Verizon Mid-Atlantic – Summary of Tentative Agreement
September 21, 2012

After negotiating for over one year, CWA, IBEW and Verizon have finally reached a tentative agreement on the terms and conditions of employment for 45,000 bargaining unit members at Verizon. The final contract reflects the difficult battles by the unions to fend off the massive assault by Verizon management to cut benefits, freeze wages, eliminate pensions, and weaken worker protections that have been the hallmark of the union contract at Verizon and its predecessors. A major victory of this prolonged fight is the return to work of all disciplined and terminated strikers. Here are highlights of the agreement:

Duration of Contract:

The terms of the contract will become effective 30-days after ratification and will remain in effect until August 1, 2015.

1. Wages and Other Compensation

The combined 3-year wage increase will result in a compounded 8.2% base wage increase by the end of the contract. A ratification bonus of $800 and yearly corporate profit sharing payments of at least $700 will add to wage gains. This is a remarkable achievement at a time when employers are aggressively seeking to roll back union-negotiated wages. Workers at Caterpillar had their wages frozen and workers at Consolidated Edison won similar annual wage increases to those in this contract only after a 26-day lockout by the employer.

a. General Wage Increase. The increases listed below are applied to all steps in the basic wage schedules on the date indicated:

- 2012, First Sunday after Ratification – 2.25%
- 2013, August 4 - 2.75%
- 2014, August 3 – 3.00%
- Compounded increase: 8.2%

b. Ratification Bonus.

- $800, payable within 30 days of ratification.

c. Corporate Profit Sharing

- The company will award corporate profit sharing distributions in each year of the contract, with the minimum distribution of $700 each year.
- The payment due in 2012 for the 2011 performance year has already been paid.

2. Preserving Job Security and Growing Jobs

The agreement preserves job protections won in past contracts and even provides for more jobs, despite management's original intent to strip all protections from the contract.

a. More Call Center Jobs

- Verizon will hire 325 new full-time employees into Mid-Atlantic call centers during the term of contract: 125 into Sales and Service Centers and 200 into Fiber Customer Support Analyst position in the Fiber Solution Centers (FSCs) and Enhanced Verizon Resolution Centers (EVRC). Initial hiring will be proportional to current number of employees in each category of center in each state.

b. New Contracting Initiative Restored

- The Contracting Initiatives Committee, charged with identifying ways to reduce contracting is continued.

c. Job Security Provisions Protected

- Job security provisions, including no involuntary layoff, forced transfer, downgrade, etc. were preserved for employees hired on or before August 3, 2003 and for designated MMS Techs employed by VCS with hire dates on or before August 3, 2003, who move to the Core in the future.

3. Changes to MEP, MCN and Other Medical Plans

A major goal for Verizon management was to totally change the medical plans that we have built over decades of bargaining. The company wanted new plans patterned after high deductible health plans. We prevented the major overhaul the company sought, instead modifying existing medical plans and holding off changes in the dental and vision plans. Even with the changes, we retain one of the best medical plans in the country. And with the health reimbursement account payment, wage increases and other negotiated compensation, we will be better off at the end of the contract than we are today.

a. Premiums. The tentative agreement includes monthly premium contributions for all medical plans (MCN, MEP, EPO and HMOs). Contributions will begin in November 2012, and will increase each January 1, as follows:

	MEP & MCN		EPO, HMOs and Other Plans	
	Employee	**Employee + Family**	**Employee**	**Employee + Family**
2012	**$30.00**	**$60.00**	**$30.00**	**$60.00**
** **2013**	**$45.00**	**$90.00**	**$67.00**	**$135.00**
** **2014**	**$50.00**	**$100.00**	**$75.00**	**$150.00**
** **2015**	**$55.00**	**$110.00**	**$82.00**	**$165.00**

** These are the rates provided the employee completes a Health Risk Assessment provided by the Company. Without the assessment an additional $8.33 per month will be charged.

- If an employee or covered dependent uses tobacco products, the rates above will be increased by $50 per month. The additional cost can be avoided by participating in a smoking cessation program or other standard determined by the company.

- The current Spousal Surcharge is eliminated
- If covering a sponsored Parent, an additional $100 monthly contribution (a $25 increase) is required.

b. A New Health Care Reimbursement Account.

