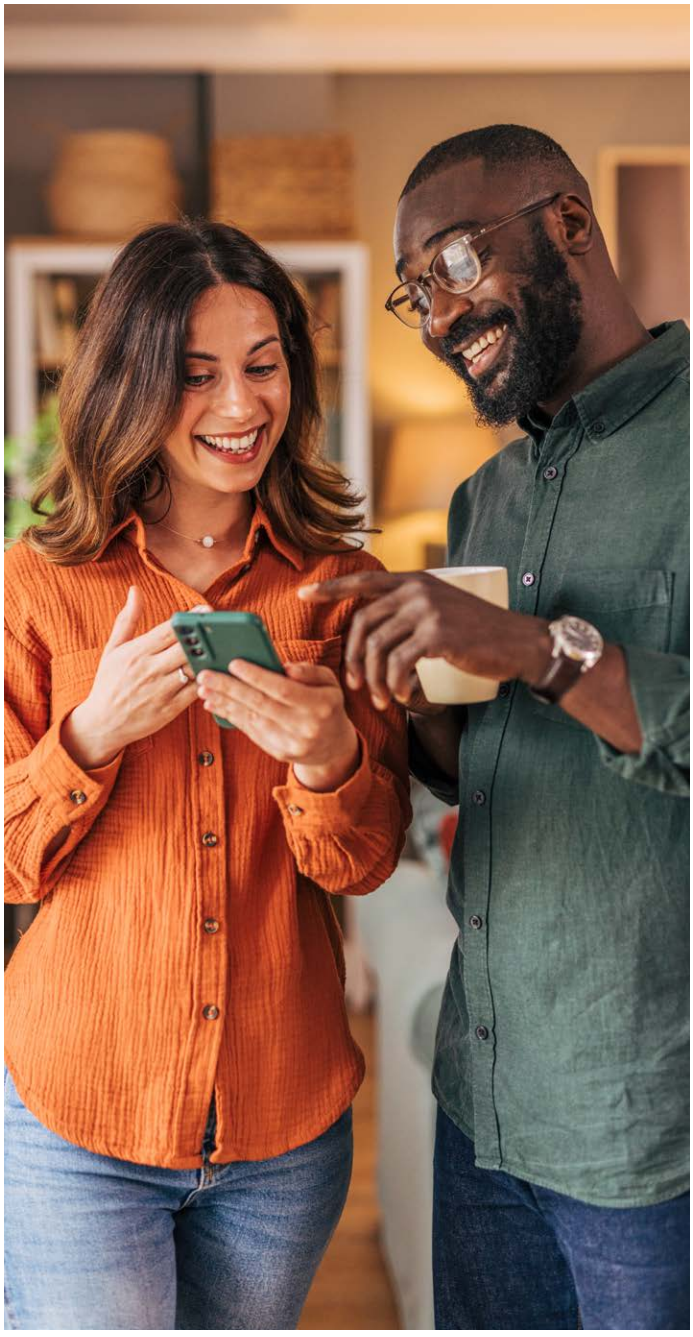
2027 Annual Enrollment

Enroll October 20 – 29, 2026

U.S. management and nonrepresented employees



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2027 Annual Enrollment

Annual Enrollment is your time to plan for your needs in the coming year and to choose the benefits that will help you and your dependents thrive. This year is different, with several important updates to our health care options. We encourage you to take a close look at your choices and make the selections that truly fit your needs for the coming year. We know that choosing benefits is a significant decision, often made with a spouse, partner or dependents. We're sharing information so that you can understand your choices for 2027 benefits.

Enroll October 20 – 29, 2026

Annual Enrollment for 2027 begins **Tuesday, October 20, at 8 AM ET** and ends **Thursday, October 29, at 11:59 PM ET**. Visit BenefitsConnection to make your benefit elections.

You don't want to miss this window. Annual Enrollment is the only time you can change coverage for yourself and your dependents unless you experience a qualifying life event, such as getting married or having a baby.

The benefits you choose will take effect January 1, 2027.

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Annual Enrollment checklist

Since we have made several important updates to your benefits for 2027, including changes to coverage and costs, it's more important than ever to review your options. Take a moment to review all the information carefully and decide what's right for you.

☑ Watch the all-new Benefits Enrollment Training: 2027 Options and Key Changes.

We've created a new benefits training module that you can use to learn about the different types of medical plan options and help you select the plans that best suit your needs and your budget.

☑ Understand your 2027 costs.

Your monthly contributions and out-of-pocket expenses are changing. Review the information below for details.

Compare your medical options. Use the medical plan comparison chart in the back of this Guide along with the dental and vision pages for a side-by-side look at what you'll pay for care. Verizon offers multiple medical plan options because employees and their families have different health care needs, financial circumstances, risk tolerances and preferences regarding how health care costs are paid. When comparing medical plan options, participants should evaluate all plan features, including out-of-pocket costs, employee contributions for the year, provider access, what is covered/not covered and, when applicable, the ability to contribute to an HSA. Verizon cannot provide individual tax, health care or financial advice. Consult your own advisor as appropriate before making an enrollment election.

Check your contributions. Review the per-pay-period 2027 employee contribution amounts. You also should consider the amount you will pay annually. The medical plan options are intended to provide you with choices concerning the timing, amount and structure of health care expenses–for example, consider whether or not you value cash-flow predictability.

If you have a Health Savings Account (HSA), elect your contribution amount for 2027. You can increase your contributions to reach the higher HSA maximum for 2027.

Elect your 2027 contribution for a Health Care Spending Account (HCSA) or a Dependent Care Spending Account (DCSA).

☑ Join a Surest webinar.

Starting in 2027, the Surest Copay Plan is available to all continental U.S. V Teamers (including residents of Alaska). This plan from UnitedHealthcare allows you to check costs and compare care options before making an appointment. No deductibles, no coinsurance, no hard math to figure out—just clear, up-front prices and fixed copays that you can see in advance. Register for a webinar using the links below:

- October 14 at 2 PM ET (Register)
- October 19 at 12 PM ET (Register)
- October 22 at 2 PM ET (Register)
- October 28 at 12 PM ET (Register)

☑ Learn about your new surgery benefit through Lantern.

Lantern gives you access to experienced providers and facilities for certain planned procedures with concierge support to guide you from start to finish. Attend one of the webinar sessions below:

- October 15 at 12 PM ET (Register)
- October 21 at 2 PM ET (Register)

☑ Review what's new or changing for 2027.

See page 5 for more information about the 2027 benefit changes.

☑ Review your beneficiaries and make any changes online.

- For 401(k), HSA or brokerage account, visit Fidelity.
- For Life and AD&D insurance visit BenefitsConnection > Health & Insurance > Beneficiaries.

Save $600 on your 2027 medical contributions

Preventive care supports early detection, improves health outcomes and helps you save on future medical contributions. To save on your 2027 medical plan contributions, schedule or complete a preventive care visit with your primary doctor or OB/GYN. Then, submit your attestation as follows:

- For visits scheduled or completed **on or before December 31, 2026**:
  - Go to Personify Health > Benefits > 2026 – $600 preventive care exam credit > Start Now. You can also attest during annual enrollment in BenefitsConnection.
  - You receive the **full credit** of $600.
- For visits scheduled or completed **after January 1, 2027**:
  - Go to BenefitsConnection.
  - You receive a **prorated credit**.

Note: Credits do not carry over. You must complete an exam and submit an attestation every year to receive the credit. See the EEOC well-being notice under "Important reminders and legal notices" on page 17 for more information.

What's new or changing for 2027

Contributions for medical, dental and vision plans

Verizon continues to pay most of the cost of your health care coverage, even as national health care costs rise. The plans remain competitively priced and provide access to quality care and leading providers.

See your contributions for each plan. Estimate your health care costs and compare plan options at Annual Enrollment > Compare Next Year's Plan Options.

