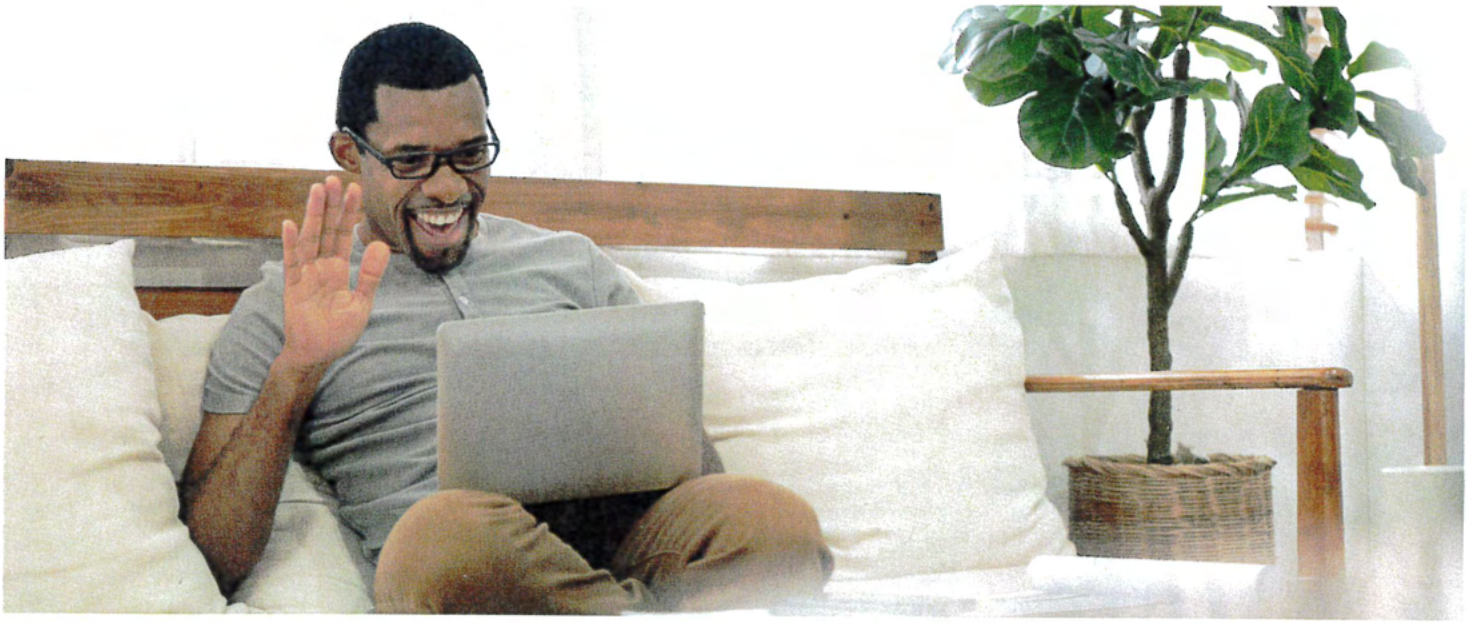
#ForwardTogether

Benefits for wellness
At work, at home, in life

2022 Annual Enrollment
October 5-14, 2021

Mid-Atlantic



verizon

Plan for health and wellness.

Annual Enrollment begins October 5 at 8 AM Eastern time and ends October 14 at 11:59 PM Eastern time.

> **BenefitsConnection**
Access BenefitsConnection through About You via Single Sign On or at verizon.com/benefitsconnection to enroll.

Your health and well-being, and that of your families, are a priority for Verizon. This guide provides information about your 2022 benefits. Be sure to visit BenefitsConnection through About You or at verizon.com/benefitsconnection to access additional information, tools and resources to help you make your benefits decisions.

We encourage you to take the time to review the information in this guide to help you select the benefit options that will be best for you and your family.

We've enhanced your BenefitsConnection experience!

Throughout this guide, look for the > for more information on how to quickly access your benefits.

