September 19, 2012

2012 COMMON ISSUES MEMORANDUM OF UNDERSTANDING

BETWEEN

VERIZON MARYLAND INC.,
VERIZON VIRGINIA INC.,
VERIZON WASHINGTON, D.C. INC.,
VERIZON PENNSYLVANIA INC.,
VERIZON DELAWARE INC.,
VERIZON NEW JERSEY INC.,
VERIZON SERVICES CORP.,
VERIZON CORPORATE SERVICES CORP.,
VERIZON ADVANCED DATA INC.,
VERIZON SOUTH INC. (VIRGINIA)

AND

COMMUNICATIONS WORKERS OF AMERICA, AFL-CIO

This Memorandum of Understanding ("2012 MOU") agreed to by and between the above-named companies (herein the "Company" or "Companies," as context requires) and the Communications Workers of America, AFL-CIO (herein the "Union" or "CWA") sets forth the terms of the agreement between the Companies and the Union on common issues.

This 2012 MOU binds each of the Companies and the CWA to incorporate the provisions set forth herein into the collective bargaining agreements between each of the Companies and the CWA. Provisions of this 2012 MOU, including the attachments, will be incorporated, by reference or otherwise, into the appropriate collective bargaining agreements.

Each of the new collective bargaining agreements will consist of the provisions of the existing collective bargaining agreements, including:

1. The provisions of the 2008 Memorandum of Understanding Between Verizon Maryland Inc., Verizon Virginia Inc., Verizon Washington, D.C. Inc., Verizon West Virginia Inc., Verizon Pennsylvania Inc., Verizon Delaware Inc., Verizon New Jersey Inc., Verizon Services Corp., Verizon Corporate Services Corp., Verizon Advanced Data Inc. and Verizon South Inc. (Virginia) and the Communications Workers of America, AFL-CIO effective August 3, 2008 ("2008

MOU") and all attachments to the 2008 MOU that were valid and enforceable immediately prior to the Effective Date of this 2012 MOU, as modified by the applicable provisions of the 2012 MOU; and

2. The provisions of the 2008 Memorandum of Agreement ("2008 MOA"), as modified by the applicable provisions of the 2012 MOA.

All letters of agreement in the parties' 2008 collective bargaining agreements (including without limitation the 2008 MOU and all attachments to the 2008 MOU) and all international union, district and 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 agreements 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, agreements 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 of this 2012 MOU 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.

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. The parties' new collective bargaining agreements (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 CWA no later than thirty calendar days after the date of this 2012 MOU, except that Customer Service Implementers shall separately vote on the ratification of the 2012 MOU and the parties' September 2012 Letter of Agreement applicable to them.

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: ______________________________

FOR THE COMPANIES

By ______________________________
JOSEPH GIMILARO Chairperson,
Common Issues Bargaining

FOR COMMUNICATIONS WORKERS OF AMERICA, AFL-CIO

By ______________________________
CWA District 2-13 Chairperson, Common Issues Bargaining

By ______________________________
CWA District 1 – New Jersey

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	3.00%	All steps of the basic wage schedules

B. Weekly Payroll Distribution. Effective no later than the week ending January 5, 2013, all CWA-represented fGTE associates located in Virginia and Pennsylvania who are currently paid on a bi-weekly basis will be paid on a weekly basis.

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 Term 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 Mid-Atlantic and South Associates (to the extent that it covers Mid-Atlantic Associates, including the GTE South Incorporated (Southeast) Plan for Hourly-Paid Employees) (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 Mid-Atlantic Associates ("Mid-Atlantic 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 Mid-Atlantic 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 Mid-Atlantic 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 Mid-Atlantic 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 Mid-Atlantic 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.

C. EMPLOYEE CONTRIBUTION LEVELS.

The Mid-Atlantic Associate Savings Plan will be amended effective ninety days following ratification of this 2012 MOU, to increase the maximum employee contributions from 16% to 25% of Basic Weekly Pay as defined in the Plan for any combination of pre-tax, after-tax and/or Roth 401(k) contributions.

VI. CHANGES IN DISABILITY BENEFITS

A. INDEPENDENT MEDICAL EXAMINATION

The following will replace the current contract provision on Independent Medical Examinations in its entirety:

Whenever the Company or SADBP Plan Administrator ("Plan Administrator") disputes an employee's eligibility or continued eligibility for SADBP benefits that is supported by a treating physician, the Plan Administrator shall arrange for an Independent Medical Examination ("IME"). The Plan Administrator may utilize one or more of the following IME vendors without review by the HCOC: Medical Consultants Network Inc. ("MCN") or Unival. The IME shall be conducted by a physician, which may include a physician specialist, who shall determine eligibility for SADBP benefits. That decision shall be final and binding. Additionally, any changes to the current IME process will first be discussed with the Union prior to implementation. If the IME doctor determines the employee is not eligible for SADBP benefits, the doctor will determine whether any medical restrictions from work activities are necessary in the course of the same examination. That decision shall also be final and binding.

If SADBP eligibility is disputed, SADBP wage replacement benefits will be paid until a determination is made, so long as the employee fully cooperates as required by the existing terms of the SADBP Plan documents.

B. FUNCTIONAL CAPACITY EXAMINATION

The following will replace the current contract provision regarding medical work restrictions/Functional Capacity Examinations ("FCE"):

Whenever the Company or SADBP Plan Administrator ("Plan Administrator") disputes an employee's medical restriction from work activities prescribed by a treating physician, the Plan Administrator shall arrange for a FCE to determine if the medical restrictions are medically necessary. The Plan Administrator may utilize one or more of the following FCE vendors without review by the HCOC: MCN or Unival. A physician, which may include a physician specialist, shall conduct the FCE, and the FCE determination shall be final and binding.

While the FCE is being scheduled and until the FCE report is received from the FCE provider, the employee will work within the restrictions as determined by his/her treating physician. Additionally, any change to the current FCE process will first be discussed with the Union.

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 Mid-Atlantic 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 Accidental Death and Dismemberment Plan for Mid-Atlantic Associates

Verizon Adoption Reimbursement Program for Mid-Atlantic Associates

Verizon Dental Expense Plan for Mid-Atlantic Associates

Verizon Dependent Accidental Death and Dismemberment Plan for Mid-Atlantic Associates

Verizon Dependent Care Account for Mid-Atlantic Associates

Verizon Dependent Group Life Insurance Plan for Mid-Atlantic Associates

Verizon Group Life Insurance Plan for Mid-Atlantic Associates

Verizon Health Care Account for Mid-Atlantic Associates

Verizon Income Security Plan for Mid-Atlantic Associates

Verizon Long Term Care Insurance Plan for Mid-Atlantic Associates

Verizon Long Term Disability Plan for Mid-Atlantic Associates

Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates

Verizon Pension Plan for Mid-Atlantic and South Associates (to the extent that it covers Mid-Atlantic Associates)

Verizon Savings and Security Plan for Mid-Atlantic Associates

Verizon Sickness and Accident Disability Benefit Plan for Mid-Atlantic Associates

Verizon Supplemental Accidental Death and Dismemberment Plan for Mid-Atlantic Associates

Verizon Supplemental Group Life Insurance Plan for Mid-Atlantic Associates

Verizon Vision Care Plan for Mid-Atlantic Associates

Verizon Dental Expense Plan for Mid-Atlantic Post-1989 Associate Retirees

Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Post-1989 Associate Retirees

Verizon Life Insurance Plan for Mid-Atlantic Associate Retirees

Verizon Supplemental Life Insurance Plan for Mid-Atlantic Associate Retirees

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

The provisions of the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates (the "VMEP") regarding medical and prescription drug benefits, and the Verizon Dental Expense Plan for Mid-Atlantic Associates ("VDEP") regarding dental benefits**,** for active associates who participate in the VMEP and VDEP will be amended as follows effective January 1, 2013, except where otherwise noted:

A. Dependent Eligibility Changes Applicable to the VMEP and the VDEP.

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

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

B. <u>Medical and Prescription Drug Benefit Changes Applicable to VMEP</u>.

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 4 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 MCN 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 MCN Option, with the coverage tier that the associate had elected before the HMO option was terminated.

Section 3 and Section 4 of the VMEP will be further amended to allow an associate to enroll in the MEP PPO Option, regardless of whether the associate lives within the MCN Option service area. The TPA for the MCN Option and the MEP PPO Option will be Anthem Blue Cross Blue Shield ("Anthem"). The TPA will apply its network of service providers to the MCN Option and the MEP PPO Option. To the extent that there is no in-network service provider for a specific covered service or supply within a 40-mile radius of an 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 MEP PPO or the MCN).

1) **MCN Benefit Changes**. The medical benefits provided to associates and their eligible dependents enrolled in the MCN 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 MCN 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 sections of the VMEP: Sections 5.1.1(a) and 5.1.1(c).)

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 MCN 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 MCN 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. Amounts paid towards the deductible will apply towards the annual out-of-pocket maximum. (Amend the following sections of the VMEP: Sections 5.1.1 and 5.1.4.)

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. While not legally applicable to out-of-network preventive care services, out-of-network preventive care 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 5.1.2, 5.1.3 and 8.16.)

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. Primary care physician's or specialist's home and office 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 5.1.2 and 5.1.3.)

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 an outpatient facility will be covered on an in-network basis at 90% of the NNF. Radiation therapy, chemotherapy, electroshock therapy and hemodialysis provided in a physician's office or at an 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 5.1.2, 5.1.3 and 8.20.)

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. Charges for outpatient physical, occupational and speech therapy visits and services 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 5.1.2, 5.1.3 and 8.14.)

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. Coverage for services with a licensed chiropractor will be covered on an out-of-network basis at 70% of the MAA after the deductible is met. 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 VMEP: Sections 5.1.2, 5.1.3 and 8.4.)

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 section of the VMEP: Section 5.1.3.)

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 after the deductible is met. Any inpatient 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 after the deductible is met. (Amend the following sections of the VMEP: Sections 5.1.3 and 6.1.)

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. 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 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 after the deductible is met. (Amend the following sections of the VMEP: Sections 5.1.2, 5.1.3 and 8.10.)

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 section of the VMEP: Section 5.1.3.)

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, 5.1.3 and 12.4.)

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 after the deductible is met. (Amend the following section of the VMEP: Section 5.1.3.)

- The Company will implement a $20 copay for each outpatient surgery performed in a primary care physician's office or 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 a $15 copay 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; and, in a physician's office or in a facility on an out-of-network basis at 70% of the MAA after the deductible is met. (Amend the following sections of the VMEP: Sections 5.1.2, 5.1.3 and 7.6.1.)

- 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 after the deductible is met. (Amend the following section of the VMEP: Section 5.1.3.)

- The Company will implement a $20 copay for each second opinion provided by a primary care physician or 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. (Amend the following sections of the VMEP: Sections 5.1.2, 5.1.3 and 7.5.1.)

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 5.1.2.)

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 5.1.2.)

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 5.1.3 and 8.1.)

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; and, on an out-of-network basis at 70% of the MAA 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 5.1.3 and 8.7.)

xv. **Infertility Treatment**. Advanced reproduction technologies and fertility treatments will be covered on an in-network basis at 90% of the NNF. (Amend the following section of the VMEP: Section 5.1.3.)

xvi. **Covered Mental Health/Substance Abuse Services and Supplies**. The provisions of Section 5.4 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 section of the VMEP: Section 5.1.3.)

- 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 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 5.1.2 and 5.1.3.)

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. 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 5.1.2, 5.1.3 and 8.6.)

