

PARTICIPATING IN THE PLAN

Who Is Eligible

You are eligible to participate in the Medical Plan if you are an **eligible retiree**.

If you are eligible to participate in the Medical Plan, you have several coverage options from which to choose. Your home zip code and **Medicare** eligibility status determine the options available to you. You have an opportunity to elect a different Medical Plan option each year during the **annual enrollment** period.

Upon your termination of service and eligibility for the Medical Plan, you can *defer* your retiree medical coverage until a later date. At your election, you can choose to be covered by The Avaya Inc. Retiree Medical Plan for Salaried Employees upon termination or any time in the future without providing proof of insurability (see “Deferring and Electing Medical Plan Coverage”).

Once you are covered by the Medical Plan, you can waive your coverage and re-enroll in the Medical Plan within 31 days of when previous coverage ends. However, you are required to 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 (see “Waiving Medical Plan Coverage”).

When You or a Dependent Become Medicare-Eligible

When you or a **covered dependent** become eligible for **Medicare** (regardless of age), coverage under the Medical Plan continues, but becomes secondary to **Medicare**. This means that **Medicare** becomes the primary payor and the Medical Plan becomes the secondary payor.

When **Medicare** is the primary payor, benefits under the Medical Plan are processed using the **Salaried Retiree Indemnity** benefit levels, even for those **covered** under the Standard **POS** option. **HMO** coverage is no longer available if you or any of your **covered dependents** are eligible for **Medicare**. For more detailed information, see “How Medicare Eligibility Affects Benefits Under the Medical Plan”.

Eligible Dependents

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

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

Situation	Administration
Your lawful spouse, domestic partner 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 a dependent. See "Avaya Inc. Families." If such person is enrolled as a dependent, he or she must enroll in the same option. If enrolled independently as an employee or retiree, he or she may or may not enroll in the same option.
You have a Class II dependent continuously enrolled since January 1, 1996 under the Medical Plan and any predecessor plans for Other Covered Charges only.	The Class II dependent is covered only for those benefits designated as Other Covered Charges and payable under the terms of the Salaried Retiree Indemnity option, regardless of the option in which the retiree enrolls.

You may enroll another Avaya Inc. salaried employee or **eligible retiree** (who participates in The Avaya Inc. Pension Plan for Salaried Employees) as your dependent, as long as the eligibility requirements are satisfied. If you enroll another eligible salaried eligible employee 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**. A salaried active or retired Avaya Inc. employee cannot enroll a represented active or retired Avaya Inc. employee as an **eligible dependent**.

The **Avaya Health and Benefits Decision Center** can tell you the substantial tax impact of covering a **domestic partner** and/or **domestic partnership dependents**. Under IRS regulations, the amount of the Company's cost to cover a **domestic partner** and/or **domestic partnership dependents** is reported as taxable income to you in your W2. 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 who you elect to cover.

Enrollment

When you retire, an enrollment package will be sent to your home address. The package will include information about your coverage options, the cost, 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 or by calling the **Avaya Health and Benefits Decision Center** (see “Important Contacts”).

You must enroll by the date specified in your enrollment package. If you do not enroll by the date specified, you will be defaulted to deferring your coverage.

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

Once the initial enrollment period is over (31 days from the date on the cover letter in your enrollment package), you can elect to begin coverage you had previously deferred at any time, but your coverage will not be made retroactive.

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 your Medical Plan option. **Annual enrollment** is held once a year, usually in the fall.

You will be sent enrollment materials that will include information about the coverage options available to you under the Medical Plan 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 due to your location or **Medicare** eligibility status. If your current option is discontinued or replaced by another option, and you do not select another option, you will be automatically enrolled in the **assigned option** based on your location and **Medicare** eligibility status.

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”).

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 *must* call 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 miss the 31-day deadline, you must wait until the next **annual enrollment** period to make applicable changes to your Medical Plan coverage. You may not make changes in the coverage option unless you move out of the area **covered** by that option. See “If You Move to a POS or Non-POS Area.” *If you do not enroll your new dependent within 31 days and you are enrolled in the Standard **POS** option or **Salaried Retiree 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 You Move to a POS or Non-POS Area

If you move into or out of a **POS** area, you may need to make a change to your medical coverage option within 31 days or be assigned coverage.

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 satisfying of your **deductible** under your new option during that calendar year. **Deductible** amounts applied **out-of-network** under the Standard **POS** option apply to **deductible** amounts under the **Salaried Retiree Indemnity** option, and vice versa.
- Amounts you have paid that apply toward your **out-of-pocket maximum** under the **Salaried Retiree Indemnity** option apply toward satisfying the **out-of-network out-of-pocket maximum** under the Standard **POS** option during that calendar year, and vice versa.
- Amounts you have paid as **copayments** under the Standard **POS** option or an **HMO** do *not* apply toward satisfying either the **deductible** or **coinsurance** requirements under the **Salaried Retiree Indemnity** option.
- Amounts you have paid as **deductibles** or **coinsurance** amounts under the **Salaried Retiree Indemnity** option do *not* apply toward satisfying the **in-network out-of-pocket maximum** under the Standard **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**.

A move may cause changes in your benefits. Promptly notifying the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) of your new address can help ensure that your benefits continue uninterrupted.

Deferring and Electing Medical Plan Coverage

You can defer Medical Plan coverage with the option to elect coverage as of the first of any month. However, once you enroll in coverage, you must remain continuously enrolled. If your coverage is terminated due to non-payment, you will not be able to reinstate coverage ever again.

Waiving Medical Plan Coverage

You can waive Medical Plan coverage and re-enroll in the Medical Plan within 31 days of when the previous coverage ends. You are required to 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.

The effective date will be the first of the month following the month in which your previous coverage ends. It is unnecessary to show a **qualified status change** to waive coverage and there’s 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.