Key dates to remember

October 5
Annual Enrollment begins

October 14
Last day to enroll in benefits

January 1, 2022
Annual Enrollment elections take effect

What's changing for 2022

- Monthly medical plan contribution amounts
- Medical plan deductibles and out-of-pocket maximums
- Prescription drug copays and out-of-pocket maximums
- The MAA for out-of-network services is changing to 190%

You can find additional details on these changes throughout this guide.

What's staying the same

- Medical plan options
- Emergency room copays
- Dental and vision options
- Spending account maximum contribution amounts

What you need to do

If you are happy with your current elections, there is no action for you to take, and the following will automatically carry over for 2022.

- Medical (including prescription drug)
- Dental
- Vision
- Life and accidental death and dismemberment (AD&D)
- Tobacco user status
- Spending account contributions

Your Wellness Activity Credit will not carry over, and you will need to complete a Wellness Activity by December 31, 2021, to receive the $100 Credit for 2022.

2022 Annual Enrollment

Annual Enrollment begins October 5 at 8 AM Eastern time and ends October 14 at 11:59 PM Eastern time. This is your annual opportunity to review and update your health and insurance coverage for you and your family.

This guide summarizes important health and insurance benefits information, including what's changing effective January 1, 2022. More detailed information about these plans is included in the Summary Plan Descriptions (SPDs) and corresponding plan and/or insurance documents (for example, the Summary of Material Modification) on the Library page of BenefitsConnection.

Enrollment is simple.

To enroll, go to BenefitsConnection. From the home page, go to Annual Enrollment > Enroll Now. From there you can add or drop dependents, review your plan options, and update your elections.

Your current benefits elections will automatically continue for 2022 unless you make a change. This includes your current medical (including prescription drug), dental, vision, life and accidental death and dismemberment (AD&D), disability insurance, tobacco user status and spending account contributions.

Your Wellness Activity Credit will not automatically carry over into 2022. In order to receive a Wellness Activity Credit for 2022, you will need to complete one Wellness Activity by December 31, 2021, which will help reduce your medical premiums by $100. For additional details, see page 8.

Helpful tools & resources	> Go to BenefitsConnection
Estimate health care costs and compare plan options	Annual Enrollment > Compare Next Year's Plan Options
Estimate how much money to contribute to your Health Care Spending Account (HCSA)	Annual Enrollment > Compare Next Year's Plan Options > My Spending Account Calculators
Complete a Wellness Activity	Annual Enrollment > Wellness Activity
Review Summary Plan Descriptions (SPDs), Summary of Material Modifications (SMMs) and vendor contact information	Library

If you have questions or need assistance, call the Verizon Benefits Center at 855.4vz.bens (855.489.2367). During Annual Enrollment, representatives are available Monday – Friday, 8 AM – 6 PM Eastern time.

Qualified life events

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

If you have a qualified life event between now and the end of the year, you will need to make any necessary changes on BenefitsConnection for both 2021 and 2022.

2022 Changes

Medical coverage

For 2022, you will continue to have a choice of the MCN and MEP PPO medical plan options. There are some changes to your deductible and out-of-pocket maximum amounts. Please refer to the following charts for details.

BenefitsConnection
Annual Enrollment > Compare Next Year's Plan Options > My 2022 Medical Plan Options to review your medical plan options.

At a glance – MCN		
Plan provision	2021	2022
Deductible: In-network and out-of-network	**Individual:** $225 in-network and out-of-network combined, plus an additional $650 out-of-network	**Individual:** $250 in-network and out-of-network combined, plus an additional $650 out-of-network
	Employee + 1 or more: Two-and-a-half times the individual deductible amount; an individual will never need to exceed his or her own individual amount	
Out-of-pocket maximum: In-network and out-of-network	**Individual:** $1,450 in-network and out-of-network combined, plus an additional $800 out-of-network	**Individual:** $1,500 in-network and out-of-network combined, plus an additional $800 out-of-network
	Employee + 1 or more: Two-and-a-half times the individual out-of-pocket maximum amount; an individual will never need to exceed his or her own individual amount	

