



2021 Benefits Annual Enrollment Guide

Enrollment Period October 7 – October 20, 2020



Active Represented Employees



Annual Enrollment is your once-a-year opportunity to review your benefit options for the coming year and select the coverages that will work best for you and your family.

**Annual Enrollment 2021
October 7 – 20, 2020**
**Benefits selected during this enrollment period
will be effective January 1, 2021.**

Please review this Guide in its entirety. It is your source of information for what's changing in 2021. Consider all of your benefit options and your financial and health care needs during Annual Enrollment. You will not need to actively enroll in most benefits for 2021 if you do not wish to make changes, **with the exception of the following elections that do not carry over from year to-year:**

- Dental DMO (call Aetna at **1-877-508-6927** in **January** to re-enroll)
- Health Care and Dependent Care Flexible Spending Account (FSA) elections

[Attend a What's New Webinar to learn about 2021 benefits](#)

October 8 at 4 p.m. ET

See the Annual Enrollment email for webinar details.

[Benefits Genius Bar](#)

Call in with your annual enrollment benefit questions.
Open weekdays from October 9 - October 20 from 3 - 4p.m. ET
for the Annual Enrollment period.
See the Annual Enrollment email for details.

Your Health
Your Benefits
Take Charge
ANNUAL ENROLLMENT

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 22 for more details.

AVAYA

Click on a topic below
to go directly to the
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What's New for 2021

Avaya knows how important health and insurance plans are for you and your family. The following pages include a summary of medical benefit changes for the year ahead. Additional details are available in later sections of this Guide and at <https://my.adp.com>. If you have questions or need assistance, contact the Avaya Health & Benefits Decision Center at **1-800-526-8056 option 1** (TDD 1-800-952-0450) or via e-mail at avayaservicecenter@adp.com.

Aetna Enhancements

If you are enrolled with Aetna through the Avaya Medical Plan following are the benefit enhancements:

New! Expert Medical Opinion through 2nd.MD

Once you receive a diagnosis, you can contact 2nd.MD to review the recommended course of treatment. Your information will be reviewed by a national board-certified physician and a specialist will schedule a consultation to review the recommendation with you via video or phone. If you are enrolled in Aetna in 2021 through the Avaya Medical Plan, go to <http://www.2nd.MD/Aetna> to sign up.

New! Aetna Behavioral Health Case Management

Aetna clinicians are available 24/7 to handle clinically urgent and complex needs to ensure access to appropriate behavioral health services and care. This also includes Autism advocacy. Aetna will provide support in navigating services and assist in identifying resources for your care.

New! Teladoc Behavioral Health

Beginning 2021, you can use Teladoc to speak with experienced psychiatrists, psychologists and Masters level therapists via an online video consultation. Providers are available seven days a week, 7 a.m. to 9 p.m. local time. Here's how it works:

- Members can request appointments through the app on their mobile device, through the website, or via phone, with appointment acceptance notice within 48 hours.
- Tele-video appointments include treatment and goal setting. Members may use the same provider throughout the course of care if desired. Teladoc has emergency protocols in place should an at-risk member need crisis care. Nurse outreach for ongoing care includes evaluation and guidance after the 2nd and 6th visits.

To enroll go to **Teladoc.com**

New! Teladoc - Caregiver

Beginning 2021, you can use Teladoc not only for yourself and immediate family members that are covered under Aetna, but also for extended family members for whom you are a caregiver; such as your parents or grandparents. If you are a caregiver, use Teladoc to get fast and affordable medical advice even if the one you care for is not covered by you Avaya medical plan option. Here's how it works:

- Add the care recipient to your Teladoc account
- Connect with a doctor in 2-way or 3-2way phone or video visits
- Pay \$47 per visit (CDHP or POS medical plan options)
- Share Teladoc visit summaries with the care recipient's doctor

To get started, visit **Teladoc.com**

What's New for 2021

Telemedicine is a convenient alternative to costly urgent care and ER visits.

