

**THE AVAYA INC.**

**MEDICAL EXPENSE PLAN**

**SUMMARY PLAN DESCRIPTION**

**Effective 1/1/2007  
Last Updated 3/31/2008**

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2007, to **eligible employees** under The Avaya Inc. Medical Expense Plan (Medical Plan).

The Board of Directors of Avaya Inc. (or its delegate) reserves the right to modify, suspend or terminate the Medical Plan at any time, subject to the terms of applicable collective bargaining agreements. Questions regarding your benefits should be addressed to the Plan Administrator (see "Important Contacts"). Because of the many detailed provisions of the Medical Plan, no one other than the Plan Administrator is authorized to advise you as to your benefits. For this reason, Avaya Inc. is not bound by statements made by anyone or any entity other than the Plan Administrator or its authorized delegates.

Please note that participation in the Medical Plan is neither an offer of employment nor a guarantee of employment for any period of time at Avaya Inc.

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## **INTRODUCTION**

The Avaya Inc. Medical Expense Plan (Medical Plan) helps you pay the cost of certain medical care and treatment for an injury or illness. Depending on your coverage option, benefits also may be available for certain **covered** preventive medical services.

If you are an **eligible employee**, Avaya Inc. automatically covers you and the **eligible dependents** you enroll starting on the first day of the month in which you complete six months of **net credited service**. You must enroll to cover eligible family members or to select a medical option other than the **assigned option**. If you wish, you may enroll for coverage earlier by paying the full coverage cost during the six-month waiting period. This cost is waived if you have been continuously **covered** as a dependent of an Avaya employee or retiree (see “Avaya Inc. Families”).

The Medical Plan offers three types of coverage options:

- **Point-of-Service (POS)**
- **Traditional Indemnity**
- **Health Maintenance Organization (HMO)**

In addition, you may decline Avaya Inc.'s coverage to be a dependent of another **eligible employee** or, if you can certify that you have medical coverage outside of Avaya, you may elect to decline Avaya Inc.'s coverage, which may allow you to receive cash back in your paycheck.

This summary can help you compare the options and choose which one best meets your needs. While the options cover many of the same services and supplies, you will see differences in how you obtain care and how you pay for that care.

## HIGHLIGHTS

Here is a summary of some features of the Medical Plan.

Plan Feature	Summary
Eligibility	<p>If you are an <b>eligible employee</b> (a regular, active, full-time or part-time, represented employee who works for a <b>Participating Company</b>), you are eligible for coverage. You may also enroll your <b>eligible dependents</b> under the same coverage option you choose for yourself.</p>
Enrollment	<p>If a Medical Plan option is assigned to you based on your job classification and on where you live, Avaya Inc. automatically covers you starting on the first day of the month in which you complete six months of <b>net credited service</b> (see “Assigned Option”). Coverage is also available for your <b>eligible dependents</b>, but you <u>must</u> enroll them within 31 days of eligibility by calling the <b>Avaya Health and Benefits Decision Center</b> (see “Important Contacts”).</p> <p>If you wish, you may enroll for coverage earlier by paying the full coverage cost during the waiting period (see “Enrolling Early”). This cost is waived if you meet the eligibility requirements to be <b>covered</b> as a dependent of another Avaya Inc. employee or retiree (see “Avaya Inc. Families”).</p> <p>You must enroll:</p> <ul style="list-style-type: none"> <li>• To begin coverage before you complete six months of <b>net credited service</b>,</li> <li>• To select an option other than your <b>assigned option</b>, including declining coverage,</li> <li>• To add your <b>eligible dependents</b>, or</li> <li>• To elect Medical Plan coverage for yourself and any dependents, if you have no <b>assigned option</b>.</li> </ul> <p>In addition, you may decline Avaya Inc.’s coverage to be a dependent of another <b>eligible employee</b> or if you certify that you have medical coverage outside of Avaya Inc. If you are an <b>eligible employee</b> and have medical coverage outside of Avaya Inc., you may be eligible to receive cash back in your paycheck.</p>

Plan Feature	Summary
Covered Expenses	<p><b>Covered</b> expenses and benefit levels vary with the option you choose and the <b>provider</b> you use. Some examples of covered expenses are the following, if <b>medically necessary</b>:</p> <ul style="list-style-type: none"> <li>• Hospitalization</li> <li>• Surgery</li> <li>• Doctor’s visits</li> <li>• Chiropractic care</li> <li>• Acupuncture</li> <li>• <b>Extended care facilities</b></li> <li>• <b>Home health care agency</b> services</li> <li>• <b>Hospice</b> care</li> </ul>
How to Get the Most from the Medical Plan	<p>To get the most from your Medical Plan, read about the options available to you. Learn what services are <b>covered</b> and how to access those services. For example, does the option pay higher levels of benefits for <b>network providers</b>? Learn when you need to pre-certify care, such as for a <b>hospital</b> stay.</p>
Information About the Medical Plan	<p>Use this document as a reference and call your <b>health care company</b> for specific benefit coverage information. For questions about eligibility, your benefit options, or to enroll, contact the <b>Avaya Health and Benefits Decision Center</b> (See “Important Contacts”).</p>
Cost	<p>The cost of coverage varies by option and level of coverage. Your contributions are generally deducted on a pre-tax basis.</p> <p>You may begin coverage before you complete six months of <b>net credited service</b> by enrolling and paying the full coverage cost.</p>

## TERMS YOU SHOULD KNOW

There are several words and phrases that have a specific meaning under the Medical Plan. This section explains those terms so you can better understand your benefits. These terms are printed in **boldface** when they appear to let you know they are defined here.

**Acupuncturist:** a **provider** carrying all recognized certifications applying to the practice of acupuncture who is licensed to practice acupuncture according to applicable state laws.

**Aetna:** the **health care company** that administers the **POS** option, **Traditional Indemnity** option, the **Prescription Drug Program** and the **Mental Health and Chemical Dependency Program**.

**Allowable amount:** the portion of a **provider's** charge that is eligible for reimbursement either in full or in part. Any amount by which the **provider's** charge exceeds the allowable amount is not reimbursable under the Medical Plan.

**In-network** under the **HMO, POS, Prescription Drug Program, Mental Health and Chemical Dependency Program** and **Traditional Indemnity** option (**National Advantage Program network providers**), a **network provider's** charge always equals the allowable amount so that no charges above the allowable amount are payable by the participant.

When **non-network providers** are used under the **Traditional Indemnity** option, **Prescription Drug Program, Mental Health and Chemical Dependency Program**, or the Medical Plan's **out-of-network POS** option provisions, the allowable amount for **medically necessary** services is based on **reasonable and customary charges**. Claims are paid based on the schedule in effect on the date on which a service was provided or based on the schedule in effect on the date the claim payment is made, in accordance with the practice of the **health care company** responsible for paying the claim. The **health care company** uses the same industry-accepted pricing schedule to ensure that out-of-network reimbursement is consistent with what nine out of ten **providers** in a given geographic area would charge.

The participant is responsible for the portion of the expense that is above the **reasonable and customary charge**. Amounts in excess of the **reasonable and customary charge** do *not* apply toward the annual **deductible** or the **out-of-pocket maximum** as described in the Medical Plan. Any references in the **Traditional Indemnity** option and **POS** option, for **out-of-network** or out-of-area provisions of the Medical Plan to the amount or percentage of the amount that the Medical Plan covers or pays, refers to the **reasonable and customary charge**.

Under the **Mental Health and Chemical Dependency Program network** benefits, the allowable amount for services from Master's degree level counselors will be 75% of what nine out of ten **providers** in a given area would charge.

**Alternative care or alternative treatment:** a type of care only available **in-network** under the **Mental Health and Chemical Dependency Program**, which is more intensive than **out-patient** treatment, and less intensive than hospitalization. Alternative treatment includes the following types of care: **partial hospitalization**, **residential treatment** and care from a **halfway house** or **group home**.

**Ambulance:** a vehicle licensed according to state laws, operated for the exclusive purpose of transporting patients with acute medical conditions and equipped to provide paramedic and stabilizing medical services.

**Annual enrollment:** the period of time each year designated by the Company in which you can generally make changes in your benefits for reasons other than a **qualified status change**. Elections made during annual enrollment are effective on the first day of the following calendar year.

**Assigned option:** the medical option to which you will be automatically assigned if you are eligible and do not enroll in one of the available options. Some employee classifications do not have an assigned option and *must* enroll to be **covered** by the Medical Plan.

**Avaya Health and Benefits Decision Center:** the resource to contact to enroll, make changes in your coverage or ask questions about the Medical Plan options. See "Important Contacts."

**Behavioral Health Care Coordinator:** Aetna, the resource to call to coordinate the medical care for the treatment of alcoholism, drug abuse and a mental disorder.

**Birthing center:** a facility for prenatal, delivery and postpartum care that is (a) staffed by certified nurse-midwives; (b) has access to consultation by an obstetrician/gynecologist with admitting privileges at a nearby **hospital**; (c) is accredited by the National Association of Child Bearing Centers or the Joint Commission on the Accreditation of Healthcare Organizations; and (d) is licensed by the state.

**Brand name drug:** one that has been patented and is produced by only one manufacturer.

**Brief counseling:** a problem-focused form of individual or family outpatient counseling that (a) seeks resolution of problems in living (e.g., parenting concerns, emotional stress, marital and family distress, alcohol- and drug-related problems) rather than basic character change; (b) emphasizes counselee skills, strengths and resources; (c) involves setting and maintaining realistic goals that are achievable in a one to five month period; (d) encourages counselees to practice behavior outside the counseling

session to promote therapeutic goals; and (e) in which the counselor provides structure, interprets behavior, offers suggestions, and assigns "homework" activities.

**Center of excellence:** a facility that is designated by the **health care company** as a preferable facility to handle selected services of a highly specialized nature, such as organ transplants.

**Chemical dependency:** both alcoholism and drug dependency, as classified by the International Classification of Diseases of the U.S. Department of Health and Human Services.

**Children:** include your biological children and/or legally adopted children (including those who are in the formal legal adoption process), stepchildren living with you, and children living with you for whom you, your **lawful spouse** or your **domestic partner** is the legal guardian (excluding "wards of the state" or "foster children.") See **Class I dependents**, **Class II dependents** and **domestic partnership dependents**.

**Chiropractor:** a Doctor of Chiropractic (D.C.) who is licensed to provide services in the state in which the service is rendered.

**Choice POS II:** the **network** of **Aetna providers** used to receive **in-network** benefits under the **POS** option.

**Claims Administrator:** the **health care company** authorized by Avaya Inc. to administer the Medical Plan.

**Class I dependents:** include your **lawful spouse** and each unmarried child through December 31st of the year in which the child reaches age 23.

To be eligible, a child must be:

- Your biological child and/or your legally adopted child, including any child in the formal legal process of adoption, regardless of residence,
- A stepchild living with you, or
- A child living with you for whom you or your **lawful spouse** is the legal guardian. This does not include "wards of the state" or "foster children."

Class I dependents also include each unmarried child of any age who is determined to be eligible by the applicable medical **Claims Administrator** through meeting all of the following:

- Incapable of self-support,
- Physically or mentally handicapped, and

- Fully dependent on you for support.

To be covered as Class I dependents, **children** beyond age 23 must be certified for coverage by the **Claims Administrator**. You must complete an application form available from the medical **Claims Administrator** and submit it for approval to the address listed on the form.

No coverage is available for a child over age 23 who is incapacitated for a short time due to illness or accident (e.g., a broken leg).

**Class II dependents:** include the following relatives who meet the eligibility requirements shown below:

- Your unmarried dependent **children** not included as **Class I dependents**,
- Your unmarried dependent stepchildren not included as **Class I dependents**,
- Your unmarried grandchildren, your unmarried brothers and sisters, and your parents and grandparents, and
- Your **lawful spouse's** parents and grandparents.

To be eligible for coverage as Class II dependents under the Medical Plan, those relatives must continue to meet the following requirements:

- They receive less than \$12,000 per year in income from all sources, other than your (the Avaya Inc. employee's) support,
- They live with you or in a nearby household provided by you, and in the case of unmarried dependent stepchildren, live with you throughout the period of coverage, and
- They either:
  - Have been continuously re-enrolled during each **annual enrollment** as a Class II dependent since January 1, 1996 (through a predecessor plan) and continue to be re-enrolled each year (non-grandfathered Class II dependents), or
  - Have been enrolled before June 1, 1986 as a Class II dependent through a predecessor plan and continuously enrolled each plan year thereafter (grandfathered Class II dependents).

**COBRA:** an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. This refers to federal legislation that governs the offer of temporary

continued medical coverage to participants who otherwise would lose coverage due to certain reasons, such as a loss of employment.

**Coinsurance:** the cost-sharing method by which the Medical Plan pays a percentage of the **provider's covered** charge (for example, 80%) and you pay the remaining percentage (for example, 20%). Your coinsurance is your share of the cost.

**Coordination of benefits (COB):** a feature of the Medical Plan designed to prevent duplicate benefit payments when you or your **eligible dependents** participate in more than one group plan.

**Copayment:** a flat dollar amount that you pay for a certain medical service (such as an office visit or supply) as your share of the cost.

**Covered:** eligible under the terms of the Medical Plan. "Covered" is often used to modify other terms. A covered expense is a medical cost that satisfies all of the rules to be considered for payment under the Medical Plan. A covered person is one who is enrolled and eligible for benefits under the Medical Plan. A covered **provider** is one who is (or which is) eligible to provide services and receive payment under the Medical Plan.

**Covered dependent:** a **Class I dependent, domestic partner or domestic partnership dependent** who is **covered** as the dependent of an **eligible employee**. Other people such as siblings, parents, and grandparents may be covered as **Class II dependents** if they are currently enrolled and if they continue to meet the eligibility criteria.

**Custodial care:** treatment or services generally prescribed by a medical professional that could be rendered safely and reasonably by a person not medically skilled. Custodial care is treatment or services that do not directly treat illness or injury but that are designed mainly to help the patient with daily living activities or are provided primarily for the convenience or comfort of the patient. These activities include but are not limited to:

- Personal care such as help in walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; and dressing
- Homemaking, such as preparing meals or special diets
- Moving the patient
- Acting as a companion or sitter
- Supervising medication that can usually be self-administered

- Treatment or services that any person may be able to perform with minimal instruction, including, but not limited to, recording temperature, pulse and respiration, or administration and monitoring of feeding systems

Custodial care is a type of care provided to a patient whose need for medical care has stabilized and whose current medical condition is not expected to significantly and objectively improve.

**Deductible:** the amount of eligible expenses you may be required to pay under the Medical Plan each year before benefits for **covered** expenses can begin. Whether a deductible applies, and the amount of the deductible, depends upon the Medical Plan option you choose, the type of service or supply you receive, and whether care is received **in-network** or **out-of-network**. There is usually no deductible under the **HMO** option. Some expenses do not count toward the deductible. (See “Expenses You Pay That Do Not Count Toward the Deductible.”)

**Domestic Partner:** an individual (same-gender or opposite-gender) is your domestic partner if you complete and file with the **Avaya Health and Benefits Decision Center** a notarized Domestic Partner Affidavit in which you both attest that you met all of the following requirements:

- Reside in the same household,
- Are age 18 or older,
- Have mental sufficiency to enter into a valid contract,
- Are not related to each other by blood,
- Are not legally married to any other person,
- Have a close and committed personal relationship with each other; intend to continue such relationship indefinitely; and have no such relationship with anyone else, and
- Have joint responsibility for each other’s welfare and financial obligations.

In additional to the aforementioned requirements, the following criteria must be satisfied if applicable:

- Have complied with any state or local registration process for domestic partners; are the same-gender, reside in a state that recognizes same-gender marriages and are legally married under the laws of that state; or reside in a state that recognizes same–sex civil unions and have legally entered into such a civil union.

**Domestic partnership dependent:** is the natural or adopted child of a **domestic partner**, a child whom the **domestic partner** is in the formal, legal process of adopting, or a child living with you for whom the **domestic partner** is the legal guardian. The child must otherwise meet the definition of an eligible child as a **Class I dependent**.

Please note that states regulate the **HMOs**, and that some states do not offer **domestic partner** coverage or have special requirements about the time you must have been with your **domestic partner**, coverage of your **domestic partner's children**, and **COBRA** continuation coverage. If you are considering **domestic partner** coverage under an **HMO**, you must check with the **HMO** for any such requirements.

**Effective date:** the date upon which coverage under the Medical Plan starts or takes effect.

**Elective care:** care that can be postponed for 10 days or more without undue risk to the patient.

**Eligible dependents:** your eligible **Class I dependents**, **Class II dependents**, **domestic partners** and **domestic partnership dependents**.

**Eligible employee:** a regular, active, full-time or part-time, represented employee who works for a **Participating Company**.

Individuals who are not paid from the U.S. payroll of a **Participating Company**, who are employed by an independent company (such as an employment agency), or whose services are rendered pursuant to an agreement excluding participation in benefit plans, are not eligible to participate in the Medical Plan.

**Emergency:** a life-threatening medical condition suddenly and unexpectedly manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could result in: (a) permanently placing the patient's health in jeopardy; (b) causing serious and/or permanent impairment of a bodily part or function; (c) causing serious and/or permanent dysfunction of any body organ or part; and (d) causing severe pain. See "Emergency Care" in the **Mental Health and Chemical Dependency Program** for the definition of emergency as it applies to a mental health condition rather than a physical condition.

The following examples are generally emergencies:

- Apparent poisoning
- Convulsions
- Excessive uncontrolled bleeding
- Severe chest pain

- Severe or multiple injuries, including fractures
- Shortness of breath or difficulty breathing
- Sudden loss of consciousness

The following examples are generally *not* considered to be emergencies:

- Childbirth, unless an unexpected complication such as premature birth occurs
- Colds, sore throat, cough
- Diarrhea
- Earaches
- Minor cuts
- Moderate fever
- Rashes
- Sprains
- Vomiting

**Employee Assistance Program or EAP:** the program that helps **eligible employees** and **eligible dependents** resolve personal problems, such as family conflict, drug or alcohol abuse, stress, marital discord, personal finances, and other personal problems through confidential assessment and **brief counseling** and/or referrals.

**Experimental or investigative treatment, drug or device:** medical, surgical and psychiatric procedures, treatments, devices, drugs and drug treatments not approved by governmental agencies such as the Food and Drug Administration (FDA), and not accepted as standard, tested and accepted effective practice by the medical community at large at the time the service is rendered, as determined by the **health care company**.

**Extended care facility:** an institution other than a **hospital** that is licensed according to state laws to provide **in-patient** medical services, and that is accredited by the Joint Commission on the Accreditation of Healthcare Organizations or approved by Medicare. An extended care facility provides direct medical treatment, and must have a professional nursing staff and operate under the supervision of a **physician**. An extended care facility is not primarily a place for rest, for the aged, for **custodial care**,

or for the treatment of **mental illness** or **chemical dependency**. The term extended care facility encompasses facilities that go by names such as **skilled nursing facilities**, convalescent facilities, intermediate care facilities, sub-acute care facilities and rehabilitation centers, provided they meet all of the conditions given here.

**FMLA:** the Family and Medical Leave Act of 1993, as amended.

**Generic drug:** a drug that does not bear the trademark of the original manufacturer. It must have the same active ingredients as their **brand name drug** counterpart. Generic drugs usually cost less than **brand name drugs**.

**Group homes and halfway houses:** settings for care that are **covered** under the **in-network** benefits of the **Mental Health and Chemical Dependency Program**. Group homes and halfway houses are residences that provide a structured living environment, deliver treatment by **mental health and chemical dependency professionals**, and afford the patient opportunities to transition into daily life activities for the purpose of recovery from mental health conditions or **chemical dependency**. Adult patients typically leave the group home or halfway house during the day to engage in outside activities such as work or school, and return at night.

**HMO:** see **Health Maintenance Organization**.

**Halfway houses:** see **group homes and halfway houses**.

**Health care company:** any company authorized by Avaya Inc. to provide services under the Medical Plan.

**Health Maintenance Organization (HMO):** a **network** of **hospitals**, doctors, and other medical **providers** who provide services through an HMO option. When you follow your HMO's rules for care, you usually pay no **deductibles** and file no claim forms. See "HMO Option" for more information.

**Home health care agency:** an organization licensed according to state laws to provide skilled nursing and certain other health services on a visiting basis in the patient's home. The agency must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations or be Medicare approved in order to be **covered** under the Medical Plan.

**Hospice:** an organization licensed according to state laws to provide care to terminally ill patients. A hospice may either be an agency that performs its services in the patient's home, or a facility in which the patient is admitted.

**Hospital:** a facility providing **in-patient** and **out-patient** care for the diagnosis and treatment of acute illness and injury. Under the **Mental Health and Chemical Dependency Program**, hospital means an acute general hospital with a psychiatric and/or **chemical dependency** unit, an acute psychiatric facility or an acute **chemical**

**dependency facility.** The facility must be licensed according to state law and be staffed by **physicians** (and qualified **mental health or chemical dependency professionals** under the **Mental Health and Chemical Dependency Program**) and maintain 24-hour nursing services. A hospital is not primarily a place for rest or **custodial care**, a nursing home, convalescent home, home for the aged or similar institution nor does it include confinement in a **residential treatment facility** under the **Mental Health and Chemical Dependency Program**.

**In-network:** the benefit choice in which you access the services of contracted **network providers** according to the rules of the option or program under which you are enrolled. For the **POS** option, you are encouraged to select a **PCP** so you have the opportunity to work with one physician who can coordinate your health care needs. Your care under the **Mental Health and Chemical Dependency Program** is coordinated by the **Behavioral Health Care Coordinator**. For the **Prescription Drug Program**, it means using a participating retail or the mail-order pharmacy.

**In-patient:** a patient who is confined in a **hospital** or other health care facility as a registered bed patient for at least 18 (out of 24) hours and incurs room and board charges. In-patient care refers to the care rendered to an in-patient. An in-patient facility is a facility that provides such care.

**Lawful spouse:** a person who is the lawful husband or lawful wife for federal income tax purposes. An **eligible employee** residing in a state that recognizes common law marriage must satisfy the specific minimum state requirements to be married under common law.

**Magellan Health Services or Magellan:** the **health care company** that administers the **EAP Program**.

**Medically necessary:** (medical necessity) the determination of medical necessity is made by the applicable **health care company**. Care is considered medically necessary if:

- It is accepted by the health care profession in the U.S. as appropriate and effective for the condition being treated,
- It is based upon recognized standards of the health care specialty involved,
- It represents the most appropriate level of care: the frequency of services, the duration of services, and the site of services, depending on the seriousness of the condition being treated (such as in the **hospital** or in the **physician's office**), and
- It is not experimental or investigative.

**Mental health and chemical dependency professional:** a psychiatrist (M.D.), a licensed psychologist (Ph.D.) or one of the following Master's degree-level **providers:** a

clinical social worker; a marriage, family, and/or child counselor; a licensed professional counselor; a certified alcoholism counselor; a certified **chemical dependency** counselor; or a registered nurse with a specialty in psychiatric and mental health nursing. The **provider** must carry all recognized certifications appropriate to his or her specialty and, where state law requires, be licensed in the state in which he or she practices. The particular certification may differ in various areas of the country.

**Mental Health and Chemical Dependency Program:** the program that provides benefits for treatment of mental health and **chemical dependency** conditions to individuals **covered** under the **POS** or **Traditional Indemnity** option.

**Mental health emergency:** a mental health condition that appears or increases suddenly and is accompanied by severe symptoms. Without immediate treatment, a mental health **emergency** condition would result in: (a) the person harming him- or herself, or others; (b) severe diminishment or long-term damage to the state of the person's mental health; or (c) permanent physical impairment of bodily parts or functions as a consequence of the mental health emergency.

**Mental illness:** for the purpose of determining benefits under the Medical Plan, means a condition that meets either of the following two requirements: (a) it is classified as a mental illness in the latest edition of the International Classification of Diseases of the U.S. Department of Health and Human Services; or (b) it is a condition generally accepted by health care professionals in the U.S. as one that requires psychiatric treatment and will respond to such treatment.

**Morbid obesity:** obesity that has become a direct and immediate threat to a person's life.

**National Advantage Program (NAP):** a **network** of **providers** offered in many areas of the country. When you are **covered** under the **Traditional Indemnity** option and you elect to receive medical care from **providers** in the National Advantage Program, charges are generally lower and guaranteed to be within the **allowable amount**. If you are **covered** under the **POS** option, you may use a NAP **provider** under the **out-of-network** provisions (if you are not using a **Choice POS II network provider**).

**Net credited service (NCS):** your continuous service plus all service credited under the service bridging rules (including mandatory portability, if applicable) of The Avaya Inc. Pension Plan and The Avaya Inc. Pension Plan for Salaried Employees.

**Network:** the **providers** in a given area who participate with the **health care company**. Network **providers** offer services to members enrolled with that **health care company** at a **prenegotiated rate**. A network **provider** means a **provider** who participates in the network.

**Non-network:** refers to a **physician, hospital** or other health care **provider** that has not signed a **network provider** agreement with your **health care company**.

**Occupational therapy:** treatment to increase a patient's use of fine motor skills to enable him or her to apply them to the tasks required in daily living, after those skills have been impaired by illness or injury.

**Out-of-network:** the benefit choice in which you access services without following the rules of the program for accessing contracted **network providers**. For the **POS** option, this means obtaining services from a **provider** who does not participate in **Aetna's Choice POS II network**. For the **Mental Health and Chemical Dependency Program**, it means obtaining services without an authorization from the **Behavioral Health Care Coordinator**. For the **Prescription Drug Program**, it means using a pharmacy not identified as a **participating pharmacy**.

**Out-of-pocket maximum:** the limit on the amount you spend for **covered** medical expenses in **copayments** and/or **coinsurance**. Some charges do not count toward this maximum.

**Out-patient:** a patient who is treated in a **hospital** or other health care facility for less than 18 hours, and who does not incur a room and board charge. Out-patient care refers to the care rendered to an out-patient. An out-patient facility is one that provides such care.

**Out-patient medical facilities:** any medical diagnosis or treatment facility that does not offer overnight care, has a staff of medical professionals (including nurses), is operated under the direction of a **physician** and is licensed according to state law. **Covered** facilities include medical laboratories, **out-patient** surgical centers, **birthing centers**, **urgent** care facilities and out-patient rehabilitation facilities. It does *not* include a **physician's** office.

**PCP:** see **Primary care physician**.

**POS:** see **Point-of-Service**.

**Partial hospitalization:** a type of alternative care **covered** under the **in-network** benefits of the **Mental Health and Chemical Dependency Program**. Partial hospitalization means **out-patient** care delivered on a daily basis in a **hospital** or other facility. The facility must have both **physicians** and nurses on staff and be authorized to administer medications. Partial hospitalization is typically a less intense level of care than **in-patient** care, but more intense than intensive **out-patient** care.

**Participating Company:** Avaya and such other companies that have elected to participate in the Medical Plan, with the prior approval of Avaya.

**Participating pharmacy:** a pharmacy that is a participating retail pharmacy under the **Prescription Drug Program**.

**Physical therapy:** treatment to increase the patient's use of large-muscle motor skills, such as those needed for walking, after those skills have been impaired by illness or injury.

**Physician:** a legally qualified physician who is licensed to practice medicine in the state in which the care is provided and is **covered** under the Medical Plan. Under the **Mental Health and Chemical Dependency Program**, care must be sought from a **provider** who is a psychiatrist or another M.D. (doctor of medicine) or D.O. (doctor of osteopathy) **provider** who is certified in the treatment of mental health and/or **chemical dependency**.

**Point-of-Service (POS):** a medical option that provides a higher level of coverage when you use **in-network providers**. However, you may go **out-of-network** and use any health care **provider** you wish. Your cost usually is higher for **out-of-network** care.

**Post-service claim:** a medical benefit claim other than a **pre-service claim** or **urgent care claim**.

**Precertification:** the process by which a **health care company** or precertification company reviews requested treatment in advance and advises you as to how benefits would be paid. In most instances, precertified care is **covered** by the Medical Plan benefits and **medically necessary** care that is not precertified is paid at a reduced level, or not **covered** at all. The need for precertification applies only to certain procedures.

**Prenegotiated rate:** a rate for medical services to which a **network provider** and the **health care company** have contractually agreed. **Network providers** agree to accept the prenegotiated rate as payment in full. This rate is usually less than their normal charge for that service.

**Prescription Drug Program:** the program that provides prescription drug benefits to individuals **covered** under the **POS** and **Traditional Indemnity** options.

**Pre-service claim:** a medical benefit claim that requires approval before you can receive the medical care.

**Primary care physician (PCP):** a **network physician** under the **HMO** or **POS** option who:

- Qualifies as a participating **provider** in general practice, internal medicine, family practice or pediatrics, and
- Has been selected by you as authorized by your **health care company** to provide your primary health care.

**Private duty nursing:** nursing services provided in the home by a private duty nurse who holds a valid, recognized nursing certificate and is licensed according to state law in the state in which services are received.

**Provider:** a person, such as a **physician**, physical therapist or **chiropractor**; an organization, such as a **home health care agency**; or a facility, such as a **hospital**, that provides health care services or supplies.

**Qualified Medical Child Support Order (QMCSO):** a judgment, decree or order issued by a court or a certain administrative process that requires medical coverage for an **eligible employee's** child and that has been determined to be qualified under the Internal Revenue Code of 1986, as amended. It is the policy of Avaya Inc. to comply with the requirements of a QMCSO (see "Important Contacts").