- Effective January 1, 2013, employees eligible for the medical plan will have Health Reimbursement Accounts (HRA) with $850 contributed by the company for full-time employees, and $425 for part-time employees. The account is to reimburse out of pocket medical expenses for the employee or dependents.
- The account cannot be used to reimburse for monthly contributions. The HRA is available only for employees hired before January 1, 2013.
- Balances in the account will roll over year after year until the balance is zero.
- An employee who retires may continue to access the HRA. Termination for any other reason will terminate the account. Claims made after termination will not be eligible for reimbursement and there will be a 3-month run off period to seek reimbursement for claims made prior to termination.
- After the death of an employee, any balance is available for 3 months to reimburse claims made by the employee and dependents before the death. If the surviving dependents choose to continue coverage under COBRA, the HRA shall be continued.

c. Deductibles and Out of Pocket Maximums. Changes were made to the deductibles and out of pocket maximums of the plans, as follows:

Plan Design	**MEP-PPO**		**MCN**	
	In Network	Out Network	In Network	Out of Network
Annual Deductible				
Individual	2013: $400 2014: $450 2015: $475	2013: $650 2014: $700 2015: $725	None	2013: $700 2014: $700 2015: $725
Family	2013: $1,000 2014: $1,125 2015: $1,187.50	2013: $1,625 2014: $1,750 2015: $1,812.50	None	2013: $1,750 2014: $1,750 2015: $1,812.50
Out Of Pocket Maximum				
Individual	2013: $1,050 2014: $1,100 2015: $1,150	2013: $2,000 2014: $2,000 2015: $2,050	2013: $1,000 2014: $1,000 2015: $1,050	2013: $1,800 2014: $1,800 2015: $1,850
Family	2013: $2,625 2014: $2,750 2015: $2,875	2013: $5,000 2014: $5,000 2015: $5,125	2013: $2,500 2014: $2,500 2015: $2,625	2013: $4,500 2014: $4,500 2015: $4,625

d. Medical Expense Plan (MEP) Selected Benefits. Elements of the MEP plan have been changed. Below are some of the changes on an in-network basis. For a more detailed description of the changes, see the side-by-side comparison.

- Doctor's Office Visits: $20 copay (was $15)
- X-rays and Lab Tests: $20 copay (was 100% covered)
- Hospital Room & Board: 90% covered after deductible (was 100% covered)
- Inpatient Surgery: 90% covered after deductible (was 100% covered)
- Inpatient Mental Health: 90% covered after deductible (was 100% for first 30 days, then 80% beginning with 31st day)
- Emergency Room Care: $75 copay, waived if admitted (was $15, waived if admitted)

e. Managed Care Network (MCN) Selected Benefits. Elements of the MCN plan have been changed. Below are some of the changes on an in-network basis. For a more detailed description of the changes, see the side-by-side comparison.

- Doctor's office visits: $20 copay.
- Specialist's office visit: $25 copay
- Second Surgical Opinion: $20 copay
- X-rays and lab tests: $20 copay.
- Hospital Room & Board: 90% covered.
- Inpatient Surgery: 90% covered.
- Inpatient Mental Health: 90% covered.
- Emergency Room: $75 copay, waived if admitted.

f. New Plan Carrier, Expanded Network and Related Plan Provisions.

- Anthem Blue Cross and Blue Shield will be the new carrier for the MCN Option and the MEP PPO option.
- All Employees/Retirees may enroll in either MCN or MEP regardless of where they live.
- If there is no network provider for a specified service within a 40 mile radius of the employee's home, the service will be covered at in-network levels, regardless of the provider's affiliation.
- Payments based on Reasonable and Customary Charges (R&C) will be changed to payments based on Maximum Allowed Amount (MAA). MAA is equal to 315% of the national Medicare fee schedule for the specified service.

g. EPO Option.

- No new associates may enroll in the EPO.
- Those employees currently enrolled may remain enrolled. However, if the employee should change coverage from the EPO to another plan, the EPO will no longer be an option for that employee and dependents.
- Coinsurance and deductibles and hospital admission copays currently applicable will not change.
- Copays may change, but will not be greater than $20 for an office visit to a PCP, not greater than $25 for a specialist office visit, and not greater than $75 for an emergency room visit.

h. HMO Options.

