2025 Annual Enrollment

Enroll October 21 – 30, 2024

U.S. management and nonrepresented employees

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2025 Annual Enrollment

Annual Enrollment is your time to look ahead to the coming year and anticipate which benefits you will need to help you and your dependents thrive. Choosing benefits is critical, but it shouldn't be hard. Plus, if you have dependents, we know this is a conversation to have as a family. That's why we're sharing information here so you can more easily make decisions.

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Enroll October 21 – 30, 2024

For 2025, Annual Enrollment begins on **Monday, October 21 at 8 AM ET** and ends on **Wednesday, October 30 at 11:59 PM ET**.

This isn't a time to miss. 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, 2025.

Anticipate your needs

What do you expect will take place in your life during 2025? Will you expand your family? Will you enroll a dependent in care? Will you need a medical procedure? If you have current coverage through Verizon, does it need to change?

Review the information on this page and all the health and well-being, financial and family support benefits Verizon offers.

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

What's new for 2025

Earn up to $900 when you prioritize self-care

When we take care of ourselves, we live well and feel well. For 2025, you can earn up to $900 by taking simple actions to support your well-being.

All actions will take place and credits will be visible in Virgin Pulse (which will be renamed Personify Health in 2025).

Act now to earn $600

Save $600 on your 2025 medical plan contributions when you complete or schedule a preventive care exam with a primary care physician or OB/GYN in 2024. Once you've completed this preventive care activity, visit Virgin Pulse > Rewards > 2025 – $600 Preventive Care Exam Credit by December 31, 2024, to earn your full credit. If you confirm in Virgin Pulse January 1 or later, your 2025 credit will be prorated.

If you waive participation in the Verizon medical plan for 2025, you won't be eligible for the $600 credit, but we encourage you to make your well-being a priority and have your annual checkup.

2024 credits do not carry forward

The new $600 preventive care exam credit replaces the $600 tobacco-free credit. You must complete or schedule your preventive care exam in 2024 to earn the full $600 credit for 2025.

Earn $300 throughout 2025

Beginning in 2025, you can earn up to $300 in rewards cash in Virgin Pulse, even if you're not enrolled in Verizon benefits. Complete easy well-being activities throughout the year; you'll find quarterly actions listed on your Virgin Pulse Rewards page in 2025. Earn up to $75 per quarter, redeemable for gift cards, charitable donations, or purchases from the Virgin Pulse store. Watch for more details later this year.

New family support benefits

Watch for details about new family support benefits through Maven Clinic in Q1 2025. Through the Maven digital platform, you'll have a dedicated advocate and care team, plus access to specialists and resources to support you in these areas:

- Fertility and family building
- Maternity and newborn care
- Breast milk shipping
- Parenting and pediatrics
- Menopause and ongoing care

New long-term care insurance

We're working to offer a voluntary long-term care insurance program in 2025. Watch for more information in Q1 2025.

What's changing for 2025

Plan design updates

With the higher cost of health care overall, you can expect to pay a bit more when you receive medical care. The table below shows some 2025 in-network costs for individual and family coverage in the HDP, PPO Plus, EPN and Surest Copay plans.

While the same menu of plans is available for 2025, we are expecting to make changes for 2026. We do not expect to offer the EPN plan after 2025, so now is a good time to start comparing your plan options.

2025 amounts	PPO Plus	EPN	Surest Copay	HDP
Deductible	$1,200 individual, $3,600 family	$600 individual, $1,800 family	$0	$1,800 individual, $3,600 family
Out-of-pocket maximum	$2,400 individual, $7,200 family	$1,600 individual, $4,800 family	$2,400 individual, $7,200 family	$3,250 individual, $6,500 family
Specialist visit	$40 copay	$40 copay	$10 – $65 copay	20% after deductible

To see the cost of care in each plan, check out the medical plan comparison chart. The Surest Copay plan is available to V Teamers in UHC states.

Preventive care can help save lives and costly care in the future. That's why we cover 100% of your preventive care costs across all plans.

Last year for EPN plan

Beginning in 2026, we expect to discontinue the EPN plan for all members, including those who were allowed to remain in the plan when it was closed to new members in 2018. If you're currently enrolled in the plan, you may want to review your alternatives now.

It's a good idea to compare the amount of 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 2025. Keep in mind that the PPO, HDP and Surest Copay plans use the same network of providers as the EPN. In addition, the PPO and Surest Copay plans have the same prescription benefits as the EPN.