With Teladoc, you can connect with a board-certified doctor any time by phone, web or mobile app for help with a variety of medical issues including general medicine, dermatology, and behavioral health (7 a.m. to 9 p.m. local time).

New! Voluntary Benefits – Beginning 2021, you can enroll in Critical Illness, Accident and/or Hospital Indemnity Insurance. Coverage is voluntary; you must enroll during annual enrollment if you want coverage.

Critical Illness Insurance can ease the financial impact of serious illness – such as cancer or a heart-related condition – with a lump-sum payment to spend on extra medical or living expenses. Here's how it works:

- Coverage is voluntary; you must enroll during annual enrollment if you want coverage. You must be actively at work and enrolled in a medical plan, but it does not have to be Avaya's plan.
- You can elect coverage of \$10,000, \$20,000 or \$30,000 for yourself only or elect coverage for eligible family members. Spouse/domestic partners receive 100% Guaranteed Insurance (GI) coverage. Children receive 50% GI. For example, if you elect \$10,000 coverage for your family, your spouse is also covered up to \$10,000 and the child coverage amount is up to \$5,000.
- You pay for coverage through after-tax payroll deductions. Rates are based on your tobacco usage status, your age and level of coverage you select.
- If you elect Critical Illness, effective Jan. 1, 2021, and are diagnosed with a covered illness, file a claim with MetLife and you will receive a lump-sum tax-free payment that can be used to cover medical and even living expenses.
- There is an annual screening benefit of \$50. If you go for a routine physical exam or an age appropriate screening and notify MetLife, they will send you a one-time payment of \$50.

For more in-depth information about voluntary benefits, please visit <https://www.metlife.com/avaya>.

What's New for 2021

Accident Insurance provides you with a lump-sum benefit if you or your eligible family members experience the following non-work related accidents:

• Fractures*	• Cuts/Lacerations
• Dislocations*	• Concussions
• Eye Injuries	• 2nd or 3rd Degree Burns
• Broken tooth	

*Chip fractures are paid at 25% of Fracture Benefit and partial dislocations are paid at 25% of Dislocation Benefit.

Accident Insurance can help you pay for out-of-pocket expenses that may not be covered by traditional insurance, such as deductibles, rehabilitation and transportation. Here's how it works:

- You must be actively at work
- There are two options you can choose: a Low Plan Option or a High Plan Option. See schedule of benefits at <https://www.metlife.com/avaya>
- You pay for coverage through after-tax payroll deductions.
- If you or your covered dependents have an accident, you would notify MetLife and payments will be paid directly to you, not to the doctors, hospitals or other health care providers. You will receive a check, payable to you, for maximum convenience.

For more in-depth information about voluntary benefits, please visit <https://www.metlife.com/avaya>.

Hospital Indemnity Insurance can help ease the financial impact of hospitalization.

Here's how it works:

- You must be actively at work
- There are two options you can choose: a Low Plan Option of \$750 admission and \$150 confinement or a High Plan Option of \$1,500 admission and \$300 confinement
- You pay for coverage through after-tax payroll deductions.
- If you or your covered dependents are hospitalized, you would notify MetLife and payments will be paid directly to you, not to the doctors, hospitals or other health care providers. You will receive a check, payable to you, for maximum convenience.

For more in-depth information about voluntary benefits, please visit <https://www.metlife.com/avaya>.

Note: If you are a New Hampshire resident, you will be offered a slightly different Hospital Indemnity plan. Please refer to the outline of coverage and click on the state you reside in to see plan specific coverages.

What's New for 2021

New! MetLife Legal Plus Parents

Parents Plus covers all eligible family members including parents and parents-in-law. You and your family members would receive fully covered legal advice and representation for a wide range of legal matters. There is a monthly after-tax cost of \$6.00 for this option.

Improved! Spouse Life and Spouse AD&D

Spouse Life Insurance can now be elected up to \$250K (increments of 25K). Statement of Health (SOH) is required for all new entrants and increases in coverage.