2) **MEP PPO Benefit Changes**. The medical benefits provided to associates and their eligible dependents enrolled in the MEP 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 MEP 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 MEP 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 5.2.2.)

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 MEP 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 MEP 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 maximum. (Amend the following section of the VMEP: Section 5.2.4.)

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 NNF and on an out-of-network basis at 100% of the MAA, in each case, 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 5.2.2, 5.2.3 and 8.16.)

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 Company will implement a $10 copay for each physician's home or office visit on an in-network basis. Physician's office 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 5.2.1, 5.2.2, 5.2.3 and 8.15.)

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 Company will implement a $10 copay for radiation therapy, chemotherapy, electroshock therapy and hemodialysis provided in a physician's office on an in-network basis. Radiation therapy, chemotherapy, electroshock therapy and hemodialysis provided at an 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 5.2.1, 5.2.2, 5.2.3 and 8.20.)

iii. **Physical, Occupational and Speech Therapy**. Provider and facility charges for 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 section of the VMEP: Section 5.2.3.)

iv. **Chiropractic Services.** Coverage for services with a licensed chiropractor 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. 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 5.2.3 and 8.4.)

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. The provisions of Section 10.4 of the VMEP that set forth days of service (visit) limits for home health care will be deleted. (Amend the following sections of the VMEP: Sections 5.2.3 and 10.)

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 5.2.2, 5.2.3 and 6.1.)

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 5.2.1, 5.2.2, 5.2.3, 6 and 8.10.)

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. The provisions of Section 11.3 of the VMEP that set forth limits applicable to days of confinement for skilled nursing facility services will be deleted. (Amend the following sections of the VMEP: Sections 5.2.3 and 11.)

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. The provisions of Section 12.5 of the VMEP that set forth limits applicable to days of hospice care will be deleted. (Amend the following sections of the VMEP: Sections 2, 5.2.2, 5.2.3 and 12.)

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 sections of the VMEP: Sections 5.2.2 and 5.2.3.)

- The Company will implement a $20 copay for each 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 for each outpatient surgery performed in a physician'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, after the deductible is met.

Outpatient surgery performed in a physician's office or 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 5.2.2, 5.2.3 and 7.6.2.)

- 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 5.2.2, 5.2.3 and 8.2.)

- 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 5.2.1, 5.2.2, 5.2.3 and 7.5.2.)

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 5.2.1.)

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 5.2.1.)

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 5.2.3 and 8.1.4.)

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 will be required on an in-network and out-of-network basis 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 5.2.3 and 8.7.)

xv. **Infertility Treatment**. Advanced reproduction 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 section of the VMEP: Section 5.2.3)

xvi. **Covered Mental Health/Substance Abuse Services and Supplies**. The provisions of Section 5.4 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 5.2.3 and 8.12.)

- 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 5.2.1, 5.2.2, 5.2.3 and 8.12.)

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 5.2.1, 5.2.2, 5.2.3 and 8.6.)

3) **EPO Option**. (Amend the following section of the VMEP: Section 16.)

a. Effective as of the Effective Date, no new associates may be enrolled in coverage in the National EPO Mid-Atlantic ("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 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/or his or her eligible dependent.

b. The medical benefits provided to associates and their eligible dependents enrolled in the EPO Option on and after January 1, 2013 shall be provided according to the same terms and conditions set forth in paragraph 1, including subparagraphs 1(a) through 1(d), of the Non-Board Settlement Agreement dated April 8, 2011 between the Company and the Union in NLRB Case No. 2-CA-39506, including the Prescription Drug Benefit Changes outlined in Section VIII.2.B.5 of this 2012 MOU.

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

d. 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.

4) **HMO Options.** (Amend the following section of the VMEP: Section 16.2.) 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. The Plan Administrator will have the full discretionary authority to designate and change the TPA of the prescription drug program from time to time. The Plan Administrator will consult with the HCOC prior to changing the TPA. (Amend the following sections of the VMEP: Sections 5.3.1 and 5.3.2.)

a. **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.

b. **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 a $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.

c. **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.

d. **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 13 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 sections of the VMEP: Section 13 and delete Section 13.4.)

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 MCN Option, MEP 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 MCN Option and the MEP 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% the Monthly Employee Contribution of the MCN Option and MEP PPO Option. For Plan Years beginning on and after 2013, if an associate covers a Sponsored Parent under the VMEP, the associate will be required to contribute $1,200 for such Plan Year in addition to the applicable Monthly Employee Contribution. 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	MEP PPO Option Monthly Employee Contribution (Tobacco User Rate)	MEP PPO Option Monthly Employee Contribution (Non-Tobacco User Rate)	MCN Option Monthly Employee Contribution (Tobacco User Rate)	MCN 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	MEP PPO Option Monthly Employee Contribution (Tobacco User Rate)	MEP PPO Option Monthly Employee Contribution (Non-Tobacco User Rate)	MCN Option Monthly Employee Contribution (Tobacco User Rate)	MCN 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	MEP PPO Option Monthly Employee Contribution (Tobacco User Rate)	MEP PPO Option Monthly Employee Contribution (Non-Tobacco User Rate)	MCN Option Monthly Employee Contribution (Tobacco User Rate)	MCN 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 5 and 16.)

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 Annual 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 December 31, 1989 ("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 MEP 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 MEP PPO Option shall remain as currently provided in the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Post-1989 Associate Retirees ("VMEP for Post-1989 Retirees"). Covered Retirees enrolled in the MEP 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 Provisions 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)(a), (b) and (c) 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)(a), (b) and (c) 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 each 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 VMEP for Post-1989 Retirees 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 for Post-1989 Retirees, 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 VMEP for Post-1989 Retirees 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 may remain continuously enrolled in the HMO as long as the HMO is offered to Covered Retirees, provided that such individuals remain continually eligible for the 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 limitations 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.** Any Covered Retiree with a Net Credited Service Date, as defined in the Pension Plan, before August 3, 2008 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 medical option under the VMEP for the Post-1989 Retirees other than the MCN Option or the MEP 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 MCN Option or the MEP 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 MCN Option or MEP PPO Option will not be required to pay a Retiree Monthly Contribution toward the cost of coverage.

(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 pay the excess, if any, of the cost of retiree medical coverage for the coverage category elected by such Covered Retiree over the Company's annual contribution limits set forth in Section VII.3.B of the 2008 MOU.

(iii) For Plan Years beginning on and after January 1, 2016, the Company's annual contribution toward the cost of coverage for the coverage category and medical option elected by a Covered Retiree shall be capped at the greater of (A) the Company's annual contribution limits set forth in Section VII.3.B of the 2008 MOU or (B) the COBRA contribution rate established in December 2014 for the 2015 Plan Year for pre-Medicare and Medicare-eligible retirees, as applicable, for the MEP PPO Option, MCN Option, or for any Other Medical Option, an amount no greater than the COBRA contribution rate established for the MCN Option (the "2016 Company Contribution Cap"). Each such Covered Retiree's annual contribution toward the cost of retiree medical coverage (such amount to be paid by the Covered Retiree on a monthly basis) for each Plan Year beginning on and after January 1, 2016 will be equal to the greater of (1) the excess, if any, of the cost of coverage for the coverage category and medical option elected by such Covered Retiree for such Plan Year over the 2016 Company Contribution Cap, or (2) the annual contribution amount(s) for such Plan Year, calculated based on the monthly contribution amounts set forth in paragraph (a) above for retiree medical coverage.

IX. PRUDENTIAL RFA LIFE INSURANCE RESERVES

The Companies will have discretion to utilize the assets of the Group Life Insurance Policy (Prudential Retirement Funding Account under Group Policy No. GO-13935) that currently funds the retiree life insurance benefit under Verizon Plan 550, for the sole purpose of funding life insurance, medical and dental claims for those retirees under Verizon Plan 550.

X. SHARING OF CALLS AMONG CENTERS

1. The Companies may implement and expand upon call routing capabilities allowing for the routine transfer and/or routing of calls between and among centers in any location performing like functions, on a next available agent, balanced load or any other basis determined by the Companies, consistent with the terms of this Article X – Sharing of Calls Among Centers. For example, a routine routing of a call between Customer Sales and Service Centers ("CSSCs") is between centers performing like functions. A routine routing of a call from an Enhanced Verizon Resolution Center ("EVRC") to a Fiber Solutions Center ("FSC") is another example of a routing between centers performing like functions, as is a routine routing of a call from an FSC to an EVRC if qualified employees are available at the EVRC to handle the call. On the other hand, a routing of a call from a CSSC to a Business Sales and Billing Center ("BSBC") is not an example of a routing between centers performing like functions.

2. The centers ("Centers") subject to this Article X – Sharing of Calls Among Centers include: CSSCs, BSBCs, FSCs, EVRCs, Multilingual Sales and Service Centers ("MSSCs") and any other or future center designed to combine or integrate the work of these existing Centers.

3. Except as provided in this provision, there will be no limitations, geographic or otherwise, on the Companies' right to transfer and route calls between and among the Centers, contractor locations and/or individuals working at home, performing like functions. Such calls (other than HSI technical support as described below) subject to this 2012 MOU shall first be

routed to available union-represented employees at like-function call centers located in the state in which the calls originate. If no union-represented employees at like-function call centers located in the state in which the calls originate are available to handle calls, the calls will be routed to other union-represented employees in Mid-Atlantic. If no union-represented employees in Mid-Atlantic are available to handle calls, the calls will be routed to union-represented employees in the Northeast. If no union-represented employees in the Northeast are available to handle calls, the calls will be routed to union-represented employees in the United States in a call center outside of the Mid-Atlantic or Northeast footprint. If no union-represented employees in the United States in a call center outside of the Mid-Atlantic or Northeast footprint are available to handle calls, the calls will be routed to contractors. For purposes of this paragraph, Maryland, Virginia and the District of Columbia will together be considered to be one state. Pennsylvania and Delaware will together be considered to be one state for CSSCs only.

4. Notwithstanding the foregoing, for the time periods of January 1, 2013 to December 31, 2013, January 1, 2014 to December 31, 2014, and January 1, 2015 to December 31, 2015 CSSCs, BSBCs, and MSSCs (collectively referred to in this provision as "Sales and Service Centers") in the Mid-Atlantic footprint will together handle an aggregate regional call volume that is equivalent to at least 67% of all calls originating from Mid-Atlantic footprint customers between January 1, 2013 and December 31, 2013, between January 1, 2014 and December 31, 2014, and between January 1, 2015 and December 31, 2015 that are routed through the electronic routing system ("ERS") to Sales and Service Centers, contractor locations and/or individuals working at home. The Companies will provide the Union quarterly with the following information broken out by month: (a) the aggregate regional call volume percentage as described above, (b) the total number of Mid-Atlantic footprint sales and service calls handled in

Sales and Service Centers, contractor locations and/or by individuals working at home, and (c) the total number of calls handled by Sales and Service Centers in the Mid-Atlantic footprint and/or employees working at home in the Mid-Atlantic footprint.