At a glance – MEP PPO		
Plan provision	2021	2022
Deductible: In-network and out-of-network	**Individual:** $650 in-network and out-of-network combined, plus an additional $225 out-of-network	**Individual:** $675 in-network and out-of-network combined, plus an additional $225 out-of-network
	Employee + 1 or more: Two-and-a-half times the individual deductible amount; an individual will never need to exceed his or her own individual amount	
Out-of-pocket maximum: In-network and out-of-network	**Individual:** $1,550 in-network and out-of-network combined, plus an additional $900 out-of-network	**Individual:** $1,600 in-network and out-of-network combined, plus an additional $900 out-of-network
	Employee + 1 or more: Two-and-a-half times the individual out-of-pocket maximum amount; an individual will never need to exceed his or her own individual amount	

Amounts paid toward the deductible apply toward the out-of-pocket maximum. Under the Affordable Care Act, additional out-of-pocket cost protection applies to your medical (including prescription drug) in-network out-of-pocket maximum.

If you receive a covered service or supply from an out-of-network provider under the MCN or MEP PPO, the percentage that you pay is based on the maximum allowed amount (MAA). In 2022, the MAA will be defined as 190% of the national Medicare schedule. For Covered Mental Health/Substance Abuse Services and Supplies, the MAA will continue to be defined as 240% of the national Medicare schedule.

The EPO medical plan option will continue to be available to those currently enrolled in it. Once you disenroll, the EPO will no longer be available.

If an HMO is currently available to you, it will continue to be available to you in 2022 as long as you live in a ZIP Code where the HMO is offered. If you had a change in address, please review the options available to you on BenefitsConnection.

Prescription drug coverage

The chart below details important changes to your prescription drug copays and out-of-pocket maximums for 2022.

At a glance – prescription drug changes		
Plan provision – Retail	**2021**	**2022**
Preferred brand	20% of discounted network price (DNP); $32.05 maximum copay	20% of DNP; $32.50 maximum copay
Non-Preferred brand	30% of DNP; $42.73 maximum copay	30% of DNP; $43.33 maximum copay
Plan provision – Mail Order	**2021**	**2022**
Preferred brand	20% of discounted network price (DNP); $64.10 maximum copay	20% of DNP; $65.00 maximum copay
Non-Preferred brand	30% of DNP; $85.46 maximum copay	30% of DNP; $86.66 maximum copay

> **BenefitsConnection**
> **Annual Enrollment > Compare Next Year's Plan Options > My 2022 Medical Plan Options > Pharmacy Benefits to see additional information about your prescription plan.**

If you're enrolled in a Kaiser, Geisinger Health or Highmark Choices plan, please reference your plan documents or the Health Plan Comparison Charts for more information regarding the prescription drug program. Go to BenefitsConnection > Annual Enrollment > Compare Next Year's Plan Options > My 2022 Medical Plan Options > Prescription Drug Benefits.

Consistent with prior years, Express Scripts will be making changes to its prescription drug formulary effective January 1, 2022. Certain drugs may be excluded from the formulary. In most cases, if you fill a prescription for one of these drugs without adhering to the formulary, you will pay the full retail price.

Also, other drugs may change between preferred and non-preferred status. If you fill a prescription for a non-preferred drug, you will pay a higher cost than if you switched to a preferred drug. Express Scripts will notify you directly if you are taking one of these drugs. A list of the excluded drugs for 2022 can be found on the Express Scripts member website, express-scripts.com/2022drugs. Please contact Express Scripts for additional details.