Medical plan design updates

As health care costs continue to rise nationwide, we've made adjustments to some medical plan designs for 2027. There are increases to PCP and ER copays, deductibles, and out-of-pocket maximums. Please review the table on the next page for a summary of 2027 changes for costs for our PPO Plus, EPN, HDP, and Surest Copay Plans, and refer to the medical plan comparison chart in the back of this Guide for a complete view of your options.

Your health remains a priority. Preventive care is one of the most effective ways to save lives and avoid costly health issues down the road, which is why we continue to cover 100% of your preventive care costs across all plans.

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2027 PPO Plus, EPN and HDP Plan Changes

	PPO Plus	EPN	HDP
Copays	$25 PCP $250 ER	$25 PCP $250 ER	N/A
Deductible	$1,250 Individual, $3,750 Family	$800 Individual, $2,400 Family	$1,850 Individual, $3,700 Family
Out-of-pocket maximum	$2,800 Individual, $8,400 Family	$2,175 Individual, $6,525 Family	$3,650 Individual, $7,300 Family

Starting January 1, 2027, separate copay maximums will be removed from Anthem plans. Going forward, all of your cost-sharing—including flat-dollar copayments—will count directly toward your overall out-of-pocket maximum, making it simpler and more transparent to track your annual health care expenses.

2027 Surest Copay Plan Changes

	In-network	Out-of-network
Out-of-pocket maximum	$3,000 Individual, $9,000 Family	$6,000 Individual, $18,000 Family
Office visits (PCP, Specialist)	$25 to $135	$220
Urgent care	$50	$50
Emergency room	$400	$400
Outpatient radiology	Complex imaging: $100-$1,450	Complex imaging: Up to $4,200
Other covered services	Copays vary by service and provider; contact Surest for more information.	Copays vary by service and provider; contact Surest for more information.

To see the cost of care in each plan, check out the 2027 medical plan comparison chart in the back of this Guide.

The Surest Copay Plan is available nationally

Starting in 2027, the Surest Copay Plan is available to V Teamers in all states (except Hawaii). Powered by UnitedHealthcare's Choice Plus Network, this plan simplifies your health care experience by removing the math. There are no deductibles or coinsurance—just clear, up-front fixed copays, so you know exactly what you'll pay before you even schedule an appointment.

How it works:

- **Search:** Use the Surest app or Surest website to find local providers.
- **Check:** View a list of eligible providers and their service costs beforehand.
- **Choose:** Select the provider that best meets your needs and budget.

With $0 virtual doctor visits, it's easier and more affordable to get the care you need.

Surgery benefit through Lantern

Planning a surgery can feel overwhelming, but you don't have to navigate it alone. Lantern gives you access to experienced providers and facilities for certain planned procedures with dedicated concierge support to guide you from start to finish. From coordinating records and appointments to managing logistics and follow-ups, Lantern helps make your care journey smoother and less stressful.

- **When to use Lantern:** If you need bariatric surgery and live within 35 miles of a Lantern provider, you are required to use Lantern for the surgery to be covered. You are also welcome to choose a Lantern facility for other planned procedures if you wish.
- **Cost:** Surgical procedures are provided at $0 cost when using a Lantern facility. If you are enrolled in the HDP, procedures are $0 after you have met your deductible.

Visit Lantern to learn more.

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Prescription drug costs

As costs for specialty and new-to-market medications continue to rise, Verizon is working to keep overall increases moderate. While your share of costs will see a slight adjustment in 2027 (detailed in the tables below), there are several ways you can manage your expenses:

- **Choose generics:** Opt for generic medications whenever available.
- **Use mail order or Maintenance Choice:** For ongoing medications, switch to mail order or the CVS Maintenance Choice program.
- **For certain specialty medications, enroll in PrudentRx:** Take advantage of this program to lower your out-of-pocket costs for specialty medications. (PrudentRx is available only with the PPO Plus, EPN, and Surest Copay options.)

Note: Prescription drug coverage for the HDP will remain unchanged for 2027. Contact Kaiser directly for information on prescription coverage for 2027.

For detailed formulary information, please review the CVS Performance Drug List.

Your 30-day supply retail cost

PPO Plus, EPN and Surest Copay	2027	2028
Generic	Lower of $14 copay or discounted network price	Lower of $15 copay or discounted network price
Preferred brand	30% after deductible; $68 max per prescription*	30% after deductible; $70 max per prescription*
Non-preferred brand	40% after deductible; $112 max per prescription*	40% after deductible; $120 max per prescription*

*Plus cost difference between generic and brand, when a covered generic is available

Your 90-day supply mail-order or Maintenance Choice cost

PPO Plus, EPN and Surest Copay	2027	2028
Generic	Lower of $28 copay or discounted network price	Lower of $30 copay or discounted network price
Preferred brand	30%; $136 max per prescription*	30%; $140 max per prescription*
Non-preferred brand	40%; $224 max per prescription,* no deductible	40%; $240 max per prescription,* no deductible

*Plus cost difference between generic and brand, when a covered generic is available

After three fills, penalties may apply for prescriptions not switched from 30-day to 90-day supplies through mail order or the Maintenance Choice program.

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Weight loss medication copay

Starting January 1, 2027, there are updates to how the plan covers medications for weight loss (including GLP-1s):

- **Copay adjustment:** Your copay for these medications will be $200. Members enrolled in the HDP pay a $200 copay after the deductible is met.
- **Program participation:** To remain eligible for this coverage with a $200 copay, you must enroll in and actively participate in the CVS Caremark Weight Management program.
- **Action required:** If you do not participate in the program or fail to meet the requirements, you will be responsible for the full cost of the medication.

Note: This change does not apply to medications used for Type 2 diabetes management.

The CVS Weight Management™ program

To ensure you get the best support and results, the Verizon prescription drug plan requires participation in the CVS Weight Management program to access benefits for weight loss medications and help you stay on top of your health goals. If you do not participate or meet the program requirements, you will be responsible for the full cost of your medication.

How the program works

- **Connect monthly:** Attend at least one live virtual meeting or member-initiated chat with a program clinician each month.
- **Track your progress:** Log your biomarker information (such as your weight) as agreed upon with your clinician.

Important note: If you do not meet these engagement criteria, you will be responsible for the entire cost of your weight loss medication.

The program includes:

- The Health Optimizer® app with helpful tips, recipes and goal-setting tools
- One-on-one support from a team of clinicians, including registered dietitians
- A nutrition plan personalized for your needs and preferences
- Behavioral strategies to help you overcome barriers to weight loss
- Connected body weight scale and other devices to track your progress

Have questions?

Visit cvs.co/WM for more information about the program and the Health Optimizer app or to find answers to frequently asked questions. You can also call 800.207.2208 from 8 AM to 11 PM ET Monday – Friday or from 9 AM to 7 PM ET on Saturday.

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Save on specialty medications with PrudentRx

Starting January 1, 2027, the PrudentRx program will be available to eligible enrollees in the PPO Plus, Surest Copay, and EPN medical plans to help you lower your out-of-pocket costs for certain specialty medications. If you take a medication included in the program and complete enrollment in PrudentRx, your cost for that covered specialty medication will be $0 when filled through Caremark Specialty Pharmacy. This program covers select specialty medications for conditions including cancer, inflammatory conditions, multiple sclerosis, blood cell deficiency, hepatitis C, hereditary angioedema and pulmonary arterial hypertension. The PrudentRx program is not available to High Deductible Plan (HDP) members.

How the program works:

- **If you currently take a specialty medication:** You'll receive information by mail in November 2026 explaining how to enroll before the program starts on January 1, 2027.
- **If you are newly prescribed a specialty medication:** You'll be contacted when you first attempt to fill your prescription through Caremark Specialty Pharmacy, which will connect you directly with PrudentRx to enroll. If you do not enroll in PrudentRx, the drug will remain covered under the Plan if it is otherwise eligible for coverage, but you will not receive the $0 cost-share available through the PrudentRx program. Instead, you may have to first satisfy any applicable deductible and then pay 30% of the medication's cost. Since many specialty medications are high-cost drugs, declining to enroll in PrudentRx for specialty drugs that are eligible for the PrudentRx program may result in significantly higher out-of-pocket costs to you.

