September 19, 2012

2012 COMMON ISSUES
MEMORANDUM OF UNDERSTANDING

BETWEEN

VERIZON NEW ENGLAND, INC.
VERIZON ADVANCED DATA INC.
VERIZON AVENUE CORP.
VERIZON CORPORATE SERVICES CORP.
VERIZON SERVICES CORP.
AND

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS, AFL-CIO
LOCALS 2222, 2313, 2320, 2321, 2322, 2323, 2324, 2325, 2327

This Memorandum of Understanding ("2012 MOU") is agreed to by and between the above-named companies (herein the "Company" or "Companies," as context requires) and the International Brotherhood of Electrical Workers Locals 2222, 2313, 2320, 2321, 2322, 2323, 2324, 2325 and 2327 (hereinafter the "Union" or "IBEW") with respect to the following IBEW-represented bargaining units:

1. IBEW Plant (Verizon New England Inc., VADI, Verizon Avenue, VCSC and VSC)
2. IBEW Traffic (Verizon New England Inc. and VSC)
3. IBEW Accounting (Verizon New England Inc., VCSC and VSC)
4. IBEW Sales (Verizon New England Inc., VADI, VCSC and VSC)

It is agreed that existing collective bargaining agreements covering the above-named bargaining units, which were extended pursuant to the parties' August 19, 2011 Return to Work Agreement, will be terminated effective 11:59 p.m. on the date this 2012 MOU is ratified. New collective bargaining agreements covering the above-named bargaining units (including without limitation this 2012 MOU, to the extent the parties have not specified different effective dates in provisions of this 2012 MOU) will become effective immediately following the expiration of the existing collective bargaining agreements (Effective Date) and

will remain in effect until 11:59 p.m. on August 1, 2015. This 2012 MOU will become effective if, and only if, ratified by the combined results of the voting in the bargaining units in the Companies represented by IBEW no later than thirty calendar days after the date of this 2012 MOU.

Each of the new collective bargaining agreements will consist of the provisions of the existing agreements, including the provisions of the 2008 Common Issues Memorandum of Understanding Between Verizon New England Inc., Verizon Advanced Data, Inc., Verizon Avenue Inc., Verizon Corporate Services Corp. and Verizon Services Corp. and the International Brotherhood of Electrical Workers, AFL-CIO, Locals 2222, 2313, 2320, 2321, 2322, 2323, 2324, 2325 and 2327 effective August 3, 2008 ("2008 MOU") and all attachments to the 2008 MOU that were valid and enforceable immediately prior to the Effective Date, as modified by the applicable provisions of this 2012 MOU and by provisions agreed to at local bargaining tables. All letters of agreement in the parties' 2008 collective bargaining agreements (including without limitation the 2008 MOU) all letters of agreement in the parties' 2008 collective bargaining agreements, and all local agreements that were valid and enforceable immediately prior to the Effective Date of this 2012 MOU, will remain in full force and effect, unless the terms of such letters of agreement have been modified or eliminated by this 2012 MOU or by the parties' collective bargaining agreements (including without limitation terms agreed to at local bargaining tables). All letters of agreement or provisions in the parties' 2008 collective bargaining agreements (including without limitation the 2008 MOU and all attachments to the 2008 MOU) that contain an expiration date of August 6, 2011 will be changed to reflect an expiration date of August 1, 2015 unless the parties have expressly agreed to a different expiration date or that such letters or provisions will not remain in effect. All letters of

agreement or provisions in the parties' 2008 collective bargaining agreements (including without limitation the 2008 MOU and all attachments to the 2008 MOU) that were valid and enforceable immediately prior to the Effective Date that contain dates other than expiration dates will be changed as necessary to ensure the continued enforceability of such agreements unless the parties have expressly agreed that such letters or provisions will not remain in effect. Provisions of this 2012 MOU, including the attachments, will be incorporated, by reference or otherwise, into the appropriate collective bargaining agreements.

To the extent that any provision of this 2012 MOU is inconsistent with or contrary to any provision of the 2008 MOU, any local collective bargaining agreement, or any other agreement, policy or past practice, such 2012 MOU provision will govern and will supersede the inconsistent or contrary provision of the 2008 MOU, any local collective bargaining agreement, or any other agreement, policy or past practice, except that a written agreement regarding a specific term newly agreed to, modified or eliminated in 2011-2012 negotiations at a local bargaining table will govern and supersede an inconsistent or contrary provision in this 2012 MOU with respect to that specific term if the local parties specify in such specific term that it supersedes the 2012 MOU.

Dated: 9/19/12

FOR THE COMPANIES

By: _____
PATRICK PRINDEVILLE
Chairperson, Common Issues Bargaining

FOR INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS

By: _____
Business Manager – Local 2222

September 19, 2012

By: _____
Business Manager – Local 2313

By: _____
Business Manager – Local 2322

By: _____
Business Manager – Local 2323

By: _____
Business Manager – Local 2320

By: _____
Business Manager – Local 2321

By: _____
Business Manager – Local 2324

By: _____
Business Manager – Local 2325

By: _____
Business Manager – Local 2327

I. WAGES

A. Wage Increases. The schedule of wage increases for the term of this 2012 MOU shall be as follows:

Effective Date	Percentage Increase	Applied to:
The first Sunday after ratification of the 2012 MOU	2.25%	All steps of the basic wage schedules
Sunday, 8/4/2013	2.75%	All steps of the basic wage schedules
Sunday, 8/3/2014	3.0%	All steps of the basic wage schedules

B. Voluntary Termination Bonus. The Voluntary Termination Bonus provision of the 2008 MOU will remain in effect through the term of the 2012 MOU.

C. Ratification Bonus. A one-time, single Ratification Bonus payment of $800 will be paid within thirty days after ratification of this 2012 MOU to full-time and part-time Regular and Temporary employees on payroll as of the ratification date. Ratification Bonus payments will be subject to all applicable federal, state and local tax withholdings. These payments will only be included in calculations relating to Union dues, or their equivalent, as authorized by the employee and the Union. Ratification Bonus payments will not be included in wages for computations of overtime, benefits or for any other purpose.

II. COST-OF-LIVING

The Company will continue the Cost-of-Living provisions set forth in Section II of the 2008 MOU during the term of this 2012 MOU. Notwithstanding the continuation of these provisions, there will be no Cost-of-Living adjustments during the term of this 2012 MOU.

III. CORPORATE PROFIT SHARING

The Corporate Profit Sharing ("CPS") Plan is modified as follows:

Section 2. Plan Years: The CPS will provide awards for results in calendar years 2011, 2012, 2013 and 2014 with awards payable in 2012, 2013, 2014 and 2015.

Section 6. CPS Distribution Calculations

(a) Standard Award: The "Standard" CPS Distribution will be as follows:

Performance Year	Standard CPS Distribution	Year Payable
2011*	$500	2012
2012	$500	2013
2013	$500	2014
2014	$500	2015

***

(c) Notwithstanding paragraphs (a) and (b) above, the minimum distribution for Performance Years 2011, 2012, 2013 and 2014 will be $700, subject in all cases to prorating under Section 3.

* The Company distributed the CPS Award for Performance Year 2011 prior to the Effective Date.

IV. PENSION BENEFIT AND OTHER CHANGES

A. PENSION PLAN.

The Verizon Pension Plan for Associates (to the extent that it covers New York and New England Associates) (the "Pension Plan") will be amended as follows:

Any associate who is first hired as a union-represented associate on or after October 28,

2012 ("Pension New Hire") will not be eligible to participate in the Pension Plan. Any associate who returns from layoff on or after October 28, 2012 pursuant to contractual recall rights, other than a Pension New Hire, will be eligible to continue participation in the Pension Plan as of the date of recall.