5. If the aggregate regional call volume percentage handled in Mid-Atlantic is less than 67% during the first six months of 2013, there shall be no layoffs during the last six months of 2013 of Mid-Atlantic footprint Sales and Service Center associates holding a job title that handles calls that are subject to this paragraph. If the aggregate regional call volume percentage handled in Mid-Atlantic is less than 67% during the last six months of 2013, there shall be no layoffs in the first six months of 2014 of Mid-Atlantic footprint Sales and Service Center associates holding a job title that handles calls that are subject to this paragraph. If the aggregate regional call volume percentage handled in Mid-Atlantic is less than 67% during the first six months of 2014, there shall be no layoffs during the last six months of 2014 of Mid-Atlantic footprint Sales and Service Center associates holding a job title that handles calls that are subject to this paragraph. If the aggregate regional call volume percentage handled in Mid-Atlantic is less than 67% during the last six months of 2014, there shall be no layoffs during the first six months of 2015 of Mid-Atlantic footprint Sales and Service Center associates holding a job title that handles calls that are subject to this paragraph. If the aggregate regional call volume percentage handled in Mid-Atlantic is less than 67% during the first six months of 2015, there shall be no layoffs during the last six months of 2015 of Mid-Atlantic footprint Sales and Service Center associates holding a job title that handles calls that are subject to this paragraph. If the aggregate regional call volume percentage handled in Mid-Atlantic is less than 67% during the last six months of 2015, there shall be no layoffs during the first six months of 2016 of Mid-

Atlantic footprint Sales and Service Center associates holding a job title that handles calls that are subject to this paragraph.

6. For the time period of January 1, 2013 to December 31, 2013, EVRCs and FSCs (collectively referred to in this provision as "Tech Support Centers") in the Mid-Atlantic footprint will together handle an aggregate regional call volume that is equivalent to at least 52% of all fiber and copper calls (other than HSI calls that are initially routed by the ERS to contractors) originating from Mid-Atlantic footprint customers between January 1, 2013 and December 31, 2013 that are routed through the ERS to Tech Support Centers, contractor locations and/or individuals working at home. The Companies will provide the Union quarterly with the following information broken out by month: (a) the aggregate regional call volume percentage as described above, (b) the total number of Mid-Atlantic footprint tech support calls (other than HSI calls that are initially routed by the ERS to contractors) handled in Tech Support Centers, contractor locations and/or by individuals working at home, and (c) the total number of calls handled by Tech Support Centers in the Mid-Atlantic footprint and/or employees working at home in the Mid-Atlantic footprint.

7. If the aggregate regional call volume percentage handled in Mid-Atlantic is less than 52% during the first six months of 2013, there shall be no layoffs in the last six months of 2013 of Mid-Atlantic footprint Tech Support Center associates holding a job title that handles calls that are subject to this paragraph. If the aggregate regional call volume percentage handled in Mid-Atlantic is less than 52% during the last six months of 2013, there shall be no layoffs in the first six months of 2014 of Mid-Atlantic footprint Tech Support Center associates holding a job title that handles calls that are subject to this paragraph.

8. For the time period of January 1, 2014 to December 31, 2014, Tech Support Centers in the Mid-Atlantic footprint will together handle an aggregate regional call volume that is equivalent to at least 53% of all fiber and copper calls (other than HSI calls that are initially routed by the ERS to contractors) originating from Mid-Atlantic footprint customers between January 1, 2014 and December 31, 2014 that are routed through the ERS to Tech Support Centers, contractor locations and/or individuals working at home.

9. If the aggregate regional call volume percentage handled in Mid-Atlantic is less than 53% during the first six months of 2014, there shall be no layoffs in the last six months of 2014 of Mid-Atlantic footprint Tech Support Center associates holding a job title that handles calls that are subject to this paragraph. If the aggregate regional call volume percentage handled in Mid-Atlantic is less than 53% during the last six months of 2014, there shall be no layoffs in the first six months of 2015 of Mid-Atlantic footprint Tech Support Center associates holding a job title that handles calls that are subject to this paragraph.

10. For the time period of January 1, 2015 to December 31, 2015, Tech Support Centers in the Mid-Atlantic footprint will together handle an aggregate regional call volume that is equivalent to at least 53% of all fiber and copper calls (other than HSI calls that are initially routed by the ERS to contractors) originating from Mid-Atlantic footprint customers between January 1, 2015 and December 31, 2015 that are routed through the ERS to Tech Support Centers, contractor locations and/or individuals working at home.

11. If the aggregate regional call volume percentage handled in Mid-Atlantic is less than 53% during the first six months of 2015, there shall be no layoffs in the last six months of 2015 of Mid-Atlantic footprint Tech Support Center associates holding a job title that handles calls that are subject to this paragraph. If the aggregate regional call volume percentage handled

in Mid-Atlantic is less than 53% during the last six months of 2015, there shall be no layoffs in the first six months of 2016 of Mid-Atlantic footprint Tech Support Center associates holding a job title that handles calls that are subject to this paragraph.

12. For purposes of this article, a calculation of "aggregate regional call volume" shall include all calls, regardless of geographic origin, handled by applicable Centers and/or employees working at home during the applicable time period, and "aggregate regional call volume percentage" shall include calls handled by both IBEW and CWA-represented employees in the Mid-Atlantic footprint. For example, if the regional call volume originating in the Mid-Atlantic footprint for calls routed through the ERS to Sales and Service Centers, contractor locations and/or individuals working from home is 40 million in 2013, Sales and Service Centers in the Mid-Atlantic footprint and/or Mid-Atlantic employees working at home will handle an aggregate of at least 26.8 million calls (67%) in 2013, which may originate anywhere in the country, provided those calls are routed consistent with the call routing provisions of this Article X – Sharing of Calls Among Centers. Nothing in this provision should be construed or interpreted as a guarantee that a certain amount of work will be performed in any single Center or location.

13. In addition, the Companies may require representatives in any CSSC, BSBC, MSSC, FSC or EVRC to handle customer inquiries and requests as listed below which would have otherwise been handled by or transferred to another Center or individual, if such inquiry or request is either part of a misrouted call (as described below) or a secondary request or inquiry that is part of a properly routed call.

14. Inquiries and requests that CSSC, BSBC and MSSC representatives (or representatives of any other or future center designed to combine or integrate the work of these existing Centers) may be assigned to resolve are:

a. Customer reports that a TV or specific channel is not working. The representative would click the desktop icon where the set top box is automatically reset and confirm that the issue is resolved.

b. Customer reports that internet service is not working. The representative would click on the desktop where the router is automatically reset and confirm that the issue is resolved.

c. Customer requests a check on internet speed. The representative would verify account setup and click the desktop icon to test speed to customer location.

d. Customer reports phone service problem. The representative would initiate automated test and restoral of service. The ticket would be auto-populated.

e. Customer requests status of repair ticket. The representative would access the open repair ticket and read the status to the customer.

f. Customer wants to know where a technician is/the status of a repair visit. The representative would access the information and advise the customer.

g. Customer requests assistance locating their WiFi credentials, such as WEP key or SSID. The representative would click the desktop tool and perform the needed steps to instruct the customer where to locate the information on their equipment.

h. Customer reports an emergency situation (i.e., fire, storm damage, flood) and requests remote activation of service recovery features, such as call forwarding. The representative would access the desktop tool and submit a request to activate the service recovery feature.

15. Inquiries and requests that FSC and EVRC representatives (or representatives of any other or future center designed to combine or integrate the work of these existing Centers) may be assigned to resolve are:

a. Customer requests out-of-service credit. The representative validates eligibility and submits credit.

b. Customer wants to order pay-per-view event. The representative would activate pay-per-view order.

c. Customer wants to add or change a channel package or to add a set top box. The representative would submit an order to add or change the feature or add a set top box.

d. Customer wants to update their records (e.g., billing address). The representative would access account record and make change.

e. Customer asks for product information. The representative would access product library to answer question.

f. Customer asks about bill payment options. The representative would provide options for payment location (web/phone/physical).

g. Customer requests last month's bill amount. The representative would review account information and advise the customer of the amount.

h. Customer questions installation charges. The representative would use system to open an investigation.

i. Customer wants to confirm an order and/or its status. The representative would review order information and change scheduled date, if needed.

j. Customer requests to add a Value Added Service (VAS) product to their account, such as VISS, Back-up & Storage. The representative would click the desktop tool and submit an order for the requested product.

k. Customer requests the need to create or change their account authentication PIN. The representative would review the account and access the desktop tool to submit the update/change request.

16. If the Companies wish to add additional cross functional duties beyond those set forth above, they will provide written notice to the Unions, and they will not implement the additional cross functional duties until 20 days after this written notice is provided. Any such additional cross functional duties will involve customer inquiries and requests that can be resolved by application of representative training comparable to that required for the above lists. In calendar year 2013 and in each succeeding calendar year, the Companies will be permitted to add two additional tasks in each calendar year to the Sales and Support Centers and two additional tasks in each calendar year to the Technical Support Centers subject to the above-stated notice and comparable training requirements. The additional tasks added pursuant to this

paragraph will not require training in excess of 120 minutes per task. Other than the additions set forth in the preceding sentences, the Companies will not add any additional cross functional duties in calendar year 2013 or any succeeding calendar year, absent the Union's agreement. The assignment of any duties pursuant to paragraphs 14, 15 and/or 16 will not entitle associates to additional pay.

17. FSC and EVRC representatives will only make sales that are initiated by the customer. FSC and EVRC representatives will also transfer the following types of sales to CSSCs, BSBCs and MSSCs even if the services are requested by the customer: HSI to FiOS service, new video service (FiOS or DirecTV orders), new data service (HSI or FiOS), and changes to bundle packages to add data or video. Types of calls that are currently routed through the ERS to CSSCs, BSBCs and MSSCs will continue to be routed to CSSCs, BSBCs and MSSCs, and types of calls that are currently routed through the ERS to FSCs and EVRCs will continue to be routed to FSCs and EVRCs. While customers may provide insufficient or incorrect information through the ERS that can result in misrouting, if the customer's identified reason for a call routed through the ERS is a sales or billing matter, the ERS will seek to route such calls to CSSC, BSBC or MSSC representatives. If the customer's identified reason for a call routed through the ERS is a problem with the functioning of a service, the ERS will seek to route the call to FSC or EVRC representatives.

18. Beginning upon ratification of this 2012 MOU, training for the Computer and Internet Knowledge Test ("CIKT") will be offered to Maintenance Administrators (MAs) and Repair Service Clerks (RSCs) up to two times and will be provided during normal work hours. Any MA or RSC who had previously taken training for the CIKT will be eligible for training one additional time. Once an associate successfully passes the CIKT, training for the Fiber Customer

Support Analyst ("FCSA") position will be scheduled and classes will begin once enrollment meets the minimum class size requirement at the Companies' discretion, consistent with business needs. In connection with the foregoing, current MAs and RSCs in the EVRCs will not be required to participate in a Fiber Customer Support Analyst Structured Interview Revised. MAs and RSCs who do not qualify for the FCSA position, or who do not pass training, will continue to perform MA or RSC functions and will be subject to normal retest guidelines.

19. Maintenance Administrators ("MAs") and RSCs in the EVRCs (English-speaking only) and FSCs will be tested for FCSA positions, and MAs and RSCs who test qualify and pass training will become FCSAs and will be assigned FCSA work, which can support fiber or copper network customers. Every MA and RSC in Mid-Atlantic EVRCs/FSCs will be offered testing and training for FCSA positions.

20. Beginning within eighteen months of ratification of this 2012 MOU, when High Speed Internet ("HSI")(copper DSL) technical support calls arrive at an FSC or EVRC, either because they are misdirected or otherwise, the FSC or EVRC will provide the appropriate resolution with associates who are test-qualified and trained in HSI work. When such calls arrive at a CSSC, BSBC or MSSC, the associates will attempt a resolution involving tasks which management determines to assign consistent with the technical support lists set forth above (including any tasks added to that list in the future, consistent with the terms of paragraph 16 above). If those actions will not resolve the issue the call will be transferred to HSI technical support. Customer calls for HSI technical support may be routed to FSCs or EVRCs, such as when FSCs or EVRCs are not fully occupied with other calls, but such calls shall not be required to be routed to FSCs or EVRCs rather than to HSI technical support center contractors.