- Coinsurance and deductibles and hospital admission copays currently applicable will not change.
- Copays may change, but not greater than $20 for an office visit to a PCP, not greater than $25 for a specialist office visit, and not greater than $75 for an emergency room visit.

k. Prescription Drug Program

<table>
<tr><th></th><th>Deductible</th><th>Generic</th><th>Single Source and Multi-Source Brand</th><th>Brand w/ Generic Alternative</th></tr>
<tr><td>In-Network*
(30 day supply)</td><td>None</td><td>100% of Discounted Network Price (DNP), max of $8 ($9 in 2015)</td><td>30% of DNP, max of $25 (beginning in 2016, the max copay increases by 6% each year)</td><td>100% of DNP, max of $8 ($9 in 2015), plus 100% of cost difference between generic and brand</td></tr>
<tr><td rowspan="2">Out-of-Network*
(30 day)</td><td rowspan="2">$50</td><td colspan="3">Associate pays 100% of the cost difference between retail and DNP, plus copays listed below</td></tr>
<tr><td>30% of DNP</td><td>40% of DNP</td><td>30% of DNP, plus 100% of generic/brand difference</td></tr>
<tr><td>Mail Order
(90 day)</td><td>None</td><td>100% of DNP, max of $16 ($18 in 2015)</td><td>30% of DNP, max of $50 (max increases 6% annually after 2015)</td><td>100% of DNP, max of $16 ($18 in 2015), plus 100% of generic/brand difference</td></tr>
<tr><td colspan="5">*After 3 fills of a prescription from a pharmacy (In or Out-of-Network), associate pays 50% of DNP with no max dollar copay</td></tr>
</table>

- An incentive program to promote use of generic medications is introduced. If a brand drug is purchased when a generic is available, the associate will pay the normal generic rate plus 100% of the cost difference between the brand-name and generic drug. There is no maximum copay. An exception may be granted if the treating physician certifies that the patient is medically unable to take the generic.
- An incentive program to promote the use of mail order prescriptions is introduced. After 3 fills at retail (the initial prescription plus two refills), the mail order program must be used for subsequent refills of long-term medications. Otherwise, continued fills at retail will be at the rate of 50% of DNP and maximum dollar amounts do not apply.
- To promote use of in-network pharmacies, an out-of-network disincentive is introduced. Individuals who have their prescriptions filled at a pharmacy that is not part of the network will have to pay a deductible, plus higher DNP rates as shown in the

chart above, plus 100% of the cost difference between the retail cost and the DNP.

- Over the counter medications are no longer covered by the plan unless required by law.

l. Dependent Eligibility

- No new Sponsored Parent or Sponsored Child may be enrolled in or added to coverage in the medical plan or the dental plan.
- Those currently enrolled may stay enrolled as long as they remain eligible.

m. "Default" Plan Rules

- If a new hire fails to make an election for medical plan coverage, s/he will be defaulted into the MCN option at employee-only coverage tier.
- If an HMO is terminated, and an HMO enrollee fails to make an election into another plan, s/he will be defaulted into the MCN option at the coverage tier the employee had elected in the HMO.

n. Voluntary Programs to Improve Quality and Contain Costs

- Associates will have the opportunity to voluntarily participate in programs aimed at reducing health care costs: inpatient care advocacy, re-admissions management, risk management program for those with chronic or complex conditions, behavioral health support, and maternity support.
- Associates diagnosed or determined to be at high risk for the following chronic conditions can participate in a program that provides guidance on proper treatment of the condition at no cost: asthma, cancer, COPD, congestive heart failure, coronary artery disease, depression, diabetes, low back pain, musculoskeletal conditions and vascular at risk.

o. Health Care Oversight Committee

- A new Health Care Oversight Committee (HCOC) is established as a forum to discuss matters of mutual concern regarding medical, dental and vision care, disease management and wellness programs.
- The National Health Care Reform initiative is eliminated and the Labor Management Partnership for Health Care Reform is dissolved.

p. Health Care Benefits Coordinators continued

- HCBCs provide assistance to employees and retirees in understanding plan options and administrative processes and providing employees with information to effectively utilize plan benefits.

4. Retiree Health Benefits

All changes made to the active health care plan will also apply for the health care benefits of retirees who retired after December 31, 1989. With the following exceptions:

a. Contributions

- Employees with a Net Credit Service Date on or after August 3, 2008 will receive a $50 increase in annual retiree benefits contribution from $430 to $480 for each year of Net Credited Service (up to 30 years).
- Retirees with a Net Credit Service Date before August 3, 2008 and who retired after January 1, 2013 will pay the following monthly contributions:

Pre-Medicare	**MCN & MEP PPO**			**EPO. HMOs and Other Plans (contributions will be not greater than the following)**		
	Retiree	**Retiree +1**	**Retiree + Family**	**Retiree**	**Retiree +1**	**Retiree + Family**
2013	$35	$60	$60	$67.50	$105	$135
2014	$35	$60	$60	$75	$115	$150
2015	$37.10	$63.60	$63.60	$82.50	$125	$165

