2026 Annual Enrollment

Enroll October 21 – 30, 2025

U.S. management and nonrepresented employees

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2026 Annual Enrollment

Annual Enrollment is your time to plan for your needs in the coming year and choose the benefits that will help you and your dependents thrive. We understand how important it is to select the benefits that truly fit your needs, so we do our best to make benefits information easy to understand. We also realize that reviewing and electing your benefits may be something you share with a spouse, partner, or your dependents. We're sharing information here to simplify your decision-making.

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Enroll October 21 – 30, 2025

For 2026, Annual Enrollment begins on **Tuesday, October 21 at 8 AM ET** and ends on **Thursday, October 30 at 11:59 PM ET**.

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, 2026.

Anticipate your needs

How do you expect your life to evolve in 2026? Are you planning for a medical procedure? Will a new dependent need to be enrolled for coverage? If you are currently covered through Verizon, does your coverage need to change to accommodate what's ahead for you and your family?

To help with your decision-making, we encourage you to read through the information in this guide, and be sure to review all the health and well-being, financial and family support benefits Verizon offers.

Not sure who's eligible for Verizon benefits? Review the eligibility pages.

What's changing for 2026

Expanded access for High Deductible Plan (HDP) participants

With the same comprehensive coverage and paycheck deductions as the PPO Plus plan, the HDP offers two advantages you don't get with any other Verizon plan: a Health Savings Account (HSA) and contributions from Verizon to cover your qualified medical expenses.

No deductible, lower copay for telehealth services

Beginning January 1, 2026, you'll pay only $10 per visit for on-demand virtual medical and mental health care through Anthem or UnitedHealthcare. Plus, you'll no longer need to meet your annual deductible before paying this low copay for telehealth services.

A free second medical opinion through 2nd.MD

If you need help making a tough medical decision, you and your covered dependents can get a second expert medical opinion from leading board-certified doctors and nurses at no cost to you.

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Higher Health Savings Account (HSA) contributions

We're upping our contribution to your Health Savings Account in 2026. When you enroll in the High Deductible Plan (HDP), Verizon will contribute $650 to your HSA for employee-only coverage or $1,300 if you cover yourself and one or more dependents. You can also contribute more to your HSA, with higher IRS limits in 2026:

- Up to $3,750 if you have individual coverage (for a total of $4,400 with Verizon's contribution)
- Up to $7,450 if you cover yourself and one or more dependents (for a total of $8,750 with Verizon's contribution)
- Up to an additional $1,000 if you're age 55 or older in 2026

If you want to contribute to the new maximum limit, be sure to increase your contributions during Annual Enrollment. Otherwise, your 2025 election will carry over to 2026.

If you're switching to the High Deductible Plan for 2026 and are currently enrolled in the Health Care Spending Account (HCSA), you will not be permitted to set aside money in the HCSA in 2026 (but you will be able to contribute to a limited-purpose HCSA in 2026). If you have a balance remaining in your 2025 HCSA, you'll be able to incur expenses through March 15, 2026, and submit them for reimbursement through May 31, 2026, but you will not be eligible to contribute or receive Verizon contributions to your HSA until April 1, 2026. To fully fund your HSA in 2026, be sure to use your entire HCSA balance by the end of 2025.

The advantages of an HSA

Your HSA lets you save to help pay for medical expenses. The account is yours to keep. If you leave Verizon, it goes with you. Your HSA offers the following tax advantages:

- Contributions are tax-deductible (yours and Verizon's).
- Any earnings grow tax-free.
- Withdrawals for qualified medical expenses are also tax-free.

The Exclusive Provider Network (EPN) plan continues for current participants

For 2026, you can remain enrolled in the Exclusive Provider Network (EPN) plan, but your contributions for coverage will increase to reflect the higher cost of coverage under this plan.

This may be a good time to review the other plans available to you and compare your plan contributions and how much you'll pay for care in each plan. You may find that another medical plan will better meet your needs and your budget in 2026. Keep in mind that the PPO Plus, HDP and Surest Copay plans use the same network of providers as the EPN. In addition, the PPO Plus and Surest Copay plans have the same in-network prescription benefits as the EPN. These other plans are all available at lower contribution levels.

The EPN plan is not available to new enrollees. If you choose to switch out of this plan, you will not be able to re-enroll in it later.