**Qualified status change:** as permitted under federal regulations, qualified changes in status include the following:

Qualified Status Change	Description
Marital Status	A change in your legal marital status, including marriage, death of your spouse, divorce, legal separation, or annulment.
Number of Family Members	Events that change the number of eligible family members, including birth, adoption, placement for adoption, or death.
Employment Status	A termination or commencement of employment by you, your spouse or a child.
Work Schedule	A reduction or increase in hours of employment by you, your spouse, or a child, including a switch between part-time and full-time or the start of or return from an unpaid leave of absence.
Family Member Meets or No Longer Meets the Eligibility Requirements	An event that causes a member of your family to meet or to no longer meet the plan's eligibility requirements for coverage. This may include a child reaching the maximum age for coverage, etc.
Residence or Worksite	A change in the place of residence or worksite of you, your spouse or a child.

Avaya Inc. also considers corresponding changes in **domestic partner** and/or **domestic partnership dependents** as a qualified status change.

The Internal Revenue Service states you may change coverage during the year if you have a qualified change in status. Qualified status changes must be reported to the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) *within* 31 days of the event.

**Reasonable and customary charge:** the fee determined by the **Claims Administrator** on the basis of:

- The fees a **provider** usually charges most patients for a similar service, and
- The range of fees charged by **providers** with similar training and experience for the same or similar services within the geographic region.

For the **Prescription Drug Program**, the reasonable and customary charge is consistent with the cost of prescriptions obtained from **participating pharmacies**.

**Rehabilitation therapy:** services provided by a physical therapist, speech therapist or occupational therapist. Rehabilitation services may be provided in a **hospital**, **extended care facility** or through a **home health care agency**. However, the need for rehabilitation cannot be the primary reason for hospital confinement. Rehabilitation therapists may work independently or be on the staff of a **hospital**, **extended care facility** or **home health care agency**.

**Residential treatment:** a type of care **covered** under the **in-network** benefits of the **Mental Health and Chemical Dependency Program**. Residential treatment means 24-hour-a-day **in-patient** care in a facility that provides sub-acute care, which is less intense than the treatment typically offered by a **hospital**. The facility must provide regular treatment activities under the supervision of licensed and certified mental health professionals, with both **physician/psychiatrist** and nursing services available on either a staff or contracted basis. A residential treatment facility is not solely or principally an alternate residence or a place of rest. On the contrary, measurable improvement, the reasonable likelihood of future improvement, and active family or guardian participation in the treatment are important criteria for authorization of continued treatment.

**Skilled nursing facility:** a facility that provides continuous skilled nursing care on an **in-patient** basis. It must be licensed in accordance with state and local law and be accredited by the Joint Commission on the Accreditation of Healthcare Organizations or approved by Medicare. A skilled nursing facility is not primarily a place for rest, for the aged, for **custodial care**, or for the treatment of **mental illness** or **chemical dependency**.

**Specialist:** a **physician** in any generally accepted medical or surgical sub-specialty who provides medical care.

**Speech therapy:** therapy services that assist in the correction of communication abilities that have been acutely impaired by illness, injury or birth defect.

**Traditional Indemnity:** a Medical Plan option for which an annual **deductible** generally applies to **covered** services. (Certain services do not require you to pay a **deductible**.) You pay the percentage of **covered** expenses that applies. Unless you use a **National Advantage Program network provider**, you file claim forms to be reimbursed. See “How the Traditional Indemnity Option Works.”

**Urgent:** a medical condition that manifests itself by acute symptoms of sufficient severity that postponing treatment for more than 48 hours would:

- Place the patient’s life in jeopardy,
- Cause serious, permanent impairment of a bodily part or function, or
- Cause severe pain.

Care that is needed to treat such a condition is called urgent care. Care rendered after the urgent situation has passed is not urgent care.

An urgent care facility is freestanding and not connected to a **hospital**. An urgent care facility is designed to respond to urgent medical conditions and perform minor surgical procedures.

**Urgent care claim:** a medical benefit claim where applying the non-urgent care time frames (i) could seriously jeopardize your health or ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain without the care or the treatment that is the subject of the claim.

## PARTICIPATING IN THE PLAN

### **Who Is Eligible**

If you are an **eligible employee** (a regular, active, full-time or part-time, represented employee who works for a **Participating Company**), you are eligible to participate in the Medical Plan. There is a six-month waiting period. If you wish, you may enroll for coverage earlier by paying the full coverage cost during the waiting period (see “Enrolling Early”). This cost is waived if you have been continuously **covered** as a dependent of another eligible Avaya employee or retiree.

Individuals who are not paid from the U.S. payroll of a **Participating Company**, who are employed by an independent company (such as an employment agency), or whose services are rendered pursuant to an agreement excluding participation in benefit plans are not eligible to participate in the Medical Plan.

### **Eligible Dependents**

As a participant in the Medical Plan, you also may enroll your **eligible dependents** for coverage.

Generally, you must enroll your **eligible dependents** in the same option that you chose for yourself, unless you are in one of the following situations:

SITUATION	ADMINISTRATION
You are enrolled in the <b>POS</b> option and your <b>covered dependents</b> permanently live separately from you and outside the <b>network</b> area.	Your dependents may be enrolled as “out-of-area” by completing special paperwork through <b>Aetna</b> . <b>Traditional Indemnity</b> option benefits will be provided.
Your <b>lawful spouse, domestic partner</b> or child is also an Avaya Inc. eligible active or retired employee.	Persons who qualify as the dependents of either an active or retired employee may be enrolled as the dependents of either, but not of both. See “Avaya Inc. Families.” If such person is enrolled as a dependent, they must enroll in the same option. Otherwise, they may or may not enroll in the same option.

SITUATION	ADMINISTRATION
You have a <b>Class II dependent</b> continuously enrolled since January 1, 1996 under the Medical Plan and any predecessor plans for other covered charges only.	The <b>Class II dependent</b> is covered only for those benefits designated at “other covered charges” and payable under the terms of the <b>Traditional Indemnity</b> option, regardless of the option in which the employee enrolls.

If you elect to enroll your **domestic partner** and/or **domestic partnership dependents**, you and your **domestic partner** must complete an Affidavit of Domestic Partnership. This affidavit is available on the Avaya Healthy Decisions Web site ([www.AvayaHealthyDecisions.com](http://www.AvayaHealthyDecisions.com)) under the “Reference Materials & Forms” section. Have the agreement notarized and return the affidavit to the **Avaya Health and Benefits Decision Center**.

The **Avaya Health and Benefits Decision Center** can tell you the tax impact of enrolling a **domestic partner** and/or **domestic partnership dependents**. Under IRS regulations, you contribute toward the cost of Medical Plan coverage on a pre-tax basis for yourself and for your family members *other than* your **domestic partner** and/or **domestic partnership dependent**. The same tax advantages do not apply when you cover your **domestic partner** and/or **domestic partnership dependent**. Under IRS regulations, you cover them with after-tax contributions and the amount of the Company’s cost to cover them is reported as taxable income to you each month. This taxable income is subject to both income tax and FICA withholding. The amount of taxable income depends on the Medical Plan option you elect, and on whom you elect to cover.

You may enroll another **eligible employee** or Avaya Inc. retiree (who participates in The Avaya Inc. Pension Plan) as your dependent, as long as the eligibility requirements are satisfied. If you enroll another **eligible employee** or represented Avaya Inc. retiree as your **eligible dependent**, he or she will have to waive his/her own coverage to be your dependent, since he or she cannot be covered as both an **eligible employee** and an **eligible dependent**. He or she would not be eligible to receive cash back in his/her paycheck. See “Avaya Inc. Families.” A represented active or retired Avaya Inc. employee cannot enroll a salaried active or retired Avaya Inc. employee as an **eligible dependent**.

### **Enrollment**

What you need to do to enroll for medical coverage depends on whether you are:

- A newly **eligible employee**,

- An employee changing your existing coverage during an **annual enrollment** period, or
- An employee changing your existing coverage during the year due to a **qualified status change** (see “Changing Your Coverage During the Year”).

### Newly Hired Employees

If you are an **eligible employee**, you may enroll in the Medical Plan immediately. However, there is a six-month waiting period before the Company contributes towards the cost of your coverage. If you wish, you may enroll for coverage earlier by paying the full coverage cost during the waiting period. This cost is waived if you have been continuously **covered** as a dependent of another eligible Avaya employee or retiree (see “Avaya Inc. Families”). For information, see “Enrolling Early” and “Your Monthly Contribution.”

After you start working for a **Participating Company**, an enrollment letter will be sent to your home address. The letter will include information about how to enroll yourself and your **eligible dependents** and the date by which you must make your elections. You can make your enrollment elections online by logging onto the Avaya Healthy Decisions Web site at [www.AvayaHealthyDecisions.com](http://www.AvayaHealthyDecisions.com) or by calling the **Avaya Health and Benefits Decision Center** (see “Important Contacts”).

After you receive the letter, by the specified date in the enrollment letter, you may:

- Change from the **assigned option** to another available option,
- Choose a coverage option, if one was not assigned, or
- Enroll your **eligible dependents**.

In addition, if you can certify that you have medical coverage elsewhere, you may decline Avaya Inc.'s medical coverage. In this case, if you are a full-time employee or part-time employee scheduled to work at least 25 hours a week, you may be able to receive cash back in your paycheck.

If you do not make any elections by the specified date indicated in your enrollment letter, here is what will happen:

- If you are a regular, full-time **eligible employee** or a regular, part-time **eligible employee** scheduled to work *at least 25 hours* a week, you will be continued to be **covered** under your **assigned option**. Your dependents *will not* be covered. You may change your coverage due to a **qualified status change** (see “Changing Your Coverage During the Year”). Otherwise, you will *not* be permitted to make any changes until the next **annual enrollment**.

- If you are a part-time **eligible employee** scheduled to work *fewer than 25 hours* per week, you do *not* have an automatic **assigned option**. This means you and your dependents *will not* be **covered** under the Medical Plan for the current year. You must wait until the next **annual enrollment** to enroll, unless you have a **qualified status change**.
- If you are already enrolled through the early enrollment process (see “Enrolling Early”), your current choices will continue unless you elect otherwise.

Generally, you do not need to re-enroll each year, unless you wish to change your coverage category.

### Assigned Option

The **assigned option** is automatically assigned if you do not enroll. Not all employees have an **assigned option**. Your eligibility for an **assigned option** depends on your job classification. The option that is assigned is determined by whether or not you live in a **POS** area. Here is how it works.

Job Classification	Your Assigned Medical Option If You Live:	
	Within a POS Area	Outside a POS Area
Full-time <b>eligible employee</b>	<b>POS</b> option	<b>Traditional Indemnity</b> option
Part-time <b>eligible employee</b> , scheduled to work 25 hours or more per week	<b>POS</b> option	<b>Traditional Indemnity</b> option
Part-time <b>eligible employee</b> , scheduled to work fewer than 25 hours per week*	No <b>assigned option</b>	No <b>assigned option</b>
*If you are a part-time employee hired before January 1, 1981, you will have an <b>assigned option</b> as if you worked 25 or more hours per week, regardless of the number of hours you are actually scheduled to work.		

Generally, coverage *automatically* begins under your **assigned option** on the first day of the month in which you complete six months of **net credited service**, unless you elect to enroll earlier (see “Enrolling Early”). If you do not meet the requirements for an **assigned option**, you must enroll by the specified date in your enrollment letter to have medical coverage.

If you enroll your **eligible dependents** at the same time you enroll yourself, coverage for those dependents begins the same day as your coverage begins.

## Enrolling Early

You may begin coverage before you complete six months of **net credited service** by enrolling and paying the full coverage cost. If you enroll, you also may enroll your **eligible dependents**.

Coverage begins as follows:

- If you enroll *within 31 days*, coverage is effective as of your first day of work as an **eligible employee**.
- If you enroll *after* the first 31 days, coverage begins based on when you enroll, but not later than the first of the month following the month in which you enroll.

An **Avaya Health and Benefits Decision Center** representative (see “Important Contacts”) can assist you with your particular situation.

Toward the end of your six-month waiting period, you will have an opportunity to select, confirm or change your coverage elections.

## Declining Avaya Inc. Medical Coverage

If you can certify that you have medical coverage from a non-Avaya Inc. source (such as a medical plan provided by your spouse’s employer), you may elect to decline Avaya Inc.’s Medical Plan coverage. In this event, if you are a full-time employee or part-time employee scheduled to work at least 25 hours a week, you will be reimbursed a portion of your cost for coverage as taxable income in your paycheck. This reimbursement is *not* available to part-time employees scheduled to work less than 25 hours a week.

The cash back option is *not* available if you are **covered** as a dependent of another Avaya Inc. employee/retiree.

As with any benefit election, you will want to carefully consider the benefits and costs for all the options available to you and to select the coverage that makes the most sense for you.

## Annual Enrollment

During **annual enrollment** each year, you will have an opportunity to select the benefits that best meet your needs for the coming year. You may change the **eligible dependents** you cover and/or change Medical Plan options. **Annual enrollment** is held once a year, usually in the fall.

You will receive enrollment information, including the coverage options available to you for the following year. If you do not elect to make any changes, your current coverage option will continue unless it is being discontinued or replaced by another option for your

area and/or job classification. If your current option is discontinued or replaced by another option, you will be enrolled in your **assigned option**. However, if you are not eligible for an **assigned option**, you will not be enrolled in any option unless you actively enroll. For more information, see “Assigned Option.”

Elections made during **annual enrollment** are effective on the first day of the following calendar year.

### **Confirmation Statements**

A confirmation statement will be generated after you enroll or change benefits during **annual enrollment** or at any other time during the year. Be sure to review the information carefully and report any discrepancies immediately to the **Avaya Health and Benefits Decision Center** (see “Important Contacts”).

### ***If You and Your Spouse or Domestic Partner Work for a Participating Company***

If you are a newly hired, regular, active, full-time or part time, represented employee *and* you were **covered** as an **eligible dependent** of another Avaya Inc. employee on the day immediately before your date of hire, you are eligible for Medical Plan coverage as an employee on your first day of active service with a **Participating Company**.

Only one employee of Avaya Inc. may enroll any given **eligible dependent**. Either you or your **lawful spouse** (or **domestic partner**), as an employee or retiree, may cover your dependent **children**. A child may not be **covered** under the Medical Plan by both parents at the same time.

### **Changing Your Coverage During the Year**

If you have a **qualified status change**, you may make a related change in your Medical Plan coverage level, that is, in the **eligible dependents** you cover and your tier of coverage (individual, two-person, family, or no coverage). You may also make a change in your coverage option. You must contact the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) any time you have a **qualified status change** and wish to make a corresponding change in coverage. You have 31 days after the event to make a change. *If you do not enroll your new dependent within 31 days and you are enrolled in the **POS** option or **Traditional Indemnity option** (non-**HMO** option), you will be permitted to elect coverage for your new dependent prospectively the first of the following month. If you do not enroll your new dependent within 31 days and you are enrolled in an **HMO** option, you will not be permitted to elect coverage for your dependent until the next **annual enrollment** period, unless you experience another applicable **qualified status change**.*

## If Your Coverage Option Changes During the Year

If your job classification changes, you move in or out of a **POS** area, or you have a **qualified status change**, your medical coverage option may change before the next **annual enrollment**.

If your coverage option changes during the calendar year, here is what will happen:

- Any amounts you have paid toward your annual **deductible** under your prior option apply toward satisfaction of your **deductible** under your new option during that calendar year. **Deductible** amounts applied **out-of-network** under the **POS** option apply to **deductible** amounts under the **Traditional Indemnity** option, and vice versa.
- Amounts you have paid that apply toward your **out-of-pocket maximum** under the **Traditional Indemnity** option apply toward satisfying the **out-of-network out-of-pocket maximum** under the **POS** option during that calendar year, and vice versa.
- Amounts you have paid as **copayments** under the **POS** option or an **HMO** do *not* apply toward satisfying either the **deductible** or **coinsurance** requirements under the **Traditional Indemnity** option.
- Amounts you have paid as **deductibles** or **coinsurance** amounts under the **Traditional Indemnity** option do *not* apply toward satisfying the **in-network out-of-pocket maximum** under the **POS** option.
- For any benefits with an annual limit, such as home health care and chiropractic care, any services incurred under your prior option count toward the benefit limits of your new option during that calendar year.
- Your **Mental Health and Chemical Dependency Program** and **Prescription Drug Program** benefits are unaffected unless you move into or out of an **HMO**.

## Special Enrollment Period

In addition to the changes you may make due to a **qualified status change**, you have a window in which you may enroll someone outside their initial enrollment period or an **annual enrollment** period if:

- The individual is an **eligible employee** or **eligible dependent**,
- You previously declined Medical Plan coverage for that person due to their coverage under another group health plan or personal health insurance, and

- That person loses their other health coverage for reasons other than failure to pay premiums as required or for termination for cause.

You must contact the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) to enroll that person *within 31 days* after the other health coverage is lost. If you miss the deadline, you must wait until the next **annual enrollment** period to enroll that person.

## OVERVIEW OF COVERAGE OPTIONS

The Medical Plan offers up to three coverage options, where available. The options include:

- **POS**
- **Traditional Indemnity**
- **HMO**

While the options cover many of the same services and supplies, you will see differences in how you obtain care and how you pay for that care.

The options available to you are based on your home zip code. Your eligibility to enroll in the Standard or Enhanced **POS** options or an **HMO** depends on whether those coverages are available where you live. If you live within a **POS** area, you may choose between the **POS** option and any **HMOs** offered to your home zip code. However, you may not choose the **Traditional Indemnity** option if you live within a **POS** area. If you do *not* live within a **POS** area, you will be offered the **Traditional Indemnity** option and any **HMOs** offered to your home zip code. If your home zip code is not in a designated **POS** area, you may be eligible to “opt-in” to **POS** coverage if you live nearby a **network** area that is available to other Avaya Inc. employees. For more information about the “opt-in” provision, contact the **Avaya Health and Benefits Decision Center** (see “Important Contacts”).

### Coverage Options: A Comparison

#### POS and Traditional Indemnity Option Comparison Chart

	Point-of-Service Option <sup>1</sup>		Traditional Indemnity Option <sup>1</sup>
	In-Network	Out-of-Network	
<b>General Provisions</b>	Offered if you live in an <b>Aetna Choice POS II</b> area (“Opt-in” coverage may also be available)		Offered if you live in a non- <b>POS</b> area
Choice of Doctors	Any <b>network provider</b> , but <b>PCP</b> selection/use required for lowest <b>copayment</b>	Any eligible <b>provider</b>	Any eligible <b>provider</b>
Annual <b>Deductible</b> <sup>2</sup>	None	\$600/individual \$1,200/two-person or family	\$250/individual \$500/two-person \$750/family
Emergency Room/ <b>Hospital Admission Copayment</b>	\$65 per emergency room visit (waived if admitted)	\$70 per emergency room visit (waived if admitted); \$200 per <b>hospital</b> admission	None

	Point-of-Service Option <sup>1</sup>		Traditional Indemnity Option <sup>1</sup>
	In-Network	Out-of-Network	
Annual <b>Out-of-Pocket Maximum</b> <sup>3</sup>	\$1,000/individual, \$2,000/two-person or family	\$3,000/individual \$6,000/two-person or family	\$1,000/individual \$2,000/two-person \$3,000/family
<b>Precertification Responsibility</b>	Your <b>PCP</b> or <b>network specialist</b>	You	You
Claim Forms	No	Yes, unless you utilize an available <b>National Advantage Program provider</b>	Yes, unless you utilize an available <b>National Advantage Program provider</b>
<b>Physician Office Visit – Diagnostic and Treatment Services</b>			
Treatment of Illness or Injury	100% of the <b>prenegotiated rate</b> after \$20 <b>copayment</b> per visit for <b>PCP</b> (or participating OB/GYN), or \$30 <b>copayment</b> per visit for <b>specialist</b> .	75% of the <b>allowable amount</b> after the <b>deductible</b>	80% of the <b>allowable amount</b> after the <b>deductible</b>
Maternity	100% of the <b>prenegotiated rate</b> after \$20 OB/GYN <b>copayment</b> for first visit	75% of the <b>allowable amount</b> after the <b>deductible</b>	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply
In-Office Surgery, In-Office Lab & X-ray, Second Surgical Opinion	100% of the <b>prenegotiated rate</b> after \$20 <b>copayment</b> per visit for <b>PCP</b> (or participating OB/GYN), or \$30 <b>copayment</b> per visit for <b>specialist</b> .	75% of the <b>allowable amount</b> after the <b>deductible</b>	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply
<b>Physician Office Visits – Preventive Services</b>			
Routine Physical Exam <sup>4</sup>	100% of the <b>prenegotiated rate (copayment waived)</b> , in accordance with age/frequency guidelines as established by the <b>Claims Administrator</b> , for age 18+.	100% of the <b>allowable amount (deductible does not apply)</b> , in accordance with age/frequency guidelines as established by the <b>Claims Administrator</b> , for age 18+.	100% of the <b>allowable amount (deductible does not apply)</b> , in accordance with age/frequency guidelines as established by the <b>Claims Administrator</b> , for age 18+.
Well-Woman Care, Well-Child Care <sup>4</sup> , Immunizations	100% of the <b>prenegotiated rate</b> after \$20 <b>copayment</b> per visit for <b>PCP</b> (or participating OB/GYN), or \$30 <b>copayment</b> per visit for <b>specialist</b> .	Not <b>Covered</b>	Not <b>covered</b>
Routine Pap Smear	100% of the <b>prenegotiated rate</b> (included with office visit). Free health screenings are covered in accordance with age/frequency guidelines as established by the <b>Claims Administrator</b> .	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply. Free health screenings are covered in accordance with age/frequency guidelines as established by the <b>Claims Administrator</b> .	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply, except at a <b>hospital</b> . Free health screenings are covered in accordance with age/frequency guidelines as established by the <b>Claims Administrator</b> .

	Point-of-Service Option <sup>1</sup>		Traditional Indemnity Option <sup>1</sup>
	In-Network	Out-of-Network	
Routine Mammography Screenings <sup>5</sup>	100% of the <b>prenegotiated rate</b> (included with office visit). Free health screenings are <b>covered</b> in accordance with age/frequency guidelines as established by the <b>Claims Administrator</b>	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply. Free health screenings are <b>covered</b> in accordance with age/frequency guidelines as established by the <b>Claims Administrator</b> .	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply. Free health screenings are <b>covered</b> in accordance with age/frequency guidelines as established by the <b>Claims Administrator</b> .
Prostate Cancer Screenings <sup>5</sup>	100% of the <b>prenegotiated rate</b> (included with office visit). Free health screenings are <b>covered</b> in accordance with age/frequency guidelines as established by the <b>Claims Administrator</b>	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply. Free health screenings are <b>covered</b> in accordance with age/frequency guidelines as established by the <b>Claims Administrator</b> .	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply. Free health screenings are <b>covered</b> in accordance with age/frequency guidelines as established by the <b>Claims Administrator</b> .
<b>Out-patient Services – Treatment and Services Performed Outside a Physician’s Office</b>			
Surgery, Maternity	100% of the <b>prenegotiated rate</b>	75% of the <b>allowable amount</b> after the <b>deductible</b>	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply
Lab & X-ray	100% of the <b>prenegotiated rate</b>	75% of the <b>allowable amount</b> after the <b>deductible</b>	100% of the <b>allowable amount</b> ; the <b>deductible</b> applies if <b>out-patient hospital</b> service
Radiation Therapy, Chemotherapy	100% of the <b>prenegotiated rate</b>	75% of the <b>allowable amount</b> after the <b>deductible</b>	100% of the <b>allowable amount</b> ; the <b>deductible</b> applies if <b>out-patient hospital</b> service
<b>In-patient Services</b>			
Hospital Room & Board <sup>6</sup>	100% of the <b>prenegotiated rate</b>	75% of the <b>allowable amount</b> after the <b>deductible</b> and \$200 per admission <b>copayment</b>	100% of the <b>allowable amount</b> after the <b>deductible</b>
Surgery, Anesthesia	100% of the <b>prenegotiated rate</b>	75% of the <b>allowable amount</b> after the <b>deductible</b>	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply
Lab & X-ray	100% of the <b>prenegotiated rate</b>	75% of the <b>allowable amount</b> after the <b>deductible</b>	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply
Physician Hospital Visits and Consultations	100% of the <b>prenegotiated rate</b>	75% of the <b>allowable amount</b> after the <b>deductible</b>	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply
Maternity	100% of the <b>prenegotiated rate</b>	75% of the <b>allowable amount</b> after the <b>deductible</b>	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply

	Point-of-Service Option <sup>1</sup>		Traditional Indemnity Option <sup>1</sup>
	In-Network	Out-of-Network	
<b>Emergency Services</b>			
Emergency Room Use	100% of the <b>prenegotiated rate</b> after \$65 <b>copayment</b> per visit (waived if admitted)	75% of the <b>allowable amount</b> after \$70 <b>copayment</b> per visit (waived if admitted)	100% of <b>allowable amount</b> ; <b>deductible</b> does not apply
Non-Emergency Emergency Room Use	75% of the <b>prenegotiated rate</b> after \$65 <b>copayment</b> per visit (waived if admitted)	75% of the <b>allowable amount</b> after the <b>deductible</b> and \$70 <b>copayment</b> (waived if admitted)	80% of the <b>allowable amount</b> after the <b>deductible</b>
<b>Ambulance – Emergency Use</b>	100% of the <b>prenegotiated rate</b>	Emergency care paid as <b>in-network</b> if <b>Aetna Member Services</b> is notified within 48 hours	80% of the <b>allowable amount</b> after the <b>deductible</b>
<b>Alternatives to In-patient Care</b>			
<b>Extended Care Facility<sup>7</sup></b>	100% of the <b>prenegotiated rate</b> <sup>8</sup>	75% of the <b>allowable amount</b> after the <b>deductible</b> , up to 60 days per Plan Year <sup>8</sup>	100% of the <b>allowable amount</b> , up to 120 days per Plan Year without the <b>deductible</b> , then 80% of the <b>allowable amount</b> after the <b>deductible</b>
<b>Home Health Care, Private Duty Nursing</b>	100% of the <b>prenegotiated rate</b> <sup>8</sup>	75% of the <b>allowable amount</b> after the <b>deductible</b> , up to 100 visits/shifts per Plan Year <sup>8</sup>	100% of the <b>allowable amount</b> , up to 200 visits/shifts per Plan Year; the <b>deductible</b> does not apply
<b>Hospice Facility Care</b>	100% of the <b>prenegotiated rate</b> <sup>8</sup>	75% of the <b>allowable amount</b> after the <b>deductible</b> , up to 210 days per lifetime <sup>8</sup>	100% of the <b>allowable amount</b> , up to 210 days per lifetime; the <b>deductible</b> does not apply
<b>Birthing Center</b>	100% of the <b>prenegotiated rate</b>	75% of the <b>allowable amount</b> after the <b>deductible</b>	100% of the <b>allowable amount</b> ; the <b>deductible</b> does not apply
<b>Other Covered Providers &amp; Supplies</b>			
<b>Occupational Therapy, Physical Therapy, Speech Therapy, Chiropractors, Podiatrists, Acupuncturists</b>	100% of the <b>prenegotiated rate</b> after \$30 <b>copayment</b> per visit, up to any applicable Plan limits on number of visits <sup>8</sup>	75% of the <b>allowable amount</b> after the <b>deductible</b> , up to any applicable Plan limits on number of visits <sup>8</sup>	80% of <b>allowable amount</b> after the <b>deductible</b> , up to any applicable Plan limits on number of visits <ul style="list-style-type: none"> <li>• <b>Speech therapy</b> is limited to 30 visits per Plan Year</li> <li>• <b>Chiropractor</b> is limited to 60 visits per Plan Year</li> <li>• <b>Acupuncture</b> is limited to 30 visits per Plan Year</li> </ul>
Durable Medical Equipment, Blood Replacement	100% of the <b>prenegotiated rate</b>	75% of the <b>allowable amount</b> after the <b>deductible</b>	80% of the <b>allowable amount</b> after the <b>deductible</b>
Nutritionist <sup>9</sup>	100% of the <b>prenegotiated rate</b> after \$30 <b>copayment</b> per visit for <b>specialist</b>	Not covered	Not covered

	Point-of-Service Option <sup>1</sup>		Traditional Indemnity Option <sup>1</sup>
	In-Network	Out-of-Network	
Smoking Deterrents, Birth Control (Prescription only)	100% of the <b>prenegotiated rate</b> after \$20 <b>copayment</b> at office visit (for <b>PCP</b> or participating OB/GYN), or \$30 <b>copayment</b> per visit for <b>specialist</b> , or as <b>covered</b> under the <b>Prescription Drug Program</b>	75% of the <b>allowable amount</b> after the <b>deductible</b> at office visit or as <b>covered</b> under the <b>Prescription Drug Program</b>	80% of the <b>allowable amount</b> after the <b>deductible</b> at office visit or as <b>covered</b> under the <b>Prescription Drug Program</b>
Prescription Drugs	<p>Retail Drugs (up to a 30-day supply)</p> <ul style="list-style-type: none"> <li>• Generic \$10</li> <li>• Brand \$25</li> <li>• Insulin (90-day supply) \$50</li> </ul> <p><b>\$0 copayment</b> for chemotherapy drugs</p> <p>Home-Delivery Drugs (up to a 90-day supply)</p> <ul style="list-style-type: none"> <li>• Generic \$20</li> <li>• Brand \$50</li> </ul> <p>Mandatory home delivery for maintenance drugs – After three consecutive fills for the same dosage at the retail level, the drugs will only be covered by <b>Aetna Rx Home Delivery</b>.</p> <p>Separate \$1,000 per person, \$3,000 per family annual <b>out-of-pocket maximum</b>.</p>	<p><b>Deductible</b> (\$50 per individual and \$150 per family) and 20% <b>coinsurance</b> applies; there is no annual <b>out-of-pocket maximum</b>.</p> <p>Mandatory home delivery for maintenance drugs – After three consecutive fills for the same dosage at the retail level, the drugs will only be covered by <b>Aetna Rx Home Delivery</b>.</p>	Same as <b>POS</b> option
Prescription Drug Utilization Management Program	The prescription drug utilization management program will require precertification for certain types of prescription drugs: non-sedating antihistamines, Proton Pump Inhibitors, migraine medications, acne products, growth hormones, weight loss products, select pain medications, flu medications, COX-IIs and Anti-fungals. Precertification means that requirements will have to be met before the Medical Plan will cover the prescription.		