B. PENSION LUMP SUM CASHOUT.

An associate covered by the cashout program set forth in the 2008 MOU who separates from service during the term of this 2012 MOU, with eligibility for a vested pension or a service pension, will be eligible to receive his or her vested or service pension under the Pension Plan as a total lump-sum cashout. The terms of the cashout program will be the same as the terms of the cashout program set forth in the 2008 MOU for the period ending August 6, 2011.

V. 401(k) PLAN CHANGES

A. MATCHING CONTRIBUTIONS

The Company will amend the Verizon Savings and Security Plan for New York and New England Associates ("NY/NE Associate Savings Plan") effective October 28, 2012 to increase Company matching contributions for the balance of the 2012, 2013, 2014 and 2015 plan years to 100% of the eligible contributions of each participating associate first hired as a union-represented associate on or after October 28, 2012 and not eligible to earn pension benefits that is covered by this 2012 MOU up to 6% of eligible compensation. No other associates covered by this 2012 MOU will be entitled to this increased Company matching contributions.

B. DISCRETIONARY CONTRIBUTIONS

The Company will also amend the NY/NE Associate Savings Plan effective October 28, 2012 to permit an additional performance-related, discretionary Company contribution for the

balance of the 2012, 2013, 2014 and 2015 plan years ("Discretionary Contribution") for associates who are first hired as a union-represented associate on or after October 28, 2012 and not eligible to earn pension benefits, subject to the additional requirements described below. An eligible associate would not have to contribute to the NY/NE Associate Savings Plan to be eligible for the Discretionary Contribution. Eligible associates would have to be employed as eligible associates on the last day of the plan year to be eligible for the Discretionary Contribution. The Discretionary Contribution would be between 0-3% of eligible compensation actually paid during the plan year to each such eligible associate and would be set at the same percentage as the performance-related contribution for wireline management employees under the management savings plan for the same plan year. The Company would determine each applicable plan year whether the Discretionary Contribution would be made in cash and/or Verizon stock invested in the Verizon stock fund under the NY/NE Associate Savings Plan. Discretionary Contributions invested in the Verizon stock fund would be subject to participant investment diversification in accordance with the current terms of the NY/NE Associate Savings Plan. Discretionary Contributions would not be available for in-service withdrawal, and they would be subject to the same vesting schedule as Company matching contributions.

VII. LONG TERM CARE INSURANCE

The Companies will continue to make available to eligible employees the opportunity to purchase long term care ("LTC") insurance coverage under the Verizon Long Term Care Insurance Plan for New York and New England Associates (the "LTC Plan"), so long as the current LTC provider continues to offer the existing level of coverage to participants in the LTC Plan.

If such provider ceases to offer the existing level of coverage to participants in the LTC Plan, the Companies may continue to make available the opportunity to purchase LTC insurance, so long as the Companies, in their discretion, are able to secure a provider of LTC insurance that is able to offer LTC coverage that the Companies determine is appropriate and reasonably priced. The design features, administrative details and costs will be determined by the LTC provider.

VIII. BENEFITS

1. CONTINUATION OF BENEFIT PLANS

The following employee benefit plans are continued in effect through the term of this 2012 MOU in accordance with their existing terms and the changes agreed to in this 2012 MOU.

Verizon Adoption Reimbursement Program for New York and New England Associates

Verizon Anticipated Disability Program for New York and New England Associates

Verizon Sickness and Accident Disability Benefit Plan for New England Associates

Verizon Sickness and Accident Disability Benefit Plan for New York Associates

Verizon Accidental Death and Dismemberment Plan for New York and New England Associates

Verizon Alternate Choice Plan for New York and New England Associates

Verizon Savings and Security Plan for New York and New England Associates

Verizon Dependent Care Spending Account for New York and New England Associates

Verizon Dependent Group Life Insurance Plan for New York and New England Associates

Verizon Health Care Spending Account for New York and New England Associates

Verizon Income Protection Plan for New York and New England Associates

Verizon Long Term Care Insurance Plan for New York and New England Associates

Verizon Long Term Disability Plan for New York and New England Associates

Verizon Medical Expense Plan for New York and New England Associates

Verizon Dental Expense Plan for New York and New England Associates

Verizon Group Life Insurance Plan for New York and New England Associates

Verizon Vision Care Plan for New York and New England Associates (including VDT User Eyecare Program).

Verizon Pension Plan for Associates (to the extent that it covers New York and New England Associates)

Verizon Sickness and Accident Disability Benefit Plan for New York and New England Associates of Non-Regulated Companies

Verizon Post-1995 Collectively Bargained Retiree Health Plan (Pre-1993 Retirees)

Verizon Post-1995 Collectively Bargained Retiree Health Plan (Post-1992 Retirees)

2. CHANGES TO EXISTING HEALTH CARE BENEFITS, INCLUDING PRESCRIPTION DRUG COVERAGE, FOR ACTIVE ASSOCIATES

The provisions of the Verizon Medical Expense Plan for New York and New England Associates (the "VMEP") regarding medical and prescription drug benefits, and the Verizon Alternate Choice Plan for New York and New England Associates (a component or subplan of the VMEP), for active associates who participate in the VMEP, will be amended as follows effective January 1, 2013, except where otherwise noted:

A. Dependent Eligibility Changes Applicable to the VMEP.

Effective as of the Effective Date, the definition of Dependent in Article 2 and Sections 3.7 and 4.5.5 of the VMEP will be amended to provide that no new Class II Dependent or Sponsored Child may be enrolled in or added to coverage under the VMEP. An eligible Class II Dependent or Sponsored Child who is enrolled in the VMEP on the Effective Date will continue to be covered under the VMEP, provided that such Class II Dependent or Sponsored Child remains continuously eligible and enrolled in the VMEP.

B. Medical and Prescription Drug Benefit Changes Applicable to VMEP.

The provisions of the VMEP regarding medical benefits and prescription drug coverage for active associates who participate in the VMEP shall be amended as set forth in this Section VIII.2.B. of this 2012 MOU.

Section 3 and Section 5 of the VMEP will be amended to specify that if a newly hired associate fails to make a medical option election within the time frame specified by the VMEP, the associate will be defaulted into the Health Care PPO Option, with Employee-Only coverage. The VMEP will be further amended to specify that if an HMO option is terminated and an associate is enrolled in such HMO and fails to elect another available medical option within the time and manner specified by the Company, the associate will be defaulted into the Health Care PPO Option, with the coverage tier that the associate had elected before the HMO option was terminated.

The TPA for the HCN Option and the Health Care PPO Option will be Anthem Blue Cross Blue Shield ("Anthem"). Anthem will be the TPA for Mental Health and Substance Abuse Benefits for both the HCN Option and the Health Care PPO Option. The TPA will apply its network of service providers to the HCN Option and the Health Care PPO Option. Section 3 and Section 5 of the VMEP will be further amended to provide that, to the extent that there is no in-network service provider for a specific covered service or supply within a 40-mile radius of the associate's home zip code, the associate and his or her eligible dependents will be eligible for the in-network provisions applicable to the specific medical option in which such associate is enrolled (i.e., the in-network provisions of the HCN Option or Health Care PPO Option).