Contributions for medical, dental and vision plans

Health care costs continue to rise nationally, and higher increases are anticipated for 2026. Despite this trend, we are committed to continuing to cover the majority of your health care expenses, ensuring that you have access to top providers and the quality care you deserve. Our plans continue to be very competitively priced for the value they deliver.

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

One big way to save

Staying proactive with preventive care supports early detection, improves health outcomes and helps you save on future medical contributions.

To save $600 on your medical plan contributions for 2026, schedule or complete a preventive care exam with a primary care physician or OB/GYN in 2025. Once you've completed this preventive care activity, self-attest by visiting Personify Health > Benefits > 2026 – $600 preventive care exam credit by December 31, 2025, to earn your full credit. Your 2025 credits will not carry forward. You will need to complete a preventive care exam and attest annually to receive the credit. If you complete your attestation after December 31, 2025, your credit will be prorated.

Prescription drug costs

Prescription drug prices, especially for GLP-1 weight loss drugs, specialty, and new-to-market drugs, are among the top drivers of rising health care costs. We remain committed to managing these costs with you.

Since 2024, your share of the cost for prescription drugs has increased slightly each year. Although this trend will continue through 2028, you can continue to make cost-saving choices, such as using generic drugs over name brands and converting to mail-order delivery or using CVS Caremark Maintenance Choice.

The prescription drug in-network cost-sharing amounts for the PPO Plus, EPN and Surest Copay medical plans are shown below. Prescription drug coverage for the HDP and Kaiser plans will not change for 2026.

For detailed formulary information, review the 2026 CVS Performance Drug List.

Your 30-day supply retail cost

PPO Plus, EPN and Surest Copay	2026	2027	2028
Generic	Lower of $13 copay or discounted network price	Lower of $14 copay or discounted network price	Lower of $15 copay or discounted network price
Preferred brand	30% after deductible; $66 max per prescription*	30% after deductible; $68 max per prescription*	30% after deductible; $70 max per prescription*
Non-preferred brand	40% after deductible; $104 max per prescription*	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	2026	2027	2028
Generic	Lower of $26 copay or discounted network price	Lower of $28 copay or discounted network price	Lower of $30 copay or discounted network price
Preferred brand	30%; $132 max per prescription*	30%; $136 max per prescription*	30%; $140 max per prescription*
Non-preferred brand	40%; $208 max per prescription,* no deductible	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 CVS Caremark Maintenance Choice program.

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How to maximize 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. For 2026, the maximum contribution is currently set at the 2025 limit of $3,300. To automatically contribute up to any new maximum the IRS may set for 2026, you must select the option to contribute the maximum amount during Annual Enrollment.

To estimate how much money to contribute to an HCSA, go to BenefitsConnection > Annual Enrollment > Compare Next Year's Plan Options > My Spending Account Calculators.

If you enroll in the HDP for 2026 and are currently enrolled in the HCSA, you will not be permitted to set aside money in the HCSA in 2026 (but you will be able to contribute to a limited-purpose HCSA in 2026). If you have a balance remaining in your 2025 HCSA, you will be able to incur expenses through March 15, 2026, and submit them for reimbursement through May 31, 2026, but you will not be eligible to contribute or receive Verizon contributions to your HSA until April 1, 2026. To fully fund your HSA in 2026, be sure to use your entire HCSA balance by the end of 2025.

Save more pretax for dependent care

For 2026, the annual contribution limit for the Dependent Care Spending Account (DCSA) was increased. You can contribute up to $7,500 if you're single or if you're married and filing a joint tax return, or $3,750 if you're married and filing separate tax returns. Current DCSA nondiscrimination rules continue to apply, so your annual pay will determine whether you can take advantage of the increase.

Higher coverage for supplemental life and AD&D insurance

We remain committed to helping you protect your loved ones' futures. That's why we continue to pay the full cost of your basic life and accidental death and dismemberment (AD&D) insurance.

For additional protection, you can purchase supplemental coverage of up to 10 times your annual pay (increased from up to 8 times your annual pay in 2025), up to a maximum of $5 million for employees and your families. Depending on the coverage you choose, you may be required to provide evidence of insurability (EOI).

The expanded coverage options also apply to supplemental accidental death and dismemberment (AD&D) insurance for 2026.

The rates are based on age ranges. As you move into a new age band, your cost will increase. Your cost for 2026 is based on the covered person's age as of December 31, 2026. See what you'll pay for supplemental coverage.