Dependent AD&D can now be elected up to \$300K (increments of 25K). Statement of Health is not required for this coverage.

Kaiser Plan Changes

2021 carrier-mandated changes (pending approval from the Department of Insurance):

Plan	Benefit	2020 Avaya Plan Design	2021 Mandated Plan Design
Kaiser All Groups	Pre-Exposure Prophylaxis (PrEP)	Not listed under preventative services	Listed as preventative service with no cost share for people at high risk of HIV infection
Kaiser CA and MAS	Chronic Condition Management	Lab testing cost share applies for testing for chronic conditions	Certain chronic conditions can get the following testing free of cost: <ul style="list-style-type: none"> • A1c testing for diabetes • Low-density lipoprotein (LDL) testing for heart disease • Internalized normalized ratio (INR) testing for liver disease or bleeding disorders
Kaiser CO	Urgent Care	\$40/visit; deductible does not apply. 10% coinsurance for covered services received during a visit.	Copayment will cover the Urgent Care visit and other services received during the visit. (Member will still owe applicable cost share for additional services such as, but not limited to X-rays, laboratory tests and office administered drugs)
Kaiser CO	Breast Imaging	Imaging cost share applies for breast cancer screening	Breast cancer screening may be covered under diagnostic imaging or may allow for supplemental imaging within the same calendar year based on factors including high risk breast density
Kaiser MAS	Pregnancy Tests	Subject to lab test cost share	No charge, when provided during a contraceptive visit
Kaiser MAS	Non-Pediatric Eyewear and Contact Lenses	Percent discount for standard vision hardware	Flat dollar allowance for standard vision hardware
Kaiser MAS	Clinically Administered Medications	Office copay applies for clinically administered medications	One copay/visit for injections and infusions in addition to the office copay for clinically administered medications

HMSA Medical Plan Changes

Please visit <http://www.avaya.com/benefits/RepresentedBenefits/> to review HMSA's 2020/2021 carrier-mandated changes.

2021 Health Care FSA Contribution Maximum

The annual contribution maximum for Health Care Flexible Spending Account elections in 2021 has increased from \$2,650 to \$2,750. Please make your new election at <https://my.adp.com>. 2020 elections will not carry over to 2021.

Annual Express Scripts (ESI) Prescription Drug Formulary Changes

The lists below describe some of the ESI carrier-mandated drug list and program changes, effective January 1, 2021. Personalized notifications, reminder communications, and targeted alerts will go out to affected members before January 1. ESI's formulary will continue to ensure that clinically sound, cost-effective drugs are available to members and will drive greater savings. ESI's 2021 carrier-mandated drug exclusion list is available at https://www.express-scripts.com/art/open_enrollment/DrugListExclusionsAndAlternatives.pdf. The 2021 formulary is available at <https://my.adp.com> under the *Forms & Plan Documents* tile. Filter on "M" and click on the "MEDICAL BENEFITS - ESI RX PREFERRED DRUG GUIDE" link.

2021 Preferred-to-Non-Preferred Changes			
ALREX	BEPREVE	FIRST-LANSOPRAZOLE	FIRST-MOUTHWASH BLM
FIRST-OMEPRAZOLE	ILEVRO	ORACEA	PRIVIGEN
PROLENSA	QBREXZA	RANITIDINE SYRUP	



2021 POS and Indemnity Medical and Prescription Drug Comparison Chart for Active Represented Employees

Kaiser HMO information can be found online at <https://my.adp.com> under *Forms & Plan Documents > Filter by the letter "S" for SBCs.*