	Point-of-Service Option <sup>1</sup>		Traditional Indemnity Option <sup>1</sup>
	In-Network	Out-of-Network	
Mental Health/ Chemical Dependency	First 5 days/visits per year free, \$25 <b>copayments</b> apply for additional visits/days; separate \$750 per person annual <b>out-of-pocket maximum</b> .	\$250 <b>deductible</b> per person and 50% <b>coinsurance</b> applies; there is no annual <b>out-of-pocket maximum</b> .  \$500 <b>copayment</b> per admission for inpatient care	Same as <b>POS</b> option
<p><sup>1</sup> Dependents under the <b>POS</b> option who permanently reside outside of a <b>POS</b> area will receive benefits according to the <b>Traditional Indemnity</b> option schedule.</p> <p><sup>2</sup> This health care <b>deductible</b> is separate from any <b>deductibles</b> under your <b>Prescription Drug Program</b> and the <b>Mental Health and Chemical Dependency Program</b>.</p> <p><sup>3</sup> Certain expenses (e.g., the <b>deductible</b>, <b>precertification</b> penalties and any expenses in excess of the <b>allowable amount</b>) do not count toward the <b>out-of-pocket maximum</b>. This <b>out-of-pocket maximum</b> is separate and apart from the <b>out-of-pocket maximums</b> under the <b>Mental Health and Chemical Dependency Program</b> and the <b>Prescription Drug Program</b>.</p> <p><sup>4</sup> Physical exams/Well-Child visits are permitted as follows: until age 1 - 7; during 2nd year – 2; ages 2 through 17 – 1 per year; ages 18 through 64 – once every 24 months; age 65+ – once every 12 months.</p> <p><sup>5</sup> These preventive services are subject to age guidelines: Routine mammograms under the <b>Traditional Indemnity</b> option or <b>out-of-network</b> under the <b>POS</b> option are restricted to one baseline for women aged 40 and then annual screenings at age 41+; Routine prostate screening is <b>covered</b> annually for men aged 40+ and then one colorectal screening per Plan Year is <b>covered</b> annually for men and women aged 50+.</p> <p><sup>6</sup> Semi-private; private if only room type available or <b>medically necessary</b>. Under the <b>Traditional Indemnity</b> option, if a non-<b>National Advantage Program</b> hospital only has private rooms, the <b>reasonable and customary charge</b> shall be 90% of the most prevalent room and board charge.</p> <p><sup>7</sup> Maximum includes both <b>hospital</b> and <b>extended care facility</b> days. Each <b>hospital</b> day counts as one full day toward this maximum and each <b>extended care facility</b> day counts as one half-day toward this maximum.</p> <p><sup>8</sup> Days/visits received <b>in-network</b> apply to day/visit maximums <b>out-of-network</b> and vice-versa.</p> <p><sup>9</sup> Not for weight loss counseling unless <b>medically necessary</b>.</p>			

## HMO Option Coverage Chart

General Provisions	HMO Option*
Choice of Doctors	Any <b>network</b> provider, as coordinated through your <b>Primary Care Physician (PCP)</b>
Annual Deductible	None
Copayment	Varies by <b>HMO</b> . Generally \$15-\$20 <b>copayment</b> per office visit and \$100 per hospital admission
Coinsurance	Generally, not applicable
Annual Out-of-Pocket Maximum	Varies by <b>HMO</b>
Precertification Responsibility	Your <b>PCP</b>
Claim Forms	No
Covered Services	Varies by <b>HMO</b>
Prescription Drugs	Varies by <b>HMO</b>
Mental Health and Chemical Dependency	Varies by <b>HMO</b>
<p>* You may select the <b>HMO</b> option if you live in an <b>HMO</b> area. To find out which services are offered by a particular <b>HMO</b>, call the applicable <b>HMO</b> directly. You need to contact the <b>Avaya Health and Benefits Decision Center</b> (see "Important Contacts"), and not your <b>HMO</b>, when you have to add or drop coverage for a dependent, or when you have questions about the medical eligibility status of your dependents.</p>	

## POS OPTION

The **POS** option provides a preferred level of benefits and reduced paperwork when you select **in-network providers** for your medical care, yet gives you the flexibility to go **out-of-network** when you choose. You choose between **in-network** and **out-of-network providers** each time you need medical care.

### *How the POS Option Works*

You do not need a referral from your **primary care physician (PCP)** to see a **network specialist**, however, you should select a **PCP** for each **covered** person to oversee **in-network** care. To receive the **in-network** level of benefits, you must use an **in-network provider**.

Generally, by obtaining services **in-network**, and utilizing your selected **PCP** as appropriate, you will receive a higher level of benefits.

When you go **out-of-network**, you have the flexibility to choose any health care **provider** you prefer. However, your cost usually is higher for **out-of-network** care.

### *In-Network Benefits: Usually a Higher Level of Benefits*

Generally, you will receive a higher level of benefits when you go **in-network**. There are a number of reasons for this:

- You do not pay a **deductible**.
- You do not need to submit claim forms and wait to be reimbursed.
- Your **PCP** or **network specialist** obtains any needed **precertification** for you.
- You only pay a **copayment** for **covered** services when required. For some services, you do not pay anything. When a **copayment** is required, you pay a specific dollar amount at the time of service. After the **copayment**, you do not have any further payment obligations.
- Additional preventive care services are available that are not **covered out-of-network**.
- A number of **covered** services (for example, home health care), which are limited **out-of-network**, are offered without a limit on the number of **medically necessary** visits when the care is coordinated by your **PCP** or **network specialist**.

## The Provider Network

The **provider network** is a system of health care suppliers - including **physicians, hospitals,** and supporting **providers** such as **home health care agencies** and **extended care facilities**. Through the **network**, you will have access to the full range of services necessary to meet your health care needs.

If you need specialized care that **Aetna** determines is **medically necessary** and it is not available in your area, you will be directed to a qualified **non-network provider**. As long as you use the **provider** directed to by your **PCP** or **network specialist**, you will receive **in-network** benefits for that care. You should verify with **Aetna** Member Services that there are no **network providers** in your area.

## Your Primary Care Physician

A **primary care physician**, or **PCP**, is a doctor who coordinates your **in-network** health care. When you enroll in the **POS** option, you should select a **PCP** for yourself and each of your **covered dependents**.

Your **PCP** is responsible for:

- Giving regular checkups
- Providing treatment when you or a **covered dependent** is ill
- Ordering necessary lab work, X-rays or other tests
- Directing you or a **covered dependent** to a **network specialist** when necessary
- Arranging for hospitalization or **out-patient** treatment
- Handling all required **precertifications**

You do not need to contact your **PCP** first in an **emergency** or before visiting a **network specialist**. In addition, you do not need a **PCP** referral for treatment of a mental health and/or **chemical dependency** condition. Simply call **Aetna** for **precertification**.

- *Emergency Care.* In an **emergency**, you or your **covered dependent** should get care immediately. However, to receive benefits at the **in-network** level:
  - The situation must qualify as an **emergency** under the **POS** option, and

- You must contact **Aetna Member Services** within 48 hours after receiving the treatment.

If these conditions are not satisfied, benefits for **covered** services will be paid at the **out-of-network** level. To avoid any misunderstandings, contact your **PCP** or **network specialist** for guidance if you are not sure if a condition is an **emergency**.

- **Specialist Visits.** You do not need a referral from your **PCP** to receive **in-network** benefits to see a **network specialist**. You will need to call **Aetna Member Services** or use the Web tools for information about participating **network specialists** in your area.

### Availability of Your PCP

**PCPs** provide coverage 24 hours a day, seven days a week. When your **PCP** is unavailable, another **physician** will be available to take your call or to see you. If you do not call during normal business hours, an answering service generally takes your call and asks your **PCP** or the covering **physician** to return your call.

### Selecting or Changing Your PCP

When you enroll in the **POS** option, you select a **PCP** for yourself and the same or different **PCPs** for each of your **covered dependents**. The names of current **PCPs** are available by calling **Aetna Member Services** or through **Aetna Navigator™** (go to [www.AetnaNavigator.com](http://www.AetnaNavigator.com), click the DocFind® link, when prompted, select the Aetna Open Access Plans, Aetna **Choice™ POS II Plan**). **PCPs** include internists, family practitioners, general practitioners and pediatricians.

You have the flexibility to change your or your dependent's **PCP** at any time. To do so, simply call **Aetna Member Services** and provide the name and ID number of the **PCP** you selected. The change to your new **PCP** is effective the day you call. Alternatively, you may change your or your dependent's **PCP** online through **Aetna Navigator** (logon as a registered user from [www.AetnaNavigator.com](http://www.AetnaNavigator.com)).

An ID card showing the newly selected **PCP** will be sent to your home address after the change is made. A temporary ID card can be printed by going to **Aetna Navigator's** Web Site at [www.AetnaNavigator.com](http://www.AetnaNavigator.com).

### Receiving Care Away From Home

If you or one of your **covered dependents** needs care when away from home, you should contact your **PCP** or **network specialist** first unless it is an **emergency**. **Emergency** treatment is **covered** at the **in-network** benefits level, but you must notify **Aetna Member Services** within 48 hours. Otherwise, the following rules apply:

- **Elective care** received from a **provider** who does not participate in the **Choice POS II network** is **covered** at the **out-of-network** benefits level.
- **Urgent care** is **covered** at the **in-network** benefits level if you use a **Choice POS II network provider** or follow your **PCP** or **network specialist's** instructions regarding care.

If your **PCP** or **network specialist** advises you to seek treatment, **in-network** benefits would apply for treatment of the **urgent** condition. Any follow-up care should be provided or coordinated by a **network provider**.

### ***Out-of-Network Benefits: More Flexibility, Lower Benefits***

When you go **out-of-network**, you may use any **covered** health care **provider** you choose. However, your cost generally will be higher than it would be if you received the same care **in-network**. For example:

- Each year, you will be required to pay a portion of your eligible expenses before the Medical Plan begins to pay benefits. This amount is called an annual **deductible**.
- After you satisfy the annual **deductible**, the Medical Plan will reimburse you for a portion of your eligible expenses and you will pay the rest. The percentage you pay is called your **coinsurance** percentage.
- You will pay a **copayment** and **coinsurance** (up to the **out-of-pocket maximum**) for each hospitalization.
- The Medical Plan will not cover any benefit reductions due to failure to precertify certain treatments.
- The Medical Plan will not cover any charges above the **allowable amount**.

There are other responsibilities that you have when you elect **out-of-network** care that are not required when you obtain **in-network** care. For example, if you elect **out-of-network** care:

- You must get **precertification** for certain **covered** services. If you do not get the required **precertification**, the amount of benefits available will be reduced or the services will not be **covered** at all. This means your cost will be higher. For more information, see "Precertification."
- You must complete claim forms and file claims with **Aetna** to receive payment of benefits, unless you use a **NAP provider**.

## Out-of-Network Care

Care is considered **out-of-network** if you or a **covered dependent**:

- Visit an **out-of-network** doctor unless **emergency** care is required,
- Do not call **Aetna** Member Services within 48 hours after receiving **emergency** treatment (or if the treatment does not qualify as an **emergency**), or
- Do not get **PCP** or **network specialist** authorization for **in-patient** or **out-patient** hospitalization.

## Free Physical Examinations

You and your **covered dependents** age 18 and over may take advantage of free physical examinations and health screenings in accordance with age guidelines as determined by the **Claims Administrator**. Screenings may include prostate screenings, mammograms and colorectal screenings.

## Your ID Card

After you enroll in the **POS** option, you will receive an ID card which contains important information such as:

- Your name and your **covered dependents** names
- Your member ID number
- The **PCP's** name for you and your **covered dependents**
- The **copayment** for key services such as office visits, **specialist** visits and **emergency** room use
- The telephone number for **Aetna** Member Services
- What to do in an **emergency**

### **Aetna Member Services**

**Aetna** Member Service representatives are available to assist you with issues related to the **POS** option Monday through Friday during normal business hours, or you can use the **Aetna** Navigator Web site at your convenience, day or night. You can reach **Aetna** Member Services at the telephone number printed on your ID card or online at [www.AetnaNavigator.com](http://www.AetnaNavigator.com):

- To request a new Provider Directory or the latest information about **network providers**,
- To change your **PCP**,
- To replace a lost ID card,
- To find out if a claim was paid,
- If you have a service issue with a **network provider**,
- To find out how your **covered dependent** child away at college should obtain care,
- To get claim forms (generally only required for **out-of-network** care), or
- To obtain more detailed information about your benefit coverage.

## THE TRADITIONAL INDEMNITY OPTION

In addition to the **POS** and **HMO** options, the Medical Plan offers a **Traditional Indemnity** option. This option is only available to employees who live in a non-**POS** area.

### *How the Traditional Indemnity Option Works*

Under the **Traditional Indemnity** option:

- You and your **covered dependents** may go to any **physician** you choose. Or you may choose to take advantage of a special feature -- the **National Advantage Program (NAP)** -- if it is available in your area.
- Each year, you will be required to pay a portion of your eligible expenses before the Medical Plan begins to pay expenses. This amount is called the annual **deductible**.
- After you satisfy the **deductible**, the Medical Plan will reimburse you for a portion of your eligible expenses and you will pay the rest. The percentage you pay is called your **coinsurance** percentage.
- The Medical Plan will not cover any benefit reductions due to failure to precertify certain treatments.
- The Medical Plan will not cover any charges above the **allowable amount**.
- You file claim forms to be reimbursed unless you use **NAP network providers**.

When you receive your medical care from **providers** in the **National Advantage Program**, benefits continue to be paid according to the **Traditional Indemnity** option schedule; however, **provider** charges generally are lower and guaranteed to be within the **allowable amount**. Another advantage is that **providers** in the **National Advantage Program** must meet strict quality guidelines to join and remain in the program. To get a directory of **NAP network providers** in your area, contact **Aetna** Member Services at the number printed on your ID card or log onto **Aetna** Navigator at [www.AetnaNavigator.com](http://www.AetnaNavigator.com).

### **Precertification Is Required for Certain Services**

The decision of whether or not to undergo any given treatment is for you and your doctor to make. However, since there are many types of services for which alternatives may be appropriate, the Medical Plan requires that you precertify certain treatments.

Under the **Traditional Indemnity** option, you and your **covered dependents** must get **precertification** for certain covered expenses. If you do not get the required **precertification**, the amount of benefits available will be reduced, and in some cases, no benefits are payable. This means your cost will be higher. See "Precertification."

### **Free Physical Examinations**

You and your **covered dependent** age 18 and over may take advantage of free physical examinations and health screenings in accordance with age guidelines as determined by the **Claims Administrator**. Screenings may include prostate screenings, mammograms and colorectal screenings.

### **Your ID Cards**

After you enroll in the **Traditional Indemnity** option, you will receive an ID card which contains important information such as:

- Your name and your **covered dependents** names
- Your member ID number
- The telephone number for **Aetna Member Services**
- The telephone number to call for **precertification**
- What to do in an **emergency**

### **Filing a Claim**

You do not need to submit a claim form when you use **NAP network providers**. You must file a claim to request benefits when you do not use **NAP network providers**. Please file your claims as soon as possible – generally, within 60 days of receiving services. Claims must be filed within 15 months from the date of service to be eligible for payment.

### **Aetna Member Services**

**Aetna** Member Services is available to help you with issues related to the **Traditional Indemnity** option. You can reach **Aetna** Member Services at the telephone number printed on your ID card or log on to **Aetna** Navigator at [www.AetnaNavigator.com](http://www.AetnaNavigator.com):

- To request information about the **NAP network** (online in DocFind, under Select a Plan, select National Advantage<sup>TM</sup> Program (NAP)),
- To replace a lost ID card,
- To find out if a claim was paid,
- If you have a service issue with a **NAP network provider**,
- To get claim forms, or
- To obtain further details on benefit coverage.

## HMO OPTION

A **Health Maintenance Organization (HMO)** is a Medical Plan option that generally requires you to follow specified rules for obtaining care.

Under an **HMO** option:

- A single **physician** coordinates your care.
- You will pay a **copayment** to the **provider** at the time of service.
- You usually do not pay any **deductibles** or **coinsurance** amounts.
- You are not responsible for paying charges for **HMO providers'** authorized services that exceed the **allowable amount**.
- You do not need to file claim forms.
- Services provided outside the **HMO** are **covered** only in certain **emergency** situations.

Your enrollment materials will tell you whether an **HMO** is available in your area. The coverage available varies depending on the **HMO** you select. You should contact the specific **HMOs** you are interested in to compare coverages. You may also request the evidence of coverage document for your **HMO** from the **HMO's** Member Services. If you are **covered** under the **HMO** option, the **Mental Health and Chemical Dependency Program** and the **Prescription Drug Program** *do not* apply to you. Instead, you will receive benefits for those expenses under the provisions of your **HMO**.

If you choose **HMO** coverage, you are required to follow your **HMO's** rules for obtaining care. Avaya Inc. has no responsibility for the benefits provided or not provided by the **HMO**, or claims relating to **HMO** coverage. Once you have elected to participate in an **HMO**, that **HMO** governs your Medical Plan coverage in lieu of all Medical Plan provisions that cover the other Avaya Inc. Plan options.

For questions about how your **HMO** works, contact the **HMO** directly.

## MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAM

If you enroll in the **POS** option or **Traditional Indemnity** option, the **Mental Health and Chemical Dependency Program** provides you and your **covered dependents** with benefits for treatment of mental health and **chemical dependency** conditions.

If you select an **HMO** for your medical option, the **Mental Health and Chemical Dependency Program** *does not* apply to you. Instead, you will receive mental health and **chemical dependency** benefits available through your **HMO**. Contact your **HMO** for specific information about the coverage available for treatment of these conditions.

### ***How the Mental Health and Chemical Dependency Program Works***

The **Mental Health and Chemical Dependency Program** gives you and your **covered dependents** the flexibility to seek **in-network** care through the **Behavioral Health Care Coordinator** or **out-of-network** care on your own.

**In-network** benefits provide you with a higher level of coverage and greater number of services. Generally, **network providers** are available in most areas. However, if the type of **provider** you need is not available in your area through the **network**, the **Behavioral Health Care Coordinator** will refer you to a local **provider** and you will receive the **in-network** level of benefits.

If you go **out-of-network**, you will receive a lower level of benefits. This means your share of the cost will be significantly higher. In addition, coverage for certain benefits may be limited or not available **out-of-network**.

### **Mental Health and Chemical Dependency Program Is Separate From Your Medical Option**

The **Mental Health and Chemical Dependency Program** is separate from the coverage available under your medical option and the **Prescription Drug Program**. Therefore, expenses incurred under one program *do not* apply under another.

Medical conditions caused by mental health or **chemical dependency** problems are **covered** under your medical option. However, your mental health and **chemical dependency provider** may ask you to involve your doctor in certain cases, or vice versa.

### Amount of Coverage

The following charts show the coverage amounts, **in-network** and **out-of-network**, under the **Mental Health and Chemical Dependency Program**:

#### PRECERTIFIED IN-NETWORK TREATMENT OF MENTAL HEALTH AND CHEMICAL DEPENDENCY CONDITIONS

Service	In-Network Benefits (upon precertification)*	In-Network Benefit Limits**
<b>Out-patient or In-patient Care</b>		
First 5 Visits/Days per Calendar Year	No charge	
Additional Visits in Same Year	\$25 per visit	Unlimited
<b>Alternative Treatment</b>		
First 5 Days per Calendar Year	No charge	
Days 6-120 in Same Calendar Year	\$25 per day	120 days/year
*You must pre-certify any mental health or chemical dependency service to receive <b>in-network</b> benefits.		
**Visits or days utilized <b>in-network</b> apply toward <b>out-of-network</b> benefit limits. Limits accumulate separately for mental health or <b>chemical dependency</b> treatment.		

#### OUT-OF-NETWORK TREATMENT OF MENTAL HEALTH AND CHEMICAL DEPENDENCY CONDITIONS

Service	Deductible (\$250 per person)	Copayment	Coinsurance	Amount Above Allowable Amount	Precertification Penalty	Benefit Limits*
<b>Out-patient Care</b>	Applies	None	50%**	You pay, if any	Not applicable	60 visits/year
<b>In-patient (Hospital) Care***</b>	Applies	\$500/admission	50%**	You pay, if any	20% reduction (\$400 maximum per occurrence)	30 days/year
<b>Alternative Treatment</b>	Not covered out-of-network					
* Visits or days utilized <b>in-network</b> apply towards <b>out-of-network</b> benefit limits. Limits accumulate separately for mental health or <b>chemical dependency</b> treatment.						
** Percentage paid by the Medical Plan applies to <b>allowable amounts</b> only.						
*** Must be precertified.						

### Covered Out-Patient Care

Benefits are available under the **Mental Health and Chemical Dependency Program** for **out-patient** care provided by **physicians, mental health and chemical dependency professionals**, and facilities.

## Physician's Services

The following **physician's** services are **covered** under the **Mental Health and Chemical Dependency Program**:

- Diagnosis and treatment of mental health and **chemical dependency** conditions
- Psychotherapy
- Prescription of therapeutic drugs, medications or other treatments specifically required by law to be performed or supervised by a medical doctor or D.O.
- **Chemical dependency** counseling
- Laboratory tests (including charges from independent medical laboratories)

## Services Provided by Mental Health and Chemical Dependency Professionals

The following services are **covered** under the **Mental Health and Chemical Dependency Program** if provided by **mental health and chemical dependency professionals**:

- Diagnosis and treatment of mental health and **chemical dependency** conditions
- Psychological testing
- Psychotherapy
- **Chemical dependency** counseling

However, for services to be **covered**, a **provider** may treat only those conditions, either mental health or **chemical dependency**, appropriate to his/her certification and licensing status.

## Through a Facility

The following **out-patient** services are **covered** under the **Mental Health and Chemical Dependency Program**, if provided through eligible facilities and associated **providers**:

- Diagnosis of mental health and **chemical dependency** conditions
- Psychological testing
- Psychotherapy

- **Chemical dependency** counseling
- Laboratory testing performed by the facility

### **Covered In-Patient Care**

To receive the full amount of **in-patient** benefits available under the **Mental Health and Chemical Dependency Program**, you must precertify **in-network** or **out-of-network** admissions to an eligible **hospital**, acute psychiatric facility or acute **chemical dependency** facility.

The following **in-patient** services are **covered** under the **Mental Health and Chemical Dependency Program**:

- Semi-private room and board charges in the appropriate unit for the participant's condition (acute care, intensive care, isolation care or rehabilitation unit)
- Services provided in an **emergency** room
- Services and supplies normally provided by a **hospital** including any professional component of those services such as those provided by a psychiatrist, other **physician** or a **mental health and chemical dependency professional** (may include individual or group therapy for the patient and **covered dependents**, stress management, **occupational therapy** and educational and disease management programs integrated with a course of treatment)
- Detoxification services (except for a newborn, whose charges would be **covered** under your medical option, not the **Mental Health and Chemical Dependency Program**)
- Laboratory services

### **Covered Alternative Treatment (In-Network Only)**

**Alternative treatment** is **covered** only for **in-network** care that is precertified through the **Behavioral Health Care Coordinator**. It may include **partial hospitalization**, **residential treatment** and the services of a **group home or halfway house**. *No* benefits are provided for **out-of-network** care.

## Partial Hospitalization

The following precertified **partial hospitalization** services are only **covered in-network** under the **Mental Health and Chemical Dependency Program**:

- **Covered** services as determined through **precertification** by the **Behavioral Health Care Coordinator** (may include treatments such as individual and group therapy)
- Medications administered during the daily visit

## Residential Treatment

The following precertified **residential treatment** services are only **covered in-network** under the **Mental Health and Chemical Dependency Program**:

- Room and board charges
- Drugs and medications administered to you while an **in-patient** at the **residential treatment** facility
- Services normally provided by a **residential treatment** facility, including services provided by the professional staff of the facility

## Group Homes and Halfway Houses

The following precertified services of a **group home or halfway house** are only **covered in-network** under the **Mental Health and Chemical Dependency Program**:

- Room and board charges
- Services normally provided by a **group home or halfway house**, including services provided by the professional staff of the facility

## ***In-Network Benefits***

When you go **in-network** under the **Mental Health and Chemical Dependency Program**, a higher level of benefits and services is available. Your first 5 authorized visits or days for **in-patient**, **out-patient** and **alternative care** are provided at no cost to you. Thereafter, you only pay a \$25 **copayment** for each visit or day in the **hospital**. No treatment maximums apply for **in-patient** or **out-patient** care, although the number of days available for **alternative treatment** is limited.

## The Provider Network

The **provider network** is a system of health care **providers** established by the **Behavioral Health Care Coordinator** who specialize in the treatment of **mental illness** and **chemical dependency**. The **network** includes:

- Psychiatrists (M.D. and D.O.)
- Licensed psychologists (Ph.D.)
- Master's degree level **mental health and chemical dependency professionals** including:
  - Clinical social workers (L.C.S.W. or A.C.S.W.)
  - Marriage, family and child counselors (M.F.C.C.)
  - Certified alcoholism counselors (C.A.C.) or certified **chemical dependency** counselors (C.C.D.C.)
- Master's degree level nurses

The **provider network** also includes treatment facilities, such as **hospitals** and **residential treatment** centers.

For more information, see “How the Mental Health and Chemical Dependency Program Works” and “In-Network Benefits.”

## Obtaining In-Network Benefits

To receive **in-network** benefits, you must call **Aetna** and speak with a **Mental Health and Chemical Dependency Program** representative (**Behavioral Health Care Coordinator**). Use the Member Services telephone number printed on your medical ID card and select the appropriate prompt. When you call, the representative will determine the type of **provider** you need to see and will offer you choices of **network providers** to meet your needs. After your initial consultation, the **network provider** will arrange for any necessary treatment. *Note that if you do not precertify your care, you will not receive **in-network** benefits.*

You can find a **network specialist** using **Aetna's** DocFind. Go to [www.AetnaNavigator.com](http://www.AetnaNavigator.com) and click the DocFind<sup>®</sup> link. Click on the “Find A Specialist” tab. Complete the requested search criteria. Select Provider Category “Behavioral Health” and then select the Provider Type. For the Plan Selection, under Aetna Open Access Plans, choose “Choice POS II (Open Access).”

## Emergency Care

Counselors are accessible by telephone 24 hours a day, seven days a week. They can help you through an **emergency** and direct you to a **provider** for immediate assistance. In an **emergency**, you or your **covered dependent** should get care immediately by calling **Aetna** or your doctor, depending on the situation. For example, a drug overdose is a medical **emergency** and the immediate need should be to seek life saving medical treatment. In this case, **Aetna** and the **Mental Health and Chemical Dependency Program** will coordinate their responsibilities.

To receive **emergency** care benefits at the **in-network** level:

- The situation must qualify as a **mental health emergency** under the **Mental Health and Chemical Dependency Program**,
- You must receive treatment in a **hospital** setting (as an **in-patient** or through the emergency room), and
- You, your doctor or a family member must call **Aetna** Member Services within 48 hours after receiving treatment, if you are admitted. (If you are not admitted, it is still recommended that you call **Aetna** Member Services regarding appropriate follow-up care, but no penalty will apply for failing to call.)

If these conditions are not satisfied, benefits for **covered** services will not be paid.

**Emergency** care rendered by a **non-network provider** in an **out-patient** setting, such as a psychologist's office, is not **covered** at the **in-network** benefit level. For all non-in-patient facility **emergency** treatment, if you do not call **Aetna** Member Services first, you will receive only **out-of-network** benefits.

## Receiving Care Away From Home

The **Mental Health and Chemical Dependency Program** is available regardless of where you are when you need care. To receive care when you are away from home, call **Aetna** Member Services at the telephone number printed on your medical ID card and follow their instructions. If you are temporarily traveling outside the United States, **Aetna** will not be able to direct you to a **provider**. However, **emergency** care will be reimbursed at the **in-network** benefit level if you contact **Aetna** Member Services upon your return to the United States.

If you permanently reside outside the United States, both **emergency** and non-emergency care provided overseas will be reimbursed at the **in-network** level. You do not need to call **Aetna** Member Services.

### **Out-of-Network Benefits**

When you seek **out-of-network** care, you may use any **covered** mental health or **chemical dependency provider** you choose. However, the amount of **out-of-network** benefits available is significantly lower than those available for **in-network** care, limitations apply and certain services are not **covered**. Your cost for **out-of-network** care will be much higher than it would be for **in-network** care (see “Amount of Coverage”). You will have to pay:

- An annual **deductible**,
- A **coinsurance** percentage,
- A **copayment** for each hospitalization,
- Any benefit reductions due to failure to precertify a **hospital** admission,
- Any charges for expenses that are not **covered out-of-network** under the **Mental Health and Chemical Dependency Program**, and
- Any charges above the **allowable amount**.