Note: New hires can now elect supplemental life insurance coverage up to the lesser of 3 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.

Other plan changes

Effective January 1, 2026, we're making a few other plan changes that don't require any action on your part during Annual Enrollment:

- We will discontinue the well-being incentive rewards program and will no longer offer up to $300 in rewards cash for completing well-being activities through Personify Health. The Personify Health platform features—including one-on-one coaching, personal healthy habit challenges, an extensive media library, quick benefits access, nutrition and sleep guides—will continue to be available. We remain committed to investing in your health and well-being and will continue to do so through increased HSA contributions and our extensive benefit partnerships.
- If you live in Oklahoma or New York, your plan options will remain the same. However, your medical plan network will change from Anthem BlueCard PPO to the Anthem Select Network. Anthem will notify you of any action you may need to take and send you new ID cards. This change provides access to higher-quality providers who deliver better outcomes, with very minimal disruption from the current available network.
  - **In Oklahoma:** Your new network is **Oklahoma BluePreferred**.
  - **In New York:** Your new network is **NY Blue Access**.
  - It's important to check that your current doctors or health care facilities are part of the new Anthem Select Network.
    - Visit anthem.com/find-care to see if your doctors are in-network. Select the **Find Care** button in the upper right corner of your screen:
      - At the prompt, (use member ID for basic search), enter the following code: **135** (Oklahoma) or **113** (New York).
      - Select **Continue**.
      - Enter the ZIP code and doctor or facility name, specialty or procedure to complete your search.
      - Contact your Anthem Health Guide team if you have scheduled any upcoming care, need assistance finding a doctor in your plan's network, or if you have any questions. You can call the number on your health plan ID card or chat via the Sydney Health app or anthem.com.
- We are excited to introduce a voluntary long-term care plan in the first quarter of 2026. With the cost of skilled nursing facilities and in-home health aides on the rise, you'll have the opportunity to purchase long-term care coverage for yourself and your spouse or domestic partner. Details will be shared before the end of 2025.

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Select the benefits you need for 2026

- Review the health and well-being, financial and family support benefits Verizon offers.
- Enroll in your benefits for 2026 on BenefitsConnection. You can change your benefit elections online through October 30, 2025, at 11:59 PM ET.
  - View the medical plan comparison chart, dental page and vision page for a side-by-side look at your coverage options, and check out the 2026 employee contribution amounts. Then, choose the medical, dental and vision coverage that's best for you and your dependents.
  - Add or remove covered dependents, as needed.
  - Enroll in programs that offer additional financial security, such as supplemental life insurance and voluntary long-term disability coverage, as desired.
  - If you haven't contributed to a Health Care Spending Account (HCSA) or a Dependent Care Spending Account (DCSA) in the past but want to in 2026, this is the time to enroll.
  - To save the most possible in the HCSA or limited-purpose HCSA in 2026, choose the option to contribute the maximum amount, so you can take advantage of any limit increase the IRS may announce after Annual Enrollment.
  - If you have a Health Savings Account (HSA), elect your contribution amount for 2026. You can increase your contributions to reach the higher HSA maximum for 2026.
- Review your beneficiaries, and make any changes online:
  - 401(k), HSA, brokerage account: Visit Fidelity.
  - Life and AD&D insurance: Visit BenefitsConnection > Health & Insurance > Beneficiaries.
- Save $600 on your 2026 medical plan contributions when you schedule or complete a preventive care exam with a primary care physician or OB/GYN in 2025. Once you've completed this preventive care activity, visit Personify Health > Benefits > 2026 – $600 preventive care credit to attest before December 31, 2025. If you complete your attestation after December 31, 2025, your credit will be prorated.

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If you don't enroll

In most cases, your current benefit elections will automatically continue in 2026 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 2025 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 2026. To contribute up to any new maximum the IRS may set for 2026 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 2025, you won't have coverage in 2026 unless you make elections during Annual Enrollment.

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.

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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 2026.

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 2026, you need to choose the no-coverage option during Annual Enrollment. If you choose no coverage, you cannot enroll in coverage during 2026 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 2026 if they earned wages from Verizon during 2025 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 2025, the plan must limit DCSA annual contributions by HCEs to $2,500. If you are classified as an HCE for 2025, you will be subject to the initial 2026 DCSA contribution limit of $2,500 during Annual Enrollment. Additional restrictions may be imposed later in 2026 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 in 2026), 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) 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 the Preventive Care Exam Credit attestation form within Personify Health. You are not required to complete this activity 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.

