

OVERVIEW OF COVERAGE OPTIONS

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

- Standard **POS**
- Enhanced **POS**
- Enhanced Indemnity
- International 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. All **eligible employees** are eligible for coverage under the Enhanced **Indemnity Option**. 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 your home zip code is not in a designated **POS** area, you may be able 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”).

If you are an International Assignee, you will be eligible for the International **Indemnity option** offered through **Aetna Global Benefits**. Your coverage will be slightly different than the benefits shown for the Enhanced **Indemnity option**. Please refer to the Certificate of Coverage through **Aetna Global Benefits**, or contact **Aetna Global Benefits** customer service for more information (see “Important Contacts”).

Coverage Options: A Comparison

Standard POS and Enhanced POS Comparison Chart

	Standard POS Option ¹		Enhanced POS Option ¹	
	In-Network	Out-of-Network	In-Network	Out-of-Network
General Provisions	Offered if you live in an Aetna Choice POS II network area ("Opt-in" coverage may also be available)		Offered if you live in an Aetna Choice POS II network area ("Opt-in" coverage may also be available)	
Choice of Doctors	Any network provider , but PCP selection/use required for lowest copayment	Any eligible provider	Any network provider , but PCP selection/use required for lowest copayment	Any eligible provider
Annual Deductible ²	None	\$500/individual \$1,000/two-person or family	None	\$500/individual \$1,000/two-person or family
Emergency Room/ Hospital Admission Copayment	\$75 per emergency room visit (waived if admitted); \$150 per hospital admission	\$75 per emergency room visit (waived if admitted); \$350 per hospital admission	\$75 per emergency room visit (waived if admitted); \$100 per hospital admission	\$75 per emergency room visit (waived if admitted); \$250 per hospital admission
Annual Out-of-Pocket Maximum ³	\$1,250/individual \$2,500/two-person or family	\$2,500/individual \$5,000/two-person or family	\$1,000/individual \$2,000/two-person or family	\$2,500/individual \$5,000/two-person or family
Precertification Responsibility	Your PCP or network specialist	You	Your PCP or network specialist	You
Claim Forms	No	Yes	No	Yes
Physician Office Visit – Diagnostic and Treatment Services				
Treatment of Illness or Injury, Maternity, In-Office Surgery, In-Office Lab & X-ray, Second Surgical Opinion	100% of the prenegotiated rate after \$25 copayment per visit for selected PCP (or a participating OB/GYN) or \$40 copayment per visit for non-selected PCP or specialist ; (Maternity – copayment for first visit only)	70% of the allowable amount after the deductible	100% of the prenegotiated rate after \$15 copayment per visit for selected PCP (or a participating OB/GYN) or \$25 copayment per visit for non-selected PCP or specialist ; (Maternity – copayment for first visit only)	70% of the allowable amount after the deductible
Physician Office Visits – Preventive Services				
Routine Physical Exam ⁴ , Well-Woman Care, Well-Child Care ⁴ , Immunizations	100% of the prenegotiated rate after \$25 copayment per visit for selected PCP (or a participating OB/GYN) or \$40 copayment per visit for non-selected PCP or specialist	Not covered	100% of the prenegotiated rate after \$15 copayment per visit for selected PCP (or a participating OB/GYN) or \$25 copayment per visit for non-selected PCP or specialist	Not covered