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Contributions for medical, dental and vision plans

We're committed to paying the majority of your health care costs and providing you with access to the best providers, so you can get the care you need. With Verizon's costs for health care services rapidly escalating, your contributions for medical, dental and vision coverage will increase in 2025. Our plans continue to be very competitively priced for the value they deliver, with Verizon covering 85% of the cost of enrolling in medical benefits.

Current forecasts expect the high rate of medical cost increases to continue in 2025. We'll keep working to find ways to keep costs down and provide opportunities for you to save money. However, you should expect to see your contributions rising at a similar rate over the next several years.

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

CVS Caremark, your new prescription drug provider

Starting January 1, 2025, we're partnering with CVS Caremark to help manage rising prescription costs and ensure you have flexibility between retail pharmacy and mail-order options to fill your prescriptions.

If you are enrolled in an Anthem or UHC PPO Plus, HDP, Surest Copay or EPN medical plan, CVS Caremark will replace Express Scripts to care for your prescription needs. This transition will enable us to provide our comprehensive prescription drug program at a more competitive price and with better technology to empower you.

Kaiser Permanente will continue to manage pharmacy benefits for its members.

More flexibility with where to fill prescriptions

Our new partnership with CVS Caremark offers greater flexibility in filling maintenance medication prescriptions through a retail pharmacy or a mail-order option. With the Maintenance Choice program, you can get 30- or 90-day supplies of maintenance medications at a CVS pharmacy, CVS Caremark mail-service pharmacy or select participating pharmacies, such as Costco and Kroger—with no difference in cost.

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

How to prepare for the transition

Watch your home mail

In December, you'll receive a welcome packet with more information about the prescription drug plan and your new CVS Caremark ID card. You will also receive information and instructions based on your current use, including changing your pharmacy or preferred medication or how to choose a participating pharmacy for specialty medication.

If you have an active mail or specialty prescription, Express Scripts will transfer it to CVS Caremark on January 1, 2025. If your prescription is compounded or a controlled substance (e.g., pain medication or sleeping aid), please call CVS Caremark at 833.870.0272 for assistance after December 15. For retail prescriptions, simply present your new CVS Caremark ID card or electronic ID card to the pharmacist after January 1.

Express Scripts will also transfer to CVS Caremark any active prior authorizations you received from your health care provider.

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Register with CVS Caremark

After you receive your welcome packet, you'll need to register and set up your first refill order.

To set up your order, register with CVS Caremark in one of three ways:

- Go to caremark.com, select Register, and follow the instructions to sign up.
- Download the CVS Caremark mobile app, open the app, and follow the registration instructions.
- Call the number on the back of your CVS Caremark ID card, and a representative will get you started with a personalized registration email or text.

Automate your prescription refills

Beginning January 1, access your CVS Caremark account to view open refills for any active prescriptions that are not for a controlled substance.

You'll need to set up your first fill order before you can see the refills available for auto-refill setup. To set up your first order, call the number on the back of your CVS Caremark ID card, or log in to your CVS Caremark account, and set up your order online.

Manage your prescriptions with CVS Caremark's digital tools

Use the CVS Caremark app or your online account to:

- Find a network pharmacy or confirm your current pharmacy is in-network
- Check drug costs
- Refill a prescription quickly

Review the CVS formulary

The formulary is a list of prescription drugs and their coverage levels. You can look up your medications on the CVS formulary.

For information about biosimilars, visit the CVS specialty website.

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Prescription drug costs

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

Starting in 2024 and continuing through 2028, your share of the cost for each prescription will increase slightly each year. You can continue to make cost-saving choices, such as using generic drugs over name brands and converting to mail-order delivery.

The prescription drug cost-sharing amounts for the PPO Plus, EPN and Surest Copay medical plans are listed below. Prescription drug coverage for the HDP and Kaiser plans will not change for 2025.

30-day supply retail cost

PPO Plus, EPN and Surest Copay	2025	2026	2027	2028
Generic	Lower of $12 copay or discounted network price	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	You pay 30% after deductible; $64 max per prescription	You pay 30% after deductible; $66 max per prescription	You pay 30% after deductible; $68 max per prescription	You pay 30% after deductible; $70 max per prescription
Nonpreferred brand	You pay 40% after deductible; $96 max per prescription	You pay 40% after deductible; $104 max per prescription	You pay 40% after deductible; $112 max per prescription	You pay 40% after deductible; $120 max per prescription

90-day supply mail-order or Maintenance Choice cost

PPO Plus, EPN and Surest Copay	2025	2026	2027	2028
Generic	Lower of $24 copay or discounted network price	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	You pay 30%; $128 max per prescription	You pay 30%; $132 max per prescription	You pay 30%; $136 max per prescription	You pay 30%; $140 max per prescription
Nonpreferred brand	You pay 40%; $192 max per prescription (no deductible)	You pay 40%; $208 max per prescription (no deductible)	You pay 40%; $224 max per prescription (no deductible)	You pay 40%; $240 max per prescription (no deductible)