There are other disadvantages as well. You are responsible for getting **precertification** for any **hospital** admissions (see “Precertification”) and submitting claim forms. Note that **out-of-network** benefits are not available if you use **network providers**.

### **Filing a Claim**

Generally, you only need to file a claim for **out-of-network** care. You should include:

- Your (the Avaya Inc. employee’s) name and Social Security number,
- The patient’s name and Social Security number, in the case of a **covered dependent**,
- The service **provider’s** name, credentials and tax identification number,
- The dates of service,
- The CPT code and the diagnostic code, and
- The amount of the charge.

For **in-network** care, payment is arranged through your **provider** and **Aetna**.

### ***Aetna Member Services***

**Aetna** Member Service representatives are available to assist you with issues related to the **Mental Health and Chemical Dependency Program** Monday through Friday during normal business hours, or you can use the **Aetna** Navigator Web site 24 hours a day. You can reach **Aetna** Member Services at the telephone number printed on your medical ID card (see “Important Contacts”) or online at [www.AetnaNavigator.com](http://www.AetnaNavigator.com):

- To find out if a claim was paid,
- If you have a service issue with a **network provider**,
- To find out how your **covered dependent** living in another area should obtain care, or
- To get claim forms (generally only required for **out-of-network** care).

## PRESCRIPTION DRUG PROGRAM

If you enroll in the **POS** option or **Traditional Indemnity** option, you are automatically **covered** under the **Prescription Drug Program**.

If you select an **HMO** for your medical option, you do not receive benefits from the **Prescription Drug Program**. Instead, you will receive the prescription drug benefits available through your **HMO**. Contact your **HMO** for specific information about prescription drug benefits.

### *How the Prescription Drug Program Works*

The **Prescription Drug Program** offers you the following three ways to fill prescriptions:

- At your local **participating pharmacy**,
- At your local non-participating pharmacy, or
- Through Aetna Rx Home Delivery<sup>SM</sup>.

Use a local pharmacy for short-term prescriptions of up to 30 days (or a 90-day supply of insulin). For a prescription drug you use on an ongoing basis, Aetna Rx Home Delivery provides prescriptions up to a 90-day supply each time. *You must use Aetna Rx Home Delivery for maintenance drugs after 3 consecutive fills for the same dosage at the retail level.* Otherwise, the prescription drug will not be covered.

Your cost varies depending on how you get your prescriptions filled.

### **Participating Pharmacy**

When you go to a **participating pharmacy**, present the pharmacist your medical ID card. The pharmacist will charge you the appropriate **copayment** for your prescription. That is the only amount you will pay.

To find a **participating pharmacy** near you:

- Visit Aetna Navigator at [www.AetnaNavigator.com](http://www.AetnaNavigator.com) (in DocFind under Select a Plan, select General Card Program),
- Call **Aetna** (see “Important Contacts”), or
- Ask your local pharmacy if it is a **participating pharmacy**.

## Non-Participating Pharmacy

When you use a non-participating retail pharmacy to fill a prescription, you pay the entire cost at the time of purchase. Then you file a claim with **Aetna** for reimbursement. After you meet the **Prescription Drug Program's** annual **deductible**, you will be reimbursed 80% of the **allowable amount** for **covered** medications. The **deductible** is \$50 for yourself and each of your **covered dependents**, up to a maximum of \$150 for your family. This **deductible** is in addition to any **deductibles** you may be required to pay under the **POS** or **Traditional Indemnity** option and the **Mental Health and Chemical Dependency Program**. Non-participating pharmacy benefits do not apply to mail order prescriptions filled by a company other than **Aetna**.

Call **Aetna** (see "Important Contacts") or go online through the Avaya Healthy Decisions Web site at [www.AvayaHealthyDecisions.com](http://www.AvayaHealthyDecisions.com) (click on "Reference Materials & Forms") to obtain claim forms.

## Filling Prescriptions by Mail, Phone or Fax

Aetna Rx Home Delivery is a great way to fill prescriptions if you regularly take the same medication on an ongoing basis. Up to a 90-day supply is available. To fill a prescription by mail, simply get an order form from **Aetna** or print a form from the Avaya Healthy Decisions Web site at [www.AvayaHealthyDecisions.com](http://www.AvayaHealthyDecisions.com) (look for the claim form under "Reference Materials & Forms"), follow the instructions and return the completed form to the address indicated along with the appropriate **copayment** and the written prescription. Generally, your prescription will be delivered to you, postage-paid, within 14 days from when your order is received.

Alternatively, your doctor can call (1-800-823-7252) or fax (1-866-681-5166) a new prescription directly to **Aetna**.

Refills are even easier. You can order a refill by mail, call the phone number on your prescription label or visit [www.aetna.com/aetnarxhomedelivery](http://www.aetna.com/aetnarxhomedelivery). You can use your credit card to pay.

Prescriptions can be filled with senior-friendly, child-resistant bottles. Each new prescription will include an informative insert about the medication.

## Covered Prescription Drug Items

Generally, the **Prescription Drug Program** covers:

- Drugs provided by a pharmacist and prescribed by a **physician** (see "Exclusions" for exceptions)

- Prescription birth control medications or contraceptive devices (including oral contraceptives or injections)
- Insulin
- Disposable supplies ordered by a **physician** for a diabetic patient including:
  - Insulin needles and syringes
  - Blood and urine testing supplies
- Prescription (not over-the-counter) smoking deterrents (including nicotine products such as gums and patches)
- Yohimbine

Diabetic testing equipment may be **covered** under the durable medical equipment benefit of your **POS** or **Traditional Indemnity** option.

### Drugs Requiring Precertification

The Prescription Drug Utilization Management Program requires **precertification** for certain medications before coverage will be provided under the Medical Plan. **Aetna** must approve the **precertification**. To request approval, your doctor must call or fax a form to **Aetna** with the relevant information. **Aetna** will confirm that the drugs are being used for specific conditions, and will work with you, your pharmacist and your **physician** to secure the necessary confirmation. If you have any questions on this approval process, you or your doctor should call **Aetna** Member Services. If the request is approved, your doctor is notified and the coverage is provided. If the request is denied, you and your doctor will be notified.

The listing below includes the drugs that require approval from **Aetna** prior to being covered under the Medical Plan. Discuss **precertification** and the best medication for your care with your doctor.

#### Non-Sedating Antihistamines\*

Allegra/Allegra-D  
Clarinet/Clarinet-D  
Fexofenadine  
Senprex-D  
Xyzal

#### Proton Pump Inhibitors\*\*

Aciphex  
Nexium  
Omeprazole  
Prevacid  
Prilosec  
Protonix  
Zegerid

#### Antifungals

Diflucan\*\*\*  
Fluconazole\*\*\*  
Itraconazole  
Lamisil  
Noxafil  
Penlac Nail Laquer  
Sporonox  
Vfend

#### Migraine Medications

Amerge  
Axert  
Frova  
Imitrex  
Maxalt/Maxalt MLT  
Migranal  
Relpax  
Zomig/Zomig ZMT

<u>Acne Products</u>	<u>Growth Hormones</u>	<u>Weight Loss Products</u>	<u>Pain Medications</u>
Accutane	Genotropin	Bontril	Butorphanol NS
Avita	Humatrope	Didrex	Stadol NS
Isotretinoin	Norditropin	Diethylpropion	
Retin-A	Nutropin/Nutropin AQ	Fastin	
Tretinoin	Protropin	Ionamin	<u>Flu Medications</u>
Ziana	Saizen	Meridia	Relenza
	Serostim	Phendimetrazine	Tamiflu
	Tev-Tropin	Phentermine	
		Prelu-2	
		Tenuate	<u>COX II's</u>
		Xenical	Celebrex

\* Requires a two-week trial of Claritin

\*\* Requires a two-week trial of Prilosec over-the-counter for certain diagnoses

\*\*\* Excludes 150 mg strength

### Drugs with Coverage Limitations

The **Prescription Drug Program** allows limited coverage for certain drugs. The following list of drugs or drug categories have coverage limitations.

- Butorphanol (quantity limit of 2 vials per 30-day supply)
- Male Erectile Dysfunctions (8 tablets/injections/units per 30-day supply)
- Migraine Medications: Amerge, Axert, Frova, Imitrex (tablets, nasal spray, injections, kits), Maxalt, Migranal, Relpax, Zomig (tablets, nasal spray) – quantity limits vary; determined by **Aetna**
- Relenza (limited to two treatments per year)
- Stadol NS (quantity limit of 2 vials per 30-day supply)
- Tamiflu (limited to two treatments per year)

## Amount of Copayment/Coinsurance\*

Retail Pharmacies	Home Delivery
<p>At <b>participating pharmacies</b>, you pay:</p> <ul style="list-style-type: none"> <li>• \$10 for <b>generic drugs</b></li> <li>• \$25 for <b>brand name drugs</b></li> <li>• \$50 for insulin (90-day supply)</li> </ul> <p>At non-participating pharmacies, you pay:</p> <ul style="list-style-type: none"> <li>• 20% of the <b>reasonable and customary</b> cost of the prescription after you satisfy the annual <b>deductible</b> (\$50 per individual or \$150 per family)</li> </ul>	<p>You pay:</p> <ul style="list-style-type: none"> <li>• \$20 for <b>generic drugs</b></li> <li>• \$50 for <b>brand name drugs</b></li> </ul>
<p>* No <b>copayment</b> is required for chemotherapy drugs.</p>	

## Out-of-Pocket Maximum

The **out-of-pocket maximum** only applies to **copayments** for prescription drugs filled through **participating pharmacies** and **Aetna Rx Home Delivery**. It does not apply to prescriptions filled at non-participating pharmacies.

The **out-of-pocket maximum** works like this. Once your **copayments** for prescriptions filled through **participating pharmacies** and **Aetna Rx Home Delivery** total \$1,000 per individual with a \$3,000 limit per family in a calendar year, you will not be required to pay any additional **copayments** for prescriptions filled through **participating pharmacies** or **Aetna Rx Home Delivery** for the rest of that calendar year.

## Mandatory Generic Drug Provision

A mandatory generic provision applies to the **Prescription Drug Program**. In cases where you select a **brand name drug** when a generic equivalent is available, you will be required to pay the generic brand copayment *plus* the difference in cost between the **brand name drug** and the **generic drug**. This cost differential requirement is waived if the **physician** indicates that the **brand name drug** is medically necessary.

## Mandatory Home Delivery

A mandatory home delivery provision applies to maintenance drugs. After a prescription for a maintenance drug is filled three consecutive times for the same dosage at a retail pharmacy, you must obtain the drug via **Aetna Rx Home Delivery** in order to receive coverage for the drug. See "Filling Prescriptions by Mail, Phone or Fax."

## Aetna Specialty Pharmacy

**Aetna** Specialty Pharmacy works to support the unique needs of patients with chronic illnesses, who require specialty medications including injectables. These drugs often aren't available at retail pharmacies. They also often require special storage and handling, fast delivery, and expert support to monitor their use. **Aetna** Specialty Pharmacy offers specialty medications and accompanying support to manage more than 20 different disease states. You are supported by a health care team, including patient care coordinators, registered nurses and pharmacists, and insurance and claims specialists.

To learn more about specialty drugs, call **Aetna** Member Services at the toll-free number on your member ID card or visit Aetna's secure member Web site, Aetna Navigator™, at [www.AetnaNavigator.com](http://www.AetnaNavigator.com).

## Additional Pharmacy Services

You are entitled to the following additional pharmacy services under the **Prescription Drug Program**:

- *Drug Utilization Review.* Prescriptions filled through the program become part of a computerized database that alerts the **participating pharmacy** or home delivery pharmacists to potential drug interactions each time you have a prescription filled.
- *Toll-Free Prescription Drug Customer Service.* **Aetna** maintains a special toll-free customer service number you can call with questions about the **Prescription Drug Program**, for help locating a **participating pharmacy**, or to get an order form for **Aetna** Rx Home Delivery or a claim form for a prescription filled at a non-participating pharmacy. To help locate a **participating pharmacy**, you may also search online using **Aetna** Navigator available at [www.AetnaNavigator.com](http://www.AetnaNavigator.com). See "Important Contacts."

Other special services available by calling **Aetna** (see "Important Contacts") include:

- **Emergency** pharmacist consultations, 24 hours a day, seven days a week
- Large print or Braille labels on medications filled through **Aetna** Rx Home Delivery, upon request

Special telephone numbers are also available for hearing impaired employees and for those overseas. See "Important Contacts."

## Filing a Claim

You do not need to file a claim if you use a **participating pharmacy**. You will only need to complete a home delivery order form when you use **Aetna** Rx Home Delivery.

On a refill, it is even easier; you can visit [www.aetna.com/aetnarxhomedelivery](http://www.aetna.com/aetnarxhomedelivery) or call **Aetna** Rx Home Delivery with your credit card number.

If you use a non-participating pharmacy, you will need to pay the full cost for the prescription and file a claim for reimbursement.

For more information, see “Filling Prescriptions by Mail, Phone or Fax” and “Non-Participating Pharmacy.”

### **Claim Appeals**

To appeal a decision for denied Preauthorization or Quantity Limited claims under the **Prescription Drug Program**, contact **Aetna** (see “Important Contacts”). Your concern will be investigated and you will be contacted. If you are not satisfied, you can appeal the decision. For more information, see “Claim Procedures.”

## EMPLOYEE ASSISTANCE PROGRAM (EAP)

If you are an **eligible employee**, you and your dependents are automatically **covered** under the **Employee Assistance Program**. This program applies even if you waive medical coverage.

The program provides prepaid, confidential counseling and referral resource coordinated through **Magellan Health Services** (see “Important Contacts”). Services are available 24 hours a day, seven days a week to help you and your family successfully deal with life's problems and challenges. **EAP** services are limited to five office visits per problem or concern, per calendar year.

If more than five sessions are needed, **covered** persons will be referred to the mental health program identified by their medical option, as applicable. Services rendered by other health providers/professionals may be covered under the employee's medical option (see “Mental Health and Chemical Dependency Program”).

The **Employee Assistance Program** is always there for you — even if you need help in the middle of the night, over the weekend, or on a holiday. Just call (see “Important Contacts”). You may call **Magellan**:

- For a telephonic consultation about your problem with a **Magellan EAP** consultant,
- If you are in crisis,
- For a referral to a **Magellan EAP network provider** for an office visit,
- If you have a service issue with a **Magellan EAP network provider**, or
- To obtain information about your **EAP** coverage.

### **Getting Help Online**

You and your dependents can access information through **Magellan's** secure Web site at [www.MagellanAssist.com](http://www.MagellanAssist.com). Through this Web site, you and your dependents can access information such as:

- A listing of Avaya specific benefits and services
- Helpful health and wellness tips
- Tools and calculators

- Self-screening tools
- Links to community resources
- Online self-referral.

To access the Web site for the first time, go to the “Member Sign In” box and click on “New or unregistered user”. When prompted, type in Avaya’s toll-free **EAP** number, 877-804-9753.

### ***Self-Directed Screening for Alcohol Misuse and Depression***

There may be times when you need help dealing with alcohol misuse or depression but do not feel ready to speak directly with a counselor. Instead, you may simply be looking for another confidential way to access information.

Accessing the self-screening system is easy, convenient and confidential. U.S. employees can call a toll free number and by following the voice prompts are able to take either an alcohol issue or depression self-directed screening. International employees can log on to [www.MagellanAssist.com](http://www.MagellanAssist.com) to access a web-based self-screening system.

The screening system also provides access to an educational library on key behavioral health items. Articles can be printed off the Web, or if you are accessing the system via the telephone, you can request that an article be faxed to you.

If you find yourself needing answers to your questions about depression or alcohol misuse, please access the **Magellan’s** Self-Screening System. To access:

- U.S. employees call 1-866-876-4975
- International employees log on to [www.MagellanAssist.com](http://www.MagellanAssist.com). First time users click on “New and unregistered users” in the “Member Sign In” box and when prompted, enter Avaya’s toll-free **EAP** number, 877-804-9753.

## YOUR COSTS

### ***Your Monthly Contribution***

Generally, you only pay for coverage under the Medical Plan if:

- You enroll for coverage before you complete six months of **net credited service** (see “Enrolling Early”),
- You are a part-time employee scheduled to work less than 25 hours a week, or
- You are **covered** under the **HMO** option and participation in that requires a contribution.

Your payroll deduction amount for benefit coverage appears on your pay statement. Any contributions toward the cost of Medical Plan coverage are on a pre-tax basis for yourself and your family members other than your **domestic partner** and/or **domestic partnership dependents**.

Cost information will be provided through the Avaya Healthy Decisions Web site at [www.AvayaHealthyDecisions.com](http://www.AvayaHealthyDecisions.com). Remember, if you elect to decline coverage under the Medical Plan, and if you are a full-time employee or part-time **eligible employee** scheduled to work at least 25 hours, you may be eligible to receive a credit in each paycheck. This amount is considered taxable income.

### ***The Annual Deductible***

The annual **deductible** is the amount you may be required to pay each year before benefits for **covered** expenses can begin. Three separate **deductibles** (medical option, **Mental Health and Chemical Dependency Program** and **Prescription Drug Program**) may apply each year if you are **covered** under the **POS** or **Traditional Indemnity** option. Your medical option, the type of service or supply (medical, mental health and **chemical dependency** or prescription drugs) and whether care is received **in-network** or **out-of-network** determines whether a particular **deductible** applies. There is no **deductible** for **EAP** services.

Expenses applied toward the **deductible** under one part of the medical program do not count toward satisfying **deductibles** under other programs. For example, **covered** expenses under the **Traditional Indemnity** option do not count toward the **deductibles** under the **Mental Health and Chemical Dependency Program** or the **Prescription Drug Program** and vice versa. There are generally no **deductibles** under the **HMO** option. Expenses applied toward the **deductible** while actively employed are generally

counted toward the **deductible** in the year of retirement. You may need to submit proof of expenses paid to receive credit for previous expenses; contact **Aetna** Member Services for more information.

### POS and Traditional Indemnity Option Deductibles

You *do not* pay an annual **deductible** for **in-network** care received under the **POS** option if it is provided by a **network provider**.

Generally, you and your **covered dependents** *must* satisfy a **deductible** each calendar year if you receive **out-of-network** care under the **POS** option, or you are **covered** under the **Traditional Indemnity** option.

Your **deductible** is based on your medical option. The following chart shows you how this works.

	POS Option		Traditional Indemnity Option
	In-Network	Out-of-Network	
<b>Annual Deductible*</b>	None	\$600/individual \$1,200/two-person or family **	\$250/individual \$500/two-person \$750/family**

\* The **deductible** under your medical option is in addition to any deductibles you may be required to pay under the **Prescription Drug Program** and the **Mental Health and Chemical Dependency Program**.

\*\* Once the family limit is reached by any combination of **covered** family members, the **deductible** is satisfied for all family members for the rest of the calendar year. Under the **Traditional Indemnity** option, if several **covered** individuals are injured in the same accident, only one **deductible** will apply for all **covered** expenses related to the accident for that calendar year.

For more information, see “Expenses You Pay That Do Not Count Towards the Deductible.”

### Mental Health and Chemical Dependency Program Deductible

You *do not* pay an annual **deductible** under the **Mental Health and Chemical Dependency Program** for **in-network** treatment of mental health or **chemical dependency** conditions. However, you and each of your **covered dependents** must pay a \$250 **deductible** each calendar year before reimbursement for **out-of-network** services can begin.

This **deductible** is in addition to any **deductibles** you may be required to pay under the **POS** or **Traditional Indemnity** option and the **Prescription Drug Program**.

For more information, see “Expenses You Pay That Do Not Count Towards the Deductible.”

## Prescription Drug Program Deductible

You *do not* pay an annual **deductible** under the **Prescription Drug Program** for prescriptions filled at **participating pharmacies** or through **Aetna Rx Home Delivery**. For prescriptions filled at non-participating pharmacies, you must pay a \$50 **deductible** for each **covered** individual, up to a maximum of \$150 per family, each calendar year.

This **deductible** is in addition to any **deductibles** you may be required to pay under the **POS** or **Traditional Indemnity** option and the **Mental Health and Chemical Dependency Program**.

For more information, see “Expenses You Pay That Do Not Count Towards the Deductible.”

## Expenses You Pay That Do Not Count Towards the Deductible

Certain expenses that you pay do not count towards the **deductibles** under the **POS** or **Traditional Indemnity** option, **Prescription Drug Program** and **Mental Health and Chemical Dependency Program**. These include:

- Charges for expenses that are not **covered** under your medical option, **Prescription Drug Program** or **Mental Health and Chemical Dependency Program** (see “Exclusions”)
- Any charges above the **allowable amount**
- Any penalties for failure to obtain **precertification** (see “Precertification”)
- **Copayments** for **in-network** or **coinsurance** for **out-of-network** services

## Coinsurance

**Coinsurance** is a cost sharing method in which the Medical Plan and you each pay a percentage of the cost for **covered** services. Your **coinsurance** is your share of the cost for **covered** expenses after you satisfy any applicable **deductible**. You do not pay **coinsurance** for **EAP** services.

**Coinsurance** *does not* apply to **in-network** care under the **POS** option if it is provided or coordinated by a **network provider**.

Generally, you will pay a percentage of the cost for **covered** expenses if:

- You receive **out-of-network** care under the **POS** option,

- You are **covered** under the **Traditional Indemnity** option, or
- You receive a prescription from a non-participating pharmacy.

The amount of your **coinsurance** is based on your coverage option. The following chart shows you how this works.

	POS Option		Traditional Indemnity Option
	In-Network	Out-of-Network	
<b>Coinsurance</b> (up to the <b>out-of-pocket maximum</b> )	None	25% of the <b>allowable amount</b>	0% or 20% of the <b>allowable amount</b> based on service
See the "Mental Health and Chemical Dependency Program" and "Prescription Drug Program" sections for <b>coinsurance</b> amounts for those programs.			

For more detailed information about the required **coinsurance** for prescription drugs, see "Prescription Drug Program."

### **Copayments**

A **copayment** is a set dollar amount that you pay to the **provider** at the time of service. **Copayments** apply for the following:

- **In-network** care under the **POS** option,
- Emergency room visits and **out-of-network hospital** admissions under the **POS** option,
- Prescriptions filled through **participating pharmacies** or **Aetna Rx Home Delivery** under the **Prescription Drug Program**,
- **In-network** treatment of mental health or **chemical dependency** conditions under the **Mental Health and Chemical Dependency Program**,
- **Out-of-network hospital** admissions for treatment of mental health or **chemical dependency** conditions under the **Mental Health and Chemical Dependency Program**, or
- Certain **covered** services under the **HMO** option (varies by **HMO**).

You do not pay **copayments** for **EAP** services. For more detailed information about some of the required **copayments**, see "Your POS and Traditional Indemnity Option

Comparison Chart,” “Prescription Drug Program” and “Mental Health and Chemical Dependency Program.”

**Out-of-Pocket Maximum**

The **out-of-pocket maximum** is the maximum amount you are required to pay each calendar year for **covered** services. Separate **out-of-pocket maximums** apply for your medical option, the **Mental Health and Chemical Dependency Program** and the **Prescription Drug Program**.

**POS or Traditional Indemnity Option Out-of-Pocket Maximums**

Your **out-of-pocket maximum** is based on your medical option and whether you receive **in-network** or **out-of-network** care. The following chart shows you how this works.

	POS Option		Traditional Indemnity Option
	In-Network**	Out-of-Network	
<b>Annual Out-of-Pocket Maximum*</b>	\$1,000/individual, \$2,000/two-person or family	\$3,000/individual \$6,000/two-person or family	\$1,000/individual \$2,000/two-person \$3,000/family
<p>* Once you or a <b>covered dependent</b> reach the individual maximum, most <b>covered</b> expenses are paid at 100% of the <b>allowable amount</b> for that individual for the rest of the calendar year. Once you reach the family maximum, most <b>covered</b> expenses are paid at 100% of the <b>allowable amount</b> for all <b>covered</b> family members for that calendar year. This <b>out-of-pocket maximum</b> is in addition to any <b>out-of-pocket maximums</b> under the <b>Prescription Drug Program</b> and the <b>Mental Health and Chemical Dependency Program</b>.</p> <p>** The <b>in-network out-of-pocket maximum</b> does not include <b>out-of-network hospital admission copayments, deductibles and coinsurance payments</b>.</p>			

### Prescription Drug Program Out-of-Pocket Maximum

Your **out-of-pocket maximum** under the **Prescription Drug Program** depends on where you fill your prescriptions. The following chart shows you how this works.

	<b>Participating Pharmacy or Through Aetna Rx Home Delivery **</b>	<b>Non-Participating Pharmacy</b>
<b>Annual Out-of-Pocket Maximum*</b>	\$1,000 per person/ \$3,000 per family	None
<p>* This <b>out-of-pocket maximum</b> is in addition to any <b>out-of-pocket maximums</b> under your medical option and the <b>Mental Health and Chemical Dependency Program</b>.  ** Once you reach the <b>out-of-pocket maximum</b> under the <b>Prescription Drug Program</b>, you are reimbursed 100% for prescriptions obtained through <b>participating pharmacies</b> or <b>Aetna Rx Home Delivery</b>.</p>		

### Mental Health and Chemical Dependency Out-of-Pocket Maximum

Your **out-of-pocket maximum** under the **Mental Health and Chemical Dependency Program** depends on whether you receive **in-network** care coordinated through the **Behavioral Health Coordinator** or **out-of-network** care. The following chart shows you how this works.

	<b>Precertified In-Network **</b>	<b>Out-of-Network</b>
<b>Annual Out-of-Pocket Maximum*</b>	\$750 per individual	None
<p>* This <b>out-of-pocket maximum</b> is in addition to any <b>out-of-pocket maximums</b> under your medical option and the <b>Prescription Drug Program</b>.  ** Once you have paid \$750 in eligible expenses under the <b>Mental Health and Chemical Dependency Program</b>, <b>in-network providers</b> should not charge you any more <b>copayments</b> for the remainder of that calendar year. If you pay an <b>in-network provider</b> any amounts after meeting your <b>out-of-pocket maximum</b>, have the <b>provider</b> reimburse you.</p>		

### Expenses You Pay That Do Not Count Towards the Out-of-Pocket Maximum

Certain expenses you must pay do not count towards the **out-of-pocket maximums** under the **POS** or **Traditional Indemnity** options, **Prescription Drug Program** and **Mental Health and Chemical Dependency Program**. These include:

- Charges for expenses that are not **covered** under your medical option, **Prescription Drug Program** or **Mental Health and Chemical Dependency Program**
- Any charges above the **allowable amount**
- Any penalties for failure to obtain **precertification**

- **Copayments** for certain **in-network** or **out-of-network** services (including office visits) under the **POS** option
- Expenses applied toward any required **deductibles**

### **HMO Option**

Generally, if you are **covered** under the **HMO** option, you only pay a **copayment** to the **provider** at the time of service, if required. This amount may vary by **HMO** or type of service. There are usually no **deductibles** or **coinsurance** amounts under the **HMO** option.

### **The Allowable Amount**

The **allowable amount** is the portion of a **provider's** charge that is eligible for partial or full reimbursement under the Medical Plan. No benefits are paid for charges that exceed the **allowable amount**.

Charges for **covered** services are always within the **allowable amount** if:

- You are **covered** under the **POS** option and **in-network** care is provided or coordinated by a **network provider**,
- You are **covered** under the **POS** or **Traditional Indemnity** option and precertified **in-network** treatment of a mental health or **chemical dependency** condition is coordinated through **Aetna** under the **Mental Health and Chemical Dependency Program**,
- You use a **NAP network provider** under the **Traditional Indemnity** option or **out-of-network** under the **POS** option, or
- You use a **participating pharmacy** under the **Prescription Drug Program**.

Your **provider's** charges may exceed the **allowable amount** if:

- You receive **out-of-network** care under the **POS** option and you do not use a **NAP provider**,
- You use non-**NAP network providers** under the **Traditional Indemnity** option,
- You receive treatment for a mental health or **chemical dependency** condition **out-of-network** under the **Mental Health and Chemical Dependency Program**, or

- You utilize a non-participating retail pharmacy.

You are responsible for paying any amounts that exceed the **allowable amount**, in addition to any **deductibles**, **copayments** or **coinsurance** amounts that may apply.

## PRECERTIFICATION

You must request **precertification**, or precertify, certain care under the **POS** and **Traditional Indemnity** option, **Mental Health and Chemical Dependency Program** and **Prescription Drug Program** in order to receive the maximum available benefits under the Medical Plan. For some types of care, you must precertify the care to receive any benefits at all. **Precertification** is the process by which **Aetna** reviews the proposed treatment and advises you and your doctor as to what services can be covered under the Medical Plan.

Generally, precertified care is paid at the highest level of coverage. If you do not follow the **precertification** procedures when required, and it is later determined the treatment:

- *Is medically necessary*, benefits generally are paid at a *reduced* level or no payment is made, or
- *Is not medically necessary*, no benefits will be paid.

### **When You Must Precertify Care**

**Precertification** is done by your **PCP** or **network specialist** if care is received **in-network** under the **POS** option.

However, you are responsible for obtaining **precertification**:

- If you receive care for certain services **out-of-network** under the **POS** option,
- If you receive care for certain services under the **Traditional Indemnity** option, or
- For services under the **Mental Health and Chemical Dependency Program**.

**Prescription Drug Program** benefits will be denied if drugs requiring precertification are not precertified. Your doctor must request the **precertification**, where applicable. See "Prescription Drug Program" for more information.

