Your benefits.

Investing together for a healthier you.

2017 Annual Enrollment
November 7 – November 18

New York/New England
August 9, 1986 – January 1, 1992
Retiree

verizon

Dear Verizon Retiree:

This guide summarizes important health and insurance benefits information and reflects the terms agreed upon by the Company and the Unions in the 2016 labor contracts.

Effective January 1, 2017, the current MEP HCP and HCN Medicare medical plan options will transition to the Verizon Advantage Plan. The Verizon Advantage Plan — a UnitedHealthcare® Group Medicare Advantage Plan (PPO) – is a passive PPO plan that offers affordable, quality health care coverage for Medicare-eligible participants from any doctor or facility that accepts Medicare. If you are Medicare-eligible, you should have already received information describing the new Verizon Advantage Plan and a summary of its features.

UnitedHealthcare® has the nation's largest contracted network of Medicare providers who participate in the Verizon Advantage Plan. We anticipate that the overwhelming majority of providers who accept Medicare will accept the Verizon Advantage Plan. In the rare instance a provider may not accept the Plan, it is important to remember that you will continue to have access to all health care providers that participate in Medicare and that the Verizon Advantage Plan will provide coverage for all Medicare-accepting providers.

While Medicare-eligible retirees are experiencing a transition in Medicare medical plan options for 2017, pre-Medicare retirees will continue to have the same pre-Medicare medical plan options available in 2017.

Please review this Annual Enrollment guide, the Verizon Advantage Plan guide, and any information UnitedHealthcare has provided you, as applicable, for more information regarding the new Verizon Advantage Plan for Medicare-eligible participants.

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.

If you are currently a pre-Medicare participant, your current benefits will automatically continue unless you make a change during Annual Enrollment.

If you are currently a Medicare-eligible participant enrolled in the MEP HCP, HCN, or HIP Health Plan of New York Medicare medical plan option, you will automatically be transitioned to the corresponding new MEP HCP or HCN Advantage Plan option under the Verizon Advantage Plan. If you are currently enrolled in another local Medicare medical plan option, coverage under that option will automatically continue in 2017. No action on your part is required. Coverage under the new Advantage Plan option will take effect January 1, 2017. For further information on this transition to the new Verizon Advantage Plan, please see the **Verizon Advantage Plan transition information** section in this guide.

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

To review or make changes to your coverage elections, dependents, or beneficiaries, visit BenefitsConnection at verizon.com/BenefitsConnection before midnight Eastern time on November 18.

If you have questions or would like to review or make changes to your coverage, you can call the Verizon Benefits Center at 855.4VzBens (855.489.2367). Representatives are available 9 AM to 5 PM, Eastern time.

Start here

Take the next step to review or update your coverage:

Log on to BenefitsConnection 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

Compare plan options
From the home page, under I want to, select See Next Year's Health Plan Comparison Charts

Make election changes, 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 at verizon.com/BenefitsConnection.

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 home address on file after you have enrolled your dependent.

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.

Dependent child 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

In order for a dependent child to be eligible for dental coverage 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 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 and 25 and is not a full-time student, and does not meet the conditions of being disabled, you must remove him/her from dental coverage during Annual Enrollment. If you would like to continue coverage for your dependent(s) through COBRA, please contact the Verizon Benefits Center at 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 coverage. If full-time student status cannot be verified, instructions will be sent to your home address on file. If you do not comply with the instructions provided, your dependent will be dropped from dental coverage.

Child life 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 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.

The Health Insurance Marketplace

If you are not eligible for Medicare, depending on your personal situation, you may have different medical plan options available to you through the Health Insurance Marketplace established by the Affordable Care Act. For more details about Marketplace options, go to the Marketplace website at healthcare.gov.