You may choose not to enroll in PrudentRx; however, if you do not enroll, you will not receive the $0 cost-share available through the PrudentRx program for covered specialty medications.

Review the list of PrudentRx covered specialty medications for eligibility.

Eligibility for $0 cost sharing depends on the specialty medication prescribed, participation in the PrudentRx program and satisfaction of applicable program requirements. Not all specialty medications qualify. Any specialty drugs that do not qualify for the PrudentRx program will be adjudicated under the Plan's otherwise applicable member cost-sharing requirements. HDP enrollees are not eligible to participate in the PrudentRx program, and specialty medications for HDP enrollees will continue to be subject to the HDP's otherwise applicable deductible, coinsurance, copayment and other cost-sharing requirements.

Higher Health Savings Account (HSA) contributions

We're increasing our contribution to your Health Savings Account in 2027. When you enroll in the High Deductible Plan (HDP), Verizon will contribute $700 to your HSA for individual-only coverage or $1,400 if you cover yourself and one or more dependents.

You can also boost your savings with higher 2027 IRS limits:

- **Individual coverage:** Contribute up to $3,800 (for a total of $4,500 with Verizon's contribution)
- **Family coverage:** Contribute up to $7,600 (for a total of $9,000 with Verizon's contribution)
- **Age 55+:** Add an extra $1,000 catch-up contribution

If you want to contribute to the new maximum limit, be sure to increase your contributions during Annual Enrollment. Otherwise, your 2026 election will carry over to 2027.

If you're switching to the High Deductible Plan for 2027 and are currently enrolled in the Health Care Spending Account (HCSA), you will not be permitted to set aside money in the HCSA in 2027 (but you will be able to contribute to a Limited Purpose HCSA in 2027). If you have a balance remaining in your 2026 HCSA, you'll be able to incur expenses through March 15, 2027, and submit them for reimbursement through May 31, 2027, but you will not be eligible to contribute or receive Verizon contributions to your HSA until April 1, 2027. To fully fund your HSA in 2027, be sure to use your entire HCSA balance by the end of 2026.

The advantages of an HSA

Your HSA is a powerful tool designed to help you save for both today's medical expenses and your future health needs. The account is yours to keep forever, even if you leave Verizon. Plus, your HSA offers tax advantages to help your savings go further:

- **Tax-free contributions:** You pay no federal taxes on your contributions or those made by Verizon.
- **Tax-free growth:** Your account balance grows without federal tax on interest or investment earnings.
- **Tax-free spending:** Withdrawals for qualified medical expenses are always federal tax-free, whether you use them now or in the future.

Maximizing your Health Care Spending Account (HCSA) contribution

The IRS sets annual limits on general purpose Health Care Spending Account (HCSA) contributions and typically updates those limits after Annual Enrollment. The 2026 maximum contribution limit is $3,400. To automatically contribute up to any new maximum the IRS may set for 2027, you must select the option to contribute the maximum amount during Annual Enrollment.

Need help planning?

To estimate your contribution, go to BenefitsConnection > Annual Enrollment > Compare Next Year's Plan Options > My Spending Account Calculators.

Switching to the High Deductible Plan (HDP) in 2027?

If you enroll in the HDP, you are not eligible for a standard HCSA, though you can contribute to a Limited Purpose HCSA.

If you have a remaining balance in your 2026 HCSA:

- **Grace Period:** You can continue to incur expenses through March 15, 2027, and submit them for reimbursement through May 31, 2027.
- **HSA Eligibility:** Because of IRS rules, you will not be eligible to contribute to or receive Verizon contributions to your HSA until April 1, 2027.
- **Tip:** To fully fund your HSA as early as possible in 2027, we recommend using your entire 2026 HCSA balance by the end of this year.

UnitedHealthcare members in Arkansas will move to Anthem plans

We regularly review our health plan offerings to ensure V Teamers continue to receive high-quality and affordable coverage. If you live in Arkansas and have a UnitedHealthcare plan, your plan will change to Anthem in 2027. This change aligns with our commitment to continue providing you and your family access to provider networks that drive better health outcomes.

While your insurance company will change, the PPO Plus, HDP, and EPN plans will remain available to you.

To help you maintain your current treatment plans, Anthem Health Guides (Anthem's customer service representatives) will help you transfer to a provider within the Anthem network. If you are currently undergoing active, complex treatment for a serious condition (such as pregnancy or ongoing cancer treatment), please reach out to an Anthem Health Guide as soon as you receive your enrollment materials to discuss the Transition of Care process.

After the transition to Anthem on January 1, you can use the Sydney Health app or anthem.com to manage your health, find doctors and access virtual visits through LiveHealth Online.

Other plan changes

Employee assistance program (EAP) with Spring Health

You and your family can count on Spring Health for support whenever you need it. For 2027 the program offers more flexibility to your 1:1 Support Sessions and Specialty Care access, as follows:

1:1 Support Sessions offer **12 free sessions** that you can use for therapy, coaching or a combination of both.

- **Counseling:** Access to licensed providers for members ages 6 and older.
- **Coaching:** Support on a range of personal and relationship topics for members ages 18 and older.

Specialty Care. With Specialty Care, you have **dedicated resources** for substance use support, eating disorders, neurodiversity, tobacco cessation and other behavioral health conditions.

Visit Spring Health for more information.

Hinge Health extends to HDP participants

Hinge Health is a digital exercise therapy program that can provide relief for back, knee, hip, neck or shoulder pain in the comfort of your home. You can reduce your pain through self-guided exercise therapy sessions that you complete at your own pace.

DCSA contribution limit increase for high earners

Per IRS rules, as a highly compensated employee (HCE) who earned $160,000 or more in 2026, you can contribute up to $3,500 to a Dependent Care Spending Account (DCSA) in 2027. Your limit could be reduced during the year if necessary for Verizon to meet IRS rules.

Reminder: Voluntary benefits

You have access to several voluntary benefits to support you and your family, including:

- Auto and home insurance
- Pet insurance
- Identity protection
- Commuter spending accounts
- Long-term disability

Group legal services plan coming in 2027

Verizon will introduce a voluntary group legal services benefit to help employees navigate legal matters more affordably. Coverage will provide you, your spouse and your dependents access to legal assistance for common matters, including:

- Will and estate planning
- Traffic violations
- Family and personal matters
- Home and real estate issues

More information on the plan and how to enroll will be shared in 2027.

AI Upskilling Program for your dependents

Verizon Dependent Upskilling Program: This program provides your eligible family members with free access to premium learning platforms designed to build new skills, enhance career readiness and support personal growth.

Mental and physical well-being platforms

As we continue to evolve our resources, the Personify Health platform will be discontinued on December 31, 2026. You can still access many of the site's features in other locations.

- **$600 medical contribution credit:** Complete your attestation in BenefitsConnection.
- **Well-being benefits, webinars and event calendar:** Visit Inside Verizon.
- **Healthy Pregnancy Program:** Use the Maven Clinic.
- **Nicotine Replacement Therapy:** Reach out to Spring Health.
- **Coaching:** Connect through Maven, Spring Health or Fidelity.
- **Well-being videos, trackers and resources:** Access these through Anthem and UnitedHealthcare.

If you don’t enroll

In most cases, your current benefit elections will automatically continue in 2027 unless you make a change during Annual Enrollment. You’ll have the same medical, dental, vision, disability, life and accidental death and dismemberment (AD&D) coverage you have now.

Your 2026 Health Care Spending Account (HCSA), limited-purpose HCSA, Dependent Care Spending Account (DCSA) and Health Savings Account (HSA) contribution elections will also automatically carry over to 2027. To contribute up to any new maximum the IRS may set for 2027 Health Care Spending Accounts, you must select the option to contribute the maximum amount during Annual Enrollment.