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

Health savings account (HSA) contributions

If you enroll in the HDP, the amount Verizon contributes to your HSA will increase from $500 in 2024 to $600 in 2025 if you have individual coverage, and from $1,000 to $1,200 if you cover yourself and one or more dependents. You can also contribute more to your HSA, with higher IRS limits in 2025:

- Up to $3,700 if you have individual coverage (for a total of $4,300 with Verizon's contribution)
- Up to $7,350 if you cover yourself and one or more dependents (for a total of $8,550 with Verizon's contribution)
- Up to an additional $1,000 if you're age 55 or older in 2025

Your 2024 HSA election will carry over to 2025, so if you want to contribute to the new maximum limit, be sure to increase your contributions during Annual Enrollment.

If you're switching to the HDP for 2025 and are currently enrolled in the health care spending account (HCSA), you will not be permitted to set aside money in the HCSA in 2025 (but you will be able to contribute to a limited-purpose HCSA in 2025). If you have a balance remaining in your 2024 HCSA, you'll be able to incur expenses through March 15, 2025, and submit them for reimbursement through May 31, 2025—but you will not be eligible to contribute or receive Verizon contributions to your HSA until April 1, 2025. To fully fund your HSA in 2025, be sure to use your entire HCSA balance by the end of 2024.

How to maximize your HCSA contribution

The IRS sets annual limits on health care spending account (HCSA) and limited-purpose HCSA contributions and typically updates those limits after Annual Enrollment. For 2024, the maximum contribution is $3,200. To automatically contribute up to any new maximum the IRS may set for 2025, 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.

New rates for supplemental life and AD&D insurance

Our commitment to helping you protect your loved ones' future remains unchanged, and we continue to pay the full cost of your basic life and accidental death and dismemberment (AD&D) insurance.

The experience in our life insurance program over the past several years has been generally unfavorable, made somewhat worse by the COVID-19 pandemic. As a result, our insurance contract renewal resulted in increased rates. These higher rates will be reflected in your cost for supplemental life and AD&D insurance elections for yourself, your spouse or domestic partner, and your children.

The rates are based on age ranges. As you move into a new age band, your cost will increase. Your cost for 2025 is based on the covered person's age as of December 31, 2025. See what you'll pay for supplemental coverage.

Voluntary long-term disability (LTD) benefit

You have the option to purchase long-term disability (LTD) insurance during Annual Enrollment or at any time of the year. Two coverage options are available: 50% or 66 2/3% of eligible pay up to a maximum annual pay of $345,000. Enrollment in this benefit is voluntary, and since you pay the full cost of coverage with after-tax dollars, any benefit you receive is not taxable. You must provide evidence of insurability (EOI) for any increase to this benefit.

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Select the benefits you need for 2025

- Review the health and well-being, financial and family support benefits Verizon offers.
- Make changes to your benefits for 2025 on BenefitsConnection from October 21 through October 30, 2024, at 11:59 PM ET.
  - View the medical plan comparison chart and the dental page for a side-by-side look at your coverage options, and check out the 2025 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 2025, this is the time to enroll.
  - To save the most possible in the HCSA or limited-purpose HCSA in 2025, 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 2025. You can increase your contributions to reach the higher HSA maximum for 2025.
- 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 2025 medical plan contributions when you complete or schedule a preventive care exam with a primary care physician or OB/GYN in 2024. Once you've completed this preventive care activity, visit Virgin Pulse > Rewards > 2025 – $600 Preventive Care Exam Credit to confirm before December 31, 2024. If you confirm in Virgin Pulse January 1 or later, your 2025 credit will be prorated.

Ready to enroll?

Enroll now.

If you don't enroll

In most cases, your current benefit elections will automatically continue in 2025 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 2024 health care spending account (HCSA), limited-purpose HCSA, dependent care spending account (DCSA), and health savings account (HSA) contribution elections will automatically carry over to 2025.

If you waived medical, dental or vision coverage for 2024, you won't have coverage in 2025 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.

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 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 end 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.

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 2025.

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 2025, you need to choose the no-coverage option during Annual Enrollment. If you choose no coverage, you cannot enroll in coverage during 2025 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 2025 if they earned wages from Verizon during 2024 in excess of $155,000. “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 2024, the plan must limit DCSA annual contributions by HCEs to $2,400. If you are classified as an HCE for 2024, you will be subject to the initial 2025 DCSA contribution limit of $2,400 during Annual Enrollment. Additional restrictions may be imposed later in 2025 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 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 (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. For example, in 2025, anxiety screening in adults and an annual screening for urinary incontinence in women must be covered at no cost in-network.