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

- If you purchase health insurance through the Marketplace, Verizon will not contribute toward the cost of coverage or help you remit your payment.
- If you enroll in Verizon retiree medical coverage instead of a Marketplace option, you are not eligible for any government subsidy to pay for that coverage (i.e., a premium tax credit).
- If you enroll in a Marketplace option, you may be eligible for a government subsidy depending on your household income level and whether you are eligible for minimum essential coverage elsewhere.
- Individuals are required to have "minimum essential coverage," or they must pay a tax. Both the Marketplace options and Verizon retiree medical coverage meet this definition, so if you are enrolled in either option, you will not be subject to a tax in 2017.

Pre-Medicare medical plan options

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

If a pre-Medicare HMO is currently available to you, it will also 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).

If you retired prior to January 1, 2017, your deductible will remain the same. Participants who retire in 2017 or later will be subject to a different deductible.

At a glance – Pre-Medicare MEP HCP

Plan provision	As of August 1, 2016	2017
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
	Individual + 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	**Individual + 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 – Pre-Medicare HCN

Plan provision	As of August 1, 2016	2017
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
	Individual + 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	**Individual + 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.

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

Medicare-eligible medical plan options

As previously communicated, the current MEP HCP and HCN Medicare medical plan options will transition to the new Verizon Advantage Plan effective January 1, 2017. The Verizon Advantage Plan – a UnitedHealthcare Group Medicare Advantage Plan (PPO) Plan – is a passive PPO plan that offers affordable, quality health care coverage for Medicare-eligible participants from any doctor or facility that accepts Medicare.

Any current participant in the MEP HCP, HCN, or HIP Health Plan of New York Medicare medical plan option will be automatically enrolled into the corresponding MEP HCP or HCN Advantage Plan option as further explained in the **Verizon Advantage Plan transition information** section of this guide.

Please reference the Verizon Advantage Plan guide mailed to you for details and information about the new Verizon Advantage Plan options.

If you did not receive a copy of the Verizon Advantage Plan guide, you can access the guide in the Library section of BenefitsConnection or by calling the Verizon Benefits Center and requesting a copy be mailed to you.

In addition, you may also have received a Plan guide from UnitedHealthcare. If you have any questions about the Verizon Advantage Plan and how it works, please call UnitedHealthcare at 877.211.6548, TTY 711, or visit UHCRetiree.com/verizoneast. UnitedHealthcare representatives are available from 8 AM to 8 PM local time, seven days a week through December 7. Starting December 8, UnitedHealthcare representatives will be available from 8 AM to 8 PM local time, Monday through Friday.

Verizon Advantage Plan transition information

If you're currently enrolled in the MEP HCP or HCN Medicare medical plan option

As part of 2017 Annual Enrollment, you will automatically transition to the corresponding new MEP HCP or HCN Advantage Plan option under the Verizon Advantage Plan. **No action on your part is required.** Your coverage under the new MEP HCP or HCN Advantage Plan option will take effect as of January 1, 2017.

You will transition to your new option as follows:

- **If you're enrolled in the MEP HCP Medicare medical plan option,** you will be automatically enrolled in the corresponding MEP HCP Advantage Plan option. Your annual deductible under the MEP HCP Advantage Plan option will be based on the level of your current deductible.
- **If you're enrolled in the HCN Medicare medical plan option,** you will be automatically enrolled in the HCN Advantage Plan option.

If you're currently enrolled in a local Medicare medical plan option through Verizon

- **If you're currently enrolled in the HIP Health Plan of New York,** note that this plan option will no longer be available as of January 1, 2017. You will be automatically enrolled in the new MEP HCP Advantage Plan option for 2017. Your annual deductible will depend on your retirement date.
- **If you're currently enrolled in any other local Medicare medical plan option through Verizon,** coverage under that option will automatically continue in 2017. You **will not** be automatically transitioned to either the MEP HCP or HCN Advantage Plan options for 2017. However, if you would like to enroll in the MEP HCP or HCN Advantage Plan option for 2017, you may do so during Annual Enrollment.

