367 تماس بگیرید.

[1] *With respect to the nondiscrimination rules explained in this notice, the following Verizon group health plans are "covered entities:" The Plan for Group Insurance, The Verizon Retiree Group Health Plan for Management & Non-Union Hourly Employees, The Verizon Retiree Group Health Plan for West Associates, Verizon Business Health and Welfare Plan, Verizon Plan 550, Verizon's Mid-Atlantic Group Health Plan for Retired Associates (Pre-1990), Verizon Medical Expense Plan for New York and New England Associates, Verizon New York and New England Retiree Health (Post-1992 Retirees) and Group Life Insurance Plan for Active and Retired Associates, and Verizon Post-1995 Collectively Bargained Retiree Health Plan (Pre-1993 Retirees).*

This Annual Enrollment Guide provides updates to your existing Summary Plan Description(s) as of January 1, 2017. Please keep this Guide and any other Summary of Material Modification (SMM) with your SPDs. As always, the official plan documents determine what benefits are provided to Verizon employees, former employees eligible for COBRA, retirees and their dependents. Please note you may not be eligible to participate in or receive benefits from all plans and programs referenced in this Guide. Your SPDs and corresponding documents (e.g., SMM) are available at verizon.com/BenefitsConnection, or you can call the Verizon Benefits Center and request a printed copy free of charge. 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 and any duty to bargain collectively.

verizon