The Agencies also clarified that items and services that are integral to the furnishing of birth control, regardless of whether the items or services are billed separately, must be covered. This includes coverage for anesthesia for a tubal ligation procedure and pregnancy tests administered prior to providing an intrauterine device.

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 Virgin Pulse. 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.

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.

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Summary of material modifications (SMM)

Actual plan provisions for company benefits are contained in the appropriate plan documents or applicable company policies. The 2025 Annual Enrollment Guide provides updates to your existing summary plan descriptions (SPDs) as of January 1, 2025. Until Verizon provides you with updated SPDs, this document is intended to be a summary of material modifications (SMM).

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 in this document.

Your SPDs and SMMs are available on BenefitsConnection, and you can call the Verizon Benefits Center at 855.4vz.bens (855.489.2367) to request printed copies free of charge. As explained in your SPDs, Verizon reserves the right to amend or terminate any of its plans or policies at any time with or without notice or cause, subject to applicable law.

Additional information

Eligibility

Yourself

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

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

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

Your spouse or domestic partner

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

Definition of eligible domestic partner

There are two ways to qualify as a domestic partner.

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

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

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

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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 2025 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	$30.57	$795
EPN	$62.50	$1,625
HDP	$30.57	$795
Surest Copay	$20.19	$525
Kaiser Mid-Atlantic	$39.03	$1,015
Kaiser Georgia	$39.03	$1,015
Kaiser Northwest	$37.88	$985
Kaiser California	$38.65	$1,005
Kaiser Hawaii	$30.96	$805
Health Plan Hawaii Plus	$38.65	$1,005

Notes for medical plan contributions:

- 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	$9.23	$240
DMO	$6.15	$160

Vision

Plan	Contribution per pay period	Full-year cost
VSP	$2.15	$56

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Medical

Plan	Contribution per pay period	Full-year cost
PPO Plus	$89.42	$2,325
EPN	$154.80	$4,025
HDP	$89.42	$2,325
Surest Copay	$60.57	$1,575
Kaiser Mid-Atlantic	$106.73	$2,755
Kaiser Georgia	$106.73	$2,755
Kaiser Northwest	$103.84	$2,700
Kaiser California	$105.96	$2,755
Kaiser Hawaii	$84.03	$2,185
Health Plan Hawaii Plus	$105.76	$2,750

Notes for medical plan contributions:

- 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	$18.46	$480
DMO	$12.30	$320

Vision

Plan	Contribution per pay period	Full-year cost
VSP	$7.80	$203

You + family

Medical

Plan	Contribution per pay period	Full-year cost
PPO Plus	$147.11	$3,825
EPN	$246.73	$6,415
HDP	$147.11	$3,825
Surest Copay	$100.96	$2,625
Kaiser Mid-Atlantic	$172.50	$4,485
Kaiser Georgia	$179.23	$4,660
Kaiser Northwest	$168.26	$4,375
Kaiser California	$171.73	$4,465
Kaiser Hawaii	$136.53	$3,550
Health Plan Hawaii Plus	$171.15	$4,450

Notes for medical plan contributions:

- 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	$27.69	$720
DMO	$18.46	$480

Vision

Plan	Contribution per pay period	Full-year cost
VSP	$13.26	$345

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Supplemental life insurance

These are the 2025 monthly rates.

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, 2025	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

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Dependents

Spouse or domestic partner age as of December 31, 2025	Monthly rate per $1,000 of coverage
Under 25	$0.049
25 – 29	$0.059
30 – 34	$0.079
35 – 39	$0.089
40 – 44	$0.099
45 – 49	$0.148
50 – 54	$0.227
55 – 59	$0.424
60 – 64	$0.650
65 – 69	$1.252
70 – 74	$2.030
75 – 79	$3.221
80 – 84	$5.219
85 – 89	$8.449
90 – 94	$13.688
95 – 99	$22.175
Dependent child up to age 26	$0.099

Long-term disability insurance

These are the 2025 monthly rates.

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

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

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

Changes after enrollment

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

Qualifying life events

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

To make a change, visit BenefitsConnection.

Qualifying changes in status include:

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

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

Continuing health coverage under COBRA

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

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

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

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

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

See your summary plan description (SPD) in the library section of BenefitsConnection for more COBRA details.

Health care spending accounts (HCSAs)

Save on eligible health expenses when you set aside before-tax dollars in a health care spending account (HCSA) or a limited-purpose HCSA.