The Avaya Inc. Medical Expense Plan for Salaried Employees

	Standard POS Option ¹		Enhanced POS Option ¹	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Routine Pap Smear	100% of the prenegotiated rate after \$25 copayment per visit for selected PCP (or a participating OB/GYN) or \$40 copayment per visit for non-selected PCP or specialist	70% of the allowable amount after the deductible (one per Plan Year)	100% of the prenegotiated rate after \$15 copayment per visit for selected PCP (or a participating OB/GYN) or \$25 copayment per visit for non-selected PCP or specialist	70% of the allowable amount after the deductible
Routine Mammograms ⁵	100% of the prenegotiated rate after \$25 copayment per visit for selected PCP (or a participating OB/GYN) or \$40 copayment per visit for non-selected PCP or specialist	70% of the allowable amount after the deductible	100% of the prenegotiated rate after \$15 copayment per visit for selected PCP (or a participating OB/GYN) or \$25 copayment per visit for non-selected PCP or specialist	70% of the allowable amount after the deductible
Prostate Cancer Screening ⁵	100% of the prenegotiated rate after \$25 copayment per visit for selected PCP or \$40 copayment per visit for non-selected PCP or specialist	70% of the allowable amount after the deductible	100% of the prenegotiated rate after \$15 copayment per visit for selected PCP or \$25 copayment per visit for non-selected PCP or specialist	70% of the allowable amount after the deductible
Colorectal Screening (test for blood in the stool) ⁵	100% of the prenegotiated rate after \$25 copayment per visit for selected PCP (or a participating OB/GYN) or \$40 copayment per visit for non-selected PCP or specialist	70% of the allowable amount after the deductible	100% of the prenegotiated rate after \$15 copayment per visit for selected PCP (or a participating OB/GYN) or \$25 copayment per visit for non-selected PCP or specialist	70% of the allowable amount after the deductible
Out-Patient Services – Treatment and Services Performed Outside a Physician’s Office				
Non-preventive Diagnostic Lab & X-ray	90% of prenegotiated rate after \$25 copayment per visit	70% of the allowable amount after the deductible	100% of the prenegotiated rate after \$15 copayment per visit	70% of the allowable amount after the deductible
Surgery, Maternity, Preventive Diagnostic Lab & X-ray, Radiation Therapy, Chemotherapy	90% of the prenegotiated rate	70% of the allowable amount after the deductible	100% of the prenegotiated rate	70% of the allowable amount after the deductible

The Avaya Inc. Medical Expense Plan for Salaried Employees

	Standard POS Option ¹		Enhanced POS Option ¹	
	In-Network	Out-of-Network	In-Network	Out-of-Network
In-Patient Services				
Hospital Room & Board ⁶ , Surgery, Anesthesia, Lab & X-ray, Physician Hospital Visits/Consultations, Maternity	90% of the prenegotiated rate after the \$150 copayment per hospital admission	70% of the allowable amount after the deductible , plus \$350 copayment per hospital admission	100% of the prenegotiated rate after the \$100 copayment per hospital admission	70% of the allowable amount after the deductible , plus \$250 copayment per hospital admission
Emergency Services				
Emergency Room Use, Ambulance Use	90% of the prenegotiated rate ; after \$75 copayment per visit (waived if admitted)	Emergency care paid as in-network if Aetna Member Services is notified within 48 hours	100% of the prenegotiated rate ; after \$75 copayment per visit (waived if admitted)	Emergency care paid as in-network if Aetna Member Services is notified within 48 hours
Non-Emergency Emergency Room Use	70% of the prenegotiated rate after \$75 copayment per visit (waived if admitted)	70% of the allowable amount after the deductible and \$75 copayment per visit (waived if admitted)	70% of the prenegotiated rate after \$75 copayment per visit (waived if admitted)	70% of the allowable amount after the deductible and \$75 copayment per visit (waived if admitted)
Alternatives to In-Patient Care				
Extended Care Facility ⁷	90% of the prenegotiated rate ⁸	70% of the allowable amount after the deductible , up to 60 days per Plan Year ⁸	100% of the prenegotiated rate ⁸	70% of the allowable amount after the deductible , up to 60 days per Plan Year ⁸
Home Health Care, Private Duty Nursing	90% of the prenegotiated rate ⁸	70% of the allowable amount after the deductible , up to 100 visits/shifts per Plan Year ⁸	100% of the prenegotiated rate ⁸	70% of the allowable amount after the deductible , up to 100 visits/shifts per Plan Year ⁸
Hospice Facility Care	90% of the prenegotiated rate ⁷	70% of the allowable amount after the deductible , up to 210 days per lifetime ⁸	100% of the prenegotiated rate ⁸	70% of the allowable amount after the deductible , up to 210 days per lifetime ⁸
Birthing Center	90% of the prenegotiated rate	70% of the allowable amount after the deductible	100% of the prenegotiated rate	70% of the allowable amount after the deductible
Other Covered Providers & Supplies				
Occupational Therapy, Physical Therapy, Speech Therapy, Podiatrists, Acupuncturists	100% of the prenegotiated rate after \$40 copayment per visit, up to any applicable Plan limits on number of visits ⁸	70% of the allowable amount after the deductible , up to any applicable Plan limits on number of visits ⁸	100% of the prenegotiated rate after \$25 copayment per visit, up to any applicable Plan limits on number of visits ⁸	70% of the allowable amount after the deductible , up to any applicable Plan limits on number of visits ⁸

