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 will begin on November 7, 2012 and will continue through November 21, 2012.

Under the new East labor contracts, there are a number of modifications to your 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.

Enclosed is important information about what you can expect for this year's annual benefits enrollment and specifically about what is new for 2013. 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.

Even though you will be contributing toward your medical plan coverage, 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 help 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.

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; or
- Want to enroll in a Health Care or Dependent Care Spending Account or change your current contribution. (Note: The new IRS limit for annual contributions to a Health Care Spending Account is $2,500. If you currently contribute more than the new limit and don't make a change, your 2013 contribution will be set automatically to $2,500.)

In addition, if you want to reduce your medical plan premium contributions for 2013, you will need to complete an online Health Assessment and certify that you and your covered dependents do not use tobacco products. More information on these valuable incentives for healthy lifestyle habits is included in this Guide.

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

Sincerely,

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 2012 elections will continue for medical, dental, vision, supplemental life insurance and flexible spending accounts.*

**The new IRS limit for annual contributions to a Health Care Spending Account is $2,500. If you currently contribute more than the new limit and don't make a change, your 2013 contribution will be set automatically to $2,500.*

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.

Online Tools

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.

BenefitsConnection (Access through About You or 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 programs as well as access to online tools to help you eat well, stay active and maintain a well-balanced lifestyle.

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:

- The Health Assessment you need to complete to lower your annual medical plan contribution
- 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

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 Sponsored Parent or Sponsored Child, his or her coverage can continue. **However, no new Sponsored Parents or Sponsored Children can be added to Verizon coverage. If you drop a Class II Dependent, Sponsored Parent or Sponsored Child from your coverage, he or she cannot be added back to coverage.** The cost of Sponsored Parent coverage will increase to $100 per month effective January 1, 2013.

When Dependents Need to be Verified

If you add a new dependent to your Verizon coverage — either during Annual Enrollment or as a result of a qualified status change — you will be required to verify his or her eligibility.

Medical Plan Options

Beginning for 2013, you can chose to be covered by either the MCN or MEP PPO regardless of where you live. There are changes to all medical plans under the new labor contracts, including changes to deductibles, copays, coinsurance, and out-of-pocket maximums.

MCN 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 MCN 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	$20 copay for PCP and $25 copay for specialist	After meeting your deductible, the plan pays 70%
Outpatient Lab and X-Ray	$20 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%
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	$75 copay (copay waived if admitted)	
Urgent Care	$20 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.*

**** Change! For IBEW associates: Expenses that you incur during October, November and December 2012 will not carry over to the deductible for 2013.*

MEP PPO 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 PPO 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	$20 copay for PCP and specialist, no deductible	After meeting your deductible, the plan pays 70%
Outpatient Lab and X-Ray	$20 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%
Deductible	**Individual:** $400 in-network and out-of-network combined, plus an additional $250 out-of-network **Family:** 2.5 times the individual deductible amount	
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 individual amount. *Note*: Amounts paid toward the deductible will now apply toward the out-of-pocket maximum.	
Emergency Room	$75 copay (copay waived if admitted)	
Urgent Care	$20 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.*

EPO Highlights

- 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.

If you are enrolled in an HMO when you retire, you and your eligible dependents may remain in the HMO until you are Medicare-eligible, as long as it is offered. If you are not enrolled in an HMO when you retire, you cannot enroll in an HMO. Once you are eligible for Medicare, a Medicare Advantage Plan may be available depending on where you live.

No Medical Coverage

If you do not want medical coverage, 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 status change or as otherwise required by law. Please refer to your Summary Plan Description (SPD) for guidelines on eligible qualified status changes.

Change! Medical Plan Administrator

Effective January 1, 2013, Anthem Blue Cross Blue Shield (Anthem) will administer Verizon's MCN, MEP PPO and EPO options. The Blue Card PPO Network is the same network that is currently used for the EPO plan option.

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 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 1-866-832-1229 if you need to take advantage of this transition of care.

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.

2013 Medical Plan Premium Contributions

Beginning in January, your medical plan premium contributions will vary depending on whether you or a covered family member use tobacco products and whether you complete a Health Assessment.