If you do not obtain **precertification** when required, benefits generally will be reduced or no benefits will be payable. For more information, see "Penalties if You Do Not Follow the Precertification Procedures."

### **Care You Must Precertify**

Different medical options and programs have different **precertification** requirements. However, in cases where primary coverage is being provided by Medicare, services need to be precertified when they are not **covered** under Medicare or when Medicare benefits are being exhausted.

### **Under the POS or Traditional Indemnity Option**

To receive the full amount of benefits available, **precertification** is required for certain services under the **Traditional Indemnity** option or **out-of-network** under the **POS** option. These include:

- Hospitalization
- Admission to an **extended care facility**
- **Home health care agency** services
- **Private duty nursing**
- The following **out-patient** surgeries:
  - Cataract surgery
  - Any type of foot surgery
  - Arthroscopy (examination or surgery on a joint using a fiber optic device)
  - Nasal endoscopy (examination or surgery of the nose or sinuses using a fiber optic tube)
  - Laparoscopy (examination or surgery in the abdomen using a fiber optic laser)
  - Lithotripsy (kidney stone fragmentation using ultrasound)

### **Under the Mental Health and Chemical Dependency Program**

To receive the full amount of benefits available under the **Mental Health and Chemical Dependency Program**, you must precertify **out-of-network** admissions to a **hospital**, acute psychiatric facility or acute **chemical dependency** facility. You must also precertify your **in-network** services.

## **How to Precertify**

### **Under the POS or Traditional Indemnity Options**

If you are required to precertify care (see “Care You Must Precertify”), call the telephone number printed on your medical ID card (see “Important Contacts”). Generally, you should call at least seven days before the scheduled date of service or admission. For maternity care, you must certify your stay if it extends beyond 48 hours for a vaginal birth or 96 hours for a birth by cesarean section. For **urgent** care, call before receiving treatment or being admitted to the **hospital**. In an **emergency**, call **Aetna** Member Services within 48 hours.

When you call, be ready to give:

- The patient’s name, address, telephone number, age, identification number and relationship to you,
- All the information on your ID card,
- The type of care for which you are requesting **precertification**,
- The doctor’s name, address and telephone number, and
- If being admitted to a **hospital**, have the name, address and telephone number of the **hospital** available.

You and your doctor will be advised whether or not the care is precertified and, if applicable, the specific duration of time for which it is certified (applies for admission to a **hospital** or **extended care facility**, or for **home health care agency** services or **private duty nursing**). If care is precertified, a **precertification** number will be given. This number verifies that your treatment is precertified and no **precertification** penalties will apply. If you obtain the **precertification**, be sure to write the number down, along with the name of the person you spoke to and the date and time of your call.

If you do not obtain **precertification** when required, benefits will be reduced or no benefits will be payable. For more information, see “Penalties if You Do Not Follow the Precertification Procedures” and “Concurrent Review After Precertification.”

## Under the Mental Health and Chemical Dependency Program

You, your **covered dependent** or the **provider** must call **Aetna** at the telephone number printed on your medical ID card (see “Important Contacts”) for an **in-network** or **out-of-network** admission to a **hospital**, acute psychiatric facility or acute **chemical dependency** facility. It is your responsibility to make sure the call is made and to know whether the admission is precertified. For **mental health emergency** admissions, you must call **Aetna** Member Services within 48 hours of being admitted. **Precertification** of **emergency** mental health treatment obtained from an emergency room is not required if you are not admitted, but it is recommended that you call **Aetna** regarding appropriate follow-up care. You must also precertify all **in-network** services by calling **Aetna**.

When you call, be ready to give:

- The patient’s name, address, telephone number, age and his or her relationship to you,
- Your (the Avaya Inc. employee’s) Social Security number,
- What you think the problem is or what the symptoms are (for example, drug use, depression or uncontrolled behavior),
- The name and telephone number of the **provider** currently treating the patient (for example, a psychiatrist or psychologist), and
- The name of the **hospital** where the patient will be admitted.

You and your doctor will be advised whether or not the admission is precertified. If it is precertified, you will be advised the number of days for which it is certified. If care is precertified, your doctor will get a **precertification** number. This number verifies your treatment is precertified and no **precertification** penalties will apply.

A call to **Aetna** to precertify an **out-of-network** admission only satisfies the **precertification** requirement. It does not entitle you to the **in-network** level of benefits, which is only available for precertified care through **in-network providers**.

If you do not obtain **precertification** for an **out-of-network hospital** admission, penalties will apply. For more information, see “Penalties if You Do Not Follow the Precertification Procedures” and “Concurrent Review After Precertification.”

### **Concurrent Review After Precertification**

All precertified **in-patient** admissions, including admissions under the **Mental Health and Chemical Dependency Program, extended care facility** stays, **home health care agency** services and **private duty nursing**, are certified for a specific duration of time. Toward the end of the certified period, **Aetna** will follow up to see if your care will be completed as expected. If it is determined that treatment will take longer than originally expected, another review will be performed to determine whether an extension will be precertified. If it is not certified, *no additional benefits* will be paid for any treatment received after the duration of time that was originally certified.

### **Penalties if You Do Not Follow the Precertification Procedures**

If you fail to follow the **precertification** procedures when required under the **POS** option, **Traditional Indemnity** option or **Mental Health and Chemical Dependency Program**, penalties will apply. These penalties are applied as benefit reductions. This means the level of benefits available will be reduced or no benefits will be paid for the treatment.

### **Under the POS (for Out-of-Network Services) or Traditional Indemnity Options**

A 20% benefit reduction, up to a \$400 maximum per occurrence, is applied to **covered** expenses if **precertification** is not obtained for:

- Hospitalization (**precertification** is not required for **emergency** care if you are not hospitalized), or
- Specific **out-patient** surgeries (see "Care You Must Precertify").

After you pay \$400 in penalties, benefits for **covered** expenses revert back to the level of benefits usually available under your medical option, provided the care is found to be **medically necessary** upon review. However, if the review finds the hospitalization or surgery is not **medically necessary**, or if the treatment is not **covered** under your medical option, no benefits will be paid.

In addition, no benefits will be paid for **hospital** days beyond the number of days for which care was certified or if **precertification** is not obtained for:

- An admission to an **extended care facility**,
- **Home health care agency** services, or
- **Private duty nursing**.

You are responsible for paying these penalties. They will not count toward your annual **deductible** or **out-of-pocket maximum**.

### **Under the Mental Health and Chemical Dependency Program**

A 20% benefit reduction, up to a \$400 maximum per occurrence, is applied to **covered** expenses if **precertification** is not obtained for an **out-of-network** admission to a **hospital**, acute psychiatric facility or acute **chemical dependency** facility for treatment of a mental health or **chemical dependency** condition.

After you incur \$400 in penalties, benefits for **covered** expenses revert back to the level of benefits usually available under the **Mental Health and Chemical Dependency Program**, provided the care is found to be **medically necessary** upon review. However, if the review determines the service is not **medically necessary**, or is not **covered** under the **Mental Health and Chemical Dependency Program**, no benefits will be paid.

You will be responsible for paying these amounts. They will not count toward your annual **deductible** or **hospital copayment** under the **Mental Health and Chemical Dependency Program**.

## BENEFIT LIMITS AND MAXIMUMS

Benefits for certain **covered** services may be subject to annual, per occurrence or lifetime maximums. No additional benefits will be paid once the applicable limit is reached. Most limits are annual limits and are restored automatically at the beginning of the next calendar year. Also, see “Exclusions” for a list of services that are not **covered** under the **POS** or **Traditional Indemnity** options, **Mental Health and Chemical Dependency Program** or **Prescription Drug Program**.

### *Three Types of Limits*

Three main types of benefit limits are described in this section.

- If you reach the *annual benefit limit* for a **covered** expense, no additional benefits for that expense will be paid for the rest of the current calendar year. However, the full benefit limit is restored each year on January 1st.
- If you reach the *per-occurrence benefit limit* on **emergency air ambulance** services, no additional benefits will be paid toward expenses for that occurrence.
- Certain **covered** expenses under the **POS** option and **Traditional Indemnity** option are subject to a *maximum lifetime benefit*.

### **POS Option In-Network Limits**

If you are **covered** under the **POS** option, no lifetime maximums apply to any **in-network** care provided or coordinated by your **PCP** or **network specialist**. The following annual or per occurrence benefit limits apply under the **POS** option to **in-network** care.

- Chiropractic care is limited to 60 visits in any calendar year. **In-network** visits also apply to the **out-of-network** benefit limit and vice versa.
- **Emergency air ambulance** benefits are limited to \$5,000 per occurrence.
- Wig benefits (provided for hair loss caused by disease or related to treatment of an unrelated temporary medical condition) are limited to \$300 per calendar year.

### **POS Option Out-of-Network Limits**

For all **out-of-network** care under the **POS** option, each **covered** individual is limited to a maximum of 210 days of **hospice** care during his or her lifetime.

The following annual or per occurrence benefit limits also apply under the **POS** option to **out-of-network** care.

- Chiropractic care is limited to 60 visits in any calendar year. **Out-of-network** visits also apply to the **in-network** benefit limit and vice versa.
- **Emergency air ambulance** benefits are limited to \$5,000 per occurrence.
- **Speech therapy** is limited to 30 visits per year.
- **Home health care agency** services are limited to 100 visits per year.
- **Private duty nursing** is limited to 100 shifts per year.
- **Extended care facility** services are limited to 60 days per year. Days spent in the **hospital** before entering the **extended care facility** count as a full day toward this limit. Once you enter the facility, however, each day in the **extended care facility** counts as one-half day toward the limit.
- Acupuncture is limited to 30 visits per year.
- Wig benefits (provided for hair loss caused by disease or related to treatment of an unrelated temporary medical condition) are limited to \$300 per calendar year.

### **Traditional Indemnity Option Limits**

Under the **Traditional Indemnity** option, each **covered** individual is limited to a maximum of 210 days of **hospice** care during his or her lifetime.

The following annual or per occurrence benefit limits apply under the **Traditional Indemnity** option.

- Chiropractic care is limited to 60 visits in any calendar year.
- **Emergency air ambulance** benefits are limited to \$5,000 per occurrence.
- **Speech therapy** is limited to 30 visits per year.
- **Home health care agency** services are limited to 200 visits per year.
- **Private duty nursing** is limited to 200 shifts per year.
- **Extended care facility** services are limited to 120 days per year. Days spent in the **hospital** before entering the **extended care facility** for the same condition

count as a full day toward this limit. Once you enter the facility, however, each day in the **extended care facility** counts as one-half day toward the limit.

- Acupuncture is limited to 30 visits per year.
- Wig benefits (provided for hair loss caused by disease or related to treatment of an unrelated temporary medical condition) are limited to \$300 per calendar year.

### **Mental Health and Chemical Dependency Program Limits**

No day or dollar limits apply to precertified **in-network in-patient** or **out-patient** treatment of mental health or **chemical dependency** conditions coordinated through the **Behavioral Health Care Coordinator**. However, **in-network alternative care** is subject to a maximum of 120 days per calendar year for mental health and 120 days per calendar year for **chemical dependency** treatment.

The following annual benefit limits apply to **out-of-network** care:

- **Out-patient** treatment is limited to 60 visits per year *each* for treatment of mental health conditions or **chemical dependency** conditions.
- **In-patient** hospitalization is limited to 30 days per year *each* for treatment of mental health or **chemical dependency** conditions. **In-patient chemical dependency** treatment is limited to two confinements per lifetime.

These additional limitations apply to **out-of-network** care:

- To receive the full amount of benefits available, you must precertify all **in-patient** admissions (see "Precertification").
- Visits or days received **in-network** apply toward the **out-of-network** limit.
- **Alternative care** is not covered.

### **Prescription Drug Program Limits**

The only limit that applies under the **Prescription Drug Program** is the number of days for which a prescription can be filled. For each prescription filled, you can obtain a supply of up to:

- 30 days from your local **participating pharmacy** or non-participating pharmacy (90 days for insulin), or
- 90 days through **Aetna Rx Home Delivery**.

- The **Prescription Drug Program** allows limited coverage for certain drugs. See “Drugs with Coverage Limitations”.

## EXCLUSIONS

Certain services, supplies or charges are *excluded* under the **POS** option, **Traditional Indemnity** option, **Prescription Drug Program** and **Mental Health and Chemical Dependency Program**. No benefits will be paid for excluded expenses under any circumstances. For information about exclusions under an **HMO**, contact the **HMO**.

### **General Exclusions**

All of the following services, supplies or expenses are excluded from benefits under the **POS** option, **Traditional Indemnity** option, **Prescription Drug Program** and **Mental Health and Chemical Dependency Program**:

- Any service or supply not specifically included as a **covered** expense and/or not satisfying the conditions of service requirements (see “Appendix A”)
- Services or supplies that are not **medically necessary**
- Treatment provided when coverage is not in effect (for example, before coverage begins or after it ends)
- **In-patient** care that begins before coverage is effective (even if the stay continues after the coverage **effective date**)
- **Custodial care** (including convalescent homes and rest cures)
- Charges for non-treatment purposes, including court proceedings (for example, **provider’s** charges to duplicate medical records, write medical assessments or perform an examination ordered as part of a legal suit, insurance physical, a condition of employment or as a component of professional certification)
- Services or supplies ordered or provided by a person or facility that does not qualify as a **provider** under the **POS** option, **Traditional Indemnity** option or **Mental Health and Chemical Dependency Program**
- Charges from a **provider** operating outside the scope of his or her license
- Services or supplies provided by a person or facility that is not properly licensed in accordance with state and local law, unless the type of **provider** is specifically named as **covered** under the **POS** option, **Traditional Indemnity** option or **Mental Health and Chemical Dependency Program** (unless the **mental health and chemical dependency professional** has appropriate certification, as determined by **Aetna**, in a locality where licensure is not available)

- Professional services provided by a parent, child or spouse or any person living in your home
- Conditions related to current or past military service
- Treatment of caffeine addictions
- Charges above the **allowable amount**
- Charges for **experimental or investigative treatment, drugs or devices**
- Charges you have no legal obligation to pay
- Charges that would not be made if there was not any health care coverage
- Work-related illness or injury **covered** by Workers' Compensation and/or The Avaya Inc. Sickness and Accident Disability Benefit Plan
- Services and supplies that are the responsibility of a school system or a local, state or federal government agency to provide or cover
- Charges another plan is required to pay
- Charges third parties are required to pay

### ***POS and Traditional Indemnity Options Exclusions***

The **POS** and **Traditional Indemnity** options will not pay any benefits for the following excluded services, supplies and expenses:

- Expenses beyond the stated limits including:
  - Charges above the **allowable amount**,
  - Charges above the semi-private room rate, and
  - Any charges for failure to obtain **precertification** when required (see "Care You Must Precertify").
- Any care delivered without the approval of a **physician** unless otherwise noted under the **POS** or **Traditional Indemnity** option
- Treatment of developmental disorders

- Predictable complications of non-covered treatment
- **Mental illness** and **chemical dependency** (for coverage information about these conditions, see “Mental Health and Chemical Dependency Program”)
- Treatment of refractive vision problems (including eye examinations, eye glasses and contact lenses, orthoptics and surgical treatment like radial keratotomy, LASIK and PRK)
- Vocational therapy
- **Speech therapy** (unless the speech was impaired by illness, injury or birth defect)
- Routine foot care
- Fertility assistance (other than basic diagnostic services specifically listed as **covered**) and other similar types of procedures including, but not limited to, in-vitro fertilization, artificial insemination, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). Any expenses incurred that are related to these procedures, treatments and services are also not **covered**.
- Treatment of obesity or weight loss conditions, unless it is **medically necessary** treatment of **morbid obesity**, subject to all other conditions (weight-related conditions that are diagnosed as anorexia nervosa or bulimia would be treated under the terms of the **Mental Health and Chemical Dependency Program**; treatment of medical conditions caused by these psychological conditions, like malnutrition or heart conditions, are **covered** under the **POS** or the **Traditional Indemnity** option)
- Cosmetic surgery or other cosmetic treatment (unless it is considered to be restorative surgery under the **POS** or **Traditional Indemnity** option)
- Growth hormone therapy (unless there is documented evidence of pituitary deficiency and there is likely to be adequate response)
- Nutritional dietary supplements (unless administered intravenously or through a gastrointestinal tube as a **medically necessary** course of treatment)
- Dental and orthodontic treatment (except for **hospital** room and board charges if hospitalization is **medically necessary** to safeguard the patient due to a specific non-dental organic impairment)

- Dental care to replace sound, natural teeth (unless the teeth are injured while the individual is **covered** under the **POS** or **Traditional Indemnity** option through an accident other than chewing; damage is not wholly or partially due to existing decay or damage; and the treatment begins within three months of the accident)
- Non-surgical treatment of the joint of the jaw (temporomandibular joint dysfunction or TMJ)
- Care provided to a person not **covered** under the **POS** or **Traditional Indemnity** option who donates an organ to a **covered eligible employee** or **eligible dependent** if the donor has other coverage
- Charges for chiropractic care, **physical therapy** or physical medicine that seeks to treat conditions other than musculoskeletal conditions (i.e., conditions related to the nerves, muscles and ligaments, such as lower back pain)
- Drugs and medicines available without a prescription
- Prescription drugs dispensed through a pharmacy (may be **covered** under the **Prescription Drug Program**)
- Acupuncture services for smoking cessation
- Personal convenience items (regardless of whether the items are on an **out-patient** basis, in the home or as part of a **hospital** stay)
- Orthotics, braces and other supports not prescribed by a **physician** or that are used for extracurricular activities such as athletics (even if they are prescribed by a **physician**) and are not necessary for daily living activities
- Hearing aids to compensate for loss of hearing due to age, repeated exposure to loud noise or congenital defect (unless hearing loss is caused by illness or injury while you are **covered** under the **POS** or **Traditional Indemnity** option and hearing aid benefits are available under the conditions specified)
- Charges for items to assist in general fitness (for example, exercise equipment)
- Charges eligible for payment under a no-fault or state-mandated automobile insurance law or policy

### **Mental Health and Chemical Dependency Program Exclusions**

The **Mental Health and Chemical Dependency Program** will not pay any benefits for the following excluded services, supplies and expenses:

- Expenses beyond the stated limits including:
  - Charges from **non-network providers** above the **allowable amount**
  - Room and board charges from a **non-network hospital** above the semi-private room rate
  - Any charges for failure to obtain **precertification** from **Aetna** for an **out-of-network in-patient** admission
  - Any charges for services furnished by a **network provider** that were not authorized or precertified by **Aetna**
- Charges for missed or cancelled appointments
- Treatment provided by telephone unless specifically authorized by **Aetna**
- **In-patient** stays primarily for environmental change
- **Alternative treatment** facilities accessed or provided **out-of-network**
- Conditions other than a mental disorder or **chemical dependency**
- Treatment of developmental disorders
- Obesity or weight loss conditions (unless there is a diagnosis of anorexia nervosa or bulimia, in which case treatment of those illnesses is **covered**)
- Routine physical exams or tests to investigate a potential physiological cause of a mental disorder (may be **covered** under your medical option)
- Psychotherapy in conjunction with self-actualization therapy
- Vocational therapy to teach or train a **covered** individual to resume employment (unless integrated with a **covered** treatment program provided to a patient in a **hospital** or **alternative treatment** facility)
- Aversion treatment of **chemical dependency** (treatment that administers alcohol with drugs designed to create an adverse reaction and a long-term psychological aversion to alcohol)

- Therapies based on nutrition or dietary supplements such as vitamins
- All drugs and supplies (except prescription drugs administered as part of a **covered** stay in an **in-patient** facility; prescription drugs filled on an **out-patient** basis may be **covered** under the **Prescription Drug Program**)

### **Prescription Drug Program Exclusions**

The **Prescription Drug Program** will not pay any benefits for:

- Drugs and medicines provided (or that can be obtained) without a prescription from a **physician**
- Non-federal legend drugs
- Injectable medications that cannot be self administered (unless approved by **Aetna**)
- Ostomy supplies (may be **covered** under the durable medical equipment benefit of your medical option)
- Therapeutic devices (not considered to be drugs, but may be **covered** under your medical option)
- Drugs used solely to promote hair growth
- Immunization agents, vaccines, biologicals, blood or blood plasma (blood and blood products may be **covered** under your medical option)
- Drugs labeled “caution -- limited by federal law to investigational use” or **experimental drugs** even if you are charged for those drugs
- Medication for which the cost is recoverable under any Workers’ Compensation or occupational disease law or any state or local governmental agency or any drug or medical service furnished at no cost to the **covered** individual
- Medication provided to a **covered** individual while a patient in a licensed **hospital**, rest home, sanitarium, **extended care facility**, **skilled nursing facility**, convalescent hospital, nursing home, **home health care agency** or similar institution that has a facility for dispensing pharmaceuticals on its premises

- Prescriptions filled in excess of the refill number specified by the **physician** or any refill dispensed one year after the original prescription
- Charges for the administration or injection of any drug
- Any drug or medicine the doctor or **Aetna** does not certify as **medically necessary** to treat the condition
- Prescriptions filled at a pharmacy that exceed the 30-day limit (90-day limit for insulin) or through **Aetna** Rx Home Delivery that exceed the 90-day limit
- Prescriptions filled for maintenance drugs after 3 consecutive fills for the same dosage through a retail pharmacy or mail order drug program other than **Aetna** Rx Home Delivery
- Prescription drugs that require precertification through the **Prescription Drug Program**. Requirements will have to be met before the drugs will be covered through the Medical Plan.
- Drugs used for experimental or investigational treatments or procedures
- Mifeprex (may be available through your medical option as supplied by your **physician**)

### ***Employee Assistance Program Exclusions***

The **EAP** will not pay any benefits for:

- Medical care, including services for a condition that requires psychiatric treatment (for example, a psychosis)
- Inpatient treatment
- Services by **providers** who are not part of **Magellan's network** of **EAP** counselors
- **EAP** sessions that were not accessed through **Magellan** (telephonically or online) for the particular episode of care
- Psychological, psychiatric, neurological, educational, or IQ testing
- Remedial and social skills education services, such as evaluation or treatment of learning disabilities, learning disorders, academic skill disorders, language

disorders, mental retardation, motor skill disorders, or communication disorders; behavioral training; cognitive rehabilitation

- Medication or medication management. If you have a **mental illness** or a **chemical dependency** condition for which medication is required, you must see a doctor to prescribe the medication and oversee your use of the medication. (See "**Mental Health and Chemical Dependency Program**").
- Evaluations for fitness for duty or excuses for leaves of absence or time off
- Examinations and diagnostic services in connection with obtaining employment or a particular employment assignment, admission to or continuing in school, securing any kind of license (including professional licenses), obtaining any kind of insurance coverage
- Court-mandated counseling, evaluations required by a state or federal judicial officer or other governmental official or agency or to be used in legal actions of any kind (for example, child custody proceedings)
- Testimony in legal proceedings, creation of records for legal proceedings or other preparation for legal proceedings
- Guidance on workplace issues when you sue, or threaten to sue, Avaya
- Acupuncture
- Biofeedback or hypnotherapy

## WHEN COVERAGE ENDS

### ***When Employee Coverage Ends***

Your coverage under the Medical Plan for active employees ends on the last day of the month in which any of the following events occur:

- You terminate your employment with a **Participating Company** or otherwise cease to be an **eligible employee**,
- You fail to make any required contributions,
- You request cancellation of coverage as a result of a **qualified status change**,
- The company you work for ceases to be a **Participating Company**, or
- The Medical Plan is terminated.

When your coverage ends, you may be able to continue coverage. For more information, see “Continuing Coverage.”

### ***When Dependent Coverage Ends***

Generally, dependent coverage under the Medical Plan ends on the:

- Date your coverage ends, or
- Last day of the month in which your **covered dependent** is no longer an **eligible dependent**. (See, “If a Dependent Loses Eligibility”)

You must notify the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) within 31 days when your dependent no longer qualifies as an **eligible dependent**.

For information about what happens to dependent coverage following your death, see “If You Die While Covered Under the Medical Plan.”

### **Other Reasons Your Coverage Will End**

In addition, when any of the following happens, you will receive written notice that your coverage (and coverage for your **covered dependents**) has ended on the date identified in the notice:

- Fraud or misrepresentation, or because you (or one of your **covered dependents**) knowingly gave the Plan Administrator (see “Important Contacts”), **Claims Administrator** or **Avaya Health and Benefits Decision Center** false, material information. Examples include false information relating to a person’s eligibility or status as a **covered dependent**.
- You (or one of your **covered dependents**) permitted an unauthorized person to use one of your ID cards, or you (or one of your **dependents**) improperly use another person’s ID card.
- You (or one of your **covered dependents**) in any other way materially violates the terms of the Medical Plan.

### **Creditable Coverage Certificates**

If you or a **covered dependent** loses Medical Plan coverage (including continued coverage), you will receive a certificate of creditable coverage. This certificate shows that you were **covered** under the Medical Plan, and will indicate either the length of your coverage, or that you had at least 18 months of coverage. The certificate may be used to offset any exclusion of coverage for a pre-existing condition that may be imposed when you or your dependent seeks coverage under another group health plan.

A **covered** person may also request a certificate of creditable coverage from Avaya Inc. within 24 months after loss of coverage. Requests should be directed to the **Avaya Health and Benefits Decision Center** (see “Important Contacts”).

## CONTINUING COVERAGE

### ***Extending Coverage During Hospitalization***

If you or a **covered dependent** is hospitalized when coverage ends, coverage for that individual's current **hospital** stay *only* may continue for a limited period of time. For a medical condition, coverage may continue for the duration of the **hospital** stay, up to a maximum of 120 days. If treatment is for a mental health or **chemical dependency** condition, benefits may continue while the individual is hospitalized, up to the applicable **in-patient** maximum. For more information, see "Mental Health and Chemical Dependency Program."

Benefits stop on the earlier of the date the individual is released from the **hospital** or the date the maximum is reached, unless you continue or replace coverage through one of the other methods described below.

### ***Continuing Your Medical Coverage Through COBRA***

A federal law known as **COBRA** (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended) requires employers to offer **eligible employees** and their **covered dependents** (excluding **Class II Dependents** who aren't children) the opportunity to continue their group health coverage *at their own expense* for a limited period of time if they lose coverage due to a qualifying event. **COBRA** applies to all the medical options -- **POS** option, **Traditional Indemnity** option and **HMO** option. Although not required under **COBRA**, the Medical Plan provides continuation coverage to your **domestic partner** and/or **domestic partner dependents**.

### **COBRA Coverage**

**COBRA** may extend your coverage under the Medical Plan for up to 18 months, 29 months or 36 months, depending on the qualifying event. The following chart summarizes who is eligible for **COBRA** continuation coverage, under what circumstances, and how long **COBRA** continuation coverage continues:

<b>If:</b>	<b>Qualifying Event</b>	<b>Who Is Eligible for COBRA Coverage</b>	<b>Duration of COBRA Coverage</b>
You	Become laid off	You and your <b>covered dependents</b>	18 months
	Have a reduction in hours	You and your <b>covered dependents</b>	18 months

<b>If:</b>	<b>Qualifying Event</b>	<b>Who Is Eligible for COBRA Coverage</b>	<b>Duration of COBRA Coverage</b>
	Terminate employment (for reasons other than gross misconduct)	You and your <b>covered dependents</b>	18 months
	Do not return from an <b>FMLA</b> leave of absence	You and your <b>covered dependents</b>	18 months
	Become disabled within the first 60 days of <b>COBRA</b> continuation coverage	You and your <b>covered dependents</b>	Up to 29 months*
	Die	Your <b>covered dependents</b>	36 months
	Become divorced or legally separated	Your <b>covered dependents</b>	36 months
Your <b>covered dependent</b>	Is no longer an <b>eligible dependent</b> (due to age limit, divorce, or legal separation)	Your <b>covered dependent</b>	36 months
	Is no longer an <b>eligible dependent</b> because of your death	Your <b>covered dependent</b>	36 months
	Becomes disabled within the first 60 days of <b>COBRA</b> continuation coverage	Your <b>covered dependent</b>	Up to 29 months*

\*Includes months of **COBRA** coverage already used

### Employee Loses Coverage

If you lose coverage because of a layoff, termination of employment (for reasons other than gross misconduct), or if you do not return to work after an **FMLA** leave of absence, **COBRA** continuation coverage is available to you and your **covered dependents** for up to 18 months from the date of the qualifying event. If you elect **COBRA** coverage and you acquire a new child (birth, adoption or placement of adoption) during your **COBRA** continuation period, you may enroll that new child in **COBRA** continuation coverage.

You and your **covered dependents** will be notified when an event makes continuation of coverage available. The **Avaya Health and Benefits Decision Center** will send you election information, including the cost of the coverage. You and each of your **covered dependents** have an independent right to elect **COBRA** continuation coverage. You (or a **covered dependent**) must notify the **Avaya Health and Benefits Decision Center** (within 60 days of the date the notice is sent or coverage is lost, whichever is later) of your decision to continue coverage. If you do not elect continuation coverage during the first 60-day election period and you become eligible for trade adjustment assistance, you may elect continuation coverage during a second 60-day period that begins on the first day of the month in which you are determined to be eligible for such

assistance. In this situation, your election must be made within 6 months of your first **COBRA** qualifying event.

If you or your **covered dependent** becomes disabled within the meaning of the Social Security Act during the first 60 days of **COBRA** continuation coverage, you and your **covered dependents** may extend the 18-month continuation period to 29 months. For the 29-month continuation coverage period to apply, you must notify the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) within 60 days of the determination of your disability by the Social Security Administration and within the initial 18-month continuation coverage period. This notice should be in writing and should include a copy of the Social Security Administration’s disability determination. If the **Avaya Health and Benefits Decision Center** determines that you or your **covered dependents** are not eligible for an extension of the **COBRA** continuation period, you will be provided a written explanation of why extended **COBRA** continuation coverage is not available.