Features	Aetna Point-of-Service (POS) Option		Aetna Traditional Indemnity Option
	Offered if you live in an Aetna Choice POS II network area. "Opt-In" coverage may also be available.		Offered if you do not live in an Aetna Choice POS II network area.
	Each time you need care, you choose:		
	In-Network	Out-of-Network	
Choice of doctors	Any Aetna Choice POS II network provider, including Teladoc physicians and dermatologists for 24/7 phone or video physician visits and behavior health through a licensed therapist by phone or video (available by downloading the Teladoc app on your smartphone or tablet or by visiting https://www.teladoc.com/Aetna). Primary Care Physician (PCP) selection recommended.	Any eligible provider	Any eligible provider
Preventive care (routine physical exams/screenings)	Free adult annual physical examinations and health screenings based on age and frequency guidelines determined by Aetna. ¹		
Your monthly cost	See your Personalized Enrollment Webpage for your cost.		
Annual deductible	\$350 per individual \$700 per two-person or family	\$1,300 per individual ² \$2,600 per two-person or family ²	\$250 per individual \$500 per two-person \$750 per family
Coinsurance	You pay: 5% after the deductible	You pay: 40% of the Reasonable & Customary charge after the deductible	You pay: 0% or 20% of the Reasonable & Customary charge depending on the type of service, after the deductible
Are you responsible for charges in excess of the Reasonable & Customary Pre-negotiated amount?	No	Yes, unless you use a National Advantage Program (NAP) network provider	Yes, unless you use a National Advantage Program (NAP) network provider
Annual Out-of-Pocket Maximum³	\$2,000 per individual \$4,000 per two-person or family	\$5,000 per individual \$10,000 per two-person or family	\$1,000 per individual \$2,000 per two-person \$3,000 per family
Precertification responsibility	Your PCP or Specialist	You	You
Are claim forms required?	No	Yes, unless you use a National Advantage Program (NAP) network provider	Yes, unless you use a National Advantage Program (NAP) network provider

Note: Cells shaded in light red denote change from 2020.

¹ Includes routine mammography, prostate screenings and colorectal screenings.

² This medical care out-of-network deductible is separate from any out-of-network deductible under the Prescription Drug Program (as noted on next page).

³ Certain expenses (e.g., precertification penalties and any expenses in excess of the Reasonable & Customary charge) do not count toward the annual Out-of-Pocket Maximum. The annual Out-of-Pocket Maximum for the POS Prescription Drug Program is combined with the annual Out-of-Pocket Maximum for the POS Medical plan. The annual Out-of-Pocket Maximum for the Indemnity Prescription Drug Program is separate from the annual Out-of-Pocket Maximum for the Indemnity Medical plan.

2021 POS and Indemnity Medical and Prescription Drug Comparison Chart for Active Represented Employees

Features	Aetna Point-of-Service (POS) Option Prescription Drug Program coverage offered through Express Scripts, Inc. (ESI)		Aetna Traditional Indemnity Option Prescription Drug Program coverage offered through Express Scripts, Inc. (ESI)
	Each time you need care, you choose:		
	In-Network	Out-of-Network	
Prescription Drug Benefits ⁴	<p>\$0 deductible</p> <p>Retail Drugs (up to a 30-day supply) Tier 1 (Generic) \$15 copay Tier 2 (Preferred Brand) \$30 copay Tier 3 (Non-preferred Brand) \$45 copay Chemotherapy drugs \$15 copay</p> <p>Mail Order (up to a 90-day supply) Tier 1 (Generic) \$30 copay Tier 2 (Preferred Brand) \$60 copay Tier 3 (Non-preferred Brand) \$90 copay</p> <ul style="list-style-type: none"> Insulin may be purchased at in-network retail pharmacies for up to a 90-day supply at the Mail Order coinsurance/copay. Preferred/Non-preferred benefits will apply to brand name insulin. 	<p>\$50 deductible per individual, up to \$100 per family</p> <p>After the deductible, you pay: 30% of the Reasonable & Customary charge for up to a 30-day supply</p>	<p>\$0 deductible</p> <p>Retail Drugs (up to a 30-day supply) Tier 1 (Generic) \$15 copay Tier 2 (Preferred Brand) \$30 copay Tier 3 (Non-preferred Brand) \$45 copay Chemotherapy drugs \$15 copay</p> <p>Mail Order (up to a 90-day supply) Tier 1 (Generic) \$30 copay Tier 2 (Preferred Brand) \$60 copay Tier 3 (Non-preferred Brand) \$90 copay</p> <ul style="list-style-type: none"> Separate \$1,000 per person/\$2,000 per two-person coverage/\$3,000 per family annual Out-of-Pocket Maximum Insulin may be purchased at in-network retail pharmacies for up to a 90-day supply at the Mail Order coinsurance/ copay. Preferred/Non-preferred benefits will apply to brand name insulin.
Prescription Drug Utilization Management Program	<ul style="list-style-type: none"> The Prescription Drug Utilization Management Program requires prior authorization for certain types of prescription drugs, including but not limited to Nonsedating Antihistamines and Antifungals. Prior authorization means that requirements must be met before the Prescription Drug Program will cover the prescription. If you purchase a brand name medication when a generic medication is available, you will pay the generic copay plus the difference in cost between the brand name and the generic. Mandatory home delivery applies to all long-term (maintenance) drugs. After three fills at the retail level, the member will pay 100% of the Express Scripts-discounted cost for the medication for future retail fills. Out-of-pocket costs for long-term medications not ordered through ESI Home Delivery do not apply to the member/family deductible or out-of-pocket maximum. 		