In summary

If you would like to change your medical plan option for 2017, you will need to take action during Annual Enrollment to elect another medical plan option or to waive your current medical coverage, as applicable. You can also change your election anytime using Anytime Enrollment. Simply log on to BenefitsConnection, go to the Life Events page and select Anytime Enrollment or call the Verizon Benefits Center. Your change will be effective the first of the month following a 30-day waiting period. For more information about mid-year changes to benefits, please refer to your SPD.

2017 Medicare plan options overview

The following charts provide a comparison of the 2016 Medicare plan options and their corresponding 2017 Verizon Advantage Plan options.

At a glance – MEP HCP to MEP HCP Advantage Plan

Plan provision	MEP HCP As of August 1, 2016		MEP HCP Advantage Plan 2017
	In-network	Out-of-network	Applies in- and out-of-network
Annual deductible	**Individual:** Deductible varies based on retirement date **Individual + 1 or More:** 2.5 times the individual deductible; an individual will never need to exceed his or her own individual deductible	**Individual:** Deductible varies based on retirement date **Individual + 1 or More:** 2.5 times the individual deductible; an individual will never need to exceed his or her own individual deductible	$21–$471 **per member,** depending on your deductible under your 2016 Verizon retiree medical plan option[1] In all cases, your individual deductible will be the same or better than it was in 2016.
Annual out-of-pocket maximum	**Individual:** $1,400 in-network and out-of-network combined, plus an additional $900 out-of-network **Individual + 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	**Individual:** $1,400 in-network and out-of-network combined, plus an additional $900 out-of-network **Individual + 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	$1,150 **per member**
Lifetime maximum	None	None	None
Preventive care	100%, no deductible	100%, no deductible	100%, no deductible
Primary care physician (PCP) visit (includes OB-GYN and mental health/ substance abuse)	$10 copay	After meeting your deductible, the Plan pays 60%	$10 copay

At a glance – MEP HCP to MEP HCP Advantage Plan (continued)

Plan provision	MEP HCP As of August 1, 2016		MEP HCP Advantage Plan 2017
	In-network	Out-of-network	Applies in- and out-of-network
Specialist visit	$15 copay	After meeting your deductible, the Plan pays 60%	$15 copay
Outpatient surgery	**If performed at an outpatient facility:** After meeting your deductible, the Plan pays 90% **If performed in a provider's office:** $10 copay (PCP) $15 copay (specialist)	After meeting your deductible, the Plan pays 60%	**If performed at an outpatient facility:** After meeting your deductible, the Plan pays 90% **If performed in a provider's office:** $10 copay (PCP) $15 copay (specialist)
Inpatient hospitalization	After meeting your deductible, the Plan pays 90%	After meeting your deductible, the Plan pays 60%	After meeting your deductible, the Plan pays 90%
Urgent care	$15 copay	$15 copay	$15 copay
Emergency room	$25 copay (waived if admitted)	$25 copay (waived if admitted)	$25 copay (waived if admitted)

[1]*If you are not enrolled in the MEP HCP in 2016, your deductible will be based on your retirement date. To find the deductible amount for your option, visit BenefitsConnection or call the Verizon Benefits Center during the Annual Enrollment period.*

2017 Medicare plan options overview (continued)

At a glance – HCN to HCN Advantage Plan

Plan provision	HCN As of August 1, 2016		HCN Advantage Plan 2017
	In-network	Out-of-network	Applies in- and out-of-network
Annual deductible	None	**Individual:** $725 **Individual + 1 or More:** 2.5 times the individual deductible; an individual will never need to exceed his or her own individual deductible	None
Annual out-of-pocket maximum (including deductible and copays)	**Individual:** $1,400 in-network and out-of-network combined, plus an additional $900 out-of-network **Individual + 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	**Individual:** $1,400 in-network and out-of-network combined, plus an additional $900 out-of-network **Individual + 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	$1,050 **per member**
Lifetime maximum	None	None	None
Preventive care	100%	80%	100%
Primary care physician (PCP) visit (includes OB-GYN and mental health/ substance abuse)	$10 copay	After meeting your deductible, the Plan pays 60%	$10 copay

At a glance – HCN to HCN Advantage Plan (continued)