If you waived medical, dental or vision coverage for 2026, you won’t have coverage in 2027 unless you make elections during Annual Enrollment.

Annual Enrollment: October 20 – 29

Enroll in your benefits for 2027 on BenefitsConnection. You can change your benefit elections October 20 through October 29, 2026, at 11:59 PM ET.

Important reminders and legal notices

In addition to the information provided here, you can always find Summary Plan Descriptions (SPDs), summary of material modifications (SMMs) and vendor contact information in the library section of BenefitsConnection.

Adding a dependent to coverage

To enroll a spouse, domestic partner or dependent child in coverage during Annual Enrollment or as a result of a qualifying life event, follow the prompts on BenefitsConnection during the enrollment process to add a new dependent and select the appropriate dependent relationship. After you add your dependent, you must also select the coverage you want to enroll them in.

You will need to provide documentation to verify eligibility. Instructions for completing the dependent verification will be sent to both your work email and home address on file after you have enrolled your dependent. If you do not submit proper documentation in a timely manner, your dependent will be dropped from coverage.

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

Dependent child coverage age limit

A dependent child is eligible for medical (including prescription drug), dental, vision, child life insurance and child AD&D insurance through the end of the month in which they attain age 26, regardless of student status. Coverage may be extended beyond age 26 for a dependent child who was enrolled in the medical plan when they were younger than 26 and meets the conditions of being disabled under the medical plan.

Once a nondisabled dependent child attains age 26, they will be automatically removed from medical (including prescription drug), dental and vision coverage at the end of the month in which their birthday occurs. You will then be provided the opportunity to continue coverage for the dependent through COBRA.

The child life insurance and child AD&D insurance plans cover all your eligible dependent children. While medical, dental and vision coverage automatically ends once your dependent attains age 26, child life and child AD&D do not automatically end. You are responsible for updating your child life and child AD&D elections once your previously eligible dependent no longer meets the eligibility requirements.

Medical plans that require or allow for the designation of primary care providers by participants or beneficiaries (HMO, Kaiser and HMSA)

Certain Verizon group health plan options generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the plan option's network and who is available to accept you or your family members.

For information on how to select a primary care provider and for a list of the participating primary care providers, contact the HMO, Kaiser or HMSA plans directly.

For children you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology.

No-coverage option for medical, dental and/or vision coverage

If you are an active employee in the no-coverage (waived-coverage) option for medical, dental and/or vision, and you make no changes during this Annual Enrollment, your no-coverage (waived-coverage) election for medical, dental and/or vision will carry over for 2027.

While there is no longer a federal requirement to maintain medical coverage to avoid a federal tax penalty, some states require you to maintain medical coverage to avoid a state tax penalty. California, Massachusetts, New Jersey, Rhode Island, Vermont and Washington, D.C., currently have such mandates. You should confirm with your tax advisor if such a mandate is a concern for you; additional states may add this requirement in the future.

If you are a Massachusetts resident, you must maintain medical coverage that meets specific state requirements, referred to as minimum creditable coverage (MCC), to avoid the state tax. All the Verizon group medical options available to you meet the Massachusetts MCC requirements.

If you have coverage today and would like to waive coverage for 2027, you need to choose the no-coverage option during Annual Enrollment. If you choose no coverage, you cannot enroll in coverage during 2027 unless you have a qualifying life event or as otherwise required by law.

Highly compensated employees

Each year, the IRS establishes a compensation limit that is used to identify a group of employees known as highly compensated employees (HCEs). Generally speaking, an employee is classified by the IRS as an HCE for 2027 if they earned wages from Verizon during 2026 in excess of $160,000. “Wages” for this purpose means the amount reported in Box 1 of IRS Form W-2 plus before-tax deferral amounts made under the 401(k) Savings Plan, cafeteria plans and qualified transportation fringe benefits, if any.

IRS guidelines require that annual contributions toward the DCSA by both HCE and non-HCE participants are within an acceptable margin. Verizon performs an annual nondiscrimination test of the DCSA plan to ensure compliance with these rules.

Based on preliminary testing for 2026, the plan must limit DCSA annual contributions by HCEs to $3,500. If you are classified as an HCE for 2026, you will be subject to the initial 2027 DCSA contribution limit of $3,500 during Annual Enrollment. Additional restrictions may be imposed later in 2027 depending on additional testing.

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, medical plans generally may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a recommended preventive care service.

As explained in your Summary Plan Description (SPD), preventive care benefits that must be offered in-network without cost sharing include, but are not limited to, a number of screenings (e.g., blood pressure, cholesterol, breast and cervical cancer based on navigation services), and beginning in 2027, HRSA has updated the cervical cancer screening guidelines to include additional testing for women ages 21 – 65 and pathological evaluation when indicated to complete the screening process and to include patient-collected hrHPV testing as an appropriate method for screening for women ages 30 – 65 at average risk), certain immunizations (including COVID-19), colonoscopies (including many related items and services, and coverage for a follow-up colonoscopy after a patient has received a positive screening test or direct visualization test), FDA-approved contraception methods, and other items and services that are designed to detect and treat medical conditions to prevent avoidable illnesses and premature death.

Preventive care benefits that must be offered in-network without cost sharing change periodically.

Contact the Verizon medical plan or prescription drug administrator, such as CVS Caremark, for more details on the types of preventive care items and services that are covered at no cost in-network.

Transparency in health care

The Affordable Care Act transparency requirements will give you access to an internet-based price-comparison tool to compare prices for medical and prescription drug items and services. Upon request, this information may be provided in paper form without a fee, subject to certain limits.

HIPAA privacy notice

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

The HIPAA Privacy Notice can be found on BenefitsConnection. You can view the notice and/or print a paper copy from the website, and you can request a paper copy by calling the Verizon Benefits Center at 855.4vz.bens (855.489.2367).

Summaries of benefits and coverage (SBCs)

Summaries of benefits and coverage (SBCs), required by the Affordable Care Act, are available on BenefitsConnection. If you would like a free paper copy of the SBCs, contact the Verizon Benefits Center at 855.4vz.bens (855.489.2367).

To help you compare your health plan options and make informed choices, Verizon is required to make SBCs—which summarize important health plan information in a standard format—available to you. 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 plan is an important decision.

You'll find SBCs, health plan comparison charts and other information about your health benefits on BenefitsConnection.

Americans with Disabilities Act (ADA)/EEOC notice regarding the well-being program

The well-being program offered to you by Verizon is voluntary and available to all employees. The program is administered according to federal rules permitting employer-sponsored well-being 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 well-being program, you will be asked to voluntarily complete a medical exam and complete the Preventive Care Exam Credit attestation form within BenefitsConnection. In addition, you will be eligible for a weight loss medication (including a GLP-1) subsidy if you are otherwise eligible and meet with a clinician. You are not required to complete these activities to receive medical coverage.

However, if you choose to participate in the well-being program, you will receive an incentive of up to $600, which will be used to reduce your medical plan contributions. Although you are not required to complete this activity, if you do, you will receive the medical plan cost reduction of up to $600.

In addition, to receive weight loss medication (including a GLP-1) at a lower cost, you may be required to periodically meet with a clinician.

The information from your preventive care exam or weight loss medication health coaching (which includes a GLP-1) can provide you with helpful insights to better understand your current health and potential health risks. You also are encouraged to share your results or concerns with your own doctor.

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 well-being program and Verizon may collect and use aggregate information to design a program based on identified health risks in the workplace, the well-being program will never disclose any of your personal information either publicly or to Verizon, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the well-being program or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the well-being program will not be provided to your supervisors or managers, and it 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 well-being program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the well-being program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the well-being program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are a registered nurse or doctor in order to provide you with services under the well-being program.