Medicare Eligible	**MCN & MEP PPO**			**EPO. HMOs and Other Plans (contributions will be not greater than the following)**		
	Retiree	**Retiree +1**	**Retiree + Family**	**Retiree**	**Retiree +1**	**Retiree + Family**
2013	$17.50	$30	$30	$33.75	$52.50	$67.50
2014	$17.50	$30	$30	$37.50	$57.50	$75.00
2015	$18.55	$31.80	$31.80	$41.25	$62.50	$82.50

- Retirees with a Net Credit Service Date before August 3, 2008 and who retired before January 1, 2013 and enroll in the MCN Option or MEP PPO Option will not be required to pay monthly contributions toward the cost of coverage.

b. Deductible

- Retirees who retire before January 1, 2013 will not be subject to the new deductible levels negotiated for active employees. Their deductible levels will remain the same.

c. Prescription Drugs

- Medicare eligible retirees and their dependents will participate in the Verizon sponsored Medicare Part D plan, which deviates from the active plan detailed above in the following ways:
  - These retirees will be eligible for three 30-day supplies of covered medication per retail visit, instead of one.
  - These retirees will not be required to pay the difference between the cost of a brand name drug and its generic equivalent.

- Copays for multi-source brand name drugs will be:

	In-Network Retail	Out-of-Network Retail	Mail Order
Multi Source	40% of DNP, max of $30	50% of DNP	40% of DNP, max of $60

d. EPO Enrollment

- No new Retirees may enroll in the EPO Option. Retirees that are currently enrolled in the EPO Option, as well as actives who retire while enrolled in the EPO Option, may continue coverage.

e. HMO Option

- Retirees and their dependents may only enroll in an HMO option if they were covered by that HMO as an active at the time of their retirement and remain continuously covered by that HMO.
- Medicare eligible retirees enrolled in HMOs will not be subject to copay limitations outlined above.

f. Company Funding of Retiree Health Insurance

- Caps on company contributions to retiree health insurance will not apply over the life of the contract.
- The company may only use the assets of the Prudential RFA Group Life Insurance Policy to fund life insurance, medical and dental claims for those retirees under Verizon Plan 550.

5. Pensions and Retirement Security

At the onset of bargaining, management demanded to freeze the pension plan, to eliminate the lump sum option, and to shift everyone into the 401(K) plan as the sole retirement income vehicle. Our strong fight to protect our pension was successful in preserving the pension for current employees.

a. Pension Plan Protected

- Maintained Defined Benefit Pension Plan for all current employees.
- The pension will retain the lump sum cash out provisions of the previous bargaining agreement.
- Pension bands remain unchanged with no reductions or benefit accrual freeze as proposed by the Company.
- Associates hired on or after Contract Ratification will be ineligible for the pension plan. New hires will instead be covered under the improved Savings and Security Plan (401(k) Plan). (see b. below)

b. Savings and Security Plan (401(k) Plan) Improved for New Hires

- For all associates hired after Contract Ratification, the matching contributions to the plan will increase to 100% match up to 6% of pay for plan years 2012 - 2015.
- For plan years 2012 - 2015, the company may provide an additional Discretionary Contribution of 0 - 3% of pay for all associates hired after Contract Ratification. The actual contribution amount will be set at the same percentage as the performance-related contribution for wire line management employees.
- The maximum employee contribution for all members is increased from 16% to 25% of base pay.

c. Disability Benefits

- **Independent Medical Exams.** In the event the company disputes an employee's eligibility or continued eligibility for disability benefits, the Company may use one or both of the following vendors for Independent Medical Examinations (IMEs): Medical Consultants Network or Unival.
- The IME will be conducted by a physician or specialist who will determine eligibility for disability benefits. The IME doctor will also determine whether any medical restrictions from work activities are necessary. The decision of the IME doctor is final and binding.
- Any changes to the IME process will be discussed with the union prior to implementation.
- **Functional Capacity Exams.** If company disputes an employee's medical restrictions as prescribed by a treating physician, then it will arrange for a Functional Capacity Examination.
- A physician shall conduct the FCE and the determination is final and binding.
- The employee will work within the restrictions until the FCE report is received after the exam.
- Any changes to the FCE process will be discussed with the union prior to implementation.

6. Provisions for Call Center Workers

From the start, the Company demanded major changes in work rules that would affect call center workers. At the end of the day, we were able to hold onto important protections that assure good working conditions in the centers, and to make some innovative agreements to keep and grow jobs in-region.

a. Sharing of Calls among Centers

- Allows call sharing among call centers that perform like-functions subject to the following limitations and job protections.
  - Calls must be routed to available union-represented employees at like-function call centers in this order: 1) in the same state; 2) in the Mid-Atlantic region; 3) in the Northeast; 4) in the United States; 5) and, only if there are no union-represented available employees, to contractors.