Plan provision	HCN As of August 1, 2016		HCN Advantage Plan 2017
	In-network	Out-of-network	Applies in- and out-of-network
Specialist visit	$15 copay	After meeting your deductible, the Plan pays 60%	$15 copay
Outpatient surgery	**If performed at an outpatient facility:** The Plan pays 90% **If performed in a provider's office:** $10 copay (PCP) $15 copay (specialist)	After meeting your deductible, the Plan pays 60%	**If performed at an outpatient facility:** The Plan pays 90% **If performed in a provider's office:** $10 copay (PCP) $15 copay (specialist)
Inpatient hospitalization	The Plan pays 90%	After meeting your deductible, the Plan pays 60%	The Plan pays 90%
Urgent care	$15 copay	$15 copay	$15 copay
Emergency room	$25 copay (waived if admitted)	$25 copay (waived if admitted)	$25 copay (waived if admitted)

Medicare prescription drug coverage

There are some important changes to how prescription drugs are covered under your plan resulting from the 2016 labor contracts.

Starting January 1, 2017, the member cost share for brand-name prescription drugs will be differentiated by preferred and non-preferred tiers. The cost of brand-name prescription drugs will vary based on the tier they fall into as displayed in the chart below.

Please refer to the following chart for details.

At a glance – Medicare prescription drug changes

Plan provision	2016	2017
Retail (In-network)	**Generic:** lower of $9 copay or discounted network price **Brand (Single-source):** 20% of discounted network price up to $25 maximum copay **Brand (Multi-source):** 20% of discounted network price up to $25 maximum copay	**Generic:** lower of $9 copay or discounted network price **Brand (Preferred):** 20% of discounted network price up to $25 maximum copay **Brand (Non-preferred):** 30% of discounted network price up to $30 maximum copay
Mail order	**Generic:** lower of $18 copay or discounted network price **Brand (Single-source):** 20% of discounted network price up to $50 maximum copay **Brand (Multi-source):** 20% of discounted network price up to $50 maximum copay	**Generic:** lower of $18 copay or discounted network price **Brand (Preferred):** 20% of discounted network price up to $50 maximum copay **Brand (Non-preferred):** 30% of discounted network price up to $60 maximum copay
Annual mail-order out-of-pocket maximum (MEP HCP medical plan option only)	$786.52 per person	$786.52 per person

Medicare Part D

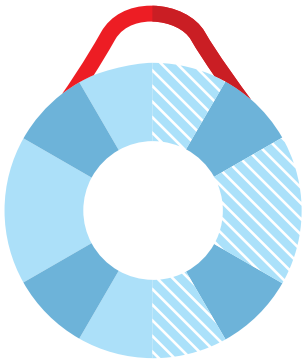
For most Medicare-eligible retirees, if you or a covered family member is or becomes eligible for Medicare, your prescription drug coverage is provided through a Verizon-sponsored group Medicare Part D plan. This benefit consists of a standard Medicare Part D benefit, plus a supplemental "wrap-around"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

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

Learn more about it

To compare plan options, from the BenefitsConnection home page, under I want to, select See Next Year's Health Plan Comparison Charts.

For more detailed information on your benefit plans, including Summary Plan Descriptions (SPDs) and vendor contact information, visit the Library page on BenefitsConnection. You can also request copies of your benefits information including SPDs, benefit comparisons, and other materials be mailed to you by calling the Verizon Benefits Center.



Life insurance

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 retiree supplemental 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.

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 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.

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.

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.

Pre-Medicare only:

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).

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.

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 855.4Vz.Bens (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.

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).*

Actual plan provisions for Company benefits are contained in the appropriate plan documents or applicable Company policies. This Annual Enrollment guide provides updates to your existing Summary Plan Description (SPD) as of January 1, 2017. Please keep this guide and any additional Summary of Material Modification (SMM) with your SPDs until Verizon provides you with SPDs that have been updated to reflect the changes to your benefits. As always, the official plan documents determine what benefits are provided to Verizon employees, 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. 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.

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