In addition, all medical information obtained through the well-being program will be maintained separately from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the well-being 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 well-being 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 well-being 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 855.4vz.bens (855.489.2367) and indicate that you have a question or concern regarding this notice.

verizon

Your rights and protections against surprise medical bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copays, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance and/or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service.

This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

- **Emergency services:** If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copays, coinsurance and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain services at an in-network hospital or ambulatory surgical center:** When you get services from an in-network hospital or ambulatory surgical center, certain providers may be out-of-network. In these cases, the most that providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you receive other types of services at these in-network facilities, out-of-network providers can't balance bill you unless you provide written consent and waive your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're responsible for paying your share of the cost only (like the copays, coinsurance and deductible that you would pay if the provider or facility were in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the Centers for Medicare and Medicaid Services (CMS) at 800.985.3059. Visit cms.gov/medical-bill-rights for more information about your rights under federal law. If you are enrolled in a fully insured medical plan option, state laws that affect balance billing may also apply. Contact your insurer if you have questions.

Women's Health Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance (this includes coverage for nipple and areola reconstruction, including nipple and areola repigmentation to restore the physical appearance of the breast, as a required stage of reconstruction and coverage for chest wall reconstruction with aesthetic flat closure, if elected by the patient in consultation with the attending physician in connection with a mastectomy, as a required type of reconstruction);
- Prostheses; and,
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your medical plan administrator or insurer at the number on your insurance card.

Requesting paper documents and summary of material modifications (SMMs)

Actual plan provisions for company benefits are contained in the appropriate plan documents or applicable company policies. This Annual Enrollment page provides updates to your existing Summary Plan Descriptions (SPDs) as of January 1, 2027. Until Verizon provides you with updated SPDs, this page is intended to be a summary of material modifications (SMMs).

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 that you may not be eligible to participate in or receive benefits from all plans and programs referenced on this page.

Your SPDs and SMMs are available in the library section of BenefitsConnection, and you can call the Verizon Benefits Center at 855.4vz.bens (855.489.2367) to request printed copies free of charge. As explained in your SPDs, 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.

Additional information

Eligibility

Yourself

If you're a full-time employee or a part-time employee scheduled to work 30 or more hours per week, you're eligible for Verizon benefits beginning your first day of work.

If you're a part-time employee scheduled to work less than 30 hours per week, visit BenefitsConnection to determine your eligibility for coverage and to review and update your eligible dependents.

As a new V Teamer, you need to enroll in (or waive) medical, dental and vision coverage and elect spending account contribution amounts within 30 days of your start date. This is also the time you can elect long-term disability and additional life insurance coverage for yourself and your dependents.

Your spouse or domestic partner

After enrolling your spouse or domestic partner, you will need to verify that they meet the requirements for dependent coverage. A dependent verification request notice and instructions will be sent to your work email address and mailed to your home shortly after you add a dependent.

Definition of eligible domestic partner

There are two ways to qualify as a domestic partner.

Domestic partnership by government registration: You and your partner have entered into a valid domestic partnership registered with a government entity under the laws of the state, county or municipality in which you live.

Domestic partnership by company registry: You and your domestic partner must meet the following requirements:

- You are each other's sole domestic partner.
- Neither of you is married to anyone else.
- You're both at least 18 years old and mentally competent to enter a marriage contract.
- You're not related by blood to the degree of closeness that would prohibit your legal marriage in your state.
- You've lived together in the same principal residence for at least six months and intend to do so indefinitely.
- You are emotionally committed to one another and jointly responsible for each other's common well-being and financial obligations.

Your children

Dependent children are eligible for medical, dental, vision, life insurance and AD&D insurance through the end of the month in which they turn age 26, regardless of student status. Coverage may be extended beyond age 26 for a dependent child who is enrolled before age 26 and meets the conditions of being disabled under the medical plan.

A dependent verification request notice and instructions will be sent to your work email address and mailed to your home shortly after you add a dependent to your coverage.

Once a nondisabled dependent child attains age 26, they will be automatically removed from medical, dental and vision coverage at the end of the month in which their birthday occurs. You will then be provided the opportunity to continue coverage for the dependent through COBRA.

The child life insurance and child AD&D insurance plans cover all your eligible dependent children. You are responsible for updating your child life and child AD&D election when your dependent no longer meets eligibility requirements; they will not be dropped automatically.

Definition of eligible child

- A child who is under age 26 who is:
  - Your, your spouse's or your domestic partner's natural child, stepchild or legally adopted child or in the process of being adopted
  - A child for whom you, your spouse or your domestic partner has been appointed legal guardian
  - A child for whom you, your spouse or your domestic partner is required to provide coverage under a qualified medical child support order
- A child of any age if they are dependent on you, your spouse or your domestic partner for support due to a physical or mental disability

Employee contributions

See how much you'll pay for the benefits you enroll in.

Medical, dental and vision coverage

These are the 2027 medical plan employee contributions.

Your contributions are made on a before-tax basis and deducted from your pay each pay period, which reduces your taxable income.

If you cover a domestic partner or domestic partner's child who does not qualify as a tax dependent, the value of their coverage will be considered imputed income.

You

Medical

Plan	Contribution per pay period	Full-year cost
PPO Plus	$42.69	$1,110
EPN	$107.31	$2,790
HDP	$42.69	$1,110
Surest Copay	$25.38	$660
Kaiser Mid-Atlantic	$53.85	$1,400
Kaiser Georgia	$53.85	$1,400
Kaiser Northwest	$52.12	$1,355
Kaiser California	$53.27	$1,385
Kaiser Hawaii	$42.69	$1,110
Health Plan Hawaii Plus	$53.27	$1,385

Medical plan contribution notes:

- The medical plan costs shown reflect the $600 preventive care credit.
- Contributions for senior directors and above are 150% of the rates shown.
- If you're a part-time V Teamer scheduled to work less than 30 hours per week, you can see your medical plan contributions in BenefitsConnection during enrollment.

Dental

Plan	Contribution per pay period	Full-year cost
PPO	$11.54	$300
DMO	$7.69	$200

Vision

Plan	Contribution per pay period	Full-year cost
VSP	$3.81	$99.06

You + 1

Medical

Plan	Contribution per pay period	Full-year cost
PPO Plus	$125.00	$3,250
EPN	$256.77	$6,910
HDP	$125.00	$3,250
Surest Copay	$76.15	$1,980
Kaiser Mid-Atlantic	$147.31	$3,830
Kaiser Georgia	$147.31	$3,830
Kaiser Northwest	$143.27	$3,725
Kaiser California	$146.15	$3,800
Kaiser Hawaii	$115.77	$3,010
Health Plan Hawaii Plus	$145.77	$3,790

Medical plan contribution notes:

- The medical plan costs shown reflect the $600 preventive care credit.
- Contributions for senior directors and above are 150% of the rates shown.
- If you're a part-time V Teamer scheduled to work less than 30 hours per week, you can see your medical plan contributions in BenefitsConnection during enrollment.

Dental

Plan	Contribution per pay period	Full-year cost
PPO	$23.08	$600
DMO	$15.38	$400

Vision

Plan	Contribution per pay period	Full-year cost
VSP	$10.67	$277.44

You + family

Medical

Plan	Contribution per pay period	Full-year cost
PPO Plus	$206.15	$5,360
EPN	$423.46	$11,010
HDP	$206.15	$5,360
Surest Copay	$126.92	$3,300
Kaiser Mid-Atlantic	$247.12	$6,425
Kaiser Georgia	$247.12	$6,425
Kaiser Northwest	$231.92	$6,030
Kaiser California	$236.73	$6,155
Kaiser Hawaii	$188.27	$4,895
Health Plan Hawaii Plus	$236.15	$6,140

Medical plan contribution notes:

- The medical plan costs shown reflect the $600 preventive care credit.
- Contributions for senior directors and above are 150% of the rates shown.
- If you're a part-time V Teamer scheduled to work less than 30 hours per week, you can see your medical plan contributions in BenefitsConnection during enrollment.