21. Nothing in this Article X – Sharing of Calls Among Centers modifies, alters or diminishes the Companies' obligations regarding calls under the "Simpkins EVRC Award" of December 2004, or the agreement under the Pennsylvania "FSC Agreement" of 2010. Further, this call sharing agreement does not supersede either the Simpkins EVRC Award or the FSC Agreement.

22. During the term of this 2012 MOU the Company will maintain a CSSC, BSBC and MSSC presence in Mid-Atlantic. The Company's obligation to maintain a CSSC, BSBC and MSSC presence in Mid-Atlantic will terminate with the expiration of this 2012 MOU and at that time the parties' rights and obligations with respect to maintaining a CSSC, BSBC and MSSC presence in Mid-Atlantic will return to those in effect prior to the effective date of this 2012 MOU.

XI. <u>SALES COMPENSATION PLAN TITLES</u>

The agreement between the Companies and the Union regarding the discussion of additional Sales Compensation Plan Titles and Sales Compensation during the term of the 2012 MOU is set forth in Attachment 1.

XII. <u>ABSENCE FROM DUTY</u>

A. Effective January 1, 2013:

1. Payment for days scheduled but not worked during the period of seven consecutive calendar days or less beginning with the first day of each absence due to an employee's personal illness or off-duty accident will be capped at ten days. Part-time employees will also be capped at 10 paid days, but the number of hours part-time employees will

be paid for each day will be pro-rated based on the number of hours such employees are normally scheduled to work, in the same manner that the Company pro-rates vacation and other paid time for part-time employees. For example, a part-time employee who always works 22.5 hours per week will receive no more than 45 hours of paid incidental absence in a calendar year.

2. All employees may take up to four (4) incidental absence days in a calendar year which shall not be charged against an employee's record for purposes of determining attendance performance on the Company's applicable absence control plan ("Exempt Days"). Incidental absence days, in excess of the four (4) Exempt Days, may be treated in accordance with the Company's applicable absence control plan. This Section XII.A.2 will not apply to an associate until such associate reaches one year of net credited service. The number of Exempt Days for such an associate will be prorated in the year he or she reaches one year of net credited service as follows: (a) an associate who reaches one year of net credited service in the first quarter of the calendar year will receive four (4) Exempt Days; (b) an associate who reaches one year of net credited service in the second quarter will receive three (3) Exempt Days; (c) an associate who reaches one year of net credited service in the third quarter will receive two (2) Exempt Days and (d) an associate who reaches one year of net credited service in the fourth quarter will receive one (1) Exempt Day. This Section XII.A.2 will have no application to tardiness.

3. Employees who use four days or fewer of paid or unpaid incidental absence in a calendar year will receive the following lump sum payment, prorated for part-time employees, which will be paid no later than the first paycheck in March of the following year. All existing provision(s) pertaining to unpaid incidental absence, including waiting days, will continue in full force and effect.

Number of Paid or Unpaid Incidental Absence Days Used in the Calendar 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 day's pay

B. Prorating Lump Sum Payment for Working a Partial Year.

Eligibility: Regular, Term and Temporary employees who are hired for an assignment expected to last more than one year must be on the payroll for at least 90 days during a calendar year, excluding time not on the job due to SADBP absence and paid and unpaid leave, to be eligible for a lump sum payment pursuant to Section XII.A.3. Temporary employees who are hired for an assignment expected to last one year or less are ineligible for a lump sum payout pursuant to Section XII.A.3. Employees who are discharged for cause on or before December 31 of the calendar year will not be eligible to receive a lump sum payment pursuant to Section XII.A.3.

Proration: The lump sum payment pursuant to Section XII.A.3 will be prorated by twelfths to correspond to the number of months the employee was on the payroll during the calendar year, exclusive of SADBP absence and paid and unpaid leaves. For purposes of proration, a month will be taken into account if the employee was on the payroll on any day of the calendar month, and not on SADBP or other paid or unpaid leave for the entire month.

C. For purposes of incentive pay under this provision, a day's pay shall be paid under this Article at one-fifth the employee's basic weekly rate, excluding differentials and overtime.

D. Paid incidental absence days will count towards the applicable annual cap. Unpaid waiting days will not count towards the applicable annual cap.

XIII. TIME OFF

Vacations – The following replaces the previous Vacation Scheduling Percentages Agreement in its entirety:

At least 18% of the employees in each vacation administrative work group shall be permitted to schedule time off in a given week, except that 12% will apply to requests for vacation time submitted fewer than five business days in advance of the requested days(s) off.

Where the application of the percentage figures specified above results in other than a whole number, the number yielded will be rounded up to the next whole number.

Regarding vacation availability during traditional fall hunting season and the December holiday season, management will make a reasonable effort to consider the need for higher availability.

Those work groups whose vacation availability is currently greater than the percentages specified above, will not be required to reduce their vacation scheduling availability.

XIV. TUITION ASSISTANCE PLAN

Except as otherwise provided for herein, the Tuition Assistance Plan ("TAP" or "the Plan") and every other tuition assistance plan or program will be modified as follows effective January 1, 2013:

A. <u>Cap</u>: There will be an annual cap on tuition assistance for eligible regular full time associates of $8,000.00 under TAP. There will be an annual cap for eligible part time associates of $3,500.00

B. <u>Exclusions and Limitations</u>: The following exclusions and limitations are added to the existing exclusions and limitations set forth in the Plan: a course of study leading to a degree or certification/license in the areas of aviation or medicine will not be covered, except in the case of associates already participating in or approved for Fall 2012 semester courses in the areas of medicine or aviation. Such associates will be grandfathered under the terms of the existing Plan as otherwise modified by this 2012 MOU until the degree or certification/license is attained.

C. <u>Repayment Obligations</u>: The repayment obligation and payment of tuition and fees set forth in the existing Plan are modified as follows:

1. Associates currently in arrears on repayment obligations will have until 30 days after ratification of this 2012 MOU to repay money owed, or agree to a payment plan for full repayment within twelve months. If the associate fails to abide by this paragraph C.1, or fails to fully comply with such payment plan by making all payments on time, the associate will be subject to the eligibility considerations set forth in paragraph C.3 below.

2. Associates who during the term of the contract incur a repayment obligation must satisfy the obligations set forth in either paragraph C.2.a or C.2.b below or they will be subject to the eligibility considerations set forth in paragraph C.3 below:

(a) complete repayment within 90 days after notification by the Plan Administrator, or

(b) agree within 30 days after notification by the Plan Administrator to a payment plan for full repayment within twelve months and fully comply with such payment plan by making all payments on time.

3. Associates who fail to comply with their repayment obligation as set forth herein will be ineligible for future participation in the TAP until they have satisfied their repayment obligation in full, at which point their eligibility will be restored. If such an associate whose eligibility is restored subsequently participates in the Plan, the associate will be required to pay all monies owed for future TAP-eligible courses directly to the educational institution. The Companies will reimburse to the associates amounts authorized to be paid under the Plan if, within sixty days of the course end date, the associate submits a receipt from the educational institution showing the amount of tuition paid for the course(s).

XV. WORK AT HOME ARRANGEMENTS

The agreement of the Companies and the Union regarding Work at Home Arrangements is set forth in Attachment 2.

XVI. NATIONAL HEALTH CARE REFORM

The agreement of the Companies and the Union regarding health care reform, which is set forth in the 2008 MOU, is eliminated and the Labor Management Partnership for Health Care Reform is dissolved.

XVII. MEDICAL RESTRICTION LEAVE OF ABSENCE

An associate who is or will be medically restricted from performing one or more essential functions of his/her normal assignment for more than 150 days will be placed on a Leave of Absence in accordance with the Medical Restriction Leave of Absence Policy Amendment contained in Attachment 4.

XVIII. ELIMINATION OF STRESS LETTER OF UNDERSTANDING

The Stress Letter of Understanding from the 1998 MOUs, which was incorporated by reference into the 2008-2011 MOU, and any related letters and agreements in the expired CBAs that implemented the 1998 Stress Letter of Understanding are eliminated and replaced by the Common Interest Forum Letter of Understanding set forth in Attachment 5.

XIX. HEALTH CARE OVERSIGHT COMMITTEE (HCOC)

The new Health Care Oversight Committee, its composition and responsibilities are set forth in Attachment 6.

XX. HEALTH CARE BENEFIT COORDINATORS

On or before November 1, 2012, the Companies will offer existing incumbents in the Health Care Benefit Coordinator and Retiree Health Care Benefit Coordinator positions an Enhanced Income Security Plan with an off-payroll date of on or before December 29, 2012. The Company may also offer additional EISP offers any time thereafter. If one or more incumbents accept an EISP offer, or if an incumbent leaves the position for any other reason, the Company will staff to three CWA Health Care Benefit Coordinator positions consistent with Attachment 7

Section 2. The CWA Health Care Benefit Coordinators' pay and responsibilities are set forth in Attachment 7.

XXI. NEW CONTRACTING INITIATIVES

The New Contracting Initiatives letter of agreement which is set forth in the 2008 MOU, is amended as set forth in Attachment 8.

XXII. MODIFICATION OR ELIMINATION OF CERTAIN COMMERCIAL PROVISIONS

The following provisions of the Commercial Stress Relief Package that were first adopted as part of the 2000 Common Issues Memorandum of Understanding, and any other contractual provisions, or any other agreement, policy or past practice related to the same subjects, are eliminated or modified as follows:

V. Commercial Stress Relief Package

***

Evaluative Observations

***

1) (a) Consultants in Potomac and New Jersey will receive advance notification of evaluative observations except for Consultants who received an overall rating of "Needs Improvement", "Does Not Meet Requirements", or "Not Rated" on their most recent annual or mid-year evaluation under the Associate Appraisal Plan in performance only. Other than the frequency of the evaluations, this provision does not change the current practice.

(b) For example, if as a result of an annual evaluation rating of "Needs Improvement" under the Associate Appraisal Plan in performance only a

Consultant does not receive advance notice of evaluative observations and that Consultant thereafter receives a mid-year evaluation rating of "Meets Requirements" under the Associate Appraisal Plan in performance only, the Consultant will receive advance notice of evaluative observations following the "Meets Requirements" mid-year rating.

(c) Existing practices in Pennsylvania and Delaware with respect to the quarterly evaluation of Consultants will remain in effect for the term of the successor collective bargaining agreements/MOUs.

***

4) Except in the case of Mondays and the day after a holiday, when Consultants are scheduled for overtime, evaluative observing may take place during the first eight paid hours of a scheduled work day for employees with a basic 35 hour work week, or during the first 8.5 hours for employees with a basic 37.5 hour work week. On a Monday and the day after a holiday evaluative observations must continue to take place during the first 7/7.5 hours of the scheduled work day.~~Evaluative observing will take place only during the first 7 paid hours of a scheduled work day for employees with a 35 hour basic work week, or during the first 7.5 paid hours of a scheduled work day for employees with a 37.5 hour basic work week. If the Company determines that a Consultant's performance is substantially different during periods of diagnostic evaluation, as compared to periods of evaluative observation, evaluative observations may be conducted on that Consultant beyond the first 7 hours or 7.5 hours, whichever applies~~.