1) **HCN Benefit Changes.** The medical benefits provided to associates and their eligible dependents enrolled in the HCN Option on and after January 1, 2013 will be as described in the VMEP, with the following modifications:

a. **Maximum Allowed Amount.** The term Reasonable and Customary Amount ("R&C") will be replaced by the term Maximum Allowed Amount ("MAA"). MAA is defined as 315% of the national Medicare schedule. (Amend the following section of the VMEP: Section 2.)

b. **Out-of-Network Deductible.** For associates and their eligible dependents enrolled in the HCN Option, an annual deductible will apply for covered services or supplies obtained on an out-of-network basis of $700 per individual and $1,750 per family for each of 2013 and 2014, and $725 per individual and $1,812.50 per family for 2015. The family annual deductible is satisfied when any combination of individual family member deductibles equals the applicable family annual deductible, within a calendar year; however, an enrolled associate or eligible dependent will never satisfy more than his or her own individual amount. (Amend the following section of the VMEP: Section 6.1.1.)

c. **Out-of-Pocket Maximum.** The out-of-pocket expense maximum applicable to covered services or supplies obtained on an in-network basis under the HCN Option during any calendar year will be $1,000 for each of 2013 and 2014 and $1,050 for 2015 per individual and $2,500 for each of 2013 and 2014 and $2,625 for 2015 per family. The out-of-pocket expense maximum applicable to covered services or supplies obtained on an out-of-network basis under the HCN Option during any calendar year will be $1,800 for each of 2013 and 2014 and $1,850 for 2015 per individual and $4,500 for each of 2013 and 2014 and $4,625 for 2015 per family. Expenses that apply towards the out-of-pocket maximum are aggregated between in-network and out-of-network expenses to reach the applicable out-of-pocket maximum. The family annual out-of-pocket maximums can be satisfied by any combination of family members within a calendar year; however, an enrolled associate or eligible dependent will never satisfy more than his or her own individual amount. (Amend the following section of the VMEP: Section 6.1.4.)

d. **Preventive Care Services.** Preventive care services and routine well-baby and well-child care (pediatric exams) will be covered on an in-network basis at 100% of the Network Negotiated Fee ("NNF"). In-network preventive care services will be covered according to the coverage, age, and frequency provisions of the Affordable Care Act. Preventive care services and routine well-baby and well-child care (pediatric exams) will be covered on an out-of-network basis at 80% of the MAA not subject to the deductible. While not legally applicable to out-of-network services, out-of-network services will be covered according to the coverage, age, and frequency provisions applicable to in-network preventive care benefits under the Affordable Care Act. (Amend the following sections of the VMEP: Sections 6.1.3 and 9.16.)

e. **Covered Medical Services and Supplies**

   i. **Physicians' Services.** The Company will implement a $20 copay for each primary care physician's home or office visit and a $25 copay for each

specialist's home or office visit on an in-network basis. The copay for an individual who is eligible for Medicare will be $10 for each primary care physician's home or office visit and $15 for each specialist's home or office visit on an in-network basis. (Amend the following section of the VMEP: Section 6.1.2.)

ii. **Radiation Therapy, Chemotherapy, Electroshock Therapy and Hemodialysis.** The Company will implement a $20 copay for radiation therapy, chemotherapy, electroshock therapy and hemodialysis provided in a physician's office on an in-network basis. The copay for an individual who is eligible for Medicare will be $10 for services provided in a physician's office on an in-network basis. Radiation therapy, chemotherapy, electroshock therapy and hemodialysis performed at a hospital outpatient facility will be covered on an in-network basis at 90% of the NNF. (Amend the following sections of the VMEP: Sections 6.1.2 and 6.1.3.)

iii. **Physical, Occupational and Speech Therapy.** The Company will implement a $20 copay for evaluations for outpatient physical, occupational and speech therapy on an in-network basis. The copay for an individual who is eligible for Medicare will be $10 on an in-network basis. Outpatient physical, occupational and speech therapy visits and services will be covered on an in-network basis at 90% of the NNF. (Amend the following sections of the VMEP: Sections 6.1.2 and 6.1.3.)

iv. **Chiropractic Services.** The Company will implement a $20 copay for services with a licensed chiropractor on an in-network basis. The copay for an individual who is eligible for Medicare will be $10 on an in-network basis. The maximum benefit payable for covered chiropractic services will be limited to $750 per plan year per individual, regardless of whether coverage is provided in-network or out-of-network. (Amend the following sections of the VMEP: Sections 6.1.2, 6.1.3 and 9.4.)

v. **Home Health Care.** Home health care will be limited to 120 days per plan year, regardless of whether such care is provided in-network or out-of-network. For purposes of the 120 day per plan year benefit limitation, every five home health care visits will count as one day. (Amend the following section of the VMEP: Section 7.2.)

vi. **Inpatient Hospital Services.** Semi-private hospital room and board will be covered on an in-network basis at 90% of the NNF. Any in-patient hospital physician's visits, newborn baby care, x-rays, diagnostic laboratory tests and other medically necessary ancillary services and supplies provided during a covered hospital confinement will be covered on an in-network basis at 90% of the NNF. (Amend the following sections of the VMEP: Sections 6.1.3, 7.1 and 9.9.)

vii. **Maternity and Newborn Care.** The Company will implement a $20 copay for maternity care (pre and post-natal), at the initial visit only, on an in-network basis. For an individual who is eligible for Medicare, the Company will implement a $10 copay for maternity care (pre- and post-natal), at the initial visit only, on an in-network basis. Birthing center charges will be covered on an in-network basis at 90% of the NNF. Newborn baby care will be covered on an in-network basis at 90% of the NNF. (Amend the following sections of the VMEP: Sections 6.1.2, 6.1.3 and 9.9.)

viii. **Skilled Nursing Facility Services.** Care in a skilled nursing facility will be limited to 120 days per plan year, regardless of whether such care is provided in-network or out-of-network. For purposes of the 120 day per plan year benefit limitation, each day of confinement in a skilled nursing facility will count as one half day. (Amend the following section of the VMEP: Section 7.2.)

ix. **Hospice Care.** Bereavement counseling visits will not be covered as hospice care on an in-network or out-of-network basis. However, coverage for bereavement counseling visits may be covered under the mental health care benefit provisions of the VMEP, to the extent that such visits are determined by the TPA to be a covered service or supply under the VMEP. Hospice care will be subject to a lifetime benefit limitation of 180 days, of which no more than 60 days may be for inpatient hospice care, regardless of whether such care is provided in-network or out-of-network. If the 180 day limitation is exhausted and the individual would otherwise have to be admitted to a hospital, then up to an additional 45 days of hospice care may be authorized, as determined by the TPA, to be used for either home or inpatient hospice care, provided the 60 day inpatient limit has not been exhausted. (Amend the following sections of the VMEP: Sections 2, 6.1.3, 6.3 and 11.)

x. **Surgery and Anesthesia.**

- Inpatient surgery will be covered on an in-network basis at 90% of the NNF. (Amend the following section of the VMEP: Section 6.1.3.)

- The Company will implement a $20 copay for each outpatient surgery performed in a primary care physician's office and a $25 copay for each outpatient surgery performed in a specialist's office on an in-network basis. The copay for an individual who is eligible for Medicare will be $10 for each outpatient surgery performed in a primary care physician's office or $15 for each outpatient surgery performed in a specialist's office on an in-network basis. Outpatient surgery performed in a facility will be covered on an in-network basis at 90% of the NNF. Precertification will be required for outpatient

surgery performed on an out-of-network basis. (Amend the following sections of the VMEP: Sections 6.1.2 and 6.1.3.)

- Anesthesia will be covered on an in-network basis at 90% of the NNF. (Amend the following section of the VMEP: Section 6.1.3.)

