

## **OVERVIEW OF COVERAGE OPTIONS**

The Medical Plan offers the following coverage options, based on age and location as available, when you retire. The options include:

- Standard **POS**
- **Salaried Retiree 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 and **Medicare**-eligibility status.

The Standard **POS** option is offered if you live in a **POS** area, unless you are eligible for **Medicare** and **cover** any dependents who are not **Medicare**-eligible. For you or any of your **covered dependents** that are eligible for **Medicare**, **Aetna** will administer **Salaried Retiree Indemnity** benefits secondary to **Medicare** (see “How Medicare Eligibility Affects Benefits Under the Medical Plan”). Standard **POS** benefits will continue to be provided for anyone who is not eligible for **Medicare**.

If you live in an area where the Standard **POS** option is *not* offered, you may be eligible to “opt-in” to Standard **POS** coverage that is available in a nearby **POS** area.

The **Salaried Retiree Indemnity** option is offered only if you do not reside in a **POS** area, or if you are **Medicare**-eligible and do not cover any dependents who are not **Medicare**-eligible. This option has different features than the Enhanced Indemnity option available to active salaried employees.

The **HMO** option is offered if you live in an **HMO** area and neither you nor any of your dependents are eligible for **Medicare**. If you are enrolled in an **HMO** and you or any of your **covered dependents** become eligible for **Medicare**, your coverage will default to the Standard **POS** or **Salaried Retiree Indemnity** option as of the first of the month in which you or your dependent become eligible for **Medicare**.

You may make a one-time election to defer enrolling in retiree health benefits. There is no limit on how long you may defer. If you elect to defer coverage you may enroll at a future date. If you later terminate coverage due to non-payment, you *cannot* re-enroll ever again.

In addition, you may waive medical coverage to participate in another, non-Avaya plan. You can re-enroll in the Medical Plan within 31 days of when your non-Avaya coverage

ends. You must show evidence of continuous health coverage for the period in which you were not enrolled in the Medical Plan (but no more than the most recent 12 months) in order to re-enroll. There is no limit to the number of times you may waive coverage and re-enroll as long as you can prove you have continuous health coverage. If you do not have continuous medical coverage for the period of coverage you were not enrolled in the Medical Plan, you will not be able to re-enroll ever again.

The default coverage is to defer coverage.

See “Appendix B” for a comparison chart of the benefits available to you under these Medical Plan options.

### ***When Dependent Benefits May Differ***

While **covered dependents** must be enrolled in the same option that you choose for yourself (see “Eligible Dependents”), dependent benefits may differ under the following circumstances:

- You are enrolled in the Standard **POS** option and your **eligible dependents** permanently live separately from you and outside the **POS network** area,
- You are **Medicare**-eligible (regardless of age) and you have one or more non-**Medicare**-eligible dependents, or
- You are non-Medicare-eligible but you have one or more **Medicare**-eligible dependents (regardless of their age).