New! Lower Your Medical Plan Costs with Healthy Lifestyle Incentives

Verizon offers two valuable incentives for healthy lifestyle habits that will reduce your annual contributions for your medical coverage.

Save Money by Completing a Health Assessment

The Health Assessment is a powerful tool that can help you manage your health and stay well. Just complete a simple, confidential online questionnaire and you will receive a detailed report about your personal health risk factors — along with a customized plan to help you reduce or eliminate them. Starting on November 7 you can take the Health Assessment, accessible through BenefitsConnection. It should only take about 10 minutes to complete.

If you enroll in a Verizon medical plan option and complete the annual Health Assessment by December 31, 2012, your contributions for medical coverage will be $8.33 lower each month. If you don't complete the Health Assessment by December 31, 2012, you can complete it at any time in 2013 and pay a lower monthly amount for the balance of the year.

Non-Tobacco Users Pay Less

You are eligible for the Non-Tobacco user premium contributions if you and your covered dependents do not use any tobacco products, or have completed a Tobacco Cessation program, such as QuitNet, within the past six months. If you don't meet this criteria now, but do so during 2013, change your status on BenefitsConnection and take advantage of the lower premium contributions for the balance of the year.

About Your Medical Plan Contributions

Beginning in January, your contributions will automatically be withheld from your paycheck as "pre-tax dollars," which means your contributions are not subject to income, Social Security, or Medicare taxes. Employees on an unpaid leave of absence will pay contributions on an after-tax basis, and will receive the first bill in mid-December reflecting contributions for medical coverage for January.

Following are the 2013 premium contributions for the medical plans based on whether you and your covered family members use tobacco products and whether or not you have completed a Health Assessment.

MCN and MEP PPO

Non-Tobacco User Credit?	Yes	Yes	No	No
Completed Health Assessment?	Yes	No	Yes	No
MONTHLY CONTRIBUTION				
Individual	$45.00	$53.33	$95.00	$103.33
Family	$90.00	$98.33	$140.00	$148.33

EPO and HMOs

Non-Tobacco User Credit?	Yes	Yes	No	No
Completed Health Assessment?	Yes	No	Yes	No
MONTHLY CONTRIBUTION (will be no greater than the amounts in this chart)				
Individual	$67.50	$75.83	$117.50	$125.83
Family	$135.00	$143.33	$185.00	$193.33

QuitNet, offered through Healthways, gives you the flexibility to choose the quit experience that best fits your personal needs, with a mix of support options, including:

- Personal coaching: Counseling and support phone calls with a trained Health Coach
- Online tools and support: 24/7 online access to personalized quitting plans, expert advice, quit buddies, and more
- A printed Quit Guide: A colorful, printed Quit Guide filled with everything you need to know about quitting tobacco—from making the decision to quit to staying quit
- Quit medications: Over-the-counter and prescription quit medications, including nicotine patches, chewing gum, and lozenges delivered directly to your home
- Quit Tips℠ E-mails: Quick tips to help you stay quit, sent to your Inbox

Prescription Drug Highlights

Under 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. Following are the new copays and coinsurance amounts.

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)	30% of discounted network price, up to $25 maximum copay per prescription.*	After deductible, 40% 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)	30% of discounted network price, up to $50 maximum copay per prescription.*	N/A

**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.*

Medco is Now Called Express Scripts

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

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 are often generic alternatives available that treat the same condition and will cost you less.

If your doctor prescribes a medication, make sure to ask if there is a generic version. 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.

Dental and Vision Coverage

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

There are no other changes to your dental and vision coverage options.

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

No changes have been made to your life and AD&D 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.

New! Health Reimbursement Account (HRA)

Verizon is establishing a Health Reimbursement Account (HRA) on January 1, 2013 for each full-time employee and each part-time employee working 17 hours or more per week, who has at least three months of net credited service and who is eligible for medical coverage.

The Company will allocate a one-time credit of $850 for each full-time employee and a one-time credit of $425 for each part-time employee working 17 hours or more per week to an HRA that you can use to reimburse yourself for eligible medical expenses. You cannot use an HRA to reimburse yourself for the cost of contributions for your medical coverage. You can use it for other eligible expenses such as copays, deductibles, and prescriptions, including over-the-counter drugs and medicines, if you have a prescription from your health care provider.