- The Company will implement a $20 copay for each second opinion provided by a primary care physician and a $25 copay for each second opinion provided by a specialist on an in-network basis. The copay for an individual who is eligible for Medicare will be $10 for each second opinion provided by a primary care physician or $15 for each second opinion provided by a specialist on an in-network basis. Second opinions will not be covered on an out-of-network basis. (Amend the following sections of the VMEP: Sections 6.1.2 and 8.4.)

xi. **Emergency Care.** The Company will implement a $75 copay for each in-network or out-of-network visit to an emergency room. The copay for an individual who is eligible for Medicare will be $25. However, the applicable emergency room copay will be waived if the associate or eligible dependent is admitted to the hospital. (Amend the following sections of the VMEP: Sections 6.1.2 and 6.1.3.)

xii. **Urgent Care.** The Company will implement a $20 copay for each in-network or out-of-network visit to an urgent care facility. The copay for an individual who is eligible for Medicare will be $10. (Amend the following section of the VMEP: Section 6.1.2.)

xiii. **Ambulance Services.** Ambulance services for emergency services will be covered on an in-network and out-of-network basis at 90% of the submitted amount. Ambulance services for non-emergency services will be covered on an in-network basis at 80% of the NNF; and, on an out-of-network basis at 80% of the MAA. (Amend the following sections of the VMEP: Sections 6.1.3 and 9.1.)

xiv. **Durable Medical Equipment and Prosthetic Devices.** Durable medical equipment (DME) and prosthetic devices will be covered on an in-network basis at 90% of the NNF. Precertification on an in-network and out-of-network basis will be required if the cost of purchase or rental of durable medical equipment, or the cost of a prosthetic device, is more than $5,000. (Amend the following sections of the VMEP: Sections 6.1.3, 9.7 and 9.18.)

xv. **Infertility Treatment.** Advanced reproductive technologies and fertility treatments will be covered on an in-network basis at 90% of the NNF. (Amend the following sections of the VMEP: Sections 6.1.3 and 9.19.)

xvi. **Covered Mental Health/Substance Abuse Services and Supplies.** The provisions of Sections 6.3.2 and 11.5 of the VMEP that set forth visit limits for mental health care and substance abuse treatment will be deleted. Mental health/substance abuse services and supplies will be covered as follows:

- Inpatient mental health care and substance abuse treatment will be covered on an in-network basis at 90% of the NNF; and, on an out-of-network basis at 70% of the MAA after the deductible is met. (Amend the following sections of the VMEP: Sections 6.3 and 11.4.)

- The Company will implement a $20 copay for outpatient mental health care and substance abuse treatment provided on an in-network basis. For an individual who is eligible for Medicare, the Company will implement a $10 copay for outpatient mental health care and substance abuse treatment provided on an in-network basis. For outpatient mental health care and substance abuse treatment received on an in-network basis, the maximum charge of $15 per week that an associate or eligible dependent pays will no longer apply. Outpatient mental health care and substance abuse treatment will be covered on an out-of-network basis at 70% of the MAA after the deductible is met. (Amend the following sections of the VMEP: Sections 6.3 and 11.4.)

xvii. **Radiology and Diagnostic Laboratory Tests.** The Company will implement a $20 copay for outpatient radiology and diagnostic laboratory tests performed in a physician's office or at an outpatient facility on an in-network basis. The copay for an individual who is eligible for Medicare will be $10 on an in-network basis for outpatient radiology and diagnostic laboratory tests performed in a physician's office or at an outpatient facility. (Amend the following sections of the VMEP: Sections 6.1.2 and 9.6.)

2) **Health Care PPO Benefit Changes.** The medical benefits provided to associates and their eligible dependents enrolled in the Health Care PPO Option on and after January 1, 2013 will be as described in the VMEP, with the following modifications:

a. **Maximum Allowed Amount.** The term Reasonable and Customary Amount ("R&C") will be replaced by the term Maximum Allowed Amount ("MAA"). MAA is defined as 315% of the national Medicare schedule. (Amend the following section of the VMEP: Section 2.)

b. **Deductible.** For associates and their eligible dependents enrolled in the Health Care PPO Option, an annual deductible will apply for covered services or supplies obtained on an in-network basis of $400 for 2013, $450 for 2014 and $475 for 2015 per individual and $1,000 for 2013, $1,125 for 2014 and $1,187.50 for 2015 per family. For associates and their eligible dependents enrolled in the Health Care PPO Option, an annual deductible will apply for covered services or supplies

obtained on an out-of-network basis of $650 for 2013, $700 for 2014 and $725 for 2015 per individual and $1,625 for 2013, $1,750 for 2014 and $1,812.50 for 2015 per family. Expenses that apply towards the deductible are aggregated between in-network and out-of-network expenses to reach the applicable deductible. The family annual deductible is satisfied when any combination of individual family member deductibles equals the applicable family annual deductible within a calendar year; however, an enrolled associate or eligible dependent will never satisfy more than his or her own individual amount. (Amend the following section of the VMEP: Section 6.2.1.)

c. **Out-of-Pocket Maximum.** The out-of-pocket expense maximum applicable to covered services or supplies obtained on an in-network basis under the Health Care PPO Option during any calendar year will be $1,050 for 2013, $1,100 for 2014, and $1,150 for 2015 per individual and $2,625 for 2013, $2,750 for 2014 and $2,875 for 2015 per family. The out-of-pocket expense maximum applicable to covered services or supplies obtained on an out-of-network basis under the Health Care PPO Option during any calendar year will be $2,000 for each of 2013 and 2014 and $2,050 for 2015 per individual and $5,000 for each of 2013 and 2014 and $5,125 for 2015 per family. Expenses that apply towards the out-of-pocket maximum are aggregated between in-network and out-of-network expenses to reach the applicable out-of-pocket maximum. The family annual out-of-pocket maximums can be satisfied by any combination of family members within a calendar year; however, an enrolled associate or eligible dependent will never satisfy more than his or her own individual amount. Amounts paid towards the deductible will apply towards the annual out-of-pocket expense maximum. (Amend the following section of the VMEP: Section 6.2.3.)

d. **Preventive Care Services.** Routine adult physical exams and routine well-baby and well-child care (pediatric exams) will be covered on an out-of-network basis at 100% of the MAA not subject to the deductible. In-network preventive care services will be covered according to the coverage, age, and frequency provisions of the Affordable Care Act. While not legally applicable to out-of-network services, out-of-network services will be covered according to the coverage, age, and frequency provisions applicable to in-network preventive care benefits under the Affordable Care Act. (Amend the following sections of the VMEP: Sections 6.2 and 9.16.)

e. **Covered Medical Services and Supplies.**

i. **Physicians' Services.** The Company will implement a $20 copay for each physician's home or office visit on an in-network basis. For an individual who is eligible for Medicare, the copay will be $10 on an in-network basis. Physician's office and home visits will be covered on an out-of-network basis at 70% of the MAA after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2 and 6.2.2.)

ii. **Radiation Therapy, Chemotherapy, Electroshock Therapy and Hemodialysis.** The Company will implement a $20 copay for radiation therapy, chemotherapy, electroshock therapy and hemodialysis provided in a physician's office on an in-network basis. For an individual who is eligible for Medicare, the copay will be $10 on an in-network basis. Radiation therapy, chemotherapy, electroshock therapy and hemodialysis provided at a hospital outpatient facility will be covered on an in-network basis at 90% of the NNF after the deductible is met. Radiation therapy, chemotherapy, electroshock therapy and hemodialysis provided in a physician's office or performed at a hospital outpatient facility will be covered on an out-of-network basis at 70% of the MAA after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2, 6.2.2 and 9.20.)

iii. **Physical, Occupational and Speech Therapy.** Outpatient physical, occupational and speech therapy will be covered on an out-of-network basis at 70% of the MAA after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2, 6.2.2 and 9.13.)

iv. **Chiropractic Services.** The Company will implement a $20 copay for services with a licensed chiropractor on an out-of-network basis. The maximum benefit payable for services with a licensed chiropractor will be limited to $92 per visit on an out-of-network basis. In addition to an associate's responsibility for the copay, an associate will be responsible for the cost of the visit, if any, in excess of $92. Chiropractic services will be subject to an aggregate limit of 60 visits per plan year regardless of whether coverage is provided in-network or out-of-network (chiropractic service visits will not exceed 1 visit per day). (Amend the following sections of the VMEP: Sections 6.2, 6.2.2 and 9.4.)