2022 Medical plan costs

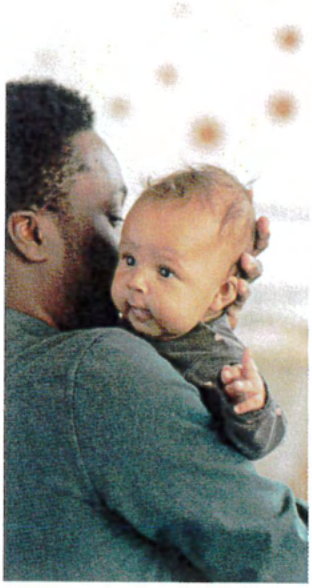
Your medical plan option contributions are changing. Below are the monthly medical plan contribution amounts for 2022.

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

MCN and MEP PPO[1]				
Non-tobacco user credit?	Yes	Yes	No	No
Completed Wellness Activity?	Yes	No	Yes	No
Employee Only (monthly)	$134.00	$142.33	$184.00	$192.33
Employee + 1 or More (monthly)	$268.00	$276.33	$318.00	$326.33

EPO and HMOs (HMOs will be no greater than the amounts in the chart)[1]				
Non-tobacco user credit?	Yes	Yes	No	No
Completed Wellness Activity?	Yes	No	Yes	No
Employee Only (monthly)	$201.00	$209.33	$251.00	$259.33
Employee + 1 or More (monthly)	$402.00	$410.33	$452.00	$460.33

[1]Contributions are based on employees scheduled to work 25 or more hours per week. If you are scheduled to work less than 25 hours per week, please go to BenefitsConnection for your contribution amounts.



> **BenefitsConnection**
> **Health & Insurance > Current Elections or Future Elections for more details about your medical plan costs.**

Save up to $700 on your medical coverage contributions.

- Save $600 by certifying that you and your covered dependents do not use tobacco products[2], or have completed a tobacco cessation course within the last six months. You can update your tobacco use status during Annual Enrollment by going to BenefitsConnection > Annual Enrollment > Tobacco User Status.
- Save $100 in medical coverage contributions by completing one of five Wellness Activity options by December 31, 2021. Go to BenefitsConnection > Annual Enrollment > Wellness Activity.

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

Dental and vision coverage

There are no changes to the dental and vision plan options for 2022.

No Coverage Option for Medical, Dental and/or Vision Coverage

If you are currently an active employee enrolled in the No Coverage option for medical, dental and/or vision, and you make no changes during this Annual Enrollment, your No Coverage election for medical, dental and/or vision will carry over for 2022.

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

Note: 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 of the Verizon medical options available to you meet the Massachusetts MCC requirements.

If you have coverage today and would like to waive coverage for 2022, you need to choose the No Coverage option during Annual Enrollment. If you choose the No Coverage option, you cannot enroll in coverage during 2022 unless you have a qualified life event or as otherwise required by law.

Spending accounts

For 2022, the annual maximum contribution amounts are as follows:

- Health Care Spending Account (HCSA): $2,750
- Dependent Day Care Spending Account (DCSA):
  $2,500 if married and filing separately
  $5,000 if married and filing jointly

As an active employee, unless you make an active election during Annual Enrollment to change your contributions, your current 2021 spending account elections will automatically carry over to 2022. **Please note that if you made a change to your election during the year, your most recent election will automatically carry over unless you make a change during this Annual Enrollment.** If you are an active employee considering changing the amount you contribute, you may want to use the My Spending Account Calculators feature on BenefitsConnection to see how you can reduce your out-of-pocket expenses each year. From the home page, go to Annual Enrollment > Compare Next Year's Plan Options > My Spending Account Calculators.

Important note: According to recent IRS changes due to COVID-19, the HCSA and DCSA grace periods have been extended as follows:

- Any balance remaining in your 2020 spending account can be used for eligible expenses through December 31, 2021. You will have until January 31, 2022 to submit claims for reimbursement for these expenses.
- Any balance remaining in your 2021 spending account can be used for eligible expenses through December 31, 2022. You will have until January 31, 2023 to submit claims for reimbursement for these expenses.