Closed Time

***

If a Consultant is offline for the entire day, either because the Consultant is on medical restrictions or for any other reason, the Consultant may not receive closed time on that day.

***

Unless the parties expressly agreed to modifications of the various provisions of the expired collective bargaining agreements/MOUs that constitute the commercial stress relief package, those provisions shall remain in full force and effect in the successor collective bargaining agreements/MOUs.

XXIII. ELECTRONIC RECORDING OF CALLS

The provisions of this Article XXIII only apply to electronic recording of calls.

1. The terms of the Service Quality Observing Letters and Articles, Service Quality and Supervisory Observing Article and all other agreements, practices and arbitration awards relating to the observation and evaluation of employee performance will remain in effect and apply to recorded calls, except as modified by the terms of this Article XXIII - Electronic Recording of Calls Agreement or other provisions of the 2012 MOU, and except that the Pennsylvania "Telsam" Award in arbitration case 1822-84, dated February 20, 1986 is no longer in effect. In addition, the Evaluative Observations Agreement, as revised in 2012 (attached as Schedule A), shall apply to recorded evaluative observations of Consultants.

2. For purposes of Supervisory and Service Observing, the Company may electronically record contacts with customers and service-related contacts with other employees.

3. The Company shall not use electronically recorded calls for any reason except as specifically identified in this agreement. The electronic recording of calls will be used for Service Observing (which measures the overall speed, accuracy and efficiency of our telecommunications network and workforces) and Supervisory Observing (which includes Evaluative Observing for determining the quality of individual employee performance and Diagnostic Observing used for individual training and development).

4. The Company will provide the Union with thirty (30) days notice before implementing electronically recorded Supervisory (Evaluative and Diagnostic) observations in any office.

5. No employee will be disciplined as a result of Service Observing or Diagnostic Observing except for gross customer misconduct (abusive, discourteous behavior towards the customer or dumping/hanging up on the customer) or violations of the Verizon Code of Conduct (sales integrity, slamming, violations of secrecy of communications, falsification of records, failure to perform regulatory requirements or conducting non-business related activities with a customer on line). Failure to attempt to sell a feature, or to bridge, is not considered gross customer misconduct or a violation of the Verizon Code of Conduct. When calls are electronically recorded, such discipline may only be imposed provided the Company endeavors to provide face-to-face feedback on Service and Diagnostic observations by the close of the day on which the observation was taken but in no event later than the close of the next business day on which both the associate and the supervisor who conducted the observation are on the job and are working at a common work location for their tours. ("Conducted the observation" refers to the supervisor who either conducted a live observation or listened to an electronically recorded call.)

6. Grounds for discipline regarding recorded Evaluative Observations are the same as for unrecorded Evaluative Observations.

7. Electronically recorded calls will be erased after ninety (90) days. Notwithstanding the foregoing, electronically recorded call(s) may be preserved if discipline has been imposed relating to such call(s) or if a call is being preserved for general training purposes (e.g., using the call as an example). For audit and compliance reasons, the Company can preserve some calls for up to a year, which the Company anticipates will be no more than one percent of the total volume of calls. Employees' personal calls will not be observed or

electronically recorded. The Company will provide employees with access to telephones not connected to any type of recording device.

8. Electronic monitoring and call recording equipment and systems will be secured and accessible only to authorized personnel. The identity of the employee being recorded will not be released to any unauthorized persons, which includes other bargaining unit members, except for use in grievance, arbitration and/or legal proceedings. Employees will only be required to listen to electronic recordings of themselves. Employees may be assigned to listen to other employees' recorded calls only for training purposes and only after the recorded employee has provided written permission for the Company to use his or her call.

SCHEDULE A

EVALUATIVE OBSERVATIONS

This letter will confirm our agreement to modify evaluative observation practices for certain Consultants in all lines of business for the life of the 2012 collective bargaining agreement.

The modifications to evaluative observation practices for Consultants in all lines of business are as follows:

1) Consultants in Potomac and New Jersey will receive advance notification of evaluative observations except for Consultants who received an overall rating of "Needs Improvement", "Does Not Meet Requirements", or "Not Rated" on their most recent annual or mid-year evaluation under the Associate Appraisal Plan in performance only. Other than the frequency of the evaluations, this provision does not change the current practice.

   For example, if as a result of an annual evaluation rating of "Needs Improvement" under the Associate Appraisal Plan in performance only a Consultant does not receive advance notice of evaluative observations and that Consultant thereafter receives a mid-year evaluation rating of "Meets Requirements" under the Associate Appraisal Plan in performance only, the Consultant will receive advance notice of evaluative observations following the "Meets Requirements" mid-year rating.

Existing practices in Pennsylvania and Delaware with respect to the quarterly evaluation of Consultants will remain in effect for the term of the successor CBAs/MOUs.

2) The Company will endeavor to provide face-to-face feedback on observations by the close of the day on which the observation was taken but in no event later than the close of the next business day on which both the Consultant and the team leader who conducted the observation are on the job and are working at a common work location for their full tours.

3) Except for Mondays and the day after a holiday, when Consultants are scheduled for overtime, evaluative observing may take place during the first 8 paid hours of a scheduled work day for employees with a 35 hour basic work week, or during the first 8.5 paid hours for employees with a basic 37.5 hour work week. On a Monday and the day after a holiday, the evaluative observations must continue to take place during the first 7/7.5 hours of the scheduled work day. If the Company determines that a Consultant's performance is substantially different during periods of diagnostic evaluation, as compared to periods of evaluative observation, evaluative observations may be conducted on that Consultant beyond the first 8 hours or 8.5 hours, or 7/7.5 hours on Mondays and the day after a holiday, whichever applies.

4) On an annual basis, evaluative observations will be limited in frequency as follows:
   - 20 observations for Consultants who received an overall rating of "Exceeds Requirements" on their most recent annual evaluation under the Associate Appraisal Plan;
   - 30 observations for Consultants who received an overall rating of "Meets All" on their most recent annual evaluation under the Associate Appraisal Plan; and

- 40 observations for Consultants who received an overall rating of "Needs Improvement", "Does Not Meet", or "Not Rated" on their most recent annual evaluation under the Associate Appraisal Plan.

5) It is expressly understood that these modifications do not apply to diagnostic evaluations, which are not appraisal-impacting.

XXIV. ADVISORY COUNCIL ON FAMILY CARE

The Advisory Council on Family Care ("ACFC") will continue with the following modifications:

a. Annual funding by the Companies for the ACFC will be $1.28 million per contract year.

b. The existing ACFC Coordinator letter is renewed with an expiration date of December 31, 2013.

All other provisions of the collective bargaining agreements/MOUs covering the ACFC under the expired collective bargaining agreements/MOUs, including the funding provisions of those agreements, that are not expressly modified by this 2012 MOU will remain in full force and effect in the successor collective bargaining agreements/MOUs.

XXV. TRAINING ADVISORY BOARD EXECUTIVE COUNCIL

The Training Advisory Board Council ("TABEC") will continue with the following modifications:

a. Annual funding by the Companies for the TABEC will be $1.69 million per contract year.

b. Any unused funds in the TABEC account as of August 6, 2011 will be carried forward to be used under the successor to the 2008 collective bargaining agreements/2008 MOU. In the future, unused funds will not be carried forward to subsequent collective bargaining agreements/MOUs and will be forfeited except as required to satisfy bills and charges incurred during the term of this 2012 MOU.

All other provisions of the collective bargaining agreements/MOUs covering the TABEC under the expired collective bargaining agreements/MOUs, including the funding provisions of those agreements, that are not expressly modified by this 2012 MOU will remain in full force and effect in the successor collective bargaining agreements/MOUs.

XXVI. ADDITIONAL CENTER JOBS AGREEMENT

The Agreement Regarding Additional Center Jobs is set forth in Attachment 9.

XXVII. AGREEMENT REGARDING FIOS DISCOUNT

The agreement regarding a FiOS discount is set forth in Attachment 10.

XXVIII. 2012 MEMORANDUM OF AGREEMENT

The 2012 Memorandum of Agreement, which updates the 2008 Memorandum of Agreement, is set forth in Attachment 11.

XXIX. DURATION

All provisions of the parties' agreeIments will remain in full force and effect until 11:59 p.m. on August 1, 2015.

September 19, 2012

ATTACHMENT 1

September 19, 2012

Mr. Dennis Trainor
Assistant to the Vice President
Communications Workers of America
80 Pine Street -37th Floor
New York, New York 10005

Ms. Gail Evans
Administrative Director to the V.P.
CWA District 2-13, AFL-CIO
9602D Martin Luther King Jr. Highway
Lanham, Maryland 20706

Mr. Myles J. Calvey
Chairman, System Council T-6
International Brotherhood of Electrical Workers AFL-CIO
1137 Washington Street
Dorchester, MA 02124

Ms. Mary Jo Arcuri
Business Manager
International Brotherhood of Electrical Workers,
AFL-CIO, Local 2213
One Telergy Parkway
6333 Route 298 – Suite 103
E. Syracuse, NY 13507

Dear Messrs. Trainor and Calvey and Mmes. Evans and Arcuri:

This will confirm our agreement that the parties to the 2012 MOUs covering the Communications Workers of America, AFL-CIO, Local 2213 and Council T-6 and its affiliated Locals of the International Brotherhood of Electrical Workers, AFL-CIO will jointly meet periodically to discuss the addition of Sales Compensation Plan titles, and variable compensation for these titles, during the term of the 2012 MOU. The parties' first meeting shall take place within 90 days after ratification of the 2012 MOU. Absent mutual agreement of the parties, the Company will not add Sales Compensation Plan titles to any bargaining unit.

Very truly yours,

Joseph Gimilaro
Executive Director – Labor Relations

September 19, 2012

Patrick Prindeville
Executive Director – Labor Relations

AGREED:

CWA

By:____________________________
Gail Evans
Administrative Director to the V.P.

By:____________________________
Dennis Trainor
Assistant to the Vice President

System Council T-6, IBEW
AFL-CIO

By:__________________________________
Myles J. Calvey
Chairman, System Council T-6

IBEW, Local 2213

By:_____________________________________
Mary Jo Arcuri
Business Manager

September 19, 2012

ATTACHMENT 2

WORK AT HOME

For a trial period beginning on the Effective Date and ending on December 31, 2013, the Companies may implement work at home arrangements at two locations. The Companies shall select the locations with the agreement of the Union, which shall not be unreasonably withheld. The participating associates' wages, benefits coverage and other terms and conditions of employment including but not limited to tour selection, vacation scheduling (vacation weeks, days, EWDs, etc.) and overtime scheduling will continue to be governed by the applicable collective bargaining agreements. Associates will be expected to comply with the same rules and policies of the Companies with which all associates must comply. During the trial, the Companies will meet with the Union quarterly to discuss any concerns that may arise. Additional terms, conditions and principles for associates working at home are as follows:

1. The Companies will designate the specific job titles and work groups eligible for each work at home arrangement with the agreement of the Union, which shall not be unreasonably withheld.
2. The Companies will select associates who volunteer in the eligible job titles and designated work groups, by seniority, who have the following qualifications:
    a. A current overall performance rating of Exceeds Requirements or Meets Requirements;
    b. At least six months experience in the associate's present title and at least one year of net credited service;

c. The at-home work location has adequate space with privacy and sufficient electric power and outlets for all equipment necessary to perform the associate's work;

d. No deed, lease, condominium or co-op restrictions would be violated by performance of the work at the home residence. The associate is accountable for determining such occupancy/use restrictions; and

e. The associate's residence or home must have broadband capability with a minimum of 3 MB upload and 3 MB download bandwidth.