The information from your preventive care exam can provide you with helpful insights to better understand your current health and potential health risks.

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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.

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 only responsible for paying your share of the cost (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.

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Important notice

Verizon is changing subrogation vendors from Equian, LLC to Conduent Inc. effective January 1, 2026. Details regarding the process of subrogation are outlined in your Summary Plan Description (SPD).

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, 2026. 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.

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Additional information

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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 2026 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.

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You

Medical

Plan	Contribution per pay period	Full-year cost
PPO Plus	$35.58	$925
EPN	$82.50	$2,145
HDP	$35.58	$925
Surest Copay	$23.08	$600
Kaiser Mid-Atlantic	$44.81	$1,165
Kaiser Georgia	$44.81	$1,165
Kaiser Northwest	$43.47	$1,130
Kaiser California	$44.43	$1,155
Kaiser Hawaii	$35.58	$925
Health Plan Hawaii Plus	$44.43	$1,155

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	$10.39	$270
DMO	$6.93	$180

Vision

Plan	Contribution per pay period	Full-year cost
VSP	$3.62	$93.97

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You + 1

Medical

Plan	Contribution per pay period	Full-year cost
PPO Plus	$104.23	$2,710
EPN	$204.43	$5,315
HDP	$104.24	$2,710
Surest Copay	$69.24	$1,800
Kaiser Mid-Atlantic	$122.70	$3,190
Kaiser Georgia	$122.70	$3,190
Kaiser Northwest	$119.43	$3,105
Kaiser California	$121.74	$3,165
Kaiser Hawaii	$96.54	$2,510
Health Plan Hawaii Plus	$121.54	$3,160

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	$20.77	$540
DMO	$13.85	$360

Vision

Plan	Contribution per pay period	Full-year cost
VSP	$10.12	$263.12

You + family

Medical

Plan	Contribution per pay period	Full-year cost
PPO Plus	$171.74	$4,465
EPN	$325.77	$8,470
HDP	$171.74	$4,465
Surest Copay	$115.39	$3,000
Kaiser Mid-Atlantic	$205.97	$5,355
Kaiser Georgia	$205.97	$5,355
Kaiser Northwest	$193.27	$5,025
Kaiser California	$197.31	$5,130
Kaiser Hawaii	$156.93	$4,080
Health Plan Hawaii Plus	$196.74	$5,115

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	$31.16	$810
DMO	$20.77	$540

Vision

Plan	Contribution per pay period	Full-year cost
VSP	$16.27	$422.87

Supplemental life insurance

If you elect supplemental life insurance during Annual Enrollment, your 2026 rate will be based on your age as of December 31, 2026. If you also elect coverage for a spouse or domestic partner, their rate will be based on their age as of December 31, 2026.

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, 2026	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, 2026	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

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Long-term disability insurance

These rates are not changing for 2026. The 2025 and 2026 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

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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.

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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.

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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**
2025 contribution limits*	$3,300	$3,300
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 2025 limits. They will likely increase for 2026 and will be updated when announced.

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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 $3,300. The IRS sets annual limits on spending account contributions. The 2025 limit is $3,300.

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.

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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 2025: $600 if you have employee-only medical coverage or $1,200 if you cover dependents too
- In 2026: $650 if you have employee-only medical coverage or $1,300 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.
- The HSA must be established and in good order before the end of the year in order to receive HSA contributions (during the year).
- 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.

2026 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
2026 IRS limit for all contributions	$4,400	$8,750
Verizon contribution	$650	$1,300
Your contribution limit	$3,750	$7,450
Additional allowable contribution for employees age 55 and older	$1,000	$1,000

Learn more about the HSA at Fidelity.

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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 2025 DCSA balance by March 15, 2026, it will be forfeited. You have until May 31, 2026, to file claims for the 2025 plan year. Similarly, you will have until March 15, 2027, to use your 2026 DCSA balance.

Your contributions may be limited. If you earn more than $160,000 in wages during 2025, your annual DCSA contributions will be capped at $2,400 in 2025 due to IRS nondiscrimination rules. If you earn more than $160,000 in wages during 2026, your annual DCSA contributions will be capped at $2,500 in 2026. Future nondiscrimination testing in 2026 could result in a different limit.