If one of your **covered dependents** experiences another qualifying event (for example, your child becomes no longer eligible due to age, or you die during the **COBRA** continuation period), the **COBRA** continuation period can be extended for that dependent. You or your **covered dependent** must notify the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) within 60 days of the second event. (Note that a second qualifying event is not triggered when you become entitled to Medicare.) This notice should be in writing and should include proof of the second qualifying event. If the **Avaya Health and Benefits Decision Center** determines that you or your **covered dependents** are not eligible for an extension of the **COBRA** continuation period, you will be provided a written explanation of why extended **COBRA** continuation coverage is not available.

If the **Avaya Health and Benefits Decision Center** determines that you and/or your **covered dependents** are not eligible for **COBRA** continuation coverage, you will be notified in writing explaining why continuation coverage is not available.

### **Dependent Continuation Coverage**

Each of your **covered dependents** may have the right to **COBRA** continuation coverage for up to 36 months from the date of the qualifying event if he or she loses coverage because:

- You die,
- You and your spouse get divorced or legally separated, or
- He or she is no longer eligible for coverage under the Medical Plan (e.g., due to the age limit)

If your **covered dependents** lose coverage because of your death, the **Avaya Health and Benefits Decision Center** will notify them of their right to continue coverage within 44 days. Your **covered dependent** must notify the **Avaya Health and Benefits Decision Center** of their decision to continue coverage within 60 days of the later of this notification or the date benefits terminate.

If you get divorced or legally separated, or if your child no longer meets the eligibility requirements, you or your **covered dependent** must notify the **Avaya Health and Benefits Decision Center** within 60 days of the event. This notice should be in writing and should include proof of the qualifying event (for example, a copy of the divorce decree). If the **Avaya Health and Benefits Decision Center** is not notified within 60 days of the qualifying event, your **covered dependent** will lose the right to elect **COBRA** continuation coverage. After the **Avaya Health and Benefits Decision Center** is notified, your **covered dependent** will be notified of his or her right to continue coverage within 14 days. Within 60 days of the later of this notification or the date benefits terminate, your **covered dependent** must notify the **Avaya Health and Benefits Decision Center** of his or her decision to continue coverage. If the **Avaya Health and Benefits Decision Center** determines that your **covered dependent** is not eligible for **COBRA** continuation coverage, your **covered dependent** will be notified in writing explaining why continuation coverage is not available.

### **When COBRA Coverage Ends**

If you and/or your **covered dependent** elect **COBRA** continuation coverage, it takes effect on the date of the qualifying event and continues until the earliest of the following:

- The end of the 18-month, 29-month or 36-month continuation period
- The date Avaya Inc. no longer provides health care coverage to any of its employees
- When there is a significant underpayment of a premium or when premiums for **COBRA** continuation coverage are not paid within the required time
- The date you or your **covered dependents** become **covered** under another group health care plan other than TRICARE (provided pre-existing condition exclusions or limitations under the new group health care plan do not apply)
- The date you or your covered dependents become eligible for Medicare, if after the date your **COBRA** coverage begins. Note that coverage will still be available for family members who are not Medicare-eligible.
- With respect to the 11-month extension for disability, the date the person is no longer disabled (you must notify the **Avaya Health and Benefits Decision Center** within 30 days of a determination by the Social Security Administration that you or the **covered dependent** is no longer disabled)

If the **Avaya Health and Benefits Decision Center** determines that your coverage is terminating before the end of the 18-month, 29-month or 36-month period (e.g., when premiums are not being paid within the required time), you will be notified that your coverage is terminating and you will be provided with the reason why and the date your coverage is terminating.

### **COBRA Coverage Cost**

You (or your **covered dependent**) pay the full cost for **COBRA** continuation coverage, plus a 2% administrative fee. If the **COBRA** period is extended to 29 months because you or a **covered dependent** is disabled under the Social Security Act, a 2% administrative fee applies for the first 18 months and a 50% administrative fee applies for you and your **covered dependents** for the next 11 months (from the 19th month through the 29th month).

The initial **COBRA** payment (which includes payment for coverage back to the date regular coverage ended) is due when you elect **COBRA**. However, the Medical Plan is legally required to provide you with a 45-day grace period for this initial **COBRA** payment. No further extension will be permitted. After the initial payment, subsequent payments are due by the first of the month for the coverage period which is being paid. The Medical Plan is legally required to provide you with a 30-day grace period for these payments. No further extension is permitted. Payments received after your 30- or 45-day grace period will result in an automatic loss of all **COBRA** coverage rights. Once **COBRA** coverage is lost, it cannot be reinstated. There are no exceptions.

### **Military Leave of Absence**

If you lose coverage because you enter into active military duty covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you and your **covered dependents** are eligible for **COBRA** continuation coverage. Under USERRA, however, you and your **covered dependents** are only required to pay the regular employee contribution for the first 30 days of coverage, and the duration of the continuation coverage is 24 months instead of 18 months.

Special rules apply if your active military duty is in connection with "Operation Enduring Freedom". In that case, Avaya provides you and your **covered dependents** with continued coverage under the Medical Plan for the first 60 months of your military leave of absence. To receive this continued coverage, you must pay the regular employee contribution. This coverage satisfies the Medical Plan's obligation to provide you with **COBRA** continuation coverage. As a result, if you lose coverage at the end of your military leave of absence because you do not return to Avaya, then you (and your **covered dependents**) will have no right to **COBRA** continuation coverage, so long as you were on military leave for at least 18 months.

## If You Have Questions

Questions concerning your **COBRA** continuation coverage rights should be addressed to the **Avaya Health and Benefits Decision Center** (see “Important Contacts”). For more information about your rights under ERISA, including **COBRA**, the Health Insurance Portability and Accountability Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA Web site.)

## Keep Your Plan Informed of Address Changes

In order to protect your family’s rights, you should keep the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the **Avaya Health and Benefits Decision Center**.

## *Converting Coverage to an Individual Policy*

You may apply for an individual policy whenever you lose eligibility under the Medical Plan or when your **COBRA** continuation coverage ends. The cost, **covered** services and cost sharing amounts under an individual policy will be different than those under the Medical Plan. To request an individual policy, contact your **health care company** within 45 days of the date your regular coverage under the Medical Plan or your **COBRA** continuation coverage ends. You will not need a medical examination if you enroll within the required time frame.

## CLAIMS

### *Filing a Claim*

One of the advantages of **in-network** care under the **POS** option, **Prescription Drug Program** (when you use **Aetna Rx Home Delivery** or a **participating pharmacy**) or **Mental Health and Chemical Dependency Program** is that you do not need to submit any claim forms. This also applies if you use **National Advantage Program network providers** under the **Traditional Indemnity** option or under the **out-of-network** provision of the **POS** option or if you use **EAP** services.

However, you do need to submit a claim to receive benefits:

- Under the **Traditional Indemnity** option or **out-of-network** care under the **POS** option, when you do not use a **NAP network provider**,
- For **out-of-network** care under the **Mental Health and Chemical Dependency Program**, or
- Under the **Prescription Drug Program**, when using a non-participating pharmacy.

Generally, you will pay the **provider** at the time of service unless he or she agrees to accept payment of benefits directly from **Aetna**.

To file a claim:

- Call **Aetna** at the telephone number printed on your medical ID card to request a claim form if you do not have one (or print one from the Avaya Healthy Decisions Web site in the "Reference Materials & Forms" section at [www.AvayaHealthyDecisions.com](http://www.AvayaHealthyDecisions.com)),
- Follow the instructions printed on the form,
- Attach a copy of the **provider's** itemized bill, and
- Submit the completed form to the address printed on the form.

Your claim will be evaluated to determine if any benefits will be paid. You will receive an explanation of benefits (EOB) statement. If benefits are payable, a check is sent to you, or to your **provider** if he or she agreed to accept payment directly from **Aetna**.

If your claim is denied, you may appeal the decision. For more information, see "Claim Procedures."

### **Filing Claims When the Medical Plan Pays Second**

You may have another medical program (such as a plan through your spouse's employment, or Medicare) that pays claims first. If The Avaya Inc. Medical Expense Plan pays claims second, you need a copy of the original bill as well as the Explanation of Benefit statement from the other program when you file your claim. For more information, see "Coordination of Benefits."

### **Prescription Drug Claims**

No claim forms are required for prescriptions filled at **participating pharmacies** or through **Aetna Rx Home Delivery**. The first time you fill a given prescription through the mail, either complete and mail the order form or have your doctor fax your prescription. However, you do need to submit a claim form for prescriptions filled at non-participating pharmacies. To obtain a prescription drug claim form, call **Aetna Member Services** (see "Important Contacts") or print one from the Avaya Healthy Decisions Web site in the "Reference Materials & Forms" section at [www.AvayaHealthyDecisions.com](http://www.AvayaHealthyDecisions.com).

### **Coordination of Benefits**

The Medical Plan has a **coordination of benefits (COB)** provision. This feature is designed to prevent duplicate benefit payments when you or your **eligible dependents** participate in more than one group plan.

### **When the COB Provision Applies**

The **COB** provision applies when you or your **eligible dependents** have medical coverage other than that provided under the Medical Plan (i.e., from another source), such as:

- Another employer's plan,
- A group-sponsored insurance or prepayment plan, or
- A government-sponsored plan.

The **Mental Health and Chemical Dependency Program** and **Prescription Drug Program** also coordinates benefits with other coverage.

See "If You or a Covered Dependent Reach Age 65 or Otherwise Become Eligible for Medicare While You Are an Active Eligible Employee" for more information about the Medical Plan's **COB** with Medicare.

## When the COB Provision Does Not Apply

The **COB** provision described in this section does not apply:

- To benefits under any personal policy (except no-fault or other state-mandated automobile insurance), and
- To two related people, both of whom are employees or retirees of a **Participating Company**, due to the following two rules:
  - One person cannot receive Medical Plan benefits as both an employee or retiree of a **Participating Company**, and as an **eligible dependent** of an employee or retiree.
  - One person cannot receive Medical Plan benefits as an **eligible dependent** of more than one employee or retiree of a **Participating Company**.

See “Avaya Inc. Families” for additional information.

## The Primary Plan Determines Benefits First

Under the **COB** provision, the **Claims Administrator** (see “Important Contacts”) determines that one plan is primary and determines its benefits first. Any other plan is secondary.

To claim benefits, submit your claim to the primary plan first. After that plan determines its benefits, submit a claim to the secondary plan(s) along with a copy of the Explanation of Benefits statement you received from the primary plan. The secondary plan(s) will then determine if any additional benefits are payable.

- If the Medical Plan through Avaya Inc. is the primary plan, it pays its benefits without regard to the secondary plan.
- If the Medical Plan is secondary, the Medical Plan coordinates benefits with the primary plan(s). Here is how this works. The **Claims Administrator** first calculates what the Medical Plan would have paid if it were the primary plan. Second, the **Claims Administrator** reviews the Explanation of Benefits statement you received from the primary plan to determine what the primary plan paid. The Medical Plan then pays the difference between the **allowable amount** and the primary plan’s payment, not more than the amount the Medical Plan would have paid if it were the primary plan. Therefore, among the primary and secondary plans, you can receive up to 100% (but not more than 100%) of the **allowable amount**.

- **COB** with Medicare as the primary plan works differently. See “When the Medical Plan Coordinates Benefits with Medicare” or contact **Aetna** for more information.

### How the Claims Administrator Determines Which Plan Is Primary

The **Claims Administrator** (see “Important Contacts”) determines which plan is primary and which plan(s) is secondary under the following rules:

- If the other plan(s) does not have a **COB** feature, that plan(s) is considered primary and the Medical Plan is considered secondary.
- If both plans have a **COB** provision, the plan covering a person as an employee is primary, and the plan covering the person as a dependent is secondary.
- For dependent **children**, determination of the primary and secondary plan(s) follows these rules in this sequence:
  - The “birthday” rule. The plan covering the parent whose birthday (month and day) comes first in the year is the primary plan for the **children**, and the plan covering the other parent is the secondary plan for the **children**. If both parents have the same birthday, the benefits of the plan that **covered** the parent longer are determined before those of the plan that **covered** the other parent for a shorter period of time. The Medical Plan uses this rule.
  - The “male-female” rule. For plans that do not use the birthday rule, the father’s group insurance is the primary plan for the **children** and the mother’s group insurance is the secondary plan for the **children**.
  - If one parent’s plan includes the male-female rule and one parent’s plan includes the birthday rule, the male-female rule applies to the extent permitted by law.
- If the parents of dependent **children** are divorced or legally separated, the Plan Administrator will determine if there is a court decree or a **Qualified Medical Child Support Order (QMCSO)** establishing financial responsibility for medical care. If an order meets the requirements of a **QMCSO**, Avaya Inc. will comply with the terms of that order. See “Important Contacts” for where to submit **QMCSOs**.
  - If there is such a decree or **QMCSO**, the plan covering the parent who has that responsibility will be the primary plan.
  - If there is no such decree or **QMCSO**, the plan that covers the parent with custody will be the primary plan; the other parent’s plan will be secondary.

- If there is no such decree or **QMCSO** and the parent with custody remarries, that parent's plan remains primary, the stepparent's plan pays secondary, and the non-custodial parent's plan pays third.
- If payment responsibilities are still unresolved, the plan that has **covered** the patient for the longest time is the primary plan.

When both parents have coverage through a **Participating Company**, either parent (but not both) may choose to cover the **children**. Claims for the **children** are submitted to the **Claims Administrator** (see "Important Contacts") of the parent covering the **children**. The other parent's medical coverage is not secondary because it does not cover the **children**. So expenses that are not paid by the primary plan cannot be submitted to the Medical Plan by the second parent.

### ***Obligation to Refund and Right of Recovery and Subrogation***

If all or some of the expenses under the Medical Plan were not paid in accordance with the terms of the Medical Plan (improper payments), or if all or some of the payments made exceed the benefits payable under the Medical Plan (excess payments), then those improper or excess payments must be refunded to the Medical Plan.

If the refund is due from another person or organization, you or your **covered dependents** must assist the Medical Plan in getting the refund when requested. You or your **covered dependents** are still responsible for any improper or excess payments made to you or your **covered dependents** or to **providers** under the Medical Plan.

Failure by you or your **covered dependents**, or any other person or organization that was improperly or excessively paid, to promptly refund the full amount may reduce the amount of any future benefits that are payable to or on behalf of you or your **covered dependents** under the Medical Plan.

The Medical Plan provides certain benefits to you and your **covered dependents** that are not provided by any third party. So, benefits provided under the Medical Plan as a result of any illness or injury that gives rise to a claim by you or your **covered dependents** against a third party (as the result of or attributable to the negligent or wrongful acts or omission of such third party, such as an auto accident in which another person is at fault) are excluded and are not **covered** under the Plan. If such benefits *have* been paid by the Medical Plan:

- The Medical Plan shall be entitled to all of your and your **covered dependents'** rights of recovery against such third party to the extent of the reasonable value of the benefits provided under the Medical Plan.
- You and your **covered dependents** agree to reimburse the Medical Plan for the reasonable value of all benefits received under the Medical Plan out of any actual

recoveries you or your **covered dependents**, received from any third party (other than the participant's family members).

- The Medical Plan's subrogation and reimbursement rights apply to any recoveries that may be received or actually are received by you or your **covered dependents**, including, but not limited to, the following:
  - Any payments as a result of a settlement, judgment, or otherwise, made by or on behalf of a third party or his or her insurance company or made under an uninsured or underinsured motorist coverage,
  - Any payments under Workers' Compensation, no-fault or other state mandated motor vehicle insurance, or
  - Any payments made as a result of coverage under any automobile, school, homeowners' or other general liability insurance policy.

You and your **covered dependents** are required to fully cooperate and perform all actions necessary to secure the Medical Plan's right of recovery and subrogation, including granting a lien on any monies recovered from a third party, refraining from taking any action or negotiating any agreement with any third party that may prejudice the Medical Plan's rights, and from assigning any rights to recover medical care expenses from any negligent party or other person or entity to any other party. You or your **covered dependents** shall not incur any expenses on behalf of the Medical Plan in pursuit of the Medical Plan's rights. No court costs or attorney's fees may be deducted from the Medical Plan's recovery without the advance express written consent of the Medical Plan.

In the event you or your **covered dependents** fail or refuse to honor these terms, the Medical Plan will be entitled to recover any cost incurred in enforcing these terms and conditions, including reasonable attorney's fees.

### ***Filing Deadlines***

Generally, you should submit claims within 60 days of the date the service is provided. If it is not reasonably possible to submit claims within this time frame, an extension of up to 15 months from the date of service will be allowed. *No benefits will be paid for claims submitted more than 15 months after the date of service.*

## EMPLOYMENT-RELATED EVENTS AFFECTING COVERAGE

### ***If You Change Your Employment Status***

Since your medical options are based, in part, on your employment status, it is possible that a change in your employment status may affect your coverage. If your current option is not available to you under your new employment status, you should select a new option. If you do not elect a new option, you will automatically be enrolled in your **assigned option** (see “Assigned Option”). However, if you are not eligible for an **assigned option**, you will not be enrolled in any option. This means you and your dependents will not be **covered** under the Medical Plan for the rest of the calendar year, and you must wait until the next **annual enrollment** to enroll.

<b>If...</b>	<b>The rule is...</b>
You change from full-time to part-time (25 or more hours per week)	Your current coverage stays the same.
You change from full-time to part-time (fewer than 25 hours per week)	You may choose any available medical option for the remainder of the Plan Year, and you may change your coverage category. If you elect coverage, you pay the required coverage cost. If you make no election, no coverage will be assigned for the remainder of the year.
You change from part-time (fewer than 25 hours per week) to full-time	If you were previously enrolled in an <b>HMO</b> , you remain in that option. If you were enrolled in another option, or not enrolled at all, you may enroll in any available option. If you make no election, you will be enrolled in the <b>assigned option</b> for the remainder of the year.
You change from represented to salaried	Your coverage under the Medical Plan will end and you will be eligible for The Avaya Inc. Medical Expense Plan for Salaried Employees.

If...	The rule is...
You change from salaried to represented	Your coverage under the Avaya Inc. Medical Expense Plan for Salaried Employees will end and you will become eligible for the Medical Plan. Coverage will be effective the later of the first of the month following your change in classification or the first of the month in which you will reach six months of <b>NCS</b> .

For information about what happens if your coverage option changes, see “If Your Coverage Option Changes During the Year.”

***If You Terminate Employment***

Your coverage under the Medical Plan ends on the last day of the month in which your employment ends. Different rules apply if you retire (see “If You Retire”).

When coverage ends, you may be eligible to continue coverage for yourself and your eligible **covered dependents** under **COBRA**. Following **COBRA**, conversion to an individual policy also may be available. If you are enrolled in an **HMO** option, call the **HMO** to see if **COBRA** coverage is available for your **domestic partner** and **domestic partnership dependents**. For more information, see “Continuation of Coverage.”

***If You Are Laid Off***

If you are laid off, you will be able to continue Medical Plan coverage through **COBRA** (see “Continuing Coverage”). Depending upon your years of service and the type of layoff, part of your cost for **COBRA** coverage may be paid by the Company. Your Force Adjustment Program package will provide the details.

***If You Retire***

If you retire with a service or disability pension, enrollment material and information about your coverage options under The Avaya Inc. Retiree Medical Expense Plan will be sent to you at your home address. If you enroll by the date specified in your enrollment material, coverage will become effective on the first day of the month following the month in which you retire.

If you retire with a service or disability pension, but you do not enroll by the enrollment deadline, you will automatically be enrolled in the assigned coverage option that applies to you under The Avaya Inc. Retiree Medical Expense Plan, if applicable.

Under The Avaya Inc. Retiree Medical Expense Plan, Medicare becomes the primary plan if you are Medicare-eligible. Your Avaya Inc. coverage will be secondary. In addition, Medicare-eligible retirees and their family members enrolled in the **POS** option will have their secondary benefits payable under the **Traditional Indemnity** schedule. If you and your **covered dependents** are Medicare-eligible, you will be enrolled in the **Traditional Indemnity** option. Please note that **COB** with Medicare as the primary plan works differently.

To continue coverage for **domestic partner** and/or **domestic partnership dependents**, they must be enrolled as your dependents in the Medical Plan when you retire. You cannot add new **domestic partner** and/or **domestic partnership dependents** after you retire.

More information may be found in the SPD for The Avaya Inc. Retiree Medical Expense Plan.

When you retire, you also have the option to continue coverage under **COBRA**; a **COBRA** enrollment package will also be sent to your home address.

### ***If You Are Rehired***

If you leave the Company and then return after a break in service, your coverage resumes based on the Medical Plan's eligibility rules and the service bridging rules of The Avaya Inc. Pension Plan or The Avaya Inc. Pension Plan for Salaried Employees (see "Who Is Eligible" and "When Coverage Begins").

### ***If You Become Disabled***

Your participation in the Medical Plan may be affected if you become disabled. Your length of service and the duration of your disability determine what happens to your coverage during a disability.

### **Accident Disabilities**

If you become partially or totally disabled due to a certified work-related accident as determined under The Avaya Inc. Sickness and Accident Disability Benefit Plan, you will continue to be eligible for coverage under the Medical Plan. You will be subject to the same costs as an active employee during that time. This coverage will continue for as long as you remain disabled under The Avaya Inc. Sickness and Accident Disability Benefit Plan. However, if you become entitled to Medicare while coverage under the

Medical Plan is in effect, coverage under the Medical Plan will be administered secondary to Medicare.

If you are eligible for a service pension under The Avaya Inc. Pension Plan and you elect to retire and waive your right to future accident disability benefits, your benefits would be provided under The Avaya Inc. Retiree Medical Expense Plan and your coverage under The Avaya Inc. Medical Expense Plan would end.

### **Sickness Disabilities**

If you become disabled due to a certified non-work-related disability as determined under The Avaya Inc. Sickness and Accident Disability Benefit Plan, you will continue to be eligible for coverage under the Medical Plan for as long as you are receiving benefits under The Avaya Inc. Sickness and Accident Disability Benefit Plan. You will be subject to the same costs as an active employee during that time.

If you continue to be disabled after you have received the maximum number of weeks of sickness disability benefits, you may be eligible for benefits under The Avaya Inc. Long-Term Disability Plan. If you are **covered** by The Avaya Inc. Pension Plan and you are eligible for a disability or service pension, you will be **covered** by The Avaya Inc. Retiree Medical Expense Plan and your coverage under The Avaya Inc. Medical Expense Plan will end. If you are not eligible for a disability or service pension, but you are eligible for benefits under The Avaya Inc. Long-Term Disability Plan, your Medical Plan coverage would continue as indicated below.

Your coverage under the Medical Plan will automatically resume on your first day of work upon your return.

### **Long-Term Disability**

Medical Plan coverage under The Avaya Inc. Medical Expense Plan is available for employees eligible for The Avaya Inc. Long-Term Disability Plan who are not eligible for coverage under The Avaya Inc. Retiree Medical Expense Plan as described above. Coverage under the Medical Plan will terminate as of the end of the month in which you are no longer eligible for long-term disability benefits or at age 65, whichever is earlier. *If you become eligible for Medicare benefits while coverage under the Medical Plan is in effect, coverage under the Medical Plan will be administered secondary to Medicare.*

### ***If You Take an Approved Leave of Absence***

If you take an approved leave of absence under the Family and Medical Leave Act of 1993, as amended (**FMLA**), your coverage under the Medical Plan may continue for up to 12 work weeks. The Company continues its share of the cost of this coverage under the **POS**, **Traditional Indemnity** and **HMO** options. You must pay your share of any

cost of coverage to continue coverage during your **FMLA** leave. If you choose not to continue such coverage, you remain eligible for reinstatement upon your return to work.

If you are eligible for an **FMLA** leave, Avaya Inc. will comply with this legislation.

## PERSONAL EVENTS AFFECTING COVERAGE

### ***If You Gain a New Dependent***

If you gain a new dependent (through marriage, birth or adoption), you may enroll your new dependent if you do so within *31 days of the date he or she became your dependent*. Contact the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) for additional information. If you enroll the dependent *within* the specified 31-day time frame, he or she is **covered** from the date he or she became your dependent. *If you do not enroll your new dependent within 31 days and you are enrolled in the **POS** option or **Traditional Indemnity option** (non-HMO option), you will be permitted to elect coverage for the dependent prospectively the first of the following month. If you do not enroll your new dependent within 31 days and you are enrolled in an **HMO** option, you will not be permitted to elect coverage for your dependent until the next **annual enrollment** period, unless you experience another applicable **qualified status change**.*

### ***If a Dependent Loses Eligibility***

Call the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) within 31 days of the date your **covered dependent** is no longer eligible. You must provide notification within 31 days when your dependent no longer qualifies as an **eligible dependent**, to make any corresponding changes to your coverage level (individual, two-person, family) and ensure that your dependent is sent timely information regarding **COBRA** continuation coverage. If you do not provide notification within 31 days of when the dependent loses eligibility, your level and rates will not be retroactively adjusted, but the dependent will be ineligible to claim benefits. If you do not provide notification within 60 days, your dependent will lose all rights to **COBRA** continuation coverage. Also, see “Continuing Your Medical Coverage Through COBRA” and “Creditable Coverage Certificate.”

### ***If Your Physically or Mentally Handicapped Child Reaches Age 23***

If your physically or mentally handicapped child is incapable of self-support when he or she reaches age 23, coverage may be continued beyond that age, if the child is fully dependent on you for support at that time. You must apply for this coverage. It is not automatic. To apply for coverage, contact the **health care company** at the telephone number printed on your medical ID card prior to the child’s 23rd birthday.

### ***If You or a Covered Dependent Reach Age 65 or Otherwise Become Eligible for Medicare While You Are an Active Eligible Employee***

Generally, when you or a **covered dependent** reach age 65, you become eligible for Medicare. To enroll for Medicare, you should contact your Social Security office at least three months before turning age 65. You or a dependent may also be eligible for Medicare before age 65 due to disability.

Medicare, a federal health insurance program that covers people age 65 and older (as well as some disabled people under age 65), provides benefits whether you are still working or retired. Generally, two parts of the Medicare program impact Medical Plan coverage for Medicare-eligible persons:

- Medicare Part A, or Hospital Insurance, helps pay for care during a **hospital** stay and for some follow-up care after you leave the **hospital**.
- Medicare Part B, or Medical Insurance, helps pay for **physician** fees, **out-patient** services, and many other services and supplies not **covered** under Medicare Part A.

### When the Medical Plan Coordinates Benefits with Medicare

If you are actively employed and Medicare-eligible (or if you are the Medicare-eligible spouse of an active employee), the Medical Plan will generally pay benefits first and Medicare will pay benefits second. The same rule applies to your **covered Class I dependents** that are Medicare-eligible. The exception is for those with End-Stage Renal Disease. In those cases, the Medical Plan is primary for a 30-month coordination period and then Medicare becomes primary for that person thereafter.

Medicare is always the primary plan for **domestic partners** that are Medicare-eligible. Medicare is the primary plan for **Class II dependents** who are Medicare-eligible due to age, but Medicare is secondary if the **Class II dependents** are Medicare-eligible due to disability.

If you elect to participate in Medicare Part D (prescription drug coverage), Medicare is primary and the Medical Plan is secondary. If you do not elect to participate in Medicare Part D, the Medical Plan is primary.

For individuals eligible for primary coverage under Medicare, the **COB** provision works differently. The Medical Plan calculates its benefits, and then reduces them by the amount Medicare would have paid for the same expenses, regardless of whether the individual has actually enrolled in Medicare. Avaya Inc. will *not* reimburse any surcharges for late applications for Medicare; so it is important to enroll in Medicare (Parts A and B) when eligible.

- If you are enrolled in the **POS** option and Medicare is primary for you or one of your dependents, the **POS** option continues to cover the employee and/or dependents for which Medicare is not primary. However, when Medicare is the primary payer for an individual, his or her **POS** coverage works differently.

**Aetna** will calculate Medical Plan benefits (now secondary) for that person as if that person were enrolled in the **Traditional Indemnity** option. In other words, Medicare will pay first, then **Aetna** will review the benefit schedule for the **Traditional Indemnity** option to see if any additional benefits are payable.

- If you are enrolled in the **HMO** option, you will not be eligible for **HMO** coverage if Medicare is primary for you or any of your **covered dependents**.

If Medicare is primary for you (and the Medical Plan is secondary), Avaya Inc. will reimburse a portion of the cost of Medicare Part B premiums, provided that you submit appropriate documentation. Contact the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) for more information. When the Medical Plan is primary, you will *not* be reimbursed for the Medicare Part B premium. However, you may still wish to enroll in Medicare when you become eligible, because it may cover expenses not **covered** by the Medical Plan.

### **Medicare Coordination Examples – Medicare as Primary Coverage**

Here are examples of how Medicare coordinates benefits with the Medical Plan when Medicare is primary. Both examples assume that your **deductible** has been met under both Medicare and the Medical Plan.

#### *Example 1: Your Office Visit*

This expense would be **covered** by Medicare at 80%. If the Medical Plan had been the primary plan, it would have paid 80% for an office visit.

Since Medicare would pay 80%, the Medical Plan would not pay any additional amount. This is because the Medical Plan will only pay up to what it would have paid if it were the primary plan, less what was paid by the plan that actually was primary, and Medicare had already paid the total amount payable by the Medical Plan.