3. The associate's normal reporting location when not working at home will remain unchanged provided the employee would not have been relocated had he or she not taken the work at home assignment. All work schedules will be posted electronically. No payment for mileage or travel time will be made when the associate is directed to report to his/her normal reporting location for meetings with his/her supervisor or training, or when the associate visits the location to pick up work related materials. Regardless of the geographic relationship between this normal reporting location and the work at home location, the associate's Local Union alignment will continue to be controlled by the normal reporting location – not the work at home location. The associate is required to notify his manager at least four weeks in advance of any planned change of residence.

4. The Companies will bear the cost of providing a Verizon computer with agent image, headset, and business voice service. Bargaining unit employees will install and maintain computer equipment and landlines provided by the Company. All equipment and items provided must only be used for business purposes. To

the extent an associate requires an accommodation, the Companies will provide equipment and items required by law. All Verizon equipment and other materials provided to an associate in connection with the work at home arrangement and all equipment, materials, correspondence, records, documents, software, promotional materials and other Company property, including all copies, summaries, synopses or portions thereof, which come into the associate's possession, whether or not created by the associate, and regardless of whether they were received by the associate at his/her residence, will at all times remain the sole and exclusive property of the Companies. At any time that the Companies request, and immediately upon the termination of an associate's employment, the associate will return to the Companies all such Company property, and will not keep any copies of such Company property. An accepted ISP/EISP volunteer must return all Company property no later than seven days prior to his or her off payroll date otherwise he/she will not receive the ISP/EISP payment until such equipment is returned in working condition. Removal and return of Company-provided computer equipment, landlines and/or related peripherals will be performed by either the employee or another bargaining unit member.

5. The work at home arrangement must enable the supervisor to evaluate associate performance, certify the accuracy of time sheets and attendance records and perform other supervisor responsibilities to the same extent as if the participating associate were working at his/her normal reporting location. Associates will be required to: (i) be logged into the Companies' instant messaging ("IM") system during all work hours, and (ii) send an IM or e-mail to their supervisor at the

commencement of their shift in order to be recorded as having timely reported to work. Supervisors will call the associate’s home for work related matters and may make announced and unannounced home visits.

6. The participating associate will be responsible for providing the broadband connection, a quiet and safe work environment, ergonomic furniture, utilities and liability homeowners or renters insurance. Associates will take all steps necessary to ensure that all Company equipment that is used in the residence is covered by such insurance policies and must supply the Company with the applicable insurance certificate if required to do so. If an associate already has liability, homeowners or renters insurance but must purchase additional liability, homeowners or renters insurance as a result of working at home, the Companies will reimburse the associate for the cost of any such additional insurance. In the event the associate receives any insurance payment arising from the insured loss of any Company property, he/she must immediately remit payment to the Company.

7. It is the associate‘s responsibility to use Company equipment in a reasonable and safe manner and to protect Company equipment and software against damage, abuse, misuse or other violation of existing rules of the Companies concerning protection of its property and information. Associates may not use Company equipment, materials, systems or software in any manner or for any purpose that violates the Companies’ policies, the Verizon Code of Conduct, or federal, state or local laws. Associates will adhere to the Companies’ policies regarding the protection of Company information from disclosure to third-parties who do not

have a need to know such information. No third party, including family or friends, may use Company equipment or software for any reason.

8. Associates will work their full tours, including split tours where such tours are permitted by existing collective bargaining agreements and will adhere to their work schedule. They will also begin work on time and give their full time and attention to the performance of their job duties. Work at home time will not be spent on dependent care activities. In the event associates need to leave their work positions at times other than scheduled breaks and the lunch hour (e.g., feeling ill), they must first confer with supervision and secure permission. If an emergency situation develops requiring immediate action on the part of the associate, he/she should react appropriately then notify his/her supervisor as soon as practicable. Upon returning to their work positions, associates must inform supervision. Associates will be expected to communicate to their family members and friends that distractions such as personal telephone calls, visitors and interruptions by children while on duty can be very disruptive to their ability to perform the job, and should be limited to emergencies. During working hours, associates will not be permitted to invite business visitors or social guests of the associate to their residence without the express written authorization of their supervisor.

9. Associates will be expected to keep their work at home area free from potential hazards and obstructions, and generally to treat it as if it were a primary Company office. If an associate suffers a work-related injury or illness in his/her residence, the associate must report the injury or illness in accordance with Company policy.

10. Associates will be expected to inform supervision expeditiously of the malfunction of any work-at-home equipment. Supervision may require the associate to report to the normal reporting location or other Company work location until malfunctioning equipment is repaired and/or replaced. As per Paragraph 3 above, no payment for mileage or travel time will be made when the associate is directed to report to his/her normal reporting location.

11. Associates may be required to report to Company or non-Company locations for purposes such as supervisor meetings, medical visits, training sessions and policy/practice coverage. Associates will be given notice of such meetings by noon the day before.

12. Emergency call outs and overtime will be handled as outlined in the applicable collective bargaining agreement and/or local practice provided it does not violate any applicable collective bargaining agreement. Overtime must be approved in advance by the associate's supervisor or authorized designee, unless an associate is in the process of completing a customer call.

13. Upon thirty days' notice to the Companies, an associate may withdraw from and discontinue a work at home arrangement. The Companies will provide an associate with fourteen (14) days' notice of a Company decision to remove the associate from a work at home arrangement. Notwithstanding the foregoing, when an associate is removed for performance reasons or a violation of the Verizon Code of Conduct the associate will be notified no later than noon the day before.

14. The Companies will designate one work day per month at the associate's normal reporting location. Associates will have the option of working from their normal reporting location or from home on that day. The Companies will notify the Union at least 48 hours in advance of the designated date. If requested by the Local Union representative or steward, associates will be permitted on a voluntary basis to meet with the representative or steward on such days. Such meeting will be permitted to occur for up to thirty minutes during normal work time at the Companies' discretion. If requested by the Local Union representative or steward, the Companies will permit such meetings to occur for up to forty-five minutes during normal work time during the months of March and September only, on a day scheduled at the Companies' discretion. Pay for any such meeting will be limited to the associate(s) participating in the meeting. The Union representative conducting the meeting shall not be paid by the Company for that time. As per Paragraph 3 above, no payment for mileage or travel time will be made when the associate is directed to report to his/her normal reporting location.

15. Alleged violations of this Article XV – Work at Home Arrangements are subject to the grievance and arbitration procedures of the applicable collective bargaining agreements.

ATTACHMENT 3

September 19, 2012

Ms. Gail Evans
Administrative Director to the V.P.
CWA District 2-13, AFL-CIO
9602D Martin Luther King Jr. Highway
Lanham, Maryland 20706

Dear Ms. Evans:

This will confirm our agreement that the protections against involuntary layoff, forced transfer and downgrade contained in the BA-GTE Merger Agreement will apply to the thirteen Multi-Media Services Technicians listed below that are currently employed by Verizon Connected Solutions, Inc. ("VCS"), in the event that he or she becomes employed in a bargaining unit position by a 2012 MOU Company immediately following his or her departure from employment with VCS.

1. Tenise A. Pope
2. David S. Allen
3. Randall Evans
4. Robert William Rollins, III
5. Robert B. Washington
6. Evelyn C. Strong
7. Lisa E. Crosse
8. David K. Shorts
9. Karen A. Gilbers
10. Donald Gary
11. Mark Anthony Rivera
12. Frederick A. Spain
13. David Hunter

Very truly yours,

Joseph Gimilaro
Executive Director – Labor Relations

AGREED:
COMMUNICATIONS WORKERS
OF AMERICA

By:____________________________
Gail Evans
Administrative Director to the V.P.

September 19, 2012

ATTACHMENT 4

MEDICAL RESTRICTION LEAVE OF ABSENCE POLICY AMENDMENT

This Medical Restriction Leave of Absence (MR-LOA) Policy is an Amendment to the 1998 Medically Restricted Policy. This Amendment applies to associates employed by Verizon Pennsylvania Inc., Verizon Delaware Inc., Verizon New Jersey Inc., Verizon Virginia Inc., Verizon Maryland Inc., Verizon Washington DC Inc., Verizon Services Corp., Verizon Advanced Data Inc., Verizon South Inc. (Virginia) and Verizon Corporate Services Corp. ("Company" or "Companies") whose normal reporting location is in Pennsylvania, Delaware, New Jersey, Maryland, Virginia, the District of Columbia or West Virginia.

This Amendment addresses the treatment of associate employees who are determined to be able to work but have medical restrictions that may prevent performance of all of the essential functions of their normal assignment with or without reasonable accommodation ("Medically Restricted Employees"). Such Medically Restricted Employees may qualify for a Medical Restricted Leave of Absence ("MR-LOA"), as determined by the Company.

When a supervisor is notified that an employee has a medical restriction from his/her normal assignment of any duration, he will ask the employee if there are any reasonable accommodations that s/he believes would enable him/her to perform the essential functions of the current job. The supervisor will then immediately consult with Human Resources to determine whether the essential functions of the current job can be performed with or without reasonable accommodations. If the essential functions of the job can be performed, the employee will continue in the current assignment.

If Human Resources, the supervisor, and the Workplace Accommodations Team (formerly known as the Reasonable Accommodations Committee) determine that one or more of the essential functions of the current job cannot be performed with or without reasonable accommodation, employees will be treated as follows:

A. <u>Employees on the payroll as of (date of Agreement):</u>

- Employees with Medical Restrictions lasting 150 or fewer days: During the first 150 days, (including any medically restricted days during the preceding 24 months in which one or more essential job functions could not be performed), the employee will be assigned work that s/he is able to perform for the duration of the restriction up to a maximum of 150 days in any rolling 24 month period. All references to "days" continue to mean calendar days.

- Employees with Medical Restrictions lasting more than 150 days: An employee who is medically restricted for more than 150 days (including any days during the preceding 24 months in which one or more essential job functions could not be performed due to a medical restriction), and for whom no Suitable Work is available as defined in the 1998 Medically Restricted Policy, will be placed on a MR-LOA effective on the 151st day of medical restriction If the employee is ineligible for MR-LOA, the employee shall be provided any leave for which s/he is eligible under the Family Medical Leave Act ("FMLA").

B. Employees Hired After (date of Agreement) ("New Hires"):

- Employees hired after (date of Agreement) ("New Hires") shall not become eligible for paid time at work while Medically Restricted or an unpaid MR-LOA until the New Hire has worked 1250 hours.

- New Hires with less than 3 years of service: During the first 60 days, (including any medically restricted days during the preceding 24 months in which one or more essential job functions could not be performed), the employee will be assigned work that s/he is able to perform for the duration of the restriction up to a maximum of 60 days in any rolling 24 month period.

- New Hires with less than 3 years of service: A New Hire with less than 3 years of service who is medically restricted for more than 60 days (including any days during the preceding 24 months in which one or more essential job functions could not be performed due to a medical restriction), and for whom no Suitable Work is available as defined in the 1998 Medically Restricted Policy, will be placed on a MR-LOA effective on the 61st day of medical restriction. If the New Hire is ineligible for MR-LOA, the New Hire shall be provided any leave for which s/he is eligible under the FMLA.

C. The terms and conditions of a MR-LOA are as follows:

1) The MR-LOA is without pay. The benefits applicable during an MR-LOA are listed at Attachment A.

