

2026 Annual Enrollment

October 7-16, 2025

New York/New England

August 9, 1986 - January 1, 1992

Retiree



verizon

Annual Enrollment begins October 7 at 8 AM ET and ends October 16 at 11:59 PM ET.

BenefitsConnection

Access BenefitsConnection at verizon.com/benefitsconnection to enroll.

We have implemented Multi-Factor Authentication (MFA) as an enhanced layer of security for your BenefitsConnection account. If you have not already done so, you will be required to complete MFA registration when accessing BenefitsConnection at verizon.com/benefitsconnection.

Be your best you in 2026

Your health and well-being, and that of your families, are a priority for Verizon. This guide provides information about your 2026 benefits. Be sure to visit BenefitsConnection at verizon.com/benefitsconnection to access additional information, tools and resources to help you make your benefit 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.

Access your benefits via BenefitsConnection

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

Key dates to remember



What's changing for 2026

- Medical plan deductibles and out-of-pocket maximums
- Emergency room copay
- Urgent Care copay
- Select Specialist copays
- Prescription drug copays and out-of-pocket maximums

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

What's staying the same

- Dental and vision coverage
- Medicare plan options

What you need to do

If you are happy with your current benefit elections and they are still available for 2026, there is no action for you to take, and they will automatically carry over for 2026.

2026 annual enrollment

Annual Enrollment begins October 7 at 8 AM ET and ends October 16 at 11:59 PM ET. 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, 2026. More detailed information about these plans is included in the Summary Plan Descriptions (SPDs) and corresponding plan and/or insurance documents located on the Library page of BenefitsConnection.

Enrollment is simple

To enroll, go to BenefitsConnection at verizon.com/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.

You can also change your elections anytime using Anytime Enrollment. Simply go to BenefitsConnection > Life Events > Retiree Anytime Enrollment. Your change will be effective the first of the month following a 30-day waiting period.

Your current benefits elections will automatically continue unless you make a change during Annual Enrollment. No action is required on your part.

> **View your current coverage:**

Access BenefitsConnection at verizon.com/benefitsconnection. From there, visit the Health & Insurance page to view your current elections.

Helpful tools & resources	> Go to BenefitsConnection
Estimate health care costs and compare plan options	Annual Enrollment > Compare Next Year’s Plan Options
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, ET.

Annual Enrollment >
Compare Next Year's
Plan Options > My
2026 Medical Plan
Options to review
your medical plan
options.

Annual Enrollment
> Enroll Now to see
your options and
rates for 2026.

2026 changes

Pre-Medicare medical plan options

There are changes to the deductible and out-of-pocket maximum amounts in the pre-Medicare MEP HCP for 2026. Please refer to the following chart for details.

At a glance – pre-Medicare MEP HCP		
Plan provision	2025	2026
Deductible: In-network and out-of-network	Individual: Deductible is based on year of retirement. To find the deductible amount, go to BenefitsConnection.	
	Individual + 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: \$2,270 in-network and out-of-network combined, plus an additional \$1,220 out-of-network	Individual: \$2,320 in-network and out-of-network combined, plus an additional \$1,220 out-of-network
	Individual + 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	
Specialist Office Visit and Urgent Care Copay	\$30 in-network 40% out-of-network	\$35 in-network 40% out-of-network
Emergency Room Copay	\$155 (Waived if admitted)	\$160 (Waived if admitted)

Other medical plan options

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

The Cigna Healthcare (VA) and Geisinger Health Plan (PA) medical HMOs will no longer be offered in 2026. If you do not make any changes you will be automatically defaulted into the pre-Medicare MEP HCP plan option. If another pre-Medicare HMO is currently available to you, it will continue to be available to you in 2026 as long as you live in a ZIP Code where the HMO is offered. If you have a change in address, please review the options available to you on BenefitsConnection.

For 2026, the Specialist copay will be \$35, the Urgent Care copay will be \$35, and the Emergency Room Copay will be \$160 (Waived if admitted) for the EPO and HMO medical plan options.

Medicare-eligible medical plan options

Please Note: If you are newly Medicare-eligible in 2026 and you do not make an election during Annual Enrollment you will be defaulted into the MEP HCP Medicare Advantage plan option.

For those that are currently Medicare-eligible, your current benefits elections will automatically continue unless you make a change. Medicare-eligible retirees who are enrolled in the Verizon Advantage Plan will receive additional information about the plan each year, as required by Medicare.

Prescription drug coverage

The annual prescription drug mail order out-of-pocket maximum and copay amounts for the pre-Medicare MEP HCP Plan option are changing, as outlined in the chart below.

At a glance – prescription drug changes (pre-Medicare only)		
Plan provision – Retail (in-network)	2025	2026
Generic	Lower of \$11.35 copay or discounted network price (DNP)	Lower of \$11.66 copay or DNP
Preferred brand	20% of DNP; \$37.79 maximum copay	20% of DNP; \$40.06 maximum copay
Non-Preferred brand	30% of DNP; \$62.97 maximum copay	30% of DNP; \$66.75 maximum copay
Plan provision – Mail Order	2025	2026
Generic	Lower of \$22.70 copay or DNP	Lower of \$23.32 copay or DNP
Preferred brand	20% of DNP; \$75.58 maximum copay	20% of DNP; \$80.12 maximum copay
Non-Preferred brand	30% of DNP; \$125.94 maximum copay	30% of DNP; \$133.50 maximum copay
Annual mail order out-of-pocket maximum	\$1,253.58 per person	\$1,328.79 per person

> BenefitsConnection

Annual Enrollment
> Compare Next Year's Plan Options
> My 2026 Medical Plan Options > Pharmacy Benefits
to see additional information about your prescription plan.