v. **Home Health Care.** Home health care will be covered on an out-of-network basis at 70% of the MAA after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2.2 and 7.2.)

vi. **Inpatient Hospital Services.** Semi-private hospital room and board will be covered on an in-network basis at 90% of the NNF and on an out-of-network basis at 70% of the MAA, in each case, after the deductible is met. Any in-patient hospital physician's visits, newborn baby care, x-rays,

diagnostic laboratory tests and other medically necessary ancillary services and supplies provided during a covered hospital confinement will be covered on an in-network basis at 90% of the NNF and on an out-of-network basis at 70% of the MAA, in each case, after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2, 6.2.2, 7.1 and 9.9.)

vii. **Maternity and Newborn Care.** The Company will implement a $20 copay for maternity care (pre and post-natal), at the initial visit only, on an in-network basis. The copay for an individual who is eligible for Medicare will be $10, at the initial visit only, on an in-network basis. Maternity care (pre- and post-natal) will be covered on an out-of-network basis at 70% of the MAA after the deductible is met. Birthing center charges will be covered on an in-network basis at 90% of the NNF and on an out-of-network basis at 70% of the MAA, in each case, after the deductible is met. Newborn baby care will be covered on an in-network basis at 90% of the NNF and on an out-of-network basis at 70% of the MAA, in each case, after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2, 6.2.2 and 9.9.)

viii. **Skilled Nursing Facility Services.** Care in a skilled nursing facility will be covered on an out-of-network basis at 70% of the MAA after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2.2 and 7.2.)

ix. **Hospice Care.** Hospice care will be covered on an out-of-network basis at 70% of the MAA after the deductible is met. Bereavement counseling visits will not be covered as hospice care on an in-network or out-of-network basis. However, coverage for bereavement counseling visits may be covered under the mental health care benefit provisions of the VMEP, to the extent that such visits are determined by the TPA to be a covered service or supply under the VMEP. (Amend the following sections of the VMEP: Sections 2, 6.2.2 and 9.11.)

x. **Surgery and Anesthesia.**

- Inpatient surgery will be covered on an in-network basis at 90% of the NNF and on an out-of-network basis at 70% of the MAA, in each case, after the deductible is met. (Amend the following section of the VMEP: Section 6.2.2.)

- The Company will implement a $20 copay for outpatient surgery performed in a physician's office on an in-network basis. The copay for an individual who is eligible for Medicare will be $10 on an in-network basis. Outpatient surgery performed in a facility will be covered on an in-network basis at 90% of the NNF after the deductible is met. Outpatient surgery performed in a physician's office or in a

facility will be covered on an out-of-network basis at 70% of the MAA after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2.2 and 8.5.)

- Anesthesia will be covered on an in-network basis at 90% of the NNF and on an out-of-network basis at 70% of the MAA, in each case, after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2.2 and 8.5.)

- The Company will implement a $20 copay for second opinions on an in-network basis. The copay for an individual who is eligible for Medicare will be $10. Second opinions will be covered on an out-of-network basis at 70% of the MAA after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2, 6.2.2 and 8.4.)

xi. **Emergency Care.** The Company will implement a $75 copay for each in-network or out-of-network visit to an emergency room. The copay for an individual who is eligible for Medicare will be $25. However, the applicable emergency room copay will be waived if the associate or eligible dependent is admitted to the hospital. (Amend the following section of the VMEP: Section 6.2.)

xii. **Urgent Care**. The Company will implement a $20 copay for each in-network or out-of-network visit to an urgent care facility. The copay for an individual who is eligible for Medicare will be $10. (Amend the following section of the VMEP: Section 6.2.)

xiii. **Ambulance Services.** Ambulance services for emergency services will be covered on an in-network basis and out-of-network basis at 90% of the submitted amount, in each case, after the deductible is met. Ambulance services will be covered for non-emergency services on an in-network basis at 70% of the NNF and on an out-of-network basis at 70% of the MAA, in each case, after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2.2 and 9.1.)

xiv. **Durable Medical Equipment and Prosthetic Devices.** Durable medical equipment (DME) and prosthetic devices will be covered on an in-network basis at 80% of the NNF and on an out-of-network basis at 70% of the MAA, in each case, after the deductible is met. Precertification on an in-network and out-of-network basis will be required if the cost of purchase or rental of durable medical equipment, or the cost of a prosthetic device, is more than $5,000. (Amend the following sections of the VMEP: Sections 6.2.2, 9.7 and 9.18.)

xv. **Infertility Treatment.** Advanced reproductive technologies and fertility treatments will be covered on an in-network basis at 90% of the NNF and on an out-of-network basis at 70% of the MAA, in each case, after the

deductible is met. (Amend the following sections of the VMEP: Sections 6.2.2 and 9.19.)

xvi. **Covered Mental Health/Substance Abuse Services and Supplies.** The provisions of Sections 6.2.2 and 9.11 of the VMEP that set forth visit limits for mental health care and substance abuse treatment will be deleted. Mental health/substance abuse services and supplies will be covered as follows:

- Inpatient mental health care and substance abuse treatment will be covered on an in-network basis at 90% of the NNF and on an out-of-network basis at 70% of the MAA, in each case, after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2.2 and 9.11.)

- The Company will implement a $20 copay for outpatient mental health care and substance abuse treatment on an in-network basis. The copay for an individual who is eligible for Medicare will be $10 on an in-network basis. Outpatient mental health care and substance abuse treatment will be covered on an out-of-network basis at 70% of the MAA after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2, 6.2.2 and 9.11.)

xvii. **Radiology and Diagnostic Laboratory Tests.** The Company will implement a $20 copay for outpatient radiology and diagnostic laboratory tests on an in-network basis. The applicable copay for an individual who is eligible for Medicare will be $10 on an in-network basis. Outpatient radiology and diagnostic laboratory tests will be covered on an out-of-network basis at 70% of the MAA after the deductible is met. (Amend the following sections of the VMEP: Sections 6.2, 6.2.2, 8.5 and 9.6.)

3) **EPO.** (Amend the following section of the Verizon Alternate Choice Plan for New York and New England Associates: Section 4.)

a. Effective as of the Effective Date, no new associates may be enrolled in the National EPO NYNE (the "EPO Option"). An associate who is enrolled in the EPO Option on the Effective Date will continue to be covered under the EPO Option provided that such associate remains continuously eligible for the Verizon Alternate Choice Plan and VMEP and enrolled in the EPO Option. If an associate changes medical options and is no longer enrolled in the EPO Option, the EPO Option will no longer be available to the associate and his or her eligible dependent(s).

b. Coinsurance and deductible(s) applicable to the EPO Option will not change during the term of this 2012 MOU.

c. Copays

i. Copay for an office visit to a primary care provider (including OB-GYN) will be no greater than $20.

ii. Copay for a specialist office visit will be no greater than $25.

iii. Copay for an emergency room visit will be no greater than $75.

iv. Copay for inpatient hospital admissions will be no greater than the copay on the Effective Date of this 2012 MOU.

d. The remaining terms of the Non-Board Settlement Agreement dated April 8, 2011 between the Company and the Communications Workers of America, AFL-CIO ("CWA") in NLRB Case No. 2-CA-39506, will remain in full force and effect, including that the Prescription Drug Benefit Changes outlined in Section VIII.2.B.5 of this 2012 MOU shall apply to the EPO Option.