HCSAs at a glance

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

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

	HCSA	**Limited-purpose HCSA**
2025 contribution limit	$3,200	$3,200
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

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 $3,200. The IRS sets annual limits on spending account contributions and typically updates those limits after you elect your contribution during Annual Enrollment. The 2024 limit is $3,200. To contribute up to any new maximum the IRS may set for 2025, select the option to contribute the maximum amount during Annual Enrollment.

If you enroll in the HDP for 2025 and are currently enrolled in the HCSA, you will not be permitted to set aside money in the HCSA in 2025 (but you will be able to contribute to a limited-purpose HCSA in 2025). If you have a balance remaining in your 2024 HCSA, you will be able to incur expenses through March 15, 2025, and submit them for reimbursement through May 31, 2025—but you will not be eligible to contribute or receive Verizon contributions to your HSA until April 1, 2025. To fully fund your HSA in 2025, be sure to use your entire HCSA balance by the end of 2024.

Your annual contribution amount will be available on January 1, although your contributions will be deducted from your paycheck in equal increments throughout the year.

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

Budget carefully

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

Health savings account (HSA)

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

How it works

The HSA offered through Verizon is administered by Fidelity.

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

Verizon also contributes to your HSA:

- In 2024: $500 if you have employee-only medical coverage or $1,000 if you cover dependents too
- In 2025: $600 if you have employee-only medical coverage or $1,200 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.

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Contribution limits

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

2025 limits

Full-year amounts	Employee-only coverage	Employee + dependents
2025 IRS limit for all contributions	$4,300	$8,550
Verizon contribution	$600	$1,200
Your contribution limit	$3,700	$7,350
Additional allowable contribution for employees age 55 and older	$1,000	$1,000

Learn more about the HSA at Fidelity.

Dependent care spending account (DCSA)

You can save on child and adult day care expenses when you contribute pretax dollars to the dependent care spending account (DCSA).

How it works

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

Set aside up to $5,000 pretax if you're single or married and filing a joint tax return ($2,500 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 2024 DCSA balance by March 15, 2025, it will be forfeited. You have until May 31, 2025, to file claims for the 2024 plan year. Similarly, you will have until March 15, 2026, to use your 2025 DCSA balance.

Your contributions may be limited. If you earn more than $155,000 in wages during 2024, your annual DCSA contributions will be capped at $2,400 in 2024 and 2025 due to IRS nondiscrimination rules. Future nondiscrimination testing in 2025 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.

As a new hire or during Annual Enrollment, 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 proof of good health or evidence of insurability (EOI).

You can also purchase coverage for your spouse or domestic partner in increments of $25,000, up to $300,000. Coverage for your children is available in increments of $5,000, up to $25,000.

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 pay of $330,000 annually. 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.

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 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.

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.

2025 Medical plan comparison chart

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Plan features

	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	$105 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	$0 routine X-rays $60 – $425 copay complex imaging	$0 routine X-rays $1,200 – $1,350 copay complex imaging	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)

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.

2025 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 $12 copay or discounted network price	Lower of $12 copay or discounted network price plus cost difference between retail and discounted network price	Lower of $12 copay or discounted network price	Lower of $12 copay or discounted network price	Lower of $12 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
Brand preferred	30% after deductible, $64 maximum per prescription 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	30% after deductible, $64 maximum per prescription plus cost difference between generic and brand	30% after deductible, $64 maximum per prescription 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	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
Brand non-preferred	40% after deductible, $96 maximum per prescription plus cost difference between generic and brand	50% after deductible plus cost difference between retail and discounted network price; plus cost difference between generic and brand	40% after deductible, $96 maximum per prescription plus cost difference between generic and brand	40% after deductible, $96 maximum per prescription plus cost difference between generic and brand	50% after deductible plus cost difference between retail and discounted network price; plus cost difference between generic and brand	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 $24 copay or discounted network price	N/A	Lower of $24 copay or discounted network price	Lower of $24 copay or discounted network price	N/A	20% after deductible	N/A
Brand preferred	30%, $128 maximum per prescription plus cost difference between generic and brand	N/A	30%, $128 maximum per prescription plus cost difference between generic and brand	30%, $128 maximum per prescription plus cost difference between generic and brand	N/A	20% after deductible plus cost difference between generic and brand	N/A
Brand non-preferred	40%, $192 maximum per prescription plus cost difference between generic and brand	N/A	40%, $192 maximum per prescription plus cost difference between generic and brand	40%, $192 maximum per prescription plus cost difference between generic and brand	N/A	20% after deductible plus cost difference between generic and brand	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 the CVS Caremark Maintenance Choice program.