If you are eligible for an HRA, you do not need to enroll in Verizon medical coverage to receive your HRA credit.

- You will receive a Welcome Letter with information about your HRA and a Visa® Debit Card along with some helpful information on how to use it before January 1, 2013*.
- If you have a Health Care Spending Account (HCSA) in addition to your Company-provided HRA, your HCSA balance must be exhausted each year (starting with your 2013 HCSA) prior to claims being reimbursed from the HRA. This is because your unused HRA balance can carry over from year to year, but unused amounts in your HCSA will be forfeited per IRS rules.

**The new Visa® debit card cannot be used for the Dependent Care Spending Account.*

Consider the money that Verizon will credit to your Health Reimbursement Account before enrolling in and/or contributing to a Health Care Spending Account. You must exhaust all of your contributions to your Health Care Spending Account on reimbursement of eligible expenses before you are eligible to use any funds in your Health Reimbursement Account. Why? You can roll over your unused Health Reimbursement Account balance from year to year, but you will forfeit any unused money in your Health Care Spending Account.

Flexible Spending Accounts

Putting money into a Flexible Spending Account can help you save on eligible out-of-pocket expenses with pre-tax dollars.

- The Health Care Spending Account can be used for eligible out-of-pocket health care expenses, including medical, dental and vision
- The Dependent Care Spending Account can be used for eligible dependent care expenses

To help you estimate how much money to put in a Flexible Spending Account, use the online calculator available on BenefitsConnection by clicking on *My Benefits* › *My Resources* › *Tools and Resources.*

Retiree Medical Contributions

Even though you are still working now, it's important to consider retiree medical benefits, especially if you are nearing retirement eligibility. The information below highlights key information about premium contributions if you retire with eligibility for retiree medical benefits.

For 2013, 2014, and 2015, you will only be required to pay the applicable monthly premium contribution amount, as noted in Table 1, 2 or 3, 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 below or (2) the annual premium contribution amounts, as noted in Table 1, 2 or 3, based on the applicable monthly premium contribution amount.

If your net credited service date is before August 3, 2008 and you retire before January 1, 2013

If you enroll in the MCN or MEP PPO option, you will not be required to contribute premiums during 2013, 2014, and 2015. However, if you elect coverage under the EPO or an HMO option, the monthly premium contribution in the chart below will apply for 2013.

TABLE 1

EPO and HMOs	Monthly Contribution
	EPO and HMO contributions no greater than the following rates*
Retiree Only	$67.50
Retiree + 1	$105.00
Retiree + Family	$135.00

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

If your net credited service date is before August 3, 2008 and you retire January 1, 2013 or later

The monthly premium contributions in the charts below will apply for 2013:

TABLE 2

MCN and MEP PPO	Monthly Contribution	
	Pre-Medicare Retiree Monthly Contribution	Medicare-Eligible Retiree Monthly Contribution
Retiree Only	$35.00	$17.50
Retiree + 1	$60.00	$30.00
Retiree + Family	$60.00	$30.00

TABLE 3

EPO and HMOs	Monthly Contribution
	EPO and HMO contributions no greater than the following rates*
Retiree Only	$67.50
Retiree + 1	$105.00
Retiree + Family	$135.00

** 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 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 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 PPO and MCN and, for the EPO and HMOs, no greater than the COBRA contribution rate for the MCN, 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

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.

Please remember that to be eligible for retiree medical benefits, you must meet applicable retirement eligibility requirements. Please also remember that retiree medical benefits are subject to change in the future.

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." While Verizon previously communicated some of the changes under the Affordable Care Act as part of 2011 Annual Enrollment, the following changes are effective January 1, 2013:

- $2,500 Contribution Limit to Health Care Spending Account:
  Under the Affordable Care Act, you cannot contribute more than $2,500 per year to your Health Care Spending Account.
- Because your medical plan options will no longer maintain the status as a grandfathered health plan under the Affordable Care Act, they will comply with the following additional requirements:
  - 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 your union and Verizon 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 agreements. 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.