4) **HMO Options.** (Amend the following section of the Verizon Alternate Choice Plan for New York and New England Associates: Section 4.1.) The:

a. Copay for an office visit to a primary care provider (including OB-GYN) will be no greater than $20.

b. Copay for a specialist office visit will be no greater than $25.

c. Copay for an emergency room visit will be no greater than $75.

d. Copay for inpatient hospital admissions will be no greater than the copay applicable to the respective HMO Options on the Effective Date of this 2012 MOU.

e. Coinsurance and deductible(s) applicable to the respective HMO Options will not change during the term of this 2012 MOU.

5) **Prescription Drug Benefit Changes Applicable to Associates and Eligible Dependents.** The prescription drug coverage currently offered to associates and eligible dependents will be amended by the provisions outlined in Section VIII.2.B.5 of this 2012 MOU. (Amend the following sections of the VMEP: Sections 6.4.1, 6.4.2, 6.4.3, 12.4 and 12.5.)

a. **Out-of-Pocket Maximum.** The provisions of Section 6.4.3 of the VMEP that set forth the $400 annual out-of-pocket expense maximum under the Health Care PPO Option for pharmacy prescription drug coverage will be eliminated. An annual out-of-pocket expense maximum under the Health Care PPO Option will apply to prescription drugs purchased at mail order pharmacies of $600 for 2013, $700 for 2014, and for 2015 and each calendar year thereafter, the annual out-of-pocket expense maximum will increase by 6% when compared to the annual out-

of-pocket expense maximum for the prior year. Any expenses incurred as a result of the provisions of Section VIII.2.B.5)(d) regarding a member paying the difference between the cost of a brand name and a generic drug when a generic equivalent is available will not count toward the out-of-pocket maximum.

b. **In-Network Pharmacies.** The following prescription drug coverage will apply for prescription drugs purchased at in-network pharmacies for up to a 30-day supply:

- The copay for generic drugs will be the Discounted Network Price ("DNP") for the original prescription and each refill, with a maximum copay of $8 for each of 2013 and 2014 and $9 for 2015.

- The copay for single-source and multi-source brand name drugs will be 30% of the DNP for the original prescription and each refill, with a maximum copay of $25 for each of 2013 and 2014, and for 2015 and each calendar year thereafter, the maximum copay will increase by 6% when compared with the maximum copay for the prior Plan Year.

- If an associate purchases a brand name drug when a generic equivalent is available, the associate will pay an amount equal to (a) the DNP, up to a maximum of $8 for each of 2013 and 2014, or $9 for 2015, plus (b) 100% of the cost difference between the brand name and generic drug, and the fixed dollar maximum copays described above will not apply. If the associate's treating physician certifies that the associate is medically unable to take the generic medication and such exception is approved by the TPA's procedures for approval of treatment or services, then the single source and multi-source coverage will apply.

- Once an associate has obtained three fills of the prescription from an in-network pharmacy (i.e., the initial prescription plus two refills), then the associate must use the mail order pharmacy to obtain subsequent refills of long-term prescription medications. If an associate does not use the mail order pharmacy to obtain such subsequent refills of a long-term prescription medication, an associate will be responsible for 50% of the DNP cost for subsequent refills of a long-term prescription medication. The fixed dollar maximum copays described above will not apply.

c. **Out-of-Network Pharmacies.** For out-of-network pharmacies, an associate will pay 100% of the cost difference between the retail cost and the DNP. In addition, an associate will pay a percentage of the DNP, as provided below. After the $50 per person out-of-network annual deductible is met, the following prescription drug coverage will apply for prescription drugs purchased at out-of-network pharmacies for up to a 30-day supply:

- The copay for generic drugs will be 30% of the DNP for the original prescription and each refill.

- The copay for single-source and multi-source brand name drugs will be 40% of the DNP for the original prescription and each refill.

- If an associate purchases a brand name drug when a generic equivalent is available, the associate will pay 30% of the DNP plus 100% of the cost difference between the brand name and generic drug, unless the associate's treating physician certifies that the associate is medically unable to take the generic medication and such exception is approved by the TPA's procedures for approval of treatment or services.

- Once an associate has obtained three fills of the prescription from an out-of-network pharmacy (i.e., the initial prescription plus two refills), then the associate must use the mail order pharmacy to obtain subsequent refills of long-term prescription medications. If an associate does not use the mail order pharmacy to obtain such subsequent refills of a long-term prescription medication, an associate will be responsible for 50% of the DNP cost for subsequent refills of a long-term prescription medication.

d. **Mail Order Pharmacy.** The prescription drug coverage for mail order drugs will be as follows for up to a 90-day supply:

- The copay for generic drugs will be the DNP for the original prescription and each refill, with a maximum copay of $16 for each of 2013 and 2014, and $18 for 2015.

- The copay for single-source and multi-source brand name drugs will be 30% of the DNP for the original prescription and each refill, with a maximum copay of $50 for each of 2013 and 2014, and for 2015 and each calendar year thereafter, the maximum copay will increase by 6% when compared with the maximum copay for the prior Plan Year.

- If an associate purchases a brand name drug when a generic equivalent is available, the associate will pay an amount equal to (a) the DNP, up to a maximum of $16 for each of 2013 and 2014, or $18 for 2015, plus (b) 100% of the cost difference between the brand name and generic drug, and the fixed dollar maximum copays described above will not apply. If the associate's treating physician certifies that the associate is medically unable to take the generic medication and such exception is approved by the TPA's procedures for approval of treatment or services, then the single source and multi-source coverage will apply.

e. **Over-the-Counter Medication.** Over-the-Counter medication will not be covered by the VMEP unless required by law.

6) **Cost-Containment Features; Health Management Program.** In addition to the cost-containment and health management programs set forth in Section 10 of the VMEP, the Company may provide associates and eligible dependents with an

additional health management program, pursuant to which the Company may, from time to time, offer and implement health management and educational programs and initiatives that address effective health care utilization, health conditions, disease management and patient safety. The health management program may include the following programs that help manage health as set forth below. The Company will retain the discretion to add, eliminate and make changes to the programs offered from time to time in consultation with the TPA. The TPA will be Anthem. (Amend the following section of the VMEP: Section 10.)

a. Inpatient care advocacy (Voluntary Participation). If an associate or eligible dependent is hospitalized, the TPA works with the associate or eligible dependent's physician to make sure that he or she is getting the care needed and that the physician's treatment plan is being carried out effectively.

b. Readmission management (Voluntary Participation). This program serves as a bridge between the hospital and home if an associate or eligible dependent is at high risk of being readmitted.

c. Risk management (Voluntary Participation). If an associate or eligible dependent has certain chronic or complex conditions, this program addresses such health care needs by providing access to medical specialists, medication information and coordination of equipment and supplies.

d. Disease management (Voluntary Participation). The TPA offers support for a wide variety of medical conditions. If an associate or eligible dependent has been diagnosed or is at high risk for the following, the TPA will provide guidance about the associate or eligible dependent's condition at no additional cost: asthma, cancer, COPD, congestive heart failure, coronary artery disease, depression, diabetes, low back pain, musculoskeletal conditions and vascular at risk.

e. Behavioral health support (Voluntary Participation).

f. Maternity support (Voluntary Participation).

