

CLAIMS

Filing a Claim

One of the advantages of **in-network** care under the Standard or Enhanced **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 providers** under the Enhanced **Indemnity option** or under the **out-of-network** provision of the Standard or Enhanced **POS** option or if you use **EAP** services.

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

- Under the Enhanced **Indemnity option** or **out-of-network** care under the Standard or Enhanced **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),
- 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 for Salaried Employees 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.

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) using the Maintenance of Benefits method. 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, subtracts that amount from what it would have paid if it were the primary plan, and pays the difference. Benefits will not be paid for any service, treatment, supply, drug or device that is not covered by the Avaya Plan. Therefore, among the primary and secondary plans, you will

be eligible to receive only up to the highest payment of benefits allowed by either plan.

- **COB** with Medicare as the primary plan works similarly. 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 noncustodial 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.*