The Avaya Inc. Medical Expense Plan for Salaried Employees

	Standard POS Option ¹		Enhanced POS Option ¹	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Chiropractors	100% of the prenegotiated rate after \$40 copayment per visit, up to any applicable Plan limits on number of visits ⁸ (Self-refer to in-network chiropractors , up to 60 visits per Plan Year ⁸)	70% of the allowable amount after the deductible , up to any applicable Plan limits on number of visits ⁸	100% of the prenegotiated rate after \$25 copayment per visit, up to any applicable Plan limits on number of visits ⁸ (Self-refer to in-network chiropractors , up to 60 visits per Plan Year ⁸)	70% of the allowable amount after the deductible , up to any applicable Plan limits on number of visits ⁸
Durable Medical Equipment, Blood Replacement	90% of the prenegotiated rate	70% of the allowable amount after the deductible	100% of the prenegotiated rate	70% of the allowable amount after the deductible
Nutritionist ⁹	100% of the prenegotiated rate after \$40 copayment per visit	Not covered	100% of the prenegotiated rate after \$25 copayment per visit	Not covered
Smoking Deterrents, Birth Control (Prescription only)	100% of the prenegotiated rate after \$25 copayment per visit for selected PCP (or a participating OB/GYN) or \$40 copayment per visit for non-selected PCP or specialist or as covered under the Prescription Drug Program	70% of the allowable amount after the deductible at office visit or as covered under the Prescription Drug Program	100% of the prenegotiated rate after \$15 copayment per visit for selected PCP (or a participating OB/GYN) or \$25 copayment per visit for non-selected PCP or specialist or as covered under the Prescription Drug Program	70% of the allowable amount after the deductible at office visit or as covered under the Prescription Drug Program

	Standard POS Option ¹		Enhanced POS Option ¹	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Program	<p>Retail Drugs (34-day supply max) 25% Coinsurance</p> <ul style="list-style-type: none"> ➤ Generic drugs <ul style="list-style-type: none"> ○ \$10 minimum ○ \$20 maximum ➤ Brand drugs <ul style="list-style-type: none"> ○ \$27 minimum ○ \$68 maximum ➤ Insulin (90-day supply) with \$54 minimum and \$136 maximum <p>\$15 copayment for chemotherapy drugs</p> <p><u>Home Delivery Drugs</u> (90 day supply max) 25% Coinsurance</p> <ul style="list-style-type: none"> ➤ Generic drugs <ul style="list-style-type: none"> ○ \$20 minimum ○ \$40 maximum ➤ Brand drugs <ul style="list-style-type: none"> ○ \$54 minimum ○ \$136 maximum <p>There is no annual out-of-pocket maximum.</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 Aetna Rx Home Delivery.</p>	<p>For out-of-network pharmacies (34-day supply max) \$100 deductible per individual</p> <p>Up to \$300 deductible per family</p> <p>After the deductible, you pay: 30% of the Reasonable & Customary charge</p> <p>There is no annual out-of-pocket maximum.</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 Aetna Rx Home Delivery.</p>	<p>Retail Drugs (34-day supply max) 20% Coinsurance</p> <ul style="list-style-type: none"> ➤ Generic drugs <ul style="list-style-type: none"> ○ \$9 minimum ○ \$15 maximum ➤ Brand drugs <ul style="list-style-type: none"> ○ \$24 minimum ○ \$60 maximum ➤ Insulin (90-day supply) with \$48 minimum and \$120 maximum <p>\$15 copayment for chemotherapy drugs</p> <p><u>Home Delivery Drugs</u> (90 day supply max) 20% Coinsurance</p> <ul style="list-style-type: none"> ➤ Generic drugs <ul style="list-style-type: none"> ○ \$18 minimum ○ \$30 maximum ➤ Brand drugs <ul style="list-style-type: none"> ○ \$48 minimum ○ \$120 maximum <p>There is no annual out-of-pocket maximum.</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 Aetna Rx Home Delivery.</p>	<p>For out-of-network pharmacies (34-day supply max) \$100 deductible per individual</p> <p>Up to \$300 deductible per family</p> <p>After the deductible, you pay: 30% of the Reasonable & Customary charge</p> <p>There is no annual out-of-pocket maximum.</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 Aetna Rx Home Delivery.</p>
Prescription Drug Utilization Management Program	<p>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-2s and Anti-fungals. Precertification means that requirements will have to be met before the Medical Plan will cover the prescription.</p>			