7) **Contributions for Medical Coverage.** Starting on November 1, 2012 and for each month thereafter, an associate who enrolls in the HCN Option, Health Care PPO Option, or any other option offered by the Company under the VMEP, including any one or more benefits options provided pursuant to any HMO Options or the EPO Option described in the VMEP ("Other Medical Option"), will pay a monthly contribution on a before-tax basis towards the cost of coverage for the medical coverage category elected by such associate ("Monthly Employee Contribution"). The Monthly Employee Contribution for the HCN Option and the Health Care PPO Option is set forth below. With respect to the Monthly Employee Contribution for any Other Medical Option offered by the Company under the VMEP, the Monthly Employee Contribution for the medical coverage category elected by such associate under such Other Medical Option may vary by option but will be no greater than the Monthly Employee Contribution for the Other Medical Option category as set forth

below, which is 150% of the Monthly Employee Contribution of the HCN Option and Health Care PPO Option. All associates and eligible dependents who participate in the VMEP and contribute on a before-tax basis will be subject to the mid-year change rules applicable to Internal Revenue Code section 125 cafeteria plans. With respect to the Monthly Employee Contributions in 2013, 2014 and 2015, an associate will be eligible for the non-tobacco user contribution rates (set forth below) for medical coverage if such associate and his or her covered dependents do not use tobacco products or satisfy a reasonable alternative standard as determined by the Company (e.g., complete an annual smoking cessation program). An associate will also be eligible to receive an annual credit of $100 in 2013, 2014 and 2015, prorated on a pay-period basis toward the associate's contribution for healthcare if an associate completes a health risk assessment provided by the Company. For 2012 only, the Monthly Employee Contribution will be the same rate for all options, regardless of whether the associate is a tobacco user, and there will be no health risk assessment credit. The Monthly Employee Contributions that appear in the charts below for 2013, 2014 and 2015 will be annualized, will reflect an additional $.04 on an annual basis, and will apply and be prorated on a pay-period basis.

Prior to November 1, 2012, the Company will offer associates an enrollment opportunity for the coverage period remaining in the 2012 Plan Year (i.e., November 1, 2012 through December 31, 2012). Effective November 1, 2012, the Monthly Employee Contribution required by associates will commence and be as specified below for the 2012 Plan Year:

Coverage Category Elected	Monthly Employee Contribution
Employee Only	$30
Employee + Family	$60

Effective January 1, 2013, the Monthly Employee Contribution required by associates will be:

Coverage Category Elected	Health Care PPO Option Monthly Employee Contribution (Tobacco User Rate)	Health Care PPO Option Monthly Employee Contribution (Non-Tobacco User Rate)	HCN Option Monthly Employee Contribution (Tobacco User Rate)	HCN Option Monthly Employee Contribution (Non-Tobacco User Rate)	Other Medical Option Monthly Employee Contribution (Tobacco User Rate) – Up to a maximum of the amounts below	Other Medical Option Monthly Employee Contribution (Non-Tobacco User Rate) – Up to a maximum of the amounts below
Employee Only	$103.33	$53.33	$103.33	$53.33	$125.83	$75.83
Employee + Family	$148.33	$98.33	$148.33	$98.33	$193.33	$143.33

Effective January 1, 2014, the Monthly Employee Contribution required by associates will be:

Coverage Category Elected	Health Care PPO Option Monthly Employee Contribution (Tobacco User Rate)	Health Care PPO Option Monthly Employee Contribution (Non-Tobacco User Rate)	HCN Option Monthly Employee Contribution (Tobacco User Rate)	HCN Option Monthly Employee Contribution (Non-Tobacco User Rate)	Other Medical Option Monthly Employee Contribution (Tobacco User Rate) – Up to a maximum of the amounts below	Other Medical Option Monthly Employee Contribution (Non-Tobacco User Rate) – Up to a maximum of the amounts below
Employee Only	$108.33	$58.33	$108.33	$58.33	$133.33	$83.33
Employee + Family	$158.33	$108.33	$158.33	$108.33	$208.33	$158.33

Effective January 1, 2015, the Monthly Employee Contribution required by associates will be:

Coverage Category Elected	Health Care PPO Option Monthly Employee Contribution (Tobacco User Rate)	Health Care PPO Option Monthly Employee Contribution (Non-Tobacco User Rate)	HCN Option Monthly Employee Contribution (Tobacco User Rate)	HCN Option Monthly Employee Contribution (Non-Tobacco User Rate)	Other Medical Option Monthly Employee Contribution (Tobacco User Rate) – Up to a maximum of the amounts below	Other Medical Option Monthly Employee Contribution (Non-Tobacco User Rate) – Up to a maximum of the amounts below
Employee Only	$113.33	$63.33	$113.33	$63.33	$140.83	$90.83
Employee + Family	$168.33	$118.33	$168.33	$118.33	$223.33	$173.33

(Amend the following sections of the VMEP: Sections 3 and 5.)

C. <u>Modification of Individualized Enrollment Process.</u>

The individualized enrollment process will be amended to provide that an associate will only be permitted to enroll in and/or modify the associate's health care benefit coverage elections on a plan year (calendar year) basis, and as permitted under the change in status rules under Section 125 of the Internal Revenue Code, or as otherwise required by law.

3. HEALTH REIMBURSEMENT ACCOUNT

A. Effective January 1, 2013, the Company will establish a Health Reimbursement Account (HRA), within the meaning of IRS Notice 2002-45 and related guidance, on behalf of each "Full-Time Employee" (as such term is defined in the VMEP) and each "Part-Time Employee" (as such term is defined in the VMEP) who is working at least 17 hours per week, in each case who has at least 3 months of net credited service and who is eligible for the VMEP. During the 2013 plan year, the Company will allocate a credit of $850 to each HRA for eligible "Full-Time Employees" as of January 1, 2013 and a credit of $425 to each HRA for eligible "Part-Time Employees" who are working at least 17 hours per week as of January 1, 2013, to reimburse otherwise unreimbursed eligible medical expenses (as defined in IRC section 213(d)) for the associate and his or her eligible IRS tax dependents, provided that the HRA may not be used to reimburse the associate for any premium or contribution under the VMEP or otherwise, including any Monthly Employee Contributions. An associate who is hired after January 1, 2013

will not be eligible for an HRA for the 2013 calendar year.

B. To the extent there is a positive balance in an associate's HRA after the 2013 plan year, the associate may continue to incur and receive reimbursement from the HRA until the balance in such notional account is zero.

C. If the associate terminates employment for any reason other than Retirement (as defined under the Pension Plan), claims incurred after the date of termination will not be eligible for reimbursement. Claims incurred before termination but not paid shall be eligible for reimbursement for three months following the date of termination. Any remaining balance after the run off period will be forfeited, unless the associate elects continued coverage under COBRA.

D. Upon the death of an associate, the remaining balance of his or her HRA account shall be used to reimburse claims incurred before the associate's death for eligible medical expenses of the associate or his or her IRS tax dependents. Claims incurred before the associate's death but not paid shall be eligible for reimbursement for three months following the date of death. Any remaining balance after the run off period will be forfeited, unless the surviving IRS tax dependent elects continued coverage under COBRA. In the event an associate is on a leave of absence, he or she shall continue to be eligible for credits to and reimbursements from the HRA in the same manner as an eligible associate who is not on a leave of absence.

E. The Company will have the sole and exclusive right to determine and implement applicable administrative details with respect to the HRAs, which include, without limitation, claims processing procedures, communications, and establishment of applicable COBRA rates. The HRAs will be established and operated in accordance with IRS guidance and applicable law.

4. RETIREE HEALTH AND WELFARE BENEFITS AND PRESCRIPTION DRUG COVERAGE CHANGES

Any changes to the health care benefits and prescription drug coverage provided to active employees as set forth in Section 2 above will also be made, effective January 1, 2013, to the health care benefits and prescription drug coverage provided to eligible retirees who retired after August 9, 1986 ("Covered Retiree") and the applicable retiree health care plans will be amended in the same manner as those provisions are amended for active employees pursuant to Section 2 above. Any future changes to health care benefits and prescription drug coverage provided to Covered Retirees will be negotiated with the Union in the same manner as that for active employees and future retirees.