2) The MR-LOA will not exceed 52 weeks in total from the date the medical restriction was first approved ("52 week period"), including time on restriction during the prior 24 rolling calendar months. For New Hires with less than 3 years service, the MR-LOA will not exceed 26 weeks in total from the date the medical restriction was first approved ("26 week period"), including time on restriction during the prior 24 rolling calendar months. FMLA leave and an MR-LOA run concurrently.

3) While on a MR-LOA, the Company will continue to look for Suitable Work**,** first within the employee's bargaining unit and then within the respective state (Virginia, Washington DC, Maryland and West Virginia are considered as one bargaining unit and state). If Suitable Work is found in an equivalent or lower paying position within 35 miles of the employee's existing commute, the employee will be offered such position. The employee

will be expected to report to work at the offered position/location within 7 calendar days. If the employee does not accept the position, the MR-LOA will end, and the employee will be dropped from the payroll and will receive no termination allowance. If the employee does accept the position, the employee's wage treatment and right of return will be governed by the 1998 Medically Restricted Policy "Disability Wage Adjustment Table".

4) While on a MR-LOA, the employee will accrue whatever service for pension eligibility he would have accrued if still working and will be eligible for benefits as outlined in Attachment A.

5) While on a MR-LOA, the employee will be expected to comply with requests for information from the Company's benefits plan administrator (presently MetLife). Failure to comply with MetLife's requests will result in the expiration of the MR-LOA and the employee will be dropped from the payroll with no termination allowance.

6) While on a MR-LOA, the employee may engage in paid employment from another employer that does not conflict with the employee's medical restriction. Prior advance approval must be obtained from the Company or its authorized administrator.

7) If MetLife deems the employee is no longer medically restricted from performing all of the essential functions of their normal assignment, MetLife will inform the employee that s/he is fit to return to work.

8) If the Medically Restricted Employee has not returned to work at the end of the 52 week period (or 26 week period for New Hires with less than 3 years of service) the employee will be dropped from the payroll (unless eligible for FMLA leave) and will be eligible to apply for Long Term Disability. If the employee does not qualify for Long Term Disability, the employee will receive a termination allowance equivalent to the layoff allowance amount defined in the respective collective bargaining agreement (Potomac – Article 37). For New Hires with less than 3 years of service, the termination allowance will be 50% of the layoff allowance amount defined in the respective collective bargaining agreement (Potomac – Article 37).

9) If an associate returns from a MR-LOA and has a subsequent medical restriction that prevents the employee from performing one or more of the essential functions of the normal assignment within 24 months of an earlier medical restriction or restrictions, the prior medical restriction(s) will be used to calculate the remaining MR-LOA eligibility based on all days the employee was restricted from performing essential job functions at work during the 24 months preceding the start of the current medical restriction. At the end of the 52 week period as a Medically Restricted Employee (or 26 week period for New Hires with less than 3 years of service), if the employee remains unable to perform one or more of the essential functions of his/her normal assignment, and no Suitable Work is available, the employee will be dropped from the payroll (unless eligible for FMLA leave) and be eligible to apply for Long Term Disability. If the employee does not qualify for Long Term Disability, the employee will receive a termination allowance

equivalent to the layoff allowance amount defined in the respective collective bargaining agreement (Potomac – Article 37). For New Hires with less than 3 years of service, the termination allowance will be 50% of the layoff allowance amount defined in the respective collective bargaining agreement (Potomac – Article 37).

10) The Company will provide the Union with quarterly written reports containing the following information, by bargaining unit:

a. For employees who are medically restricted:
   - Name
   - Title
   - Net Credited Service (NCS) Date
   - Work Location
   - Work Restriction(s)
   - Effective Date of Medical Restriction
   - Date Employee was Placed on a MR-LOA

b. Medically Restricted employees who have been placed into Suitable Work in the previous three months, and the job title and work location where these employees were placed;

c. A list of all available positions as of the date of each report, including title and work location, in the applicable bargaining unit and state.

D. <u>Partial Day Restrictions</u>

This Section is intended to establish the pay and benefit treatment for associate employees who (1) return to work from a disability absence, but due to medical reasons are unable to perform their job on a full-time basis ("partial day restrictions"), or (2) who report to work with a partial day restriction that does not immediately follow a disability absence.

1) Pay and Benefit treatment for Full-Time associates who return to work from a disability absence under the Sickness and Accident Disability Benefit Plan ("SADBP") with a partial day medical restriction:

a) During the first 30 calendar days, the employee will be paid for a full tour.

b) If the employee's partial day restriction continues beyond 30 days, or multiple partial day restrictions following multiple SADBP absences cumulatively exceed 30 partial days within a 52 week period, the Company will only pay for hours worked by the employee.

c) During any period of time the employee is working a partial tour due to a medical restriction approved by the Company, and paid only for hours worked, prior to reclassification to part-time status under Section 2 of this Agreement, any other time off provisions in the respective collective bargaining agreements will be administered and paid for in accordance with the number of days and hours the employee is approved to work. Examples of pay treatment for time off include:

1. Vacation Time – if the employee is taking a week's vacation, the employee will be using 5 days of vacation and paid the hours the employee is approved to work that week. If the employee is taking a single vacation day, the employee will be paid the hours the employee is approved to work that day. If employee is taking ½ vacation day, the employee must work ½ of scheduled hours that day, will receive pay for ½ of scheduled hours, and be using ½ a vacation day.

2. Illness Paid – if the employee is ill during the period of time he/she is working partial days, employee will be paid for the hours/days scheduled, in accordance with Absence From Duty, Article XII.

3. Jury Duty / Death in Family (and other similar time off) – employee will be paid for the hours/days scheduled.

4. Holidays – If the holiday falls on a day the employee is normally scheduled to work, and the employee has a partial day restriction:

   - if the employee is excused from working that holiday, the employee will be paid for his/her scheduled hours.
   - if the employee works the holiday, the employee will be paid the holiday premium for the hours worked.

2) Reclassification of Full-time Employees to Part-Time Status

For employees working on partial day restrictions following a return from a short term disability absence, for the period of time up to 52 weeks (up to 26 weeks for New Hires with less than 3 years of service) from the employee's first day of disability absence, or, for those employees whose restriction was not consecutive with a preceding approved SADBP absence, from the employee's first day working a partial day, the Company agrees it will not involuntarily reclassify employees to part-time. Such employees will, accordingly, continue to receive medical benefit coverage as a full-time employee.

If such an employee's partial day restrictions is in effect beyond the 52 week period (26 weeks for New Hires with less than 3 years of service) (measured from the first day of disability absence, or, for employees whose restriction was not consecutive with a preceding approved SADBP Absence, from the employee's first day working a partial day) the employee's pay and benefits will be treated as follows at the end of the period:

a) the employee will be reclassified from full-time to part-time.

b) the employee's pay treatment as well as benefit coverage will be administered in accordance with part-time provisions of the respective collective bargaining agreements.

If an associate has a subsequent disability absence commencing within 52 weeks of the start of any earlier disability absence(s), and the employee has a partial duty restriction upon return to work from the disability absence, or the employee submits a partial day restriction that is not consecutive with a preceding approved SADBP absence, the original first day of absence for the first short term disability absence period or the first day of the partial restriction for those restrictions that were not consecutive with a preceding approved SADBP absence will be used to calculate the 52 week waiting period (26 weeks for New Hires with less than 3 years of service) for reclassification and pay/benefit treatment. All days that the employee was receiving SADBP benefits or was on partial day restrictions during the preceding 52 weeks will be counted toward the 52 week limit (26 week limit for New Hires with less than 3 years of service).

3. <u>For partial day restrictions not consecutive with a SADBP absence</u>

For employees who submit a partial day medical restriction and such restriction is not consecutive with a preceding approved SADBP absence, the Company will pay the employee only for the hours worked starting the first day that the employee works a partial day. Payment for other time off will be covered by Paragraph D, Section 1 (c) above.

4. <u>Pay Treatment for Employees Downgraded</u>

Associate employees who are placed in a lower wage classification as a result of their Medical Restriction will have their wages lowered in accordance with the "Disability Wage Adjustment Table" contained in the 1998 MR Policy.

ATTACHMENT A

MEDICAL RESTRICTION LEAVE OF ABSENCE
BENEFIT ELIGIBILITY
(applies only to employees who are eligible/enrolled on the day prior to the start of the leave)

Issue	Eligibility
Service Credit	Same availability as if active employee
Sickness Benefits	None
Death Benefits	If eligible on the date preceding the start of the leave, the same eligibility continues
Medical/Dental	Same as if active employee
Employee Life / AD&D	Employee pays for coverage over Basic
Dependent Life/Dependent AD&D	Employee pays
Vision	Employee pays
LTD	Same as if active employee
Health Care Reimbursement	Contributions and claims may continue per plan terms via COBRA
Dependent Care Reimbursement	Contributions suspended. Claims permitted for expenses incurred through the plan year.
Savings Plan	Contributions suspended. Withdrawals allowed.

September 19, 2012

ATTACHMENT 5

COMMON INTEREST FORUM

The Companies, the CWA and the IBEW mutually believe that it would be beneficial for the parties to engage in periodic discussions regarding the state of the business and workplace issues of mutual concern. Accordingly, as a result of the 2011 negotiations, the Companies and the unions will establish a separate Common Interest Forum ("CIF") for Pennsylvania/Delaware Commercial, Pennsylvania/Delaware Plant, New Jersey CWA, New Jersey IBEW and the Potomac region to facilitate such discussions.

The Pennsylvania/Delaware Commercial CIF will consist of no more than ten union and ten management representatives. The Pennsylvania/Delaware Plant CIF will consist of no more than ten union representatives and ten management representatives. The New Jersey CWA CIF will consist of no more than eight CWA representatives and no more than eight management representatives. The New Jersey IBEW CIF will consist of no more than six IBEW representatives and six management representatives. The Potomac CIF will consist of no more than six union representatives and six management representatives. The unions' representatives will be selected by the unions in their sole discretion. A CWA National Union representative, or the designee of the IBEW Business Manager/President, will attend meetings, but will not be counted against the allotment of union representatives. The management representatives will be selected by the Companies in their sole discretion, but will include at least one Labor Relations Director, one Vice President with responsibility for operations and one Director with responsibility for operations.

The CIF will meet twice a year, at mutually agreeable times and places. The parties will set an agenda in advance of each meeting. Each party has the right to place items of interest on the agenda of any CIF meeting.

September 19, 2012

ATTACHMENT 6

HEALTH CARE OVERSIGHT COMMITTEE (HCOC)

The Company and the Union agree that it would be beneficial for there to be a forum to discuss matters of mutual concern with respect to certain defined aspects of medical, dental and vision care, disease management and wellness programs.

Accordingly, the parties agree to establish a Health Care Oversight Committee (HCOC) for the Mid-Atlantic region, consisting of eight members, four of whom are Company officials designated by the Company and four of whom are Union officials designated by the Unions, who will represent both the IBEW and the CWA. Health Care Benefit Coordinators will not be designated by the Union as members of this Committee. Where appropriate, outside experts or others may be invited to attend the meetings by mutual agreement of the Union and the Company Committee members. The HCOC will meet from time to time, but no less frequently than four times per calendar year, with the first meeting taking place no later than two months after ratification of the 2012 MOU.

The HCOC will, at a high level, discuss matters of mutual concern with respect to the following, as applied to medical, dental and vision care:

- Network utilization and obstacles to in-network utilization
  - Examine network utilization and obstacles to in-network utilization to identify areas for additional educational efforts or cost containment initiatives.