⁴ Out-of-Pocket Maximum applies to in-network retail and mail order copayments. The annual Out-of-Pocket Maximum for the POS Prescription Drug Program is combined with the annual Out-of-Pocket Maximum for the POS Medical plan. The annual Out-of-Pocket Maximum for the Indemnity Prescription Drug Program is separate from the annual Out-of-Pocket Maximum for the Indemnity Medical plan.

Dental DMO

If you are enrolled in the Dental DMO in 2020 and want to continue your DMO coverage into 2021, you need to call Aetna at **1-877-508-6927** in **January** to re-enroll. Your DMO election does not carry over from year to year.

The Avaya Well-Being Program

All Avaya employees have access to a complete wellness platform through Aetna. Check out some additional tools that will get you closer to achieving your health goals. Track your activity, get wellness advice, find healthy recipes, and much more. All of this can be done simply by logging into your Well-Being health site at <https://www.aetna.com> and select Avaya Well-Being Program..

Cutoff Date for Earning Incentives with Avaya's Well-Being Program

The cutoff date for earning incentives is November 30, 2021.

2020 Flexible Spending Account Elections Do Not Rollover to 2021

If you wish to participate in the Health Care Flexible Spending Account (HCFSA) and/or the Dependent Care Flexible Spending Account (DCFSA) in 2021, you must re-enroll during Annual Enrollment. Your 2020 elections do not carry over to 2021.

Flexible Spending Account Balance Carryover

Avaya allows HCFSA participants to carryover up to \$550 of unused funds into the following calendar year. If you have unused HCFSA funds at the end of 2020, the rollover will happen for you automatically. Please factor this in to your 2021 elections to ensure you don't over-contribute in the upcoming year.

Dependent Verification

If you choose to enroll an eligible dependent(s) that is not currently covered under Avaya's health benefits, you will be required to provide proof that they are your eligible dependent(s) per the Plan guidelines. **Dependent coverage will be pended until the appropriate documentation is received by ADP**, our Dependent Verification vendor. Upon completion of your enrollment, you will receive a verification letter from ADP explaining how to verify dependent eligibility. Verification is due by the deadline on your request for verification form.

2021 Mid-Year Changes

Once Annual Enrollment ends, you will not be able to make changes to most benefits unless you have a qualified status change. Information on qualified status changes is available in the Summary Plan Descriptions (SPDs) <https://www.avaya.com/benefitanswers>.

Important Reminders

Prescription Drug Coverage

Drugs are the fastest growing category of health spending. In cases where you select a brand name drug when a generic equivalent is available, you will be required to pay the generic copayment plus the difference in cost between the brand name drug and the generic drug. If you are prescribed a medication, ask your doctor or pharmacist if your condition could be treated effectively with a lower-cost or generic version of the drug.