A. **Changes to Deductible.** Notwithstanding the foregoing, the deductible provisions for the Health Care PPO Option set forth in Section VIII.2.B.2)b. of the 2012 MOU shall not apply to Covered Retirees who retire prior to January 1, 2013. The deductible for such Covered Retirees and their eligible dependents enrolled in the Health Care PPO Option shall remain as currently provided in the VMEP. Covered Retirees enrolled in the Health Care PPO Option who retire on or after January 1, 2013 will be subject to the deductibles set forth in Section VIII.2.B.2)b. of this 2012 MOU during the term of the 2012 MOU and will thereafter be subject to the same increase in deductibles as active associates on a going forward basis.

B. **Prescription Drug Coverage for Medicare Beneficiaries.**

1) Notwithstanding the foregoing, effective as of January 1, 2013, Medicare-eligible Covered Retirees and dependents will participate in the Verizon sponsored Medicare Part D plan. While the prescription drug coverage outlined by Section VIII.2.B.5) of this 2012 MOU will apply to Medicare-eligible Covered Retirees and dependents, the Company will be required to comply with legal requirements applicable to Medicare Part D prescription drug plans, such as Covered Retirees will be eligible for three (3) 30-day supplies of covered medication per visit at retail (even though Section VIII.2.B.5) of this 2012 MOU only allows for up to one 30-day supply per visit at retail), and the provisions of Sections VIII.2.B.5)(b), (c) and (d) regarding a member paying the difference between the cost of a brand-name and a generic drug when a generic equivalent is available will not apply to Medicare-eligible Covered Retirees.

2) Notwithstanding the provisions of Sections VIII.2.B.5)(b), (c) and (d) regarding the copayment amount for multi-source brand name prescription drugs, the copay for Medicare-eligible Covered Retirees for multi-source brand name drugs will be as follows:

a. The copay for in-network retail pharmacies will be 40% of the DNP for the original prescription and each refill, with a maximum copay of $30.

b. The copay for mail order pharmacies will be 40% of the DNP for the original prescription and each refill, with a maximum copay of $60.

c. The copay for out-of-network retail pharmacies will be 50% of the DNP for the original prescription and each refill.

C. **EPO Enrollment Provisions.** Effective on the Effective Date, no new Covered Retirees may be enrolled in the EPO Option. A Covered Retiree who is enrolled in the EPO Option on the Effective Date will continue to be covered under the EPO Option provided that such Covered Retiree remains continuously eligible for the Verizon Alternate Choice Plan and VMEP and enrolled in the EPO Option. If a Covered Retiree changes medical options and is no longer enrolled in the EPO Option, the EPO Option will no longer be available to the Covered Retiree and his or her eligible dependents. If an associate is enrolled in the EPO Option at the time of retirement and is eligible for retiree medical coverage under the VMEP, the Covered Retiree and/or his or her eligible dependent(s) may remain continuously enrolled in the EPO Option provided that such individuals remain continuously eligible for the Verizon Alternate Choice Plan and VMEP and enrolled in the EPO Option and are not Medicare-eligible.

D. **HMO Option.** To the extent that the Company determines to offer or retain any particular HMO at any time the following shall apply:

1) After the enrollment opportunity for 2012, if an associate is enrolled in an HMO Option at the time of retirement, the Covered Retiree and/or his or her eligible dependents can remain continuously enrolled in the HMO as long as the HMO is offered to Covered Retirees provided that such individuals remain continuously eligible for the Verizon Alternate Choice Plan and VMEP and enrolled in the HMO and are not Medicare-eligible. After the enrollment opportunity for 2012, if an associate is not enrolled in an HMO Option when the associate retires, the Covered Retiree cannot enroll in an HMO Option as a Covered Retiree. Notwithstanding the foregoing, the Company may provide Medicare-eligible retirees the opportunity to enroll in certain HMOs.

2) HMOs that cover Medicare-eligible retirees that require governmental approval will not be subject to the limitation on copays set forth in Section VIII.2.B.4)(a), (b) and (c) of the 2012 MOU.

E. **Changes to Contributions.**

1) **Retirees with Net Credited Service Date On or After August 3, 2008.** Any associate whose Net Credited Service date, as defined in the Pension Plan, is on or after August 3, 2008 and who otherwise did not qualify for any Company-subsidized retiree medical coverage upon his or her initial employment termination, will continue to be subject to the "New Hire" contribution requirements outlined in Section VII.3.C. of the 2008 MOU, as modified by this paragraph 1). Any such New Hire will receive upon retirement an annual benefit for medical coverage, for the rest of his or her life, of $480 for each year of Net Credited Service which the New Hire completes that commences on or after August 3, 2008 (up to a maximum of 30 years net credited service). All other provisions of Section VII.3.C of the 2008 MOU will remain unchanged.

2) **Retirees with Net Credited Service Date Before August 3, 2008 and who Retired After January 1, 1992.** Any Covered Retiree with a Net Credited Service Date, as defined in the Pension Plan, before August 3, 2008 and who retired after January 1, 1992 will be required to contribute to obtain retiree medical coverage. The minimum contribution for retiree medical coverage will be required on an after-tax basis.

a. **Contributions for Retiree Medical Coverage.**

(i) Such Covered Retiree who enrolls in any Option under the VMEP other than the HCN Option or the Health Care PPO Option, such as an HMO option or the EPO Option ("Other Medical Option") will pay a monthly contribution, on an after-tax basis, towards the cost of coverage for the medical coverage category elected by such Covered Retiree. These contributions will commence on January 1, 2013. The monthly contribution rate for such Other Medical Option may vary by option but will be no greater than the monthly contribution rate for the

applicable Plan Year set forth below; provided that the monthly contribution rate for Medicare-eligible Covered Retirees will be no greater than 50% of such rates:

	2013	2014	2015
Retiree Only	$67.50	$75	$82.50
Retiree + 1	$105	$115	$125
Retiree + Family	$135	$150	$165

(ii) Starting on January 1, 2013 and for each month thereafter, each such Covered Retiree who retires on or after January 1, 2013 and who enrolls in the HCN Option or the Health Care PPO Option will pay a monthly contribution, on an after-tax basis, towards the cost of coverage for the medical coverage category elected by such Covered Retiree ("Retiree Monthly Contribution"), as specifically provided below. Each such Covered Retiree who retires prior to January 1, 2013 and who enrolls in the HCN Option or the Health Care PPO Option will not be required to pay a Retiree Monthly Contribution toward the cost of coverage during the term of this 2012 MOU.

(A) Effective January 1, 2013, the Retiree Monthly Contribution for Plan Years 2013 and 2014 shall be as follows:

	Pre-Medicare Retiree Monthly Contribution	Medicare-Eligible Retiree Monthly Contribution
Retiree Only	$35	$17.50
Retiree + 1	$60	$30
Retiree +Family	$60	$30

(B) For each Plan Year beginning on and after January 1, 2015, the Retiree Monthly Contribution for such Plan Year will increase by 6% when compared with the applicable Retiree Monthly Contribution for the previous Plan Year for each coverage category available to a Covered Retiree. For example, a Medicare-eligible Covered Retiree enrolled in the Health Care PPO Option who retires after January 1, 2013 will pay a Monthly Contribution in 2015 of $18.55 ($17.50 + 6%) for Retiree Only coverage for the 2015 Plan Year and will pay a Monthly Contribution in 2016 of $19.66 ($18.55 + 6%) for the 2016 Plan Year.

b. Calculation of Annual Contribution.

(i) The minimum contribution requirements for retiree medical coverage set forth in paragraph (a) of this Section VIII.4.E.2 will apply annually with monthly contributions.

(ii) For Plan Years 2012, 2013, 2014 and 2015, each such Covered Retiree will only be required to pay the monthly contribution amount relating to each Plan Year pursuant to paragraph (a) above, as applicable, and shall not be required to