- Participant utilization and educational efforts to encourage efficient utilization
  - Receive periodic updates regarding general trends of cases in which the carrier/administrator has denied coverage for procedures, protocols or drugs because of their experimental nature and receive informational updates on the current standards utilized by the carrier/administrator in making such determinations.

- General participant health status and opportunities to improve same
  - Review general participant health status, identify opportunities to improve same, and develop recommendations.

- Workplace wellness, health programs and screenings and participation in them
  - Review workplace wellness, health programs and screenings and participation in them to develop cost-effective recommendations on preventive health care benefits, personal health care practices and wellness programs.

- Plan performance data, including disease and case management programs and claims data related to high-cost and chronic conditions

  -- Review the impact of current cost containment plan initiatives and any additional measures that are developed in the marketplace, and to recommend changes or additions, if appropriate.

- Review Summary Plan Descriptions (SPDs) within the Company's defined timeline, for clarity, quality and understandability and recommend changes or additions for consideration by the Company.

- Discuss changing medical patterns of practice to determine areas of the Plans that may need to be adjusted and recommend changes, if appropriate.

- Review employee communications related to health care plans, including but not limited to enrollment, as practicable.

- Review and select IME/FCE vendors.

- Review SADBP vendor performance and make recommendations for consideration by the Company.

Working within and consistent with the labor agreements, the HCOC may develop facts and study the issues identified herein, and communicate such information to the Company so that the Company can make well-informed decisions on matters involving healthcare, disease management and wellness programs. The HCOC may, on a consensus basis only, make recommendations with respect to the issues identified above for consideration by the Company. However, the HCOC will have no power or authority to formulate policy, make binding decisions or agreements, or to modify provisions of any labor agreement or benefit plan.

The HCOC can be cancelled by either party upon 30 days' notice to the other party but in no event can such cancellation occur during the twelve months following ratification of this 2012 MOU.

September 19, 2012

ATTACHMENT 7

HEALTH CARE BENEFIT COORDINATORS

1. The HCBCs for the CWA and IBEW will be paid at the highest wage rate in the selected associate's bargaining unit. Incumbent CWA represented HCBC(s), will continue to be paid according to the current CWA Staff Representative wage schedule. No increases to the CWA Staff Representative wage schedule will be applied to the HCBCs during the term of the 2012 Agreement.

2. The Union will select the HCBCs, and will only consider employees who have an overall rating of at least a Meets Requirements in performance and attendance. When the HCBC assignment ends, the employees will be returned to their regular jobs. The HCBCs will report to a Company-designated manager and provide a full accounting of his/her daily activities.

3. The HCBCs must successfully complete a Company training program and demonstrate full understanding of the provisions of the Company's medical, dental, vision, and disability benefits plans available to associate employees.

4. The role of the HCBCs will be to assist associate employees/retirees by providing assistance in understanding plan options and administrative processes and providing employees with information to effectively utilize plan benefits. The HCBCs may provide associate employees with general assistance in resolving questions and/or problems under the Company's medical, dental, vision and disability plans, and may help the associate employee follow the appropriate escalation and/or appeal process for a denial of benefits. The HCBCs will have authority to act on behalf of or represent employees in the initiation of an escalation to a Company designated escalation team and/or point(s) of contact. The HCBCs will have no authority to make representations or act on behalf of the Company.

5. The HCBCs will only be authorized to receive medically sensitive information of an associate employee (or his or her family member) from the Company and/or its vendors during the course of the ERISA claims and appeals process, and only if a HIPAA compliant authorization has been obtained from the applicable associate. A copy of such authorization must be provided to the Company and/or its vendors. HCBCs will not discuss or disclose information on health care issues, questions or disputes of any individual to anyone other than the affected employee or the Company designated escalation team or point(s) of contact.

6. These provisions will not be subject to challenge through the grievance or arbitration procedures or in any other forum.

September 19, 2012

ATTACHMENT 8

NEW CONTRACTING INITIATIVES

September 19, 2012

Ms. Gail Evans
Administrative Director to the V.P.
CWA District 2-13, AFL-CIO
9602D Martin Luther King Jr. Highway
Lanham, Maryland 20706

Dear Ms. Evans:

This will confirm our September 19, 2012, agreement regarding contracting initiatives.

The Company agrees, subject to certain conditions described below, that through 12-31-14, it will not contract out work of a type that it has not contracted out during the three years preceding the effective date of the agreement. This restriction shall not preclude contracting out work to deal with emergency situations including severe weather conditions.

The parties further agree to create a Contracting Initiatives Committee, which will be co-chaired by the CWA District Vice President and a company Senior Operations Manager (or their designee). The CEO of Verizon and the President of CWA shall be ex-officio members of the Committee. Each party may appoint up to two additional members.

The purpose of this Committee is to find ways by which the levels of contracting can be reduced within the Verizon (Mid-Atlantic) Operating companies. The objective is for company employees to do more work in a more productive and efficient manner than that performed by contractors. The company will provide all necessary resources needed by the Committee to carry out its purpose.

In addition, the Company will notify the Union at least six months in advance of planned new, major, contracting initiatives that are to be implemented on or after January 1, 2015, and which affect employees represented by the Union. The Contracting Initiatives Committee will then have the opportunity to discuss such new major initiatives. It is understood, however, that after the end of the six month period, the Company is free to implement planned, new, major initiatives that do not otherwise violate the collective bargaining agreement.

Very Truly Yours,

AGREED:

(s) ______________________________
Administrative Director to the V.P.
Communications Workers of America

September 19, 2012

ATTACHMENT 9

ADDITIONAL CENTER JOBS AGREEMENT

This agreement ("Agreement") is made and entered into by the Communications Workers of America, AFL-CIO and its local unions and affiliates ("CWA"), International Brotherhood of Electrical Workers Locals 827 and 1944 ("IBEW") (CWA and IBEW shall herein be collectively referred to as "Unions"), Verizon Advanced Data Inc. ("VZAD"), Verizon Services Corp. ("VSC"), Verizon Corporate Services Corp. ("VCSC"), Verizon Maryland Inc. ("VZMD"), Verizon Virginia Inc. ("VZVA"), Verizon Washington, D.C. Inc. ("VZDC"), Verizon Pennsylvania Inc. ("VZPA"), Verizon Delaware Inc. ("VZDE"), Verizon New Jersey Inc. ("VZNJ") and Verizon South Inc. (Virginia) ("VZSV") (company parties herein collectively referred to as "Companies").

WHEREAS, the Companies and the Unions are parties to various collective bargaining agreements ("Labor Agreements");

WHEREAS, the Unions represent employees in a number of bargaining units ("Bargaining Units") covered by the above-mentioned Labor Agreements;

WHEREAS, the Companies employ Bargaining Unit employees in, among others, Customer Sales and Service Centers ("CSSCs"), Business Sales and Billing Centers ("BSBCs"), Multilingual Sales and Service Centers ("MSSCs") (CSSCs, BSBCs and MSSCs will collectively be referred to herein as "Sales and Service Centers"), and Fiber Solutions Centers ("FSCs"), and Enhanced Verizon Resolution Centers ("EVRCs") (Sales and Service Centers, FSCs and EVRCs will collectively be referred to herein as "Centers");

WHEREAS, the Unions and the Companies, in conjunction with their negotiation of successor agreements to the Labor Agreements that the parties agreed to in 2008, desire to provide for the addition of newly hired employees into certain Centers during the term of said successor Labor Agreements as provided for herein;

THEREFORE, for good and valuable consideration, the parties agree as follows:

1. The Companies agree that, in return for the Unions' agreement to the Companies' current Sharing of Calls Among Centers proposal, they will add 325 regular full-time, newly hired employees ("Additional Hires") during the term of the successor contract to the 2008 Labor Agreements, into one or more Centers that employ Bargaining Unit employees covered by the Labor Agreements, contingent upon obtaining sufficient qualified and successfully trained candidates.

    (a) The Companies will hire 125 of the Additional Hires into positions in Sales and Service Centers located in Mid-Atlantic.

    (b) The Companies will hire 200 of the Additional Hires into the Fiber Customer Support Analyst ("FCSA") position in FSCs and EVRCs located in Mid-Atlantic.

(c) The 325 Additional Hires requirement is a single, aggregate number of Additional Hires to be hired pursuant to this Agreement, whether represented by CWA or the IBEW. The Companies will have no obligation pursuant to this Agreement to either maintain any particular headcount or backfill in the event that Additional Hires leave employment or transfer from the Centers.

(d) Initial staffing of the 200 Additional Hires for the FSCs will be applied proportionately to each state based on the current number of employees in the EVRCs and FSCs in each state, excluding Pennsylvania EVRCs and FSCs. In addition, initial staffing of the 125 Additional Hires for the Sales and Service Centers will be applied proportionately based on the current number of employees in the Sales and Service Centers in each state, excluding West Virginia. Initial staffing placement may be adjusted if there is insufficient space to accommodate the additional headcount.

2. All Additional Hires will be subject to existing testing, training and other pre- and post-hire procedures as appropriate, except that any internal staffing obligation, such as the 50% internal staffing obligation, shall not apply to the hiring of Additional Hires pursuant to this Agreement. Individuals who do not successfully complete training will not be counted towards the 325 Additional Hires requirement.

3. The terms and conditions of Additional Hires will be based on the provisions of the 2012 MOU applicable to employees first hired or re-hired on or after the date of ratification of the 2012 MOU, if any.

For: CWA District 2-13 ____________________ Date: ____________	For: Verizon Services Corporation ____________________ Date: ____________
For: IBEW Local 827 ____________________ Date: ____________	For: Verizon Corporate Services Corp. ____________________ Date: ____________

For: IBEW Local 1944 ____________________________ Date: ____________________	For: Verizon Maryland Inc. ____________________________ Date: ____________________
	For: Verizon Virginia Inc. ____________________________ Date: ____________________
	For: Verizon Washington, D.C. Inc. ____________________________ Date: ____________________
	For: Verizon Pennsylvania Inc. ____________________________ Date: ____________________

For: Verizon Delaware Inc. ____ Date: __________________________
For: Verizon New Jersey Inc. ____ Date: __________________________
For: Verizon South Inc. (Virginia) ____ Date: __________________________
For: Verizon Advanced Data Inc. ____ Date: __________________________

ATTACHMENT 10

September 19, 2012

Ms. Gail Evans
Administrative Director to the V.P.
CWA District 2-13, AFL-CIO
9602D Martin Luther King Jr. Highway
Lanham, Maryland 20706

Re: FiOS Discount

Dear Ms. Evans:

This will confirm our understanding that Verizon Advanced Data Inc., Verizon Services Corp., Verizon Corporate Services Corp., Verizon Maryland Inc., Verizon Virginia Inc., Verizon Washington, D.C. Inc., Verizon Pennsylvania Inc., Verizon Delaware Inc., Verizon New Jersey Inc. and Verizon South Inc. (Virginia) (collectively "the Company") will continue to offer an employee discount to all associates on the same basis that it offers such discount to the Company's management employees.

The Company presently expects to keep these employee offers indefinitely. However, the Company reserves the right in its sole discretion to make adjustments from time-to-time to the discounted rate (up or down) or otherwise modify or suspend the promotions or discontinue them entirely either temporarily or permanently. Furthermore, employees who newly subscribe to the aforementioned services should this discount program be modified will be subject to the rate that is in effect at that time. If the Company decides to modify, adjust, suspend or terminate the discount to employees, it will provide thirty (30) days' notice to the Union before such change takes effect.

Sincerely,

Joseph Gimilaro
Executive Director, Labor Relations