Remember, the Prescription Drug Program has a mandatory mail order provision. Aside from a limited number of exceptions, after the third fill of a long-term (maintenance) medication, you must begin obtaining your prescription through Express Scripts Pharmacy Mail Order service to avoid paying a penalty.

Beneficiaries

Maintaining beneficiary information is an important part of your financial planning. Annual Enrollment is a good time to review your life and AD&D insurance beneficiaries. You can update life and AD&D insurance beneficiary information online at any time at <https://my.adp.com> by selecting “MANAGE” under the *Manage Information* tile on the home page. If you do not have Internet access, you may contact the Avaya Health & Benefits Decision Center at **1-800-526-8056 (option 1)**, TDD 1-800-952-0450, or via e-mail at avayaservicecenter@adp.com to obtain a beneficiary form.

Summary of Benefits Coverage (SBC)

In compliance with health care reform, Avaya provides a SBC for each medical plan for which you are eligible to help you compare your coverage options. Please note that the SBC is not a full plan description like the Summary Plan Descriptions. SBCs are available at <https://my.adp.com> under the *Forms & Plan Documents* tile on the home page. Paper copies are also available, free of charge, by contacting the Avaya Health & Benefits Decision Center at **1-800-526-8056 (option 1)**, TDD 1-800-952-0450, or via **e-mail at avayaservicecenter@adp.com**.

MetLife Legal Plans

Annual enrollment is the one time of year you can enroll in (if not already enrolled) or *drop* the MetLife Legal benefit. To make changes to your legal services plan coverage, visit <https://my.adp.com>.



Helpful Links & Tools to Take Control of Your Health

Taking Control of Your Health	Tool (click link)	Description
<ul style="list-style-type: none"> • Enroll in or change your benefits • Change a beneficiary • Find information on your medical carrier 	https://my.adp.com	Your one-stop-shop for all of your benefit needs.
Get the best price on health care services without sacrificing quality	<p>www.aetna.com (for Aetna medical members)</p> <p>Login using your existing Navigator credentials or download the Aetna Health app at the App Store® or Google Play™ store</p>	Search for doctors and health care services based on cost, quality and convenience.
Locate Aetna in-network physicians or dentists where you need them	<p>Current Aetna members may log on to their account at www.aetna.com</p> <p>Potential members may log on to www.aetna.com > Find a doctor > Under “Not a member yet?”, select “Plan from an employer” > When asked to Select a Plan, choose <i>Aetna Choice POS II (Open Access)</i></p>	<p>Aetna’s online participating directory allows you to locate physicians and other health care providers such as dentists and hospitals. Try the <i>Aetna Mobile App</i> for quick and convenient access to in-network providers.</p> <p>Participating physicians and dermatologists are also available 24/7 via phone or video chat through Teladoc, Avaya’s telemedicine vendor through Aetna. You may download the Teladoc app on your smartphone or tablet or visit https://www.teladoc.com/Aetna for access.</p>
Express Scripts (ESI) Annual Enrollment website	www.express-scripts.com/avayarep	Annual Enrollment support including formulary lookup, pharmacy lookup and pricing medications.
Locate Kaiser physicians in your region	https://www.kp.org	It’s important to find a doctor who’s right for you. Choose or change doctors at any time, browse online profiles by region, or call Member Services in your area.
Take control of your well-being with Avaya Wellness	https://www.aetna.com	All Avaya employees have access to a complete wellness platform. Check out some additional tools that will get you closer to achieving your health goals. Track your activity, get wellness advice, find healthy recipes, and much more.
Wondering where to get your next EyeMed in-network eye exam?	https://www.eyemedvisioncare.com	Check out EyeMed’s Virtual Benefit Fair to find an eye doctor near you and other plan information: https://eyemedvirtualbenefitfair.com/ Password: XT