Dental

Plan	Contribution per pay period	Full-year cost
PPO	$34.62	$900
DMO	$23.08	$600

Vision

Plan	Contribution per pay period	Full-year cost
VSP	$17.15	$445.83

Supplemental life insurance

If you elect supplemental life insurance during Annual Enrollment, your 2027 rate will be based on your age as of December 31, 2027. If you also elect coverage for a spouse or domestic partner, their rate will be based on their age as of December 31, 2027.

Your contributions are deducted from your pay each pay period after taxes.

You must provide evidence of insurability (EOI) for any increase to this benefit.

You

Employee age as of December 31, 2027	Non-tobacco user monthly rate per $1,000 of coverage	Tobacco user monthly rate per $1,000 of coverage
Under 25	$0.022	$0.037
25 – 29	$0.022	$0.045
30 – 34	$0.024	$0.060
35 – 39	$0.026	$0.066
40 – 44	$0.040	$0.074
45 – 49	$0.082	$0.112
50 – 54	$0.128	$0.171
55 – 59	$0.242	$0.319
60 – 64	$0.419	$0.515
65 – 69	$0.805	$0.990
70 – 74	$1.453	$1.606
75+	$1.953	$1.953

Dependents

Spouse or domestic partner age as of December 31, 2027	Monthly rate per $1,000 of coverage
Under 25	$0.049
25 – 29	$0.059
30 – 34	$0.079
35 – 39	$0.089
40 – 44	$0.099
45 – 49	$0.148
50 – 54	$0.227
55 – 59	$0.424
60 – 64	$0.650
65 – 69	$1.252
70 – 74	$2.030
75 – 79	$3.221
80 – 84	$5.219
85 – 89	$8.449
90 – 94	$13.688
95 – 99	$22.175
Dependent child up to age 26	$0.099

Long-term disability insurance

These rates are not changing for 2027. The 2026 and 2027 monthly rates are below.

Your contributions are deducted from your pay each pay period after taxes.

You must provide evidence of insurability (EOI) if you enroll after your new-hire enrollment period and for any increase to this benefit.

Monthly rate	Employees enrolled in plan less than 5 years	Employees enrolled in plan 5 or more years
50% option	$0.30 per $100 of eligible coverage	$0.20 per $100 of eligible coverage
66 2/3% option	$0.52 per $100 of eligible coverage	$0.39 per $100 of eligible coverage

Changes after enrollment

Annual Enrollment is generally the only time during the year when you can make changes to your benefits coverage unless you have a qualifying life event, such as the birth of a child or marriage.

Qualifying life events

Benefit changes must be made within 60 days of the event and are retroactive to the date of the qualifying change in status. Changes to your elections must be due to and consistent with the qualifying change in status.

To make a change, visit BenefitsConnection.

Qualifying changes in status include:

- You have a baby, adopt or have a child placed in your care for adoption.
- You get married, divorced or legally separated, or your marriage is annulled.
- You gain a domestic partner or lose one through termination of the domestic partnership or death.
- Your spouse or dependent dies.
- You, your spouse or your dependent has a change in employment status, resulting in a loss or gain of eligibility for coverage. For example, one of you:
  - Takes or returns from an unpaid leave of absence
  - Switches from full-time to part-time employment (or vice versa)
  - Begins or ends employment (and is not rehired within 30 days)
- Your dependent gains or loses eligibility for coverage (for example, they become a legal dependent or turn 26).
- You, your spouse or your dependent moves to a new place of residence, resulting in a loss or gain of eligibility for coverage (for example, you participate in an HMO and move outside of the service area).

See your Summary Plan Description (SPD) in the library section of BenefitsConnection for other circumstances, including the HIPAA special enrollment rules pertaining to midyear changes.

Continuing health coverage under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents can continue coverage in some Verizon plans if you lose coverage in the following circumstances:

- Your employment is terminated
- You lose coverage because your work hours are reduced or you take an unpaid leave of absence
- Your child no longer qualifies as a dependent
- Divorce or legal separation
- Death

For qualifying events, such as divorce, legal separation or a child's loss of eligibility, you must notify the Verizon Benefits Center.

If you or a covered dependent is eligible for COBRA, you'll receive an enrollment packet from the Verizon Benefits Center within two weeks of the qualifying event. You'll have 60 days from the qualifying event date to make your election, which will be effective retroactive to the day after your loss of coverage.

You pay the full cost of COBRA coverage plus an additional 2% for administrative costs.

See your Summary Plan Description (SPD) in the library section of BenefitsConnection for more COBRA details.

Health Care Spending Accounts (HCSAs)

Save on eligible health expenses when you set aside before-tax dollars in a Health Care Spending Account (HCSA) or a limited-purpose HCSA.

HCSAs at a glance

The type of spending account you're eligible for depends on which Verizon health plan you choose:

- **HCSA:** Contribute if you're not enrolled in the High Deductible Plan (HDP).
- **Limited-purpose HCSA:** Contribute only if you're enrolled in the HDP.

	HCSA	**Limited-purpose HCSA**
2026 contribution limits*	$3,400	$3,400
Eligible medical plans	All plans except HDP	HDP
Examples of eligible expenses	• Medical copays, coinsurance and deductibles • Prescription drugs • Dental expenses, including orthodontia • Vision expenses, such as eye exams and glasses, contact lenses and solution, prescription sunglasses, and Lasik procedures • Over-the-counter (OTC) medical products obtained without a prescription and menstrual products • Durable medical equipment, such as wheelchairs	• Dental expenses, including orthodontia • Vision expenses, such as eye exams and glasses, contact lenses and solution, prescription sunglasses, and Lasik procedures
Can I also have an HSA?	No	Yes

*The limits shown are the current 2026 limits. They will likely increase for 2027 and will be updated when announced.

How they work

Enroll through BenefitsConnection as a new V Teamer or during Annual Enrollment. Your election will carry over to the next year unless you make changes during Annual Enrollment or midyear following a qualifying life event.

Use the money in your HCSA to cover qualified health expenses.

Set aside up to $3,400. The IRS sets annual limits on spending account contributions. The 2026 limit is $3,400.

Your contributions will be deducted from your paycheck in equal increments throughout the year.

To estimate how much money to contribute to an HCSA, go to BenefitsConnection > Compare Your Plan Options > My Spending Account Calculators.

Budget carefully

You have until March 15 of the next year to incur expenses and until May 31 to submit claims for the prior year's HCSA-eligible expenses. You'll forfeit any unused balance after March 15.

Health Savings Account (HSA)

An HSA is an individual account used in conjunction with an eligible high-deductible medical plan to cover eligible out-of-pocket medical expenses on a tax-advantaged basis.

How it works

The HSA offered through Verizon is administered by Fidelity.

You can contribute pretax dollars to your account, withdraw contributions to pay for current qualified medical expenses and potentially grow your account on a tax-free basis by investing your savings in a wide array of investment options.

Verizon also contributes to your HSA:

- In 2026: $650 if you have employee-only medical coverage or $1,300 if you cover dependents too
- In 2027: $700 if you have employee-only medical coverage or $1,400 if you cover dependents too

Your HSA belongs entirely to you and can be used to pay for your and your eligible dependents' qualified medical expenses now or in the future, even in retirement.