CVS Caremark

CVS Caremark will continue as the prescription benefit manager for the Anthem MEP HCP and EPO medical plan options, as well as the Harvard Pilgrim, Aetna, CDPHP, BlueAlliance NY and Univera HMOs. If you are enrolled in a local HMO, your insurance carrier will communicate any changes to prescription drugs.

Review the CVS formulary

The formulary is a list of prescription drugs that are covered by the Plan and their coverage levels. To view the current CVS Caremark formulary, please visit: [Caremark.com/portal/asset/Advanced_Control_Specialty_Performance_Drug_List.pdf](https://caremark.com/portal/asset/Advanced_Control_Specialty_Performance_Drug_List.pdf). If a prescription drug is not on this list, then it is not covered by the Plan.

Certain drugs may be excluded from the CVS 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.

Medicare members

If you are Medicare eligible and enrolled in a Verizon Medicare advantage or select HMO plan option, then SilverScript, a CVS company, will administer your prescription drug benefit and you will continue to be able to fill your retail or mail prescription at the same low copay. If you are enrolled in another plan option then that insurance carrier will continue to communicate any prescription drug vendor changes.

Prescription drug coverage for most Medicare-eligible Verizon retirees or their Medicare-eligible dependents is provided through a Verizon-sponsored group Medicare Part D plan. This benefit consists of an enhanced Medicare Part D benefit that preserves a comprehensive level of prescription drug benefits.

Under your Medicare Part D plan with SilverScript, the out-of-pocket prescription drug costs is capped at \$2,100. Some exclusions, restrictions or limitations will not apply if you are enrolled in the SilverScript Medicare Part D prescription drug plan. Please contact SilverScript for additional details.

Medicare-eligible retirees who have moved to the enhanced Medicare Part D plan, SilverScript, will receive additional information about the program each year, as required by Medicare. Other retirees and family members will receive additional information when they become Medicare-eligible.

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 group medical options available to you meet the Massachusetts MCC requirements.

No Coverage option for medical and/or dental

If you are currently a retiree enrolled in the No Coverage option for medical and/or dental, and you make no changes during this Annual Enrollment, your No Coverage election for medical and/or dental will carry over for 2026.

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 are considering adding this requirement in the future.

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 the No Coverage option, you can later enroll in coverage during 2026 under the Anytime Enrollment provisions of your medical plan. You can also later enroll due to a qualified life event, or when required by law.

Important reminders

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

Adding a dependent to coverage

To enroll a spouse or a dependent into coverage during Annual Enrollment, or at any time 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 your home address on file after you have enrolled your dependent.

If you do not submit appropriate documentation in a timely manner, your dependent will be dropped from coverage. If you have questions about eligibility, please refer to your SPD.

Dependent child coverage age limit

Medical

A dependent child is eligible for medical coverage 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

In order for a dependent child to be eligible for dental 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 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 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, 2025.

Verizon will partner with the National Student Clearinghouse in early 2026 to confirm student eligibility for dependents between the ages of 19 and 25 who are enrolled in dental coverage. If full-time student status cannot be verified, instructions will be sent to your home address on file. If you do not comply with the instructions provided, your dependent will be dropped from dental coverage.

Life Insurance

The rates for supplemental life insurance are based on age ranges. As you age and move into a new age band, your costs could increase. Your costs for 2026 are based on age as of December 31, 2026.

Verify your beneficiary information

Please check your beneficiary information on BenefitsConnection. 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.

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 (free of charge) by calling the Verizon Benefits Center.

Important information regarding your plan

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, breast cancer for 40 to 74), certain immunizations (including COVID-19), colonoscopies (including many related items and services, such as coverage for a follow-up colonoscopy after a patient has received a positive screening test or direct visualization test), FDA-approved contraception methods, HIV pre-exposure prophylaxis (PrEP), 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.

Contact the Verizon medical plan option or prescription drug administrator 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 give you access to an internet-based price comparison tool to compare prices for all items and services. Upon request, this information may be provided in paper without a fee, subject to certain limits.

Important legal notices

HIPAA Privacy Notice

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

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.

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 copayments, 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.

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“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 copayments, 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 balance 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 there may be out-of-network. In these cases, the most those 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 get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up 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 copayments, coinsurance, and deductible that you would pay if the provider or facility was 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 800.985.3059 if related to Medicare Advantage or Medicare Part D benefits. Visit cms.gov/medical-bill-rights for more information about your rights under federal law. Contact the U.S. Department of Labor for benefits not managed by the Centers for Medicare & Medicaid Services. If you are enrolled in a fully-insured medical plan option, state laws that impact 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.



Actual plan provisions for Company benefits are contained in the appropriate plan documents or applicable Company policies. Unless specified otherwise, this Annual Enrollment guide provides updates to your existing Summary Plan Description (SPD) as of January 1, 2026. Please keep this guide and any additional Summary of Material Modification (SMM) with your SPDs until Verizon provides you with SPDs that have been updated to reflect the changes to your benefits. As always, the official plan documents determine what benefits are provided to Verizon employees, former employees eligible for COBRA, retirees and their dependents. Please note you may not be eligible to participate in or receive benefits from all plans and programs referenced in this guide. Your SPDs and corresponding documents (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.