COBRA Health Care Spending Account (HCSA)

If you had a COBRA qualifying event in 2021 and enrolled in COBRA HCSA, you can continue your COBRA HCSA contributions through December 31, 2021. As long as you have paid your COBRA premiums through December 31, 2021, you may incur eligible expenses through December 31, 2022 and must submit all claims by January 31, 2023, or any balance will be forfeited.

Important reminders

Be sure to consider the following information when reviewing and updating your coverage.

Verifying Your Dependents

Adding a dependent to coverage

To enroll a spouse or a dependent into coverage during Annual Enrollment, or as a result of a qualified life event that occurs during the year, follow the prompts on BenefitsConnection during the enrollment process to add a new dependent and select the appropriate dependent relationship.

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

Medical

A dependent child is eligible for medical coverage 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 meets the conditions of being disabled.

Dental and vision

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

Dental and vision coverage can continue through the end of the calendar year in which a dependent child attains age 25 as long as the child maintains full-time student status. If the child is between the ages of 19 and 25, is not a full-time student and does not meet the conditions of being disabled, you must remove them from dental and vision coverage during Annual Enrollment.

If you would like to continue coverage for your dependents through COBRA, contact the Verizon Benefits Center at 855.4vz.bens (855.489.2367) by December 31, 2021.

Verizon will partner with the National Student Clearinghouse in early 2022 to confirm student eligibility for dependents between the ages of 19 and 25 who are enrolled in dental and/or vision coverage. If full-time student status cannot be verified, instructions will be sent to both your work email and home address on file. If you do not comply with the instructions provided, your dependent will be dropped from dental and/or vision coverage.

Child Life Insurance and Child AD&D Insurance

You may cover a dependent child for 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 meets the conditions of being disabled.

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

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

Take the time to assess your current insurance needs. They can change from year to year, especially if your family dynamic or lifestyle has changed.

Verify your beneficiary information.

It's important to verify that your beneficiary information on BenefitsConnection is both accurate and up to date. In the event of your death, the insurance plan administrator will pay proceeds based on your beneficiary information on record. To review your beneficiaries, go to BenefitsConnection > Health & Insurance > Beneficiaries.

> **BenefitsConnection**
> **Annual Enrollment > Enroll Now to see your options and rates for 2022.**

Supplemental Life Insurance Age Bands

Supplemental Life Insurance rates

The rates for an active employee with supplemental life insurance and spouse life insurance are based on age ranges. As you and your spouse age and move into a new age band, your costs could increase. Your costs for 2022 are based on age as of December 31, 2022.

Retiree Medical Contributions

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

For all retirees who retired after December 31, 1989, with a net credited service date before August 3, 2008

The labor contracts provide for limits on the amount the Company will contribute toward retiree medical coverage. These limits are referred to as retiree medical caps, which are listed below.

Retiree medical caps		
Coverage category	Pre-Medicare	Medicare-eligible
Retiree Only	$12,580	$6,330
Retiree + 1	$25,160	$12,660
Retiree + Family	$31,450	$18,990

In the 2022 plan year, the cost of coverage of each of the Medicare plan options is less than the applicable retiree medical caps.

In the 2022 plan year, the cost of coverage for the pre-Medicare MCN and MEP PPO plan options will not exceed the applicable retiree medical caps.

In the 2022 plan year, the cost of coverage of the pre-Medicare EPO (Retiree + 1 and Retiree + Family coverage levels only), Cigna, and Aetna HMO plan options will exceed the applicable retiree medical caps, and this excess amount over the retiree medical caps is greater than the annual minimum contribution for all retirees.

The cost of coverage of the other Mid-Atlantic pre-Medicare HMO will either not exceed the retiree caps, or will exceed the retiree caps by an amount not greater than the minimum retiree contribution applicable to that plan option.