	Standard POS Option ¹		Enhanced POS Option ¹	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health and Chemical Dependency Program	First 5 days/visits per year free, \$25 copayments apply for additional visits/days; there is a \$750 annual out-of-pocket maximum per person.	\$400 deductible per person and 50% coinsurance apply; there is no annual out-of-pocket maximum . \$500 copayment per admission for inpatient care.	First 5 days/visits per year free, \$15 copayments apply for additional visits/days; there is a \$750 annual out-of-pocket maximum per person.	\$400 deductible per person and 50% coinsurance apply; there is no annual out-of-pocket maximum . \$500 copayment per admission for inpatient care.

¹ Dependents under the Standard **POS** option who permanently reside outside of a **POS** area will receive benefits according to the Enhanced **Indemnity Option** schedule.

² This health care **deductible** is separate from any **deductibles** under your **Prescription Drug Program** and the **Mental Health and Chemical Dependency Program**.

³ Certain expenses (e.g., the **deductible**, **precertification** penalties and any expenses in excess of the **allowable amount**) do not count toward the **out-of-pocket maximum**. This **out-of-pocket maximum** is separate and apart from the **out-of-pocket maximum** under the **Mental Health and Chemical Dependency Program**.

⁴ 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.

⁵ This preventive service is subject to age guidelines: **out-of-network** under the **POS** options, routine mammograms are restricted to one baseline for women aged 40 and then annual screenings at age 41+; routine prostate screening is **covered** annually for men aged 50+; and one colorectal screening per Plan Year is **covered** annually for men and women aged 50+.

⁶ Semi-Private; Private if only room type available or **medically necessary**.

⁷ Maximum includes both **hospital** and **extended care facility** days. Each **hospital** day counts as one full day towards Plan maximum and each **extended care facility** day counts as one half-day toward this maximum.

⁸ Days/visits received **in-network** apply to day/visit maximums **out-of-network** and vice-versa.

⁹ Not for weight loss counseling unless **medically necessary**.

Enhanced Indemnity Option Coverage Chart

	Enhanced Indemnity Option
General Provisions	Offered nationwide
Choice of Doctors	Any eligible provider
Annual Deductible ¹	\$250/individual \$500/two-person \$750/family
Emergency Room (ER)/ Hospital Admission Copayment	None
Annual Out-of-Pocket Maximum ²	\$2,500/individual \$5,000/two-person or family
Precertification Responsibility	You
Claim Forms	Yes, unless you utilize an available National Advantage Program provider
Physician Office Visit – Diagnostic and Treatment Services	
Treatment of Illness or Injury, Maternity, In-Office Surgery, In-Office Lab & X-ray, Second Surgical Opinion	90% of the allowable amount after the deductible
Physician Office Visits – Preventive Services	
Routine Physical Exam ³ , Well-Woman Care, Well-Child Care ³ , Immunizations	90% of the allowable amount ; the deductible does not apply
Routine Pap Smear	90% of the allowable amount ; the deductible does not apply
Routine Mammograms ⁴	90% of the allowable amount ; the deductible does not apply
Prostate Cancer Screening ⁴	90% of the allowable amount ; the deductible does not apply
Colorectal Screening (test for blood in the stool) ⁴	90% of the allowable amount ; the deductible does not apply
Out-Patient Services – Treatment and Services Performed Outside a Physician’s Office	
Non-preventive Diagnostic Lab & X-Ray	90% of the allowable amount after the deductible
Surgery, Maternity, Preventive Diagnostic Lab & X-ray, Radiation Therapy, Chemotherapy	90% of the allowable amount after the deductible
In-Patient Services	
Hospital Room & Board ⁵ , Surgery, Anesthesia, Lab & X-ray, Physician Hospital Visits/Consultations, Maternity	90% of the allowable amount after the deductible
Emergency Services	
Emergency Room Use, Emergency Ambulance Use	90% of the allowable amount after the deductible
Non-Emergency Emergency Room Use	90% of the allowable amount after the deductible
Alternatives to In-Patient Care	
Extended Care Facility ⁶	90% of the allowable amount after the deductible , up to 120 days per Plan Year.
Home Health Care, Private Duty Nursing	90% of the allowable amount after the deductible , up to 200 visits/shifts per Plan Year
Hospice Facility Care	90% of the allowable amount after the deductible , up to 210 days per lifetime