What you need to know

- When you enroll in the HDP for the first time, you are automatically prompted to review and certify that you agree to the HSA terms and conditions. Once you certify, Fidelity will establish your HSA and send you a letter that explains other features of your HSA, including the debit card and your investment options.
- To receive and access employer and payroll-deducted HSA contributions during the calendar year, the HSA must be established and in good standing (i.e., all required custodian documentation has been completed, and the account is able to receive deposits). In addition, Verizon imposes a year-end deadline for the funding of certain HSA contributions, including applicable employer contributions and the age 55 catch-up contributions.
- You contribute to your HSA through pretax payroll contributions up to annual limits set by the IRS. Your contributions—and Verizon's annual contribution—are deposited into your HSA at Fidelity.
- You pay no federal taxes on your contributions, withdrawals or interest on investment earnings. If you live in California or New Jersey, your contributions and earnings are subject to state taxes.
- You can open and contribute to an HSA only if you meet the following IRS requirements:
  - You must maintain enrollment in the Verizon HDP plan.
  - You cannot be enrolled in Medicare or any other medical plan (including plans offered by your spouse's employer) or in a Health Care Flexible Spending Account (except a Limited-Purpose Flexible Spending Account).
  - You cannot be claimed as a dependent on another person's tax return.

2027 Contribution limits

The IRS sets annual limits on how much you and Verizon can contribute to your HSA.

Full-year amounts	Employee-only coverage	Employee + dependents
2027 IRS limit for all contributions	$4,500	$9,000
Verizon contribution	$700	$1,400
Your contribution limit	$3,800	$7,600
Additional allowable contribution for employees age 55 and older	$1,000	$1,000

Learn more about the HSA at Fidelity.

Dependent Care Spending Account (DCSA)

You can save on child and adult day care expenses when you contribute pretax dollars to the Dependent Care Spending Account (DCSA).

How it works

Enroll through BenefitsConnection as a new V Teamer or during Annual Enrollment. You can make changes each year during Annual Enrollment or following a qualifying life event.

Set aside up to $7,500 pretax in 2026 if you're single or married and filing a joint tax return ($3,750 if you're married and file separate tax returns). Dependent care expenses are DCSA-eligible only when you and your spouse or domestic partner are both working or attending school full time.

Plan carefully. If you do not use your 2026 DCSA balance by March 15, 2027, it will be forfeited. You have until May 31, 2027, to file claims for the 2026 plan year. Similarly, you will have until March 15, 2028, to use your 2027 DCSA balance.

Your contributions may be limited. If you earn more than $160,000 in wages during 2026, your annual DCSA contributions will be capped at $3,500 in 2027 due to IRS nondiscrimination rules. Your limit could be reduced during the year if necessary for Verizon to meet IRS rules.

Eligible expenses

Dependent care expenses are incurred when the care is provided, not when you are billed. Eligible expenses include:

- Preschool and day care for children until kindergarten
- Before- and after-school care (other than tuition) up to age 13
- Child care at a day camp or nursery school or by a private babysitter up to age 13
- Summer or holiday camps, including registration fees, up to age 13
- Transportation to and from the caregiver when they provide the transportation
- Nonresidential day care expenses for an adult dependent who is mentally or physically incapable of caring for themself and who lives with you at least eight hours per day

Life and AD&D insurance

When the unexpected happens, insurance can offer the security you and your loved ones need. We offer two levels of financial protection.

Basic life and AD&D insurance

If you regularly work 20 or more hours per week, you automatically receive free basic life and accidental death and dismemberment (AD&D) insurance equal to your annual pay.

Supplemental life insurance

For additional protection, you can purchase supplemental life insurance and accidental death and dismemberment (AD&D) coverage of up to 10 times your annual pay up to a maximum of $5 million for yourself and your family. Depending on the coverage you choose, you may be required to provide EOI.

New hires can elect supplemental life insurance coverage up to the lesser of three times annual salary or $500,000 without providing evidence of insurability (EOI). New hires who enroll after 30 days or increase their coverage after the initial enrollment period will need to provide EOI to increase coverage.

Disability

When you can't work because of an injury or medical condition, we've got you covered.

Short-term disability

Our free short-term disability (STD) plan provides income protection if you are unable to work as the result of injury or medical condition (including pregnancy).

The benefit amount paid varies based on how long you've worked at Verizon. Our disability coverage is administered through Sedgwick.

Length of employment	Weeks at 100% pay	Weeks at 60% pay
6 months to less than 5 years	8 weeks	18 weeks
5 years to less than 7 years	13 weeks	13 weeks
7 years to less than 10 years	18 weeks	8 weeks
10 or more years	26 weeks	0 weeks

Long-term disability

We also offer voluntary long-term disability (LTD) coverage for limited income protection if your disability lasts longer than 26 weeks.

You pay the full cost of coverage with after-tax dollars. After you've been covered under the LTD plan for more than five years, you're eligible for reduced rates. Any benefits you receive through LTD will be tax-free.

Choose from two coverage options: 50% or 66 2/3% of eligible pay up to maximum annual pay of $345,000. If you're enrolled in the plan at 50% and choose to increase your coverage to 66 2/3%, you'll need to provide evidence of insurability (EOI).

As a new hire, you're automatically enrolled at the 50% coverage level. If you opt out of coverage but decide you want it later, you'll need to provide EOI to obtain coverage.

See the cost of coverage.

Dental

Keep smiling with your choice of two Aetna dental plans.

Plan features

Both plans provide comprehensive coverage and preventive services at no cost to you.

Dental Preferred Provider Organization (PPO): With both in- and out-of-network coverage, this plan gives you the freedom to receive covered care from any dental provider. It comes with a higher per-paycheck contribution, and you may also pay more out of pocket for services.

Dental Maintenance Organization (DMO): To enroll in this plan, you must live within the DMO service area. The plan offers in-network coverage only, and you must choose a primary care dentist. Even if your dentist leaves the network or you select a dentist who is not accepting new patients, you are required to stay in the plan until the next Annual Enrollment or you experience a qualifying life event.

Dental plan coverage

Here's what you'll pay for services with each plan.

	PPO	**DMO**
Annual deductible (applies to basic and major services only)	$50 individual, $100 family	None
Annual benefit maximum	$2,000 per individual	None
Preventive services	$0	$0
Basic services	20% after deductible	$0
Major services	50% after deductible	40%
Orthodontia services (child and adult)	50% after deductible	50%
Lifetime orthodontia maximum	$2,500 per individual	24 months of comprehensive orthodontic treatment, plus 24 months of retention per individual

Vision

The Verizon vision plan through VSP helps you stay focused with coverage for annual routine eye exams and prescription eyewear.

Vision plan coverage

Here's what you'll pay for in-network vision services.

Service	What you pay
Eye exam	$20 copay
Retinal screening	$0
Contact lenses	$0 up to a $200 allowance (for frames or contact lenses)
Contact lens exam and fitting	Up to a $40 copay
Frames	$0 up to a $200 allowance (for frames or contact lenses), then receive a 20% discount on any balance over $200
Standard lenses	$0
Premium progressive lenses	$0

You can receive one exam and one set of frames or lenses every 12 months.

2027 medical plan comparison chart

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Plan features

	PPO Plus	EPN	Surest Copay	HDP with HSA
Annual Verizon HSA contribution	N/A	N/A	N/A	$700 individual $1,400 family

	PPO Plus		EPN	Surest Copay		HDP with HSA	
	In-network	Out-of-network[1]	In-network	In-network	Out-of-network[1]	In-network	Out-of-network[1]
Annual deductible	$1,250 individual $3,750 family	$1,250 individual $3,750 family	$800 individual $2,400 family	$0	$0	$1,850 individual $3,700 family	$1,850 individual $3,700 family
Annual out-of-pocket maximum	$2,800 individual $8,400 family	$2,800 individual $8,400 family	$2,175 individual $6,525 family	$3,000 individual $9,000 family	$6,000 individual $18,000 family	$3,650 individual $7,300 family	$3,650 individual $7,300 family