#### *Example 2: Your Surgery*

This expense would be **covered** by Medicare at 80%. If the Medical Plan had been the primary plan, it would have paid 100% for your surgery.

Since Medicare would pay 80%, the Medical Plan will pay an additional benefit up to 20%. This is because the Medical Plan will pay up to what it would have paid if it were the primary plan (the **allowable amount** of the surgical bill) less what the primary plan paid.

### **If You Die While Covered Under the Medical Plan**

Coverage for your enrolled **Class I dependents, domestic partner, domestic partnership dependents, and Class II dependents** automatically continues for six months after you die. If you pay for your coverage, your dependents must pay the same amount to continue coverage. After six months, your dependents (other than **Class II dependents** who are not **children**) have the option of continuing coverage under **COBRA** for up to another 30 months (for a total of 36 months) if they make the required contributions. **Class II dependents, other than Class II dependent children, are not** eligible to continue coverage under **COBRA**. For more information about continuing coverage under **COBRA**, see “Continuing Coverage.”

At the end of the **COBRA** continuation period, your surviving **lawful spouse** or **domestic partner** may choose to continue coverage under the **Traditional Indemnity** option through the Family Security Program if he or she pays the full cost for this coverage. Your **lawful spouse** also may cover any **Class I dependent children** who were enrolled immediately before your death as long as they still qualify as eligible **Class I dependents**.

As long as the required contributions are made under the **Traditional Indemnity** option, Medical Plan coverage under the Family Security Program may continue as follows:

- Spousal coverage may continue indefinitely, and
- Dependent child coverage may continue until the earlier of the date:
  - The spouse’s coverage ends, or
  - The dependent child ceases to be an **eligible dependent** under the Medical Plan.

### ***If You Move***

A move may require a change in your coverage option or the **health care company** that administers your benefits.

## **How a Move Affects Your Health Care Options**

If...	And you move...	The rule is*...
You are enrolled in the <b>POS</b> option	Into another <b>POS</b> area	You stay in the <b>POS</b> option. If you move outside the area serviced by your <b>PCP</b> , you should select a new <b>PCP</b> .
You are enrolled in the <b>POS</b> option	Into an area where the <b>POS</b> option is not available	You may select one of the options available ( <b>Traditional Indemnity</b> or <b>HMO</b> option) in your new area. An “opt-in” <b>POS</b> option also may be possible. If you make no election, the <b>Traditional Indemnity</b> option will be assigned.
You are outside a <b>POS network</b> area and are enrolled in the <b>Traditional Indemnity</b> option	Into a <b>POS</b> area	You may select one of the options available in your new area, which may include either the <b>POS</b> option or an <b>HMO</b> .
You are enrolled in an <b>HMO</b> option	Within the same area serviced by your current <b>HMO</b>	You stay in the same <b>HMO</b> option.
You are enrolled in an <b>HMO</b>	Outside of the area serviced by your current <b>HMO</b>	You may select one of the options available in your new area, which may include the <b>POS</b> , <b>Traditional Indemnity</b> option or other <b>HMO</b> . The available options will depend on whether or not you move into a <b>POS network</b> area.
* If your move requires that you change your enrollment option and you fail to make a selection within the required time, you will be enrolled in the <b>assigned option</b> for that area, unless otherwise indicated. See “Overview of Coverage Options.”		

Remember, **POS** coverage may be available to you if you elect to “opt-in” to **POS** coverage, even if you live outside a designated **POS network** area. Contact the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) for details and to enroll.

For information about what happens if your coverage option changes, see “If Your Coverage Option Changes During the Year.”

### **Qualified Status Changes**

Because you pay for your medical coverage on a pre-tax basis, federal rules limit your ability to make changes to your medical coverage during a calendar year. Generally, you may not elect a change unless you have a **qualified status change**.

Under Internal Revenue Service (IRS) regulations, if you have a **qualified status change**, you may change your *coverage level* (individual, two-person, family or no coverage), and only to the extent that the change in coverage is consistent with your **qualified status change**. For example, if you marry, you may elect to change your coverage from “individual” coverage to “two-person” coverage. Or, if you declined medical coverage and your spouse loses coverage under his or her employer’s medical plan, you may elect coverage under the Medical Plan. You may also make a change in your coverage option.

To be eligible to make a change, you must report your **qualified status change** to the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) *within 31 days of the event*. Contact the **Avaya Health and Benefits Decision Center** for additional information. *If you do not enroll your new dependent within 31 days and you are enrolled in the POS option or Traditional Indemnity option (non-HMO option), you will be permitted to elect coverage for your new dependent prospectively as of the first of the following month. If you do not enroll your new dependent within 31 days and you are enrolled in an HMO option, you will not be permitted to elect coverage for your dependent until the next annual enrollment period, unless you experience another applicable qualified status change.*

### ***If You Have a Change in Dependent Status***

You must update your dependent information whenever you have a change in dependent status, for example, if your dependent no longer meets the eligibility requirements (see “Participating in the Plan”). To update dependent information, contact the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) within 31 days of the change.

### ***Qualified Medical Child Support Orders***

Payments under the Medical Plan will be made according to the terms of a **Qualified Medical Child Support Order (QMCSO)**. If the Plan Administrator determines that a medical child support order qualifies, benefit payments from the Medical Plan may be made according to the qualified order to the child or **children** named in the order, or to the custodial parent or legal guardian, where appropriate, or to health care **providers** (if benefits have been properly assigned by the child or **children** or by the custodial parent or legal guardian). See “Important Contacts” for the address to submit correspondence concerning a **QMCSO**.

## AVAYA INC. FAMILIES

Avaya Inc. has many families -- employees (or retired Avaya Inc. employees) whose **lawful spouse, domestic partner, children, domestic partnership dependents** or parents also are employed by (or retired from) Avaya Inc. This may affect your coverage under the Medical Plan.

### **Enrollment Rules**

You may only elect to be **covered** as a dependent under another Avaya Inc. family member's coverage if you are a part-time employee regularly scheduled to work fewer than 25 hours per week.

During your initial six-month period of employment or if you are a part-time employee regularly scheduled to work fewer than 25 hours per week, your cost of employee coverage under the Medical Plan is waived if you meet the eligibility requirements to be **covered** as a dependent of another Avaya Inc. (represented or salaried) employee or retiree.

An **eligible employee** may cover another represented Avaya Inc. employee or retiree. Therefore, if your **lawful spouse** or **domestic partner** is an active represented employee, you may enroll as his or her dependent under the Medical Plan, or he or she may enroll as your dependent, but not both. If your **lawful spouse** is a retired represented employee, you may enroll as his or her dependent under The Avaya Inc. Retiree Medical Expense Plan. If you elect to be **covered** as a dependent under another represented Avaya Inc. employee or retiree, you would not be eligible for cash back.

A represented active or retired Avaya Inc. employee cannot enroll a salaried active or retired Avaya Inc. employee as an **eligible dependent**.

Each Avaya Inc. employee may choose any of the options available to him or her, regardless of the option the other family member selects.

Only one Avaya Inc. employee or retiree may enroll any given **eligible dependent**. Either you or your Avaya Inc. **lawful spouse** or **domestic partner**, as an employee or retiree, may cover your dependent **children**. A child may not be **covered** by both parents or by both a parent and a **domestic partner** at the same time.

### **Benefits/Family Deductible and Out-of-Pocket Maximums**

Expenses incurred by you and any dependents enrolled with you under your selected option count toward the two-person or family **deductible** and two-person or family **out-of-pocket maximum** under that option.

The following rules apply for each family member who enrolls separately from you as an Avaya Inc. employee:

- The individual, two-person or family **out-of-pocket maximum** limit applies separately.
- The two-person or family **deductible** will apply only if at least one of you is eligible to claim the other as a **Class I dependent** and both of you are enrolled in the **Traditional Indemnity** option.
- If the family **deductible** does apply, it is not automatic. You will need to submit your Explanation of Benefits statements to **Aetna** to show that you paid more toward the family **deductible** than required. You will also need to submit a claim for reimbursement.

### **Employee Contribution Waiver**

Sometimes employee contributions otherwise required for Medical Plan coverage will be waived.

#### **Waiver #1**

Waiver #1 applies when:

- Two Avaya Inc. employees enroll for separate coverage under the Medical Plan,
- One of the employees is “fully eligible” (in an Avaya Inc. job classification that does not require a 50% or 100% contribution for benefits) and one employee is not “fully eligible,”
- The employee who is not fully eligible would otherwise qualify as the **Class I dependent** of the fully **eligible employee**, has been enrolled as a dependent of the fully **eligible employee**, and
- The employee who is not fully eligible is a part-time employee who regularly works fewer than 25 scheduled hours per week or a newly hired employee with less than six months of **net credited service**.

In this case, the non-fully **eligible employee** would not be required to contribute more than the premium that would be required of a fully **eligible employee**.

**Waiver #2**

Waiver #2 applies when:

- Two Avaya Inc. employees enroll in the same **HMO**, and
- At least one of the employees would qualify as a **Class I dependent** of the other.

In this case, only one employee will be required to pay the full employee contribution. The other may be **covered** at a lesser dependent contribution rate, if applicable. If this applies for you, one of you must notify the **Avaya Health and Benefits Decision Center** (see "Important Contacts"). Avaya Inc. reserves the right to verify these situations.

## IMPORTANT CONTACTS

Here is a list of resources for the Medical Plan.

Aside from this summary, your other primary sources of Medical Plan information are the member services representatives at **Aetna** and the **Avaya Health and Benefits Decision Center**. Additional resources include the Avaya Healthy Decisions Web site at [www.AvayaHealthyDecisions.com](http://www.AvayaHealthyDecisions.com).

### **Avaya Health and Benefits Decision Center**

The **Avaya Health and Benefits Decision Center** is the enrollment administrator. You can reach the **Avaya Health and Benefits Decision Center** by phone on business days Monday through Friday from 8 a.m. to 8 p.m., Eastern time, at 1-800-526-8056 (option 1). You can call 1-800-952-0450 to reach a telecommunications device for the deaf.

### **Online With Avaya Healthy Decisions**

You can access the Avaya Healthy Decisions Web site at [www.AvayaHealthyDecisions.com](http://www.AvayaHealthyDecisions.com).

Through the Web site, you can:

- Obtain claim forms,
- Browse through health and insurance information, or
- Make your benefit elections (during designated enrollment periods).

### **Aetna**

A source for Medical Plan information is **Aetna**, the **Claims Administrator** of the Medical Plan.

### **By Phone**

**Aetna** Member Service representatives are available to assist you with issues related to the **POS** option or **Traditional Indemnity option**. Call **Aetna** Member Service (see "Other Resources" below) to:

- To request a new Provider Directory or the latest information about **network providers**

- To change your **PCP**,
- To replace a lost ID card,
- To find out if a claim was paid,
- If you have a service issue with a **network provider**,
- To find out how your **covered dependent** child away at college should obtain care,
- To get claim forms (if needed), or
- To obtain further details on benefit coverage.

### **Online**

You can access the self-service **Aetna** Navigator Web site at [www.AetnaNavigator.com](http://www.AetnaNavigator.com).

Through the Web site, you can:

- Find participating **providers** and/or change your **PCP**,
- Get eligibility information or replacement member ID card,
- Check the status of a claim,
- Research information about drugs, their uses, side effects and generic alternatives, if available.
- Estimate the cost of generic versus brand name drugs and for prescriptions filled at participating pharmacies or through **Aetna** Rx Home Delivery, or
- Contact **Aetna** Member Services.

## Other Resources

The following resources have specific responsibilities, as explained below:

Contact / Service Provider	Telephone Number
<p><b>Aetna POS Option and Traditional Indemnity Option</b> (including the <b>Prescription Drug Program and Mental Health and Chemical Dependency Program</b>)</p>	<p>Member Services: 1-877-508-6927 Monday-Friday 8:00 a.m. to 6:00 p.m., Eastern time TDD: 1-800-346-3344 Web site: <a href="http://www.AetnaNavigator.com">www.AetnaNavigator.com</a></p> <p><b>Aetna Rx Home Delivery</b> 1-800-227-5720 Monday-Friday 7:00 a.m. to 11:00 p.m., Saturday 8:00 a.m. to 9:30 p.m., Sunday 8:00 a.m. to 6:00 p.m., Eastern time TDD: 1-800-201-9457</p> <p>Web site: <a href="http://www.aetna.com/aetnarxhomedelivery">www.aetna.com/aetnarxhomedelivery</a></p>
<p><b>Employee Assistance Program (Magellan)</b></p>	<p>In the U.S.: 1-877-804-9753 Outside the U.S., call collect: 1-314-344-3009 24 hours a day/seven days a week TDD: 1-800-456-4006 <a href="http://www.MagellanAssist.com">www.MagellanAssist.com</a></p>
<p><b>HMO Option</b></p>	<p>Call the specific <b>HMO</b> or the <b>Avaya Health and Benefits Decision Center</b> (1-800-526-8056 option 1, TDD: 1-800-952-0450)</p>
<p><b>Domestic Relations Matters Group:</b> Contact for matters relating to a <b>Qualified Medical Child Support Order (QMCSO)</b></p>	<p>Domestic Relations Matters Group Aon Corporation 270 Davidson Avenue 8<sup>th</sup> Floor Somerset, NJ 08873</p>
<p><b>Plan Administrator:</b> Contact for all legal actions, except for legal actions regarding a claim for benefits. Legal actions regarding a claim for benefits should be directed to the <b>Claims Administrator</b> at the above address.</p>	<p>Avaya Inc. Medical Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920</p> <p>E-mail: <a href="mailto:hwplanadmin@avaya.com">hwplanadmin@avaya.com</a></p>

## OTHER IMPORTANT INFORMATION

This section contains administrative information about the Medical Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

### **Claim Procedures**

Participants, their beneficiaries (if applicable) or any individual duly authorized by them, have the right under ERISA and the Medical Plan to file a written claim for benefits with the **Claims Administrator** or Plan Administrator (see “Important Contacts”), as the case may be.

Claims concerning whether you or your dependent is eligible to participate in the Medical Plan are decided by the Plan Administrator (see “Important Contacts”). Claims concerning the amount and extent of benefits are decided by the **Claims Administrator**.

You (or another person) cannot challenge a claim decision in court until the following claim and appeal procedures have been complied with and exhausted.

### **Initial Claim Decision**

When a claim is received, the **Claims Administrator** must decide whether (and/or at what level) the benefit is covered under the Medical Plan, as the case may be. When the medical benefit is provided or denied, you will receive a notice explaining how the coverage level was calculated or why benefits have been denied. How fast this notice must be given to you depends on whether the claim is an **urgent care claim**, a **pre-service claim** or a **post-service claim**. The deadline for this notice is no later than:

For an **urgent care claim**, 72 hours after the claim is received.

For a **pre-service claim**, 15 days after the claim is received.

For a **post-service claim**, 30 days after the claim is received.

The notice will contain the information outlined under the section “Claims Decision Notices”.

If your claim is an **urgent care claim** or a **pre-service claim**, you can be notified of an initial denial decision orally, and a written or electronic notice will be provided no more than 3 days after the oral notice.

## Failure to Follow Urgent Care or Pre-Service Claims Procedure

If you fail to follow the procedures for filing an **urgent care claim** or a **pre-service claim**, you will be notified by the **Claims Administrator** of the failure and the proper procedure that you must follow. This notice must be provided no later than 24 hours after the failure for **urgent care claims** or 5 days after the failure for **pre-service claims**. This notice may be oral unless you (or your authorized representative) request a written notice. This notice is triggered when:

You (or your authorized representative) make a communication that is received by a person or organization unit customarily responsible for handling benefit matters; and

The communication names a specific participant or covered dependent, a specific medical condition and a specific treatment, service or product for which approval is requested.

## Notice of Incomplete Urgent Care Claim

If you (or your authorized representative) submit an **urgent care claim** that is missing necessary information, you will receive a notice from the **Claims Administrator**. This notice will tell you the specific information needed to complete the claim. The notice will be given no later than 24 hours after receiving the claim. You must be given a reasonable time to provide the information but not less than 48 hours. You will be notified of the decision concerning your **urgent care claim** as soon as possible but no later than 48 hours after the earlier of:

When the Medical Plan receives the requested information, or

The end of the period you were given to provide the information.

## Concurrent Care Claim

At times the **Claims Administrator** may approve a course of treatment that is provided over time or for a specific number of treatments. If the **Claims Administrator** later terminates or reduces the previously approved course of treatment, the **Claims Administrator** will notify you of this decision so you (or your authorized representative) will have sufficient time to appeal that decision before the course of treatment is deemed not covered or coverage is provided at a reduced rate.

If you need to extend a course of treatment and the original request for the treatment was an **urgent care claim**, you should contact the **Claims Administrator** at least 24 hours before the approved course of treatment will expire. If you do so, the **Claims Administrator** will provide you with a notice of its decision concerning the requested extension within 24 hours of your request. If you (or your authorized representative) request an extension later, you will receive a notice of the **Claims Administrator's** decision based on whether that request is an **urgent care claim** or **pre-service claim**.

## Appeal Procedures

After the **Claims Administrator** (for benefits) or Plan Administrator (see “Important Contacts”) (for eligibility to participate) denies your claim, you (or your authorized representative) may request a full review if you disagree with the denial. You (or your authorized representative) must submit a written request for review to the **Claims Administrator** (for benefits claims) or the Plan Administrator (for eligibility to participate claims) within 180 days after you receive the denial notice. In connection with your appeal, you (or your authorized representative) may review relevant documents and submit issues and comments in writing.

The relevant documents that must be made available to you upon request include documents, records and other information that:

- Were relied on in deciding your benefit claim;
- Were submitted, considered or generated in the course of deciding your benefit claim;
- Demonstrate that the decision complied with the Medical Plan’s administrative procedures or safeguards; or
- State the Medical Plan’s policy or guidelines regarding the benefits for your diagnosis, whether or not it was relied upon.

Your appeal will be reviewed by someone other than the person who made the first decision on your claim. Upon written request, the **Claims Administrator** must disclose the identity of any medical experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the **Claims Administrator** must consult with a health care professional who has the appropriate training and experience in the field of medicine involved.

After a decision by the **Claims Administrator** or Plan Administrator, as the case may be, is made concerning your appeal, you will be notified of the findings and decision in writing. This notice will be provided no later than:

For an **urgent care claim**, 36 hours after receiving the appeal.

For a **pre-service claim**, 15 days after receiving the appeal.

For a **post-service claim**, 30 days after receiving the appeal.

If you disagree with the first appeal decision, you (or your authorized representative) may request a second appeal in writing no later than 60 days after you receive the first appeal decision. In connection with your second appeal, you (or your authorized

representative) may review relevant documents and submit issues and comments in writing. After a decision by the **Claims Administrator** is made concerning your second appeal, you will be notified of the findings and decision in writing. This notice will be provided no later than:

- For an **urgent care claim**, 36 hours after receiving the appeal.
- For a **pre-service claim**, 15 days after receiving the appeal.
- For a **post-service claim**, 30 days after receiving the appeal.

This decision is final and is not subject to further internal review unless your claim qualifies for the Third Party Appeal Review described in the section “Third Party Appeal Review Process.”

### **Claims Decision Notices**

The notice given to you concerning the decision on either your initial claim or your appeal will include:

- The specific reason or reasons for the decision;
- The specific Medical Plan provisions upon which the benefit decision is based;
- A statement that you are entitled to receive upon request (and free of charge) reasonable access to, and copies of, all document, records and other information relevant to your claim;
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary;
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request;
- If the decision is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the Medical Plan’s terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request;
- For an initial claim, a description of the appeal procedures; and
- A statement that the claimant has the right to bring a civil action under ERISA Section 502(a) following a denial upon appeal.

### Third Party Appeal Review Process

An independent Third Party Appeal Review Process is available to **eligible employees** and their dependents enrolled in Medical Plan options other than the **HMO** option. The process applies to certain claims for services that have been denied by the **POS** option, **Traditional Indemnity** option, **Prescription Drug Program** and/or **Mental Health and Chemical Dependency Program** service providers.

Claims are reviewed by Island Peer Review Organization (IPRO), the third-party review administrator. If your claim is eligible for the independent review process, you (or your **covered dependent**) will be notified by the appropriate **Claims Administrator**.

Claims eligible for Third Party Review must meet *all* of the following:

- The claimant must have exhausted all administrative appeals or processes available through the **Claims Administrator** under the terms of the Medical Plan,
- The claim must relate to an extreme illness or injury,
- The appeal must have been denied either due to a lack of medical necessity or because the claim relates to an **experimental or investigative treatment, drug or device**, as defined in the Medical Plan, and
- The claim must otherwise be payable under the terms of the Medical Plan.

### EAP Claim Procedures

The Claims Administrator for the **EAP** is **Magellan**. **Magellan** will generally decide whether your request for **EAP** services is covered under the **EAP** and inform you of its determination during your initial telephone call to request services.

If **Magellan** cannot decide during the initial call, **Magellan** will decide within 5 calendar days of your request for services or of notice to **Magellan** of a circumstance that affects the availability of further **EAP** services. **Magellan** will inform you by telephone of its determination within 1 business day after a decision is made.

If you are receiving an ongoing course of **EAP** counseling, **Magellan** will notify you in advance if **Magellan** intends to terminate or reduce the number of **EAP** sessions that can be provided so that you will have an opportunity to appeal the decision before the termination or reduction takes effect.

If **Magellan** determines that you need **urgent care**, **Magellan** will provide telephonic crisis counseling and make an appropriate referral to your Medical Plan and/or

emergency resources in the community. **Magellan** does not make claim determinations relating to **urgent care**.

Because **Magellan** pays all **EAP providers** directly, you should not pay a **provider** for **EAP** services. In the event that you mistakenly pay a **provider** for **EAP** services, **Magellan** will decide your request for reimbursement within 30 days after receipt of the claim.

If a claim for **EAP** benefits is wholly or partially denied, **Magellan** will provide written notice of the denial to you or your authorized representative. The notice will contain the information outlined under the section "Claims Decision Notices". If **Magellan** denies your claim, you (or your authorized representative) may request a full review if you disagree with the denial. You (or your authorized representative) must submit a written request for review to **Magellan** within 180 days after you receive the denial notice. In connection with your appeal, you (or your authorized representative) may review relevant documents and submit issues and comments in writing. If your appeal of a denial of claim for **EAP** benefits is wholly or partially denied, **Magellan** will provide written notice of the denial to you or your authorized representative. The notice will contain the information outlined under the section "Claims Decision Notices".

### ***Your Rights Under ERISA***

It is Avaya Inc.'s policy to provide meaningful benefits -- above and beyond your paycheck. Part of this additional protection is provided through the Medical Plan. You are entitled to certain rights and protection under ERISA. These rights are described in this section.

#### **Right to Receive Information About the Plan and Its Benefits**

It is your right to know about your benefits. Therefore, in addition to this SPD of your benefits under the Medical Plan, you will have the opportunity to obtain a summary of the Medical Plan's annual financial report. You also may examine all Medical Plan documents governing the Medical Plan and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor. These documents are available for you to examine without charge in the Plan Administrator's office.

You also may request assistance and information about your health benefits rights under ERISA and HIPAA (Health Insurance Portability and Accountability Act of 1996) by contacting the Plan Administrator (see "Important Contacts").

You can receive a copy of any of these documents, for a reasonable charge, by making a written request to the Plan Administrator.

You also have the right to:

- Continue medical coverage for yourself, spouse, or dependents if there is a loss of coverage under the Medical Plan as a result of a qualifying event under **COBRA**. You or your dependents will have to pay for such coverage. Review this summary plan description and the documents governing the Medical Plan for the rules governing your **COBRA** continuation rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under that plan, when you become entitled to elect **COBRA** continuation coverage, when your **COBRA** continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **Prudent Action by Plan Fiduciaries**

You also have the right to expect the fiduciaries -- the people responsible for the operation of the Medical Plan -- to act prudently and in the best interest of those who participate as a whole. The Medical Plan's fiduciaries must act in the best interest of all Medical Plan participants.

No one, including the Company may dismiss you or discriminate against you to prevent you from obtaining benefits or exercising any of your rights under ERISA.

### **Enforce Your Rights**

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of plan documents or the latest annual report (Form 5500 Series) from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials – unless the materials were not sent for reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits that is denied or ignored – in whole or in part – after going through the appeals procedures, you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack of response to your request concerning the qualified status of a **qualified medical child support order (QMCSO)**, you may file suit in federal court.
- If it should happen that the Medical Plan fiduciaries misuse the Medical Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court.
- If you file suit against the Medical Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees – if, for example, it finds your claim is frivolous.

### **If You Have Questions**

For answers to questions about the Medical Plan, contact the **Claims Administrator** or the Plan Administrator (see "Important Contacts"). If you have any questions about this statement of your rights or about your rights under ERISA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA), listed in your telephone directory; or contact the Division of Technical Assistance and Inquiries, U.S. Department of Labor, EBSA, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA or visit the EBSA Web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA Web site.)

### **Plan Funding and Payment of Benefits**

With certain limited exceptions, the Company pays a majority of the costs associated with providing benefits under The Avaya Inc. Medical Expense Plan through the Avaya Inc. Health Plans Benefit Trust, which is a trust set up under Section 501(c)(9) of the Internal Revenue Code. State Street Bank and Trust Company is the trustee of this Trust.

### ***Benefits Cannot Be Assigned***

Assignment or alienation of any benefits provided by the Medical Plan will not be permitted or recognized, except as otherwise required by applicable law. This means that benefits provided under the Medical Plan are not subject to sale, assignment, anticipation, alienation, attachment, garnishment, levy, execution or any other form of transfer. Generally, state and local laws will not be recognized unless permitted by or under applicable federal law, such as ERISA.

### ***Union Agreement***

The benefits described in this SPD reflect the provisions of the Medical Plan for represented employees as referred to in applicable collective bargaining agreements between the Company and the unions representing employees of the Company. Copies of these agreements are distributed or made available to those employees **covered** by the agreements and to any other employee who submits a written request for a copy to the Plan Administrator. A reasonable duplication charge may be made for copies furnished in response to such written request.

### ***Plan May Be Amended or Terminated***

The Company expects to continue the Medical Plan, but reserves the right to amend or terminate the Medical Plan at any time by the resolution of the Board of Directors or its properly authorized designee, subject to the terms of applicable collective bargaining agreements. In addition, the Company does not guarantee the continuation of any medical benefits during employment or during retirement nor does it guarantee any specific level of benefits or contributions.

### ***Plan Administrator and Claims Administrator***

The Plan Administrator and **Claims Administrator** have the full discretionary authority and power to control and manage all aspects of the Medical Plan, to determine eligibility for Medical Plan benefits, to interpret and construe the terms and provisions of the Medical Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Medical Plan as they may deem appropriate in accordance with the terms of the Medical Plan, applicable collective bargaining agreements and all applicable laws.

### ***Plan Sponsor***

The Plan Sponsor may allocate or delegate its responsibilities for the administration of the Medical Plan to others and employ others to carry out or render advice with respect

to its responsibilities under the Medical Plan, including discretionary authority to interpret and construe the terms of the Medical Plan, to direct disbursements, and to determine eligibility for Medical Plan benefits.

## ADMINISTRATIVE INFORMATION

<b>Plan Name</b>	The official Plan Name is The Avaya Inc. Medical Expense Plan which is part of The Avaya Inc. Health & Welfare Benefits Plan.
<b>Plan Sponsor</b>	The Plan Sponsor is Avaya Inc.
<b>Plan Administrator</b>	The Plan Administrator is:  Avaya Inc. Medical Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920  E-mail: <a href="mailto:hwplanadmin@avaya.com">hwplanadmin@avaya.com</a>
<b>Type of Administration</b>	The Medical Plan is administered by the applicable <b>health care company</b> . These include: <b>Aetna (POS option, Traditional Indemnity option, Prescription Drug Program and Mental Health and Chemical Dependency Program)</b> ; and various <b>HMOs</b> .
<b>Claims Administrator</b>	Claims under the Medical Plan ( <b>POS option, Traditional Indemnity option, Prescription Drug Program and Mental Health and Chemical Dependency Program</b> ) are administered on behalf of Avaya Inc. by <b>Aetna</b> . Claims under the Medical Plan ( <b>HMOs</b> ) are administered by the various <b>HMOs</b> . Claims under the <b>EAP</b> are administered by <b>Magellan Health Services</b> .
<b>Agent for Service of Legal Process</b>	Legal actions regarding a claim should be sent to the applicable <b>Claims Administrator</b> . All other legal actions should be sent to the Plan Administrator.
<b>Plan Records and Plan Year</b>	The Medical Plan and all its records are maintained on a calendar year basis, beginning on January 1st and ending on December 31st of each year.
<b>Type of Plan</b>	The Medical Plan is considered a "health & welfare plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
<b>Trustee</b>	State Street Bank and Trust Company is the trustee of the Avaya Inc. Health Plans Benefit Trust. State Street Bank and Trust Company is located at 1 Enterprise Drive, North Quincy, MA 02171.
<b>Plan Number</b>	The Plan Number is 551.
<b>Employer Identification Number</b>	The Employer Identification Number is 22-3713430.

## APPENDIX A: COVERED SERVICES AND CONDITIONS OF SERVICE: POS AND TRADITIONAL INDEMNITY OPTIONS

### ***Covered Services and Conditions of Service***

To be a “**covered service**” under the **POS** and **Traditional Indemnity** options, the service:

- Must be **medically necessary** for the treatment of illness or injury or it must be for the preventive care benefits that are specifically stated as **covered**,
- Must be provided by a licensed and accredited health care **provider** practicing within the scope of his or her license in the state in which the license applies,
- Must be listed as a **covered** service and satisfy all the required conditions of service as shown in this Appendix, and
- Must not be listed as excluded (see “Exclusions”).

