

## **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 (other than a **domestic partner** and/or **domestic partnership 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 day he or she became your dependent. *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 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 Die While Covered Under the Retiree Medical Expense Plan for Salaried Employees***

Coverage for your enrolled **Class I dependents**, **domestic partner**, **domestic partnership dependents**, and **Class II dependents** may continue 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 “COBRA Continuation Coverage.”

At the end of the **COBRA** continuation period, your surviving **lawful spouse** or **domestic partner** may choose to continue coverage under the **Salaried Retiree Indemnity** option through the Family Security Program (see “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 **Salaried Retiree 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.

In addition, any time your home address changes, it is important to provide the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) with your new address. You should notify the **Avaya Health and Benefits Decision Center** before, or as soon as possible after, your move. This ensures that your benefits will continue uninterrupted.

## How a Move Affects Your Health Care Options\*

If...	And you move...	The rule is...
You are enrolled in the Standard <b>POS</b> option	Into another <b>POS</b> area	You stay in the Standard <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 Standard <b>POS</b> option	Into an area where the <b>POS</b> option is not available	You may select one of the options available in your new area which includes the <b>Salaried Retiree Indemnity</b> option. You may elect to “opt-in” to the Standard <b>POS</b> option. You may also be able to elect coverage in an <b>HMO</b> .
You are outside a <b>POS network</b> area and are enrolled in the <b>Salaried Retiree Indemnity</b> option	Into a <b>POS</b> area	You will automatically be enrolled in the Standard <b>POS</b> option. If you or any of your dependents are eligible for <b>Medicare</b> , your benefits will be administered in accordance with the <b>Salaried Retiree Indemnity</b> option. You may also be able to select coverage through 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 must select from one of the options available in your new area, which may include other <b>HMOs</b> , Standard <b>POS</b> or <b>Salaried Retiree Indemnity</b> option. The available options depend on whether 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, Standard **POS** coverage may be available to you if you elect to “opt-in” to Standard **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 “Changing Your Coverage During the Year.”

### **Qualified Status Changes**

If you have a **qualified status change**, you may *only* change your *coverage level* (individual, two-person, family coverage 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 waived medical coverage and your spouse loses coverage under his or her employer’s medical plan, you may elect coverage under the Medical Plan.

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 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 event.

### **If You Are Rehired**

If you are returning to Avaya Inc. within six months of your date of separation, your prior **net credited service** will be immediately bridged, minus the period of time that you were not employed by Avaya Inc. If you are returning to Avaya Inc. and it has been longer than six months since your date of separation, your **net credited service** will not be immediately bridged. Upon completion of two years of continuous Avaya employment after re-employment, your prior Avaya Inc. service will be bridged for certain Avaya Inc. benefits purposes.

Should you terminate employment before your **net credited service** is bridged, your new **net credited service** date will be based on your rehire date and any previous service will not have an impact in the calculation of this new **net credited service**.

If you were previously service pension-eligible on your first termination date and you are rehired, you will continue to be eligible for subsidized coverage under the Medical Plan at your next termination. The amount the Company will contribute will be based on the rules in effect at the time of your next termination. Currently, the Company will contribute 3% of the Maximum Company Contribution for every year of **net credited**

**service** up to service accrued as of 2003 with a Maximum Company Contribution amount set at 75%.

If you were not previously service pension-eligible or a participant of the account balance plan on your first termination date and you are rehired, your age plus **net credited service** must equal at least 60 with at least 5 years of **net credited service** at the next termination. You will have access to purchase group retiree health insurance through Avaya at 100% of the cost.

### ***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**.