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 campus, 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 coverage for yourself and your family.

In 2025, you can choose coverage from 1 to 8 times your annual pay, up to a maximum of $5 million. You may be required to provide evidence of insurability (EOI).

Beginning January 1, 2026, you can purchase supplemental life insurance coverage of up to 10 times your annual pay up to a maximum of $5 million for employees and your families. Depending on the coverage you choose, you may be required to provide EOI.

The expanded coverage options also apply to supplemental accidental death and dismemberment (AD&D) insurance for 2026.

In 2026, new hires can elect supplemental life insurance coverage up to the lesser of 3 times annual salary or $500,000 without providing 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.

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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.

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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.

2026 medical plan comparison chart

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Plan features

	PPO Plus	EPN	Surest Copay[2]	HDP with HSA
Annual Verizon HSA contribution	N/A	N/A	N/A	$650 individual $1,300 family

	PPO Plus		EPN	Surest Copay[2]		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	$1,200 individual $3,600 family	$1,200 individual $3,600 family	$600 individual $1,800 family	$0	$0	$1,800 individual $3,600 family	$1,800 individual $3,600 family
Annual out-of-pocket maximum	$2,400 individual $7,200 family	$2,400 individual $7,200 family	$1,600 individual $4,800 family	$2,400 individual $7,200 family	$4,800 individual $14,400 family	$3,250 individual $6,500 family	$3,250 individual $6,500 family

Your cost for covered services

	PPO Plus		EPN	Surest Copay[2]		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	$20 copay PCP and OB/GYN $40 copay specialist	40% after deductible	$20 copay PCP and OB/GYN $40 copay specialist	$10 – $65 copay	$195 copay	20% after deductible	40% after deductible
Urgent care visit	$50 copay	$50 copay	$50 copay	$35 copay	$35 copay	20% after deductible	20% after deductible
Emergency room visit	$200 copay	$200 copay	$200 copay	$350 copay	$350 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: $60 – $950 copay	Routine X-rays: $0 Complex imaging: $1,650 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)

2026 medical plan comparison chart

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Your cost for prescription drugs (30-day retail supply)[3]

	PPO Plus		EPN	Surest Copay[2]		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 $13 copay or discounted network price	Lower of $13 copay or discounted network price plus cost difference between retail and discounted network price	Lower of $13 copay or discounted network price	Lower of $13 copay or discounted network price	Lower of $13 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, $66 maximum per prescription plus cost difference between generic and brand[4]	40% after deductible plus cost difference between retail and discounted network price; plus cost difference between generic and brand[4]	30% after deductible, $66 maximum per prescription plus cost difference between generic and brand[4]	30% after deductible, $66 maximum per prescription plus cost difference between generic and brand[4]	40% after deductible plus cost difference between retail and discounted network price; plus cost difference between generic and brand[4]	20% after deductible plus cost difference between generic and brand	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, $104 maximum per prescription plus cost difference between generic and brand[4]	50% after deductible plus cost difference between retail and discounted network price; plus cost difference between generic and brand[4]	40% after deductible, $104 maximum per prescription plus cost difference between generic and brand[4]	40% after deductible, $104 maximum per prescription plus cost difference between generic and brand[4]	50% after deductible plus cost difference between retail and discounted network price; plus cost difference between generic and brand[4]	20% after deductible plus cost difference between generic and brand	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[2]		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 $26 copay or discounted network price	N/A	Lower of $26 copay or discounted network price	Lower of $26 copay or discounted network price	N/A	20% after deductible	N/A
Preferred brand	30%, $132 maximum per prescription plus cost difference between generic and brand[4]	N/A	30%, $132 maximum per prescription plus cost difference between generic and brand[4]	30%, $132 maximum per prescription plus cost difference between generic and brand[4]	N/A	20% after deductible plus cost difference between generic and brand[4]	N/A
Non-preferred brand	40%, $208 maximum per prescription plus cost difference between generic and brand, no deductible[4]	N/A	40%, $208 maximum per prescription plus cost difference between generic and brand, no deductible[4]	40%, $208 maximum per prescription plus cost difference between generic and brand, no deductible[4]	N/A	20% after deductible plus cost difference between generic and brand[4]	N/A

[1] Maximum allowed amount for covered services will be determined by the administrator.
[2] The Surest Copay plan is available to V Teamers in UHC states.
[3] 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.
[4] When a covered generic is available.

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.