

## 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**.