This Appendix highlights **covered** services and conditions of service in alphabetical order.

For **covered** services and conditions of service under an **HMO**, contact your **HMO**.

### ***Acupuncturist’s Services***

The following **medically necessary acupuncturist’s** services are **covered** under the **POS** and **Traditional Indemnity** options:

- Use of acupuncture instead of traditional anesthesia during surgery, and
- Acupuncture to relieve pain, illness or impaired mobility in the muscles and joints.

The following conditions of service apply to **medically necessary covered** services provided by an **acupuncturist**:

- Limitations apply under the **Traditional Indemnity** option and **out-of-network** under the **POS** option (see “Benefit Limits and Maximums” under each of the medical options). However, use of acupuncture as a surgical anesthetic does not count toward the limit on your number of acupuncture visits.

- Coverage is provided only for an acute condition (one that is currently causing pain, illness or decreased mobility and for which improvement can be measured in the short term). Periodic visits for preventive care or to maintain a current state of health are not **covered**.

### **Ambulance**

The following **ambulance** services are **covered** under the **POS** and **Traditional Indemnity** options:

- Transportation to the nearest appropriate medical facility in an **emergency** (a **physician's** order is not required)
- **Medically necessary emergency** services (including administering to wounds, electrocardiograms, cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions) delivered by appropriately licensed personnel employed by the **ambulance** company
- Transfer from a **non-network** to a **network hospital** (only applies if **covered** under the **POS** option)
- Transfer to the closest qualified **hospital** if the first **hospital** was not equipped to handle the patient's condition
- Transfer from a **hospital** to an **extended care facility** or transfer from a **hospital** or an **extended care facility** to the patient's home if the:
  - Patient is being discharged into a **home health care agency's** care,
  - Patient's condition requires a medical professional's attendance, and
  - The **extended care facility** or home health care was **precertified**.

Air **ambulance** is limited to a maximum payment of \$5,000 per occurrence, and is **covered** only when the participant is in a location that is inaccessible to ground **ambulance** or the patient's status and travel conditions indicate that delays resulting from the use of ground **ambulance** would create significant and unnecessary risk to the patient, and the risk would be clearly diminished with the use of an air **ambulance**.

### **Anesthesia**

Anesthesia is **covered** when **medically necessary**, and includes services related to upper and lower gastrointestinal (GI) endoscopies.

### **Blood and Blood Derivatives**

Blood and blood derivatives are **covered** when **medically necessary** for treatment or therapy due to an illness or injury, and include blood, blood plasma, and other blood products.

### **Centers of Excellence**

**Aetna** has arrangements with certain facilities to act as **centers of excellence** to treat special conditions such as organ transplants. Under the **POS** option, if you are directed to a **center of excellence** by your **PCP** or **network specialist** or through the **precertification** process, you will receive **in-network** benefits. Under the **Traditional Indemnity** option, you must be referred through the **precertification** process to receive benefits.

**Covered** services include **medically necessary** services certified by the **health care company** as requiring the specialized care generally associated with a **center of excellence**, such as organ transplants.

Treatment at a **center of excellence** is subject to all conditions of service that apply to any treatment of illness or injury, including the exclusion of an **experimental or investigative treatment, drug or device**.

While you are encouraged to utilize these centers, you are not required to do so. You may obtain these specialized services from any facility licensed to provide them.

### **Travel and Lodging Benefit**

If you or a **covered dependent** is referred to a **center of excellence** more than 50 miles from your home for non-experimental transplant surgeries, certain travel and lodging expenses are **covered** for the patient and an accompanying family member or individual approved by **Aetna**.

To be eligible:

- The patient must be certified by **Aetna** for admission to a **center of excellence** more than 50 miles from his or her residence.
- The patient must be a **covered** participant under the Medical Plan, and

- The travel companion must be essential to the patient's ability to secure the medical care.

The following charges are **covered** under the Travel and Lodging benefit:

- Subject to the maximums shown below, transportation costs are **covered** for the patient, and transportation and lodging costs are **covered** for one travel companion or, if the patient is under 23 years old, for both parents or guardians.
- Transportation costs are **covered** for one round trip to and from the **hospital** location. For airline travel, the generally available coach fare will be reimbursed. When travel by private automobile is used, mileage will be reimbursed at the per-mile rate in force at that time.
- Reasonable lodging and meal expenses are **covered**. Lodging must be pre-approved by **Aetna** to be **covered**. Benefits are limited to a maximum of \$50 per day per person (not including the patient), and up to \$10,000 per admission for transportation, lodging and meal expenses combined for patient and companion(s).

### **Chiropractic Services**

The following **medically necessary** chiropractic services are **covered** under the **POS** and **Traditional Indemnity** options:

- Neuromuscular treatment and manipulation to relieve pain or restore mobility by maladjustment of the muscles and ligaments associated with the spinal column, and
- **Medically necessary** X-rays.

The following conditions of service apply to **covered** chiropractic services:

- Coverage is provided only for treatment of musculoskeletal conditions. That means conditions that are related to the muscles and ligaments. Conditions such as a stiff neck and lower back pain are **covered**. Conditions such as nausea and dizziness are not **covered** for treatment with chiropractic services.
- Coverage is provided only for the treatment of an acute condition -- that is, one that is currently causing pain or decreased mobility, and for which improvement can be measured in the short term. The Medical Plan does not cover for the treatment for maintenance conditions. Periodic visits for preventive care or to maintain a current state of health are not **covered**.

- Care must be provided in an office setting. Services are not **covered** if provided in your home, or if delivered in a **hospital** or other facility.
- A **chiropractor** may order X-rays when **medically necessary**. However, any other tests (for example, a magnetic resonance image, or MRI) must be ordered through a **physician**.
- Coverage is limited to 60 visits in a calendar year for **POS** and **Traditional Indemnity** option benefits. Under the **POS** option, **out-of-network** visits will apply to the **in-network** limit, and **in-network** visits will apply to the **out-of-network** limit.

### ***Circumcision***

Circumcision of a male is **covered** if performed by a **physician** or mohel. Under the **POS** option, only **out-of-network** benefits are available if a mohel performs the circumcision.

### ***Colorectal Screening***

Participants at least age 50 are **covered** for preventive colorectal screening under the **POS** option and **Traditional Indemnity option**.

Under the **POS** option or **Traditional Indemnity option**, benefits for routine colorectal screenings are limited to one screening (home test kit to check for blood in the stool) per Plan Year for those age 50 and over. This schedule applies only to colorectal screenings that are for preventive health screening. If a **physician** orders a colorectal screening to diagnose specific symptoms or observations, that is considered treatment of illness and is not subject to the schedule of this preventive care benefit.

### ***Durable Medical Equipment***

The following **medically necessary** durable medical equipment is **covered** under the **POS** and **Traditional Indemnity** options:

- Purchase or rental of durable medical equipment supplied by a properly licensed vendor. Examples include wheelchairs, kidney dialysis equipment, and mechanical equipment for the administration of oxygen.
- Prosthetic devices supplied by a properly licensed vendor. A prosthesis is a device designed to partially compensate for the loss of a body part. **Covered** prostheses include artificial legs or arms (or parts thereof, such as a foot), eyes, and portions of internal bodily organs.

- Orthotics necessary for daily living activities.
- Compression garments are covered in accordance with the **health care company's** guidelines

The following conditions of service apply to **covered** durable medical equipment:

- Supplies must be prescribed by a **physician**. Under the **POS** option, for **in-network** benefits to be available, the equipment must be prescribed by your **PCP** or a **network specialist**, and you must rent or purchase the equipment from a medical supplier that participates in the **network**.
- Supplies must be (a) manufactured specifically for medical use, (b) usable only by the patient (and not, for example, by the patient's **lawful spouse**), and (c) not for exercise, environmental control (such as air conditioners and humidifiers), or personal comfort.
- Purchase or rental of the original equipment is **covered**. Total **covered** charges for purchase and rental combined will not exceed the purchase price of the item.
- Repair and replacement of orthotics and durable medical equipment are **covered** when the equipment no longer fits the participant in the manner that is both the most efficient for the participant and the most cost effective for the **Participating Company**, as determined by the **health care company**.
- Replacement of prosthetic devices is **covered** only when made necessary by anatomical change.

### ***Emergency Room***

If you enrolled in the **POS** option, you pay the emergency room **copayment** for services provided in an emergency room during an **emergency**. This emergency room **copayment** is waived if you are admitted to the **hospital** for continued care.

### ***Extended Care Facility***

To receive the full amount of benefits available under the **Traditional Indemnity** option or for **out-of-network** care under the **POS** option, **precertification** is required for admission to an **extended care facility**. **Precertification** is done by your **PCP** for **extended care facility** services provided **in-network** under the **POS** option.

**Covered** expenses include:

- Room and board in a semi-private room.
- Prescription drugs administered during the stay.
- Nutritional support.
- Professional **physician** and nursing services provided by facility staff. The Medical Plan covers the initial consultation between your doctor and another **specialist** (or a number of different **specialists**, as **medically necessary**), as well as one **physician's** visit per day in addition to normal postoperative visits by your surgeon(s). Charges for **physician** visits in excess of one per day are **covered** if medically necessary.
- **Medically necessary physician's** visits.
- **Medically necessary** services provided on the order of a **physician** that are normally provided by an **extended care facility**, including, but not limited to, X-ray and laboratory tests, medical and surgical dressings, radiation therapy, and anesthetics and their administration.

The following conditions of service apply to **covered extended care facility** expenses:

- Generally, you must receive **precertification** for **extended care facility** benefits to be **covered**.
- Confinement must be on the order, and under the supervision, of a **physician**.
- Confinement must not be mainly for the convenience of the patient's family.
- Under the **POS** option, **out-of-network** benefits are limited to 60 days of **in-patient** care in a year. Any days incurred **in-network** count towards the maximum available days **out-of-network** and vice versa. **Traditional Indemnity** option benefits are limited to 120 days of **in-patient** care in a year. Under the **POS** and **Traditional Indemnity** options, these limits are combined with the number of days of **hospital** confinement if preceding confinement and for the same condition in the **extended care facility**. Days in the **hospital** count as full days toward this limit. Days in an **extended care facility** count as one-half day.

### **Family Planning Services**

The following family planning services are **covered** under the **POS** and **Traditional Indemnity** options:

- Fertility testing and examination.

- Voluntary sterilization or reversal of voluntary sterilization.
- Birth control devices and medication, excluding those available over the counter. Birth control obtained through a pharmacy may be **covered** under the **Prescription Drug Program**.
- Certain medical and surgical procedures (including prescription drugs and devices not available over the counter) supporting treatment to improve a normally caused infertility problem (please note “Exclusions”).

No other family planning services are **covered**.

If family planning prescriptions or devices are provided directly by the doctor, they are **covered** under your medical option. If these items are provided through a pharmacy, they are **covered** by the **Prescription Drug Program**. No benefits are provided for over-the-counter products.

### **Home Health Care**

To receive the full amount of benefits available under the **Traditional Indemnity** option or for **out-of-network** care under the **POS** option, **precertification** is required for **home health care agency** services. **Precertification** is done by your **network provider** for **in-network home health care agency** services under the **POS** option.

**Covered** services include:

- **Speech therapy, physical therapy and occupational therapy.**
- Services of a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN).
- Services of a home health aide who is not a nurse, but only if nursing services are also being provided during the course of treatment.
- Services of licensed clinical social workers.
- Drugs and medications administered to you by the **home health care agency**. This does not include drugs and medications that may be picked up from a pharmacy and/or delivered to your home. Drugs received by filling a prescription at a pharmacy may be **covered** under the terms of the **Prescription Drug Program** (see “Prescription Drug Program”).

The following conditions of service apply to **covered home health care agency** expenses:

- Generally, you must receive **precertification** for home health care benefits to be **covered**.
- Care must be provided in accordance with a **physician's** written treatment plan. The treatment plan must be re-certified by the attending **physician** at least every 30 days if care continues.
- Care must be given in the patient's home and provided in lieu of **in-patient** care. That means that you are not physically able to go to a **provider's** office for treatment, and without home health care services you would have to be confined in a **hospital** or other facility.
- Services must be provided by a person who is employed by the **home health care agency**, or who has a subcontracting relationship with the agency.
- Custodial and domestic services are not **covered**.
- Under the **POS** option, **out-of-network** benefits are limited to a maximum of 100 visits in a calendar year. **Traditional Indemnity** option benefits are limited to a maximum of 200 visits in a calendar year. Under the **POS** option, any visits incurred **in-network** count toward the maximum available visits **out-of-network**. Each visit by a nurse or therapist, regardless of duration, is one visit. Up to four hours of care provided by a home health aide counts as one home health care visit.

### **Hospice**

The following **hospice** services are **covered** under the **POS** and **Traditional Indemnity** options:

- Room and board when the patient is confined as a **hospice in-patient**.
- Part-time nursing services for the provision of medical and palliative care. Palliative care is care that is rendered to relieve the symptoms or effects of a disease without curing the disease.
- Services of the **hospice's** non-clinical staff, such as home health aides.
- Counseling services provided to the patient and immediate family, when provided by duly licensed social workers, psychologists (Ph.D.) or pastoral counselors.

These services are part of the overall charge of the **hospice**; any separate charges made for these services are not **covered**.

- Bereavement counseling provided to **covered dependents**, when provided by duly licensed social workers, psychologists (Ph.D.) or pastoral counselors on staff or under contract to the **hospice**. Coverage is for a maximum of 15 sessions, provided within three months of the patient's death.
- Nutritional counseling and special meals.
- Administration of pain-relief medications.
- Drugs and medications administered to you by the **hospice**. This does not include drugs and medications you may obtain from a pharmacy and have delivered to your home. Drugs received by filling a prescription at a pharmacy come under the terms of the **Prescription Drug Program** (see "Covered Prescription Drug Items").

The following conditions of service apply to **covered hospice** expenses:

- **Hospice** services are **covered** only when provided to terminally ill patients. There must be a written prognosis from a **physician** that the patient's life expectancy will not exceed six months.
- Respite care is **covered** to a maximum of five days during a period of six months. Respite care is provided by a **hospice** so that an unpaid caretaker, such as a **lawful spouse**, may be temporarily relieved of caretaking duties.
- Services must be provided by a person who is employed by the **hospice** or who has a subcontracting relationship with the **hospice**.
- When services are provided in the patient's home, services of a nurse and home health aide are **covered** on a part-time basis (less than 24-hour care). Full-time (24-hour) care is not **covered**.
- **POS out-of-network** and **Traditional Indemnity** option benefits are subject to a maximum of 210 days in a lifetime. Under the **POS** option, **in-network** benefits are provided as authorized by your **PCP** or **network specialist**. **In-network** days count toward the **out-of-network** limit, and vice versa.

### ***Hospitalization***

To receive the maximum amount of benefits available under the **Traditional Indemnity** option or **out-of-network** under the **POS** option, **precertification** is required for all

**hospital** admissions. **Precertification** is done by the **PCP** or **network specialist** for **in-network** hospitalization under the **POS** option.

**Covered hospital** expenses include:

- Room and board charges for the appropriate unit for your condition (acute care, intensive care, isolation care or a rehabilitation unit).
- **Medically necessary** services provided on the order of a **physician** that are normally provided by a **hospital** (including, but not limited to, X-ray and laboratory tests, medical and surgical dressings, radiation therapy and anesthetics and their administration).
- Services in the emergency room, delivery room, operating room or therapy unit.
- Diagnostic and therapeutic services provided on an **out-patient** basis, such as pre-admission testing or **out-patient** surgery.
- Diagnostic services provided on an **in-patient** basis when you are hospitalized primarily for treatment (such as surgery).
- Professional **physician** and nursing services provided by facility staff (including the initial consultation between your doctor and another **specialist** -- or multiple **specialists**, if **medically necessary** -- as well as one in-hospital **physician's** visit a day in addition to normal postoperative visits by your surgeon(s); more than one visit a day is **covered** if **medically necessary**).
- Drugs and medications administered while you are in the **hospital** as an **in-patient** or **out-patient**.

The following conditions of service apply to **covered hospital** expenses:

- The **hospital** admission and services must be ordered by a **physician**. You cannot admit yourself to the **hospital**.
- Room and board charges are **covered** for a semi-private room. If you request a private room, you must pay the difference in cost between a semi-private room and a private room. Under the **Traditional Indemnity** option, if a non-**NAP network hospital** only has private rooms, the **allowable amount** will be 90% of the most prevalent room and board charge. However, if the patient's condition is contagious and a private room is **medically necessary** for the health of the other patients, eligible expenses for a private room will be covered.

- Charges for room and board on a Saturday or Sunday will not be **covered** if you enter the **hospital** on Friday, Saturday or Sunday for a non-**emergency** condition and surgery is not performed on the admission date.
- If you are admitted for surgery, it must be performed on the admission date (unless an earlier admission was precertified as **medically necessary**).
- If you enter a **hospital** as an **in-patient** primarily for diagnostic studies, lab tests or physical therapy, room and board charges are not **covered**.

Under the Newborn's and Mothers' Health Protection Act, you are entitled to minimum **hospital** coverage of 48 hours following a vaginal birth and 96 hours following a cesarean birth. Care beyond this point must be precertified to be **covered**. The Medical Plan cannot require you to obtain **precertification** for this minimum length of stay. Mother and child may leave earlier if the care **provider**, in consultation with the mother, decides to discharge the patients earlier.

For admissions for treatment of mental health or **chemical dependency** conditions, see "Mental Health and Chemical Dependency Program."

### **Mammograms**

Female participants are **covered** for routine mammogram testing under the **POS** and **Traditional Indemnity** options, in accordance with age/frequency guidelines established by the **Claims Administrator**.

The age/frequency guidelines apply to mammograms that are for preventive health screening. If a **physician** orders a mammogram to diagnose specific symptoms or observations, that is considered treatment of illness and is not subject to the schedule of this preventive care benefit.

### **Maternity Care**

Maternity benefits cover prenatal care (periodic exams during pregnancy), childbirth, routine nursery care for a newborn and postpartum care. For **POS in-network** benefits, care may be provided by a **PCP** or a **network** obstetrician.

The following maternity expenses are **covered** under the **POS** and **Traditional Indemnity** options:

- Prenatal visits on a schedule approved by the attending **physician**.
- Hospitalization for delivery.

- Services of a **birthing center** in lieu of a **hospital**.
- Services of a licensed midwife. A licensed midwife may bill as an independent **provider** for services provided in the **hospital, birthing center**, or home, or provide services as part of a **birthing center's** services.
- Routine nursery care provided to the newborn during the mother's stay at the **hospital**. Under **POS in-network**, such care is provided as authorized or furnished by the **PCP** or **network specialist**; however under **POS out-of-network** and **Traditional Indemnity** option benefits, this includes one pediatric examination by a **hospital** staff **physician**. Medical services for newborns by an outside **physician** or beyond routine care are considered treatment of an illness and may be **covered** services as long as the newborn is enrolled within 31 days of the birth.

### ***Mental Health and Chemical Dependency***

See "Mental Health and Chemical Dependency Program" for more information.

A **provider** may treat only those conditions, either mental health or **chemical dependency**, appropriate to his or her certification and licensing status, in order for such services to be **covered** under the Medical Plan.

If **out-patient** treatment is provided through a facility, the following conditions of service apply:

- Services must be provided at a facility that is a general acute care **hospital**, an acute care psychiatric **hospital** or an acute care **chemical dependency** facility, and
- Services must be provided by a professional who meets the requirements of a **covered** mental health professional.

The following conditions of service apply to **covered in-patient** care under the **Mental Health and Chemical Dependency Program**:

- Services must be ordered by a **physician**. You cannot admit yourself to the **hospital**.
- Room and board charges are **covered** for a semi-private room. If you request a private room, you must pay the difference in cost between a semi-private room and a private room.

For **partial hospitalization, residential treatment** or services of a **group home or halfway house (alternative care)**:

- Services are **covered** only if provided **in-network**. Services received **out-of-network** are not **covered**.
- Services must be provided with the prior approval of **Aetna** and rendered by a **network provider**.

### ***Nutritional Counseling***

Nutritional counseling is **covered** under the **POS** option only if it is coordinated by your **network provider**.

**Covered** services include:

- Nutritional education and planning by a certified nutritionist, upon the initial diagnosis or change in severity of a medical condition that can be partially managed through special diets. Diabetes is one example of such a condition.

The following conditions of service apply to **medically necessary** nutritional counseling services **covered** under the **POS** option:

- Services are **covered** under the **POS** option only when provided **in-network** by a licensed nutritionist as directed by your **PCP** or **network specialist**. Services are not **covered** under the **Traditional Indemnity** option or **out-of-network** under the **POS** option.
- Services are intended to assist a person in defining and managing a dietary plan in response to a newly recognized medical condition. Services are not intended to be ongoing. Meal preparation is not **covered**.
- Services are not **covered** for general health or wellness, or weight loss or gain objectives that are not associated with a diagnosed illness.

### ***Organ Donation***

Under certain circumstances, the costs for a living person to donate an organ are **covered** under the **POS** and **Traditional Indemnity** options.

**Covered** expenses may include necessary medical and surgical charges (including **hospital** charges) for extraction of the donated organ or bone marrow and necessary follow-up care.

The following conditions of service apply to **covered** organ donation services:

- If both the donor and recipient are **covered** under the Medical Plan, the recipient's **health care company** must have precertified the transplant procedure. Benefits will be provided to both the donor and recipient.
- If the donor is **covered** under the Medical Plan and the recipient is not **covered** under the Medical Plan, the transplant must be one that the **health care company** would precertify if the recipient were **covered** under the Medical Plan. If the recipient's coverage does not provide for donor expenses, the Medical Plan will provide benefits for the donor for his or her expenses only. No benefits will be provided for the recipient.
- If the donor is not **covered** under the Medical Plan and the recipient is **covered** under the Medical Plan, the recipient's **health care company** must precertify the transplant procedure. Additionally, benefits for the donor are available from the Medical Plan only if the donor has no other coverage of his or her own for the procedure.

### ***Out-Patient Medical Facilities***

The following **out-patient medical facility** expenses are **covered** under the **POS** and **Traditional Indemnity** options:

- Services of a medical laboratory in the taking and analysis of fluid or tissue samples.
- Services of an **out-patient** surgical center for surgeries that may be safely performed on an **out-patient** basis.
- **Birthing centers** for childbirth, including the services of a licensed midwife.
- Services of an **urgent** care facility for treatment of **emergency** and **urgent** medical conditions.
- Services of an **out-patient** rehabilitation facility for rehabilitation services (see "Rehabilitation Therapy").

**Out-patient medical facility** services must be ordered by and under the direction of a **physician**. For example, if you go to a lab to request your own blood test without a **physician's** order, the lab fee is not **covered**.

### **Physician's Services**

The following **physician's** services are **covered** under the **POS** and **Traditional Indemnity** options:

- General medical services (the diagnosis and treatment of illness within generally accepted parameters of **physician** practice)
- Obstetrical (maternity) services, including delivery (for more information, see "Maternity")
- Surgery
- Administration of anesthesia
- Pathology (laboratory) services
- Radiology (X-rays), chemotherapy, nuclear medicine, diagnostic ultrasound services and any imaging or scanning techniques
- Services provided by the **physician's** nursing staff
- Preventive services (generally not **covered** for **out-of-network** care under the **POS** option or under the **Traditional Indemnity** option; for more information, see "Preventive Services")
- Medical supplies such as casts and dressings provided as part of the **physician's** services

### **Podiatric Services**

**Covered** podiatric services include all **medically necessary** services within the scope of a Doctor of Podiatric Medicine's license.

### **Prescription Drugs**

See "Prescription Drug Program."

## **Preventive Care**

Preventive care including mammograms, pap tests and prostate cancer screenings are **covered** under the **POS** option and **Traditional Indemnity** option according to age/frequency guidelines followed by the **Claims Administrator**.

**Covered** services include:

- Routine physical examinations - in accordance with age, frequency and range of service guidelines followed by the **Claims Administrator**. As of this publication: Age 18 through 64 – once every 24 months; age 65+ - once every 12 months.
- Mammograms – see separate listing “Mammograms”
- Prostate cancer screening - see separate listing “Prostate Cancer Screenings”

**Covered** services **in-network** under the **POS** option also include

- Well-woman care -- annual gynecological exam and certain appropriate diagnostic tests, including pap smears
- Well-child care -- in accordance with age, frequency and range of service guidelines as established by the **Claims Administrator**. As of this publication: Up to age 1 – 7 exams; between age 1-2 – 2 exams; ages 2 through 17 – 1 per year.
- Immunizations - routine immunizations as appropriate.

## **Private Duty Nursing**

To receive the full amount of benefits available under the **Traditional Indemnity** option or for **out-of-network** care under the **POS** option, **precertification** is required for **private duty nursing**. **Precertification** is done by your **PCP** or **network specialist** for **private duty nursing** services provided by an **in-network provider** under the **POS** option. **Covered private duty nursing** services include nursing services of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) delivered to a **covered** individual who is confined in the home due to a medical condition.

The following conditions of service apply to **covered private duty nursing** services:

- You must receive **precertification** for **private duty nursing** benefits. Without **precertification**, there is no benefit.
- Custodial and domestic services are not **covered**.

- **POS out-of-network** benefits are limited to 100 shifts in a calendar year and **Traditional Indemnity** benefits are limited to a maximum of 200 visits in a calendar year. Under the **POS** option, any shifts incurred **in-network** count toward the maximum available shifts **out-of-network**.

### ***Prostate Cancer Screenings***

Under the **Traditional Indemnity** and **POS** options, routine screenings, a digital rectal examination and blood test for PSA (prostate-specific antigen) are **covered** for male participants subject to age/frequently guidelines established by the **Claims Administrator**.

These guidelines apply to services that are for preventive health screening. If a **physician** orders a service to diagnose specific symptoms or observations, that is considered treatment of illness and is not subject to the schedule of this preventive care benefit.

### ***Rehabilitation Therapy***

The following **rehabilitation therapy** expenses are **covered** under the **POS** and **Traditional Indemnity** options:

- **Physical therapy** services that assist in the restoration of normal, necessary physical movement, after movement has been acutely impaired by illness or injury. Medically necessary physical therapy services must be for restorative or for the purpose of designing and teaching a maintenance program for the patient to carry out at home.
- **Speech therapy** services that assist in the correction of communication abilities that have been impaired by illness, injury or birth defect.
- **Occupational therapy** services that assist a person in regaining the ability to perform normal activities of daily living after those abilities have been acutely impaired by illness or injury.

The following conditions of service apply to **covered rehabilitation therapy** services:

- Care must be provided under the direct order of a **physician** who determines that you need the services and prescribes how many treatments are necessary. For example, if you go directly to a physical therapist and request services without seeing a **physician** first, the services will not be **covered**.
- The services must be likely to result in clear and reasonable improvement in your condition within three months.

- Generally, rehabilitation services provided in the home are **covered** only when services are provided as part of a **home health care agency's** services and the home health care has been precertified.
- Generally, rehabilitation services provided during an **in-patient** stay in a **hospital** or **extended care facility** are **covered** only when the **in-patient** stay has been precertified.
- **POS out-of-network** and **Traditional Indemnity** option benefits for **speech therapy** are limited to a maximum of 30 **out-patient** visits in a calendar year. Under the **POS** option, any visits incurred **in-network** count toward the maximum available visits **out-of-network**.

The Individual Development Enhancement Act (IDEA) requires that school systems provide this care from age 3 through 18. The Medical Plan will pay benefits for **medically necessary** services that are **covered** under the Medical Plan, but are not otherwise provided through a school system. The Medical Plan will also pay benefits for **medically necessary covered** services outside this age range.

### ***Restorative Surgery***

Cosmetic surgery (surgery primarily to improve appearance) is generally not **covered** under the Medical Plan. However, certain restorative surgeries in response to a more serious condition may also be for the purpose of improving appearance. Under these circumstances, restorative surgery and any necessary related services would be **covered**.

The following restorative surgery expenses are **covered** under the **POS** and **Traditional Indemnity** options:

- Surgery to restore an area seriously injured in an accident
- Surgery to correct a birth defect that causes a functional disability
- Surgery to restore breast tissue that was surgically removed, wholly or partially, in response to an illness. In accordance with the Women's Health and Cancer Rights Act of 1988, if a participant is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with the mastectomy, the following are **covered**:
  - Reconstruction of the breast on which the mastectomy was performed,
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

- Prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Post-mastectomy bras are covered in accordance with the **health care company's** guidelines.

The following conditions of service apply to **covered** restorative surgery expenses:

- The treatment must be to correct a condition that represents a serious malformation.
- The treatment must be for the least expensive medically accepted procedure that will adequately restore the malformation.

### ***Second Surgical Opinion***

Second surgical opinions are not required, but they are **covered** under the **POS** and **Traditional Indemnity** options. A second opinion is not a substitute for any required **precertification**.

The following expenses are **covered**:

- A second **physician's** opinion concerning the need for a surgery that was recommended by your treating **physician**.
- A third **physician's** opinion if the second opinion conflicts with the first recommendation.

The second and, when warranted, third surgical opinions must be rendered by a **physician** with the appropriate specialty for the recommended procedure.

### ***Wigs***

Under special conditions, the **POS** and **Traditional Indemnity** options cover the cost of a wig used for temporary hair loss due to disease or treatment of disease such as chemotherapy. Charges for wigs are **covered** up to a maximum of \$300 in any calendar year.