Your cost for covered services

	PPO Plus		EPN	Surest Copay		HDP with HSA	
	In-network	Out-of-network[1]	In-network	In-network	Out-of-network[1]	In-network	Out-of-network[1]
Preventive care	$0	$0	$0	$0	$0	$0	$0
Office visit	$25 copay PCP and OB/GYN $40 copay specialist	40% after deductible	$25 copay PCP and OB/GYN $40 copay specialist	$25 – $135 copay	$220 copay	20% after deductible	40% after deductible
Urgent care visit	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	20% after deductible	20% after deductible
Emergency room visit	$250 copay	$250 copay	$250 copay	$400 copay	$400 copay	20% after deductible	20% after deductible
Outpatient lab	$20 copay	40% after deductible	$20 copay	$0	$0	20% after deductible	40% after deductible
Outpatient radiology	20% coinsurance	40% after deductible	10% coinsurance	Routine X-rays: $0 Complex imaging: $100 – $1,450 copay	Routine X-rays: $0 Complex imaging: Up to $4,200 copay	20% after deductible	40% after deductible
Other covered services	20% after deductible	40% after deductible	10% after deductible	Copays vary by service and provider; contact Surest for more information	Copays vary by service and provider; contact Surest for more information	20% after deductible	40% after deductible
Fertility services	50% after deductible $75,000 lifetime maximum (combined with prescription drug)	50% after deductible $75,000 lifetime maximum (combined with prescription drug)	50% after deductible $75,000 lifetime maximum (combined with prescription drug)	$100 – $1,500 copay $75,000 lifetime maximum (combined with prescription drug)	$200 – $3,000 copay $75,000 lifetime maximum (combined with prescription drug)	50% after deductible $75,000 lifetime maximum (combined with prescription drug)	50% after deductible $75,000 lifetime maximum (combined with prescription drug)
Bariatric and other surgeries at a Lantern facility (required for bariatric surgery if you live within 35 miles of a designated Lantern facility.)	$0	$0	$0	$0	$0	$0 after deductible	$0 after deductible

2027 medical plan comparison chart

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Your cost for prescription drugs (30-day retail supply)[2]

	PPO Plus		EPN	Surest Copay		HDP with HSA	
	In-network	Out-of-network[1]	In-network	In-network	Out-of-network[1]	In-network	Out-of-network[1]
Generic	Lower of $14 copay or discounted network price	Lower of $14 copay or discounted network price plus cost difference between retail and discounted network price	Lower of $14 copay or discounted network price	Lower of $14 copay or discounted network price	Lower of $14 copay or discounted network price plus cost difference between retail and discounted network price	20% after deductible	40% after deductible plus cost difference between retail and discounted network price
Preferred brand	30% after deductible, $68 maximum per prescription plus cost difference between generic and brand[3]	40% after deductible plus cost difference between retail and discounted network price plus cost difference between generic and brand[3]	30% after deductible, $68 maximum per prescription plus cost difference between generic and brand[3]	30% after deductible, $68 maximum per prescription plus cost difference between generic and brand[3]	40% after deductible plus cost difference between retail and discounted network price plus cost difference between generic and brand[3]	20% after deductible plus cost difference between generic and brand[3]	40% after deductible plus cost difference between retail and discounted network price plus cost difference between generic and brand
Non-preferred brand	40% after deductible, $112 maximum per prescription plus cost difference between generic and brand[3]	50% after deductible plus cost difference between retail and discounted network price plus cost difference between generic and brand[3]	40% after deductible, $112 maximum per prescription plus cost difference between generic and brand[3]	40% after deductible, $112 maximum per prescription plus cost difference between generic and brand[3]	50% after deductible plus cost difference between retail and discounted network price plus cost difference between generic and brand[3]	20% after deductible plus cost difference between generic and brand[3]	40% after deductible plus cost difference between retail and discounted network price plus cost difference between generic and brand

Your cost for prescription drugs (90-day supply, mail-order or Maintenance Choice)

	PPO Plus		EPN	Surest Copay		HDP with HSA	
	In-network	Out-of-network[1]	In-network	In-network	Out-of-network[1]	In-network	Out-of-network[1]
Generic	Lower of $28 copay or discounted network price	N/A	Lower of $28 copay or discounted network price	Lower of $28 copay or discounted network price	N/A	20% after deductible	N/A
Preferred brand	30%, $136 maximum per prescription plus cost difference between generic and brand[3]	N/A	30%, $136 maximum per prescription plus cost difference between generic and brand[3]	30%, $136 maximum per prescription plus cost difference between generic and brand[3]	N/A	20% after deductible plus cost difference between generic and brand[3]	N/A
Non-preferred brand	40%, $224 maximum per prescription plus cost difference between generic and brand, no deductible[3]	N/A	40%, $224 maximum per prescription plus cost difference between generic and brand, no deductible[3]	40%, $224 maximum per prescription plus cost difference between generic and brand, no deductible[3]	N/A	20% after deductible plus cost difference between generic and brand[3]	N/A

1. Maximum allowed amount for covered services will be determined by the administrator.
2. After three fills, penalties may apply for prescriptions not switched from 30-day to 90-day supplies through mail order or the CVS Caremark Maintenance Choice program.
3. When a covered generic is available

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Weight loss medication copay

Starting January 1, 2027, there are updates to how the plan covers medications for weight loss (including GLP-1s):

- **Copay adjustment:** Your copay for these medications will be $200.
- **Program participation:** To remain eligible for this coverage with a $200 copay, you must enroll in and actively participate in the CVS Caremark Weight Management program.
- **Action required:** If you do not participate in the program or fail to meet the requirements, you will be responsible for the full cost of the medication.

This change does not apply to medications used for Type 2 diabetes management.

Learn more on verizonbenefits.com.

Terms to know

Deductible: The total you'll pay out of your pocket for health care services in a calendar year before your medical plan begins paying for those expenses

Coinsurance: The percentage of eligible charges you pay after you meet your deductible but before you reach the out-of-pocket maximum

Copay: Fixed-dollar payment amounts for certain services in certain plans. These amounts do not count toward your deductible or your out-of-pocket maximum.

Out-of-pocket maximum: An annual maximum that limits the amount each covered person pays each calendar year for covered services

Save on specialty medications with PrudentRx

Starting January 1, 2027, the PrudentRx program will be available to eligible enrollees in the PPO Plus, Surest Copay, and EPN medical plans to help you lower your out-of-pocket costs for certain specialty medications. If you take a medication included in the program and complete enrollment in PrudentRx, your cost for that covered specialty medication will be $0 when filled through Caremark Specialty Pharmacy. This program covers select specialty medications for conditions including cancer, inflammatory conditions, multiple sclerosis, blood cell deficiency, hepatitis C, hereditary angioedema, and pulmonary arterial hypertension. The PrudentRx program is not available to High Deductible Plan (HDP) members.

How the program works:

- **If you currently take a specialty medication:** You'll receive information by mail in November 2026 explaining how to enroll before the program starts on January 1, 2027.
- **If you are newly prescribed a specialty medication:** You'll be contacted when you first attempt to fill your prescription through Caremark Specialty Pharmacy, which will connect you directly with PrudentRx to enroll. If you do not enroll in PrudentRx, the drug will remain covered under the Plan if it is otherwise eligible for coverage, but you will not receive the $0 cost-share available through the PrudentRx program. Instead, you may have to first satisfy any applicable deductible and then pay 30% of the medication's cost. Since many specialty medications are high-cost drugs, declining to enroll in PrudentRx for specialty drugs that are eligible for the PrudentRx program may result in significantly higher out-of-pocket costs to you.

You may choose not to enroll in PrudentRx; however, if you do not enroll, you will not receive the $0 cost-share available through the PrudentRx program for covered specialty medications.

Review the list of PrudentRx covered specialty medications for eligibility.

Eligibility for $0 cost sharing depends on the specialty medication prescribed, participation in the PrudentRx program, and satisfaction of applicable program requirements. Not all specialty medications qualify. Any specialty drugs that do not qualify for the PrudentRx program will be adjudicated under the Plan's otherwise applicable member cost-sharing requirements. HDP enrollees are not eligible to participate in the PrudentRx program, and specialty medications for HDP enrollees will continue to be subject to the HDP's otherwise applicable deductible, coinsurance, copayment and other cost-sharing requirements.