	Enhanced Indemnity Option
Birth Center	90% of the allowable amount after the deductible
Other Covered Providers & Supplies	
Occupational Therapy, Physical Therapy, Speech Therapy, Podiatrists, Acupuncturists	90% of the allowable amount after the deductible , up to any applicable Plan limits on number of visits ⁷
Chiropractors	90% of the allowable amount after the deductible , up to any applicable Plan limits on number of visits ⁷
Durable Medical Equipment, Blood Replacement	90% of the allowable amount after the deductible
Nutritionist	Not covered
Smoking Deterrents, Birth Control (Prescription only)	90% of the allowable amount after the deductible at office visit or as covered under the Prescription Drug Program
Prescription Drug Program	<p><u>Retail Drugs</u> 20% Coinsurance</p> <ul style="list-style-type: none"> ➤ Generic drugs <ul style="list-style-type: none"> ○ \$9 minimum ○ \$15 maximum ➤ Brand drugs <ul style="list-style-type: none"> ○ \$24 minimum ○ \$60 maximum ➤ Insulin (90-day supply) with \$48 minimum and \$120 maximum <p>\$15 copayment for chemotherapy drugs</p> <p><u>Home Delivery Drugs</u> 20% Coinsurance</p> <ul style="list-style-type: none"> ➤ Generic drugs <ul style="list-style-type: none"> ○ \$18 minimum ○ \$30 maximum ➤ Brand drugs <ul style="list-style-type: none"> ○ \$48 minimum ○ \$120 maximum <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 Aetna Rx Home Delivery.</p> <p>There is no annual out-of-pocket maximum.</p> <p><u>For out-of-network pharmacies</u> \$100 deductible per individual Up to \$300 deductible per family After the deductible, you pay: 30% of the Reasonable & Customary charge</p>

	Enhanced Indemnity 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 and Anti-fungals. Precertification means that requirements will have to be met before the Medical Plan will cover the prescription.
Mental Health and Chemical Dependency Program	<p>In-network: First 5 days/visits per year free, \$15 copayment apply for additional visits/days; annual out-of-pocket maximum per person is \$750.</p> <p>Out-of network: \$400 deductible; 50% coinsurance apply; there is no annual out-of-pocket maximum. \$500 copayment per admission for inpatient care.</p>
<p>¹ This health care deductible is separate from any deductibles under your Prescription Drug Program and the Mental Health and Chemical Dependency Program.</p> <p>² Certain expenses (e.g., the deductible, precertification penalties and any expenses in excess of the allowable amount) do not count toward the out-of-pocket maximum. This out-of-pocket maximum is separate and apart from the out-of-pocket maximum under the Mental Health and Chemical Dependency Program.</p> <p>³ 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>⁴ This preventive service is subject to age guidelines: under the Enhanced Indemnity option, routine mammograms are restricted to one baseline for women aged 40 and then annual screenings at age 41+; routine prostate screening is covered annually for men aged 50+; and one colorectal screening per Plan Year is covered annually for men and women aged 50+.</p> <p>⁵ Semi-Private; Private if only room type available or medically necessary. Under the Enhanced Indemnity Option, if a non-National Advantage Program network hospital only has private rooms, the reasonable and customary charge shall be 90% of the most prevalent room and board charge.</p> <p>⁶ Maximum includes both hospital and extended care facility days. Each hospital day counts as one full day towards Plan maximum and each extended care facility day counts as one half-day toward this maximum.</p> <p>⁷ Days/visits received in-network apply to day/visit maximums out-of-network and vice-versa.</p>	

HMO Option Coverage Chart

General Provisions	HMO Option ¹
Choice of Doctors	Any network provider , as coordinated through your Primary Care Physician (PCP)
Annual Deductible	None
Copayment	Varies by HMO . Generally \$15-\$30 copayment per office visit and \$100 per hospital admission
Coinsurance	Generally, not applicable
Annual Out-of-Pocket Maximum	Varies by HMO
Precertification Responsibility	Your PCP
Claim Forms	No
Covered Services	Varies by HMO
Prescription Drugs	Varies by HMO
Mental Health and Chemical Dependency	Varies by HMO
¹ HMO coverage varies. To find out which services are offered by a particular HMO , call the applicable HMO directly. You need to contact the Avaya Health and Benefits Decision Center (see "Important Contacts"), and not your HMO , when you have to add or drop coverage for a dependent, or when you have questions about the medical eligibility status of your dependents.	