- Sales and Service Centers (Customer Sales and Service Centers (CSSC), Business Sales and Billing Centers (BSSC), and Multilingual Sales and Service Centers (MSSC)) shall handle at least 67% of all calls originating in the Mid-Atlantic footprint. Tech Support Centers (Enhanced Verizon Resolution Center (EVRC) and Fiber Solution Centers (FSC)) shall handle at least 52% in 2013 and 53% in 2014 of all calls originating in the Mid-Atlantic footprint. If the call volume falls below the designated level over a six-month period, there shall be no-layoffs in that category of center for the next six months.
- Establishes a list of clearly defined cross-functional duties that representatives in Sales and Service Centers and Tech Support Centers shall be required to handle. The Company must give advance notice and may only add two additional duties per year.
- Requires Company-provided training on work time so that Maintenance Administrators (MAs) and Repair Service Clerks (RSCs) can prepare to test into and transition to the Fiber Customer Support Analyst position.

b. Work at Home Trial

- Allows work at home trial at two locations, subject to Union agreement to the locations. Collective bargaining agreements shall govern participating employees' wages, benefits, and conditions of employment. Establishes Union/Company oversight of the trial.

c. Stress Letter of Understanding

- Modifies existing language preserving a forum to deal with issue of stress in the workplace.

d. Commercial Stress Relief Package

- Preserves most elements of the existing stress relief package.
- In Potomac and New Jersey (already exists in Pennsylvania), requires pre-notification of evaluative observations if Consultant "meets requirements" in a mid-year evaluation even if the Consultant fell below this rating in the annual evaluation. No change with respect to quarterly evaluation of Consultants in Pennsylvania/Delaware.
- Limits evaluative observation to first eight hours of scheduled work day for employees with 35 hour work week, or 8.5 hours for employees with 37.5 hour work week. Limits evaluative observations on a Monday and day after holiday to the first 7/7.5 hours of scheduled work.

e. Electronic Recording of Calls

- Permits electronic recording of calls for service and supervisory (evaluative and diagnostic) observing, subject to limitations.
- Same protections for evaluative observations will apply to recorded evaluative observations.

7. Absence and Time Off

a. New Absence Provisions. The absence plan has been revised to reward workers who have few incidental absence days.

- Employees who use four days or fewer of paid incidental absence in a calendar year will receive the following lump sum payment:

Incidental Absence Days Per Year	Lump Sum Payment
Zero Days	5 days' pay
More than Zero Days but less than 2 Days	4 days' pay
At least 2 Days but less than 3 Days	3 days' pay
At least 3 Days but less than 4 Days	2 days' pay
4 Days	1 days' pay

- Effective January 1, 2013, payment for days scheduled but not worked due to an employee's personal illness or off-duty accident will be capped at ten days.
- Payments for part-time employees will also be capped at ten days, but prorated in the same way that vacation and other paid time is prorated for part-time workers.
- All employees may take up to 4 incidental absence days per year without being charged against their record on the absence control plan.
- All existing provision(s) pertaining to unpaid incidental absence, including waiting days, will continue in full force and effect.

b. Vacation Time-Off

- At least 18% of employees in each vacation administrative work group will be permitted to schedule time off in a given week; at least 12% of employees will be permitted vacation time when the request is made less than 5 business days in advance. The current rounding rules continue to apply in each instance.

c. Medical Restriction Leave of Absence

- The current Medically Restricted Policy is amended to care for an associate who is or will be medically restricted for more than 150 days placing them on a Medically Restricted Leave of Absence.
- The Leave of Absence is without pay, and will not exceed 52 weeks from the start of the medical restriction. If the restriction extends beyond 52 weeks the associate may apply for Long Term Disability Benefits.

8. Other Benefits

a. Advisory Council on Family Care

- Annual funding for the ACFC will be $1.28 million per contract year.

- The existing ACFC Coordinator letter will be renewed, with an expiration date of December 31, 2013.
- All other provisions of the ACFC are unchanged from the previous bargaining agreement.

b. Training Advisory Board Executive Council

- Annual funding for the TABEC will be $1.69 million per contract year.
- Any unused funds in the TABEC account as of August 6, 2011 will be carried forward to be used in the new bargaining agreement. In the future, unused funds will not be carried forward, and will be forfeited.
- All other provisions of the TABEC are unchanged from the previous bargaining agreement.

c. Tuition Assistance Plan

- Annual cap of $8,000 for eligible full-time employees; $3,500 for eligible part-time employees.
- Provides for more stringent repayment obligations.