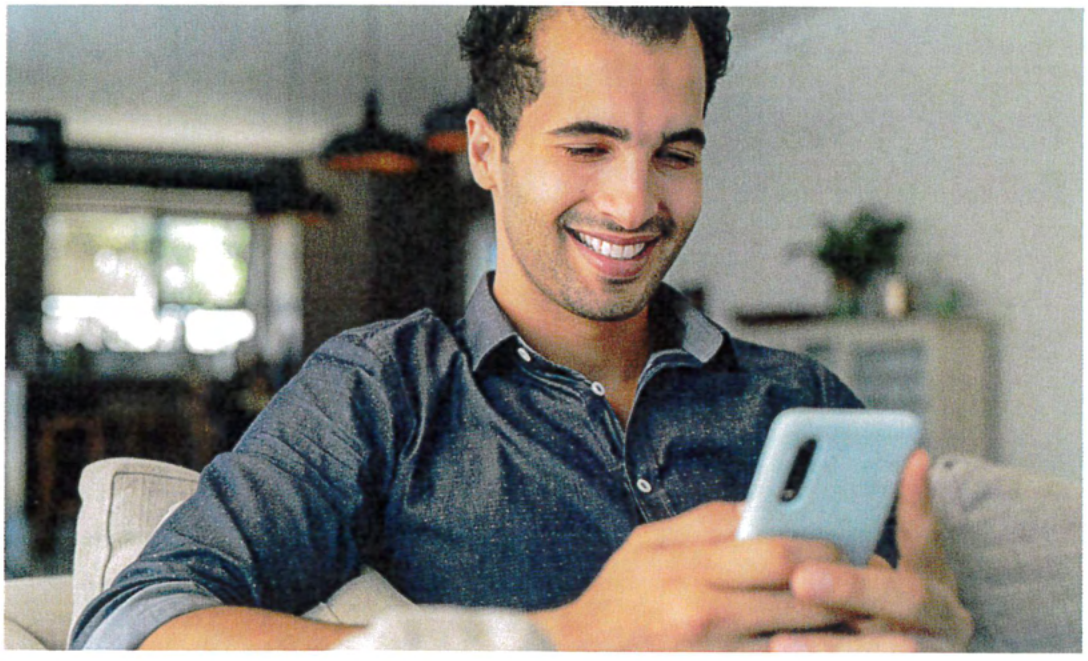
Consistent with the labor contracts and the previously described provisions, the 2022 retiree medical contributions that are payable each month for post-December 31, 1989, retirees are as follows:

2022 pre-Medicare MEP PPO and MCN monthly retiree contributions		
Coverage category	Retired before January 1, 2013	Retired on or after January 1, 2013
Retiree Only	$0	$44.19
Retiree + 1	$0	$75.76
Retiree + Family	$0	$75.76

2022 pre-Medicare EPO and Mid-Atlantic HMO monthly retiree contributions				
Coverage category (retired before, on or after January 1, 2013)	EPO	Cigna	Aetna HMO	Other Mid-Atlantic HMOs (varies by plan option)
Retiree Only	$201.00	$224.33	$195.33	$167.50 – $187.60
Retiree + 1	$321.83	$448.67	$390.67	$254.17 – $284.67
Retiree + Family	$402.33	$560.83	$488.33	$335.00 – $375.20

2022 Medicare-eligible monthly retiree contributions		
Coverage category	MCN Advantage Plan	Mid-Atlantic HMOs
Retiree Only	$0	$20.00 – $100.50
Retiree + 1	$0	$34.00 – $152.50
Retiree + Family	$0	$34.00 – $152.50

In plan years after 2022, cost of plans that exceed the caps may increase and require additional contributions above the cap. Additional plan options may also exceed the applicable retiree medical caps and require contributions pursuant to the caps. If you would like more information about the retiree caps and how they affect retiree contributions, go to BenefitsConnection > Library > Plan Information & SPDs > Annual Enrollment Materials > Retiree Medical Contributions Supplemental Guide.



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

For the 2022 plan year, the Company will provide the following contributions toward the cost of retiree medical coverage for eligible retirees:

- **Not eligible for Medicare:** $480 for each full year of net credited service that commences on or after August 3, 2008, up to a maximum of 30 years
- **Medicare-eligible:** $240 for each full year of net credited service that commences on or after August 3, 2008, up to a maximum of 30 years

Additional information

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

Important Changes To Your Plan

Important information regarding your plan

A Summary of Material Modification was issued pertaining to recent changes primarily as a result of the COVID-19 pandemic. Please review that communication as well as this important information.

Preventive care medical plan benefits, including prescription drug options

Your medical options must offer certain preventive care benefits to you in-network without cost sharing. Under the Affordable Care Act, the medical plans generally may use reasonable medical management techniques to determine frequency, method, treatment or setting for a recommended preventive care service.

As explained in your 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), certain immunizations, colonoscopies (including many related items and services) and other items and services that are designed to detect and treat medical conditions to prevent avoidable illness and premature death. Preventive care benefits that must be offered in-network without cost sharing change periodically. For example, for 2022, due to updates and clarifications by the USPSTF, the plan will cover at no cost, in- network Hepatitis C virus screening for adolescents and adults age 18 to 79 years (or other ages if increased risk of Hepatitis C virus infection), and unhealthy drug use screening. In addition, as noted in a separate communication, the COVID-19 vaccination will be covered at no cost in- and out-of-network through the end of the Public Health Emergency (PHE) period. After the PHE period, approved COVID-19 vaccines will be covered in-network like other preventive care services required by the Affordable Care Act. Contact the Verizon medical plan option or prescription drug administrator, such as Express Scripts, for more details.

Important Legal Notices

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 may view the notice and/or print a paper copy from the website; or you also may request a paper copy by calling the Verizon Benefits Center at 855.4vz.bens (855.489.2367).

Summaries of Benefits and Coverage (SBCs) required by the Patient Protection and Affordable Care Act

Summaries of Benefits and Coverage (SBCs) required by the Affordable Care Act are available on BenefitsConnection at verizon.com/benefitsconnection. If you would like a paper copy of the SBCs (free of charge), you may contact the Verizon Benefits Center at 855.4vz.bens (855.489.2367).

Verizon is required to make SBCs, which summarize important information about health benefit plan options in a standard format, available to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family in the case of illness or injury and choosing a health benefit option is an important decision. SBCs are available – in addition to other information regarding your health benefits, including Health Plan Comparison Charts – on BenefitsConnection.

Americans with Disabilities Act (ADA) notice regarding wellness program

The wellness program offered to you by Verizon is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008 and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to voluntarily complete one of five wellness activities: a health assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (for example, cancer, diabetes or heart disease); a biometric screening; finding a Primary Care Physician or getting an annual wellness exam; participating in a session with a WebMD coach; or volunteering in your local community. You are not required to complete any of these activities to receive medical coverage.

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

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

Protections from disclosure of medical information

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

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

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

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Verizon Benefits Center at 855.4vz.bens (855.489.2367), and indicate that you have a question or concern regarding this notice.

Requesting paper documents

To print a confirmation statement, go to BenefitsConnection > Health & Insurance > Future Elections > Print.

Though all of your benefits information including SPDs, Health Plan Comparison charts, and confirmation statements are available online, you may request paper copies if needed by calling the Verizon Benefits Center.

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Actual plan provisions for Company benefits are contained in the appropriate plan documents or applicable Company policies. This Annual Enrollment Guide provides updates to your existing Summary Plan Descriptions as of January 1, 2022. Please keep this guide and any other Summary of Material Modification (SMM) with your SPDs. As always, the official plan documents determine what benefits are provided to Verizon employees, former employees eligible for COBRA, retirees and their dependents. Please note you may not be eligible to participate in or receive benefits from all plans and programs referenced in this guide. Your SPDs and corresponding documents (for example, SMM) are available at verizon.com/benefitsconnection, or you can call the Verizon Benefits Center and request a printed copy free of charge. As explained in your SPD, Verizon reserves the right to amend or terminate any of its plans or policies at any time with or without notice or cause, subject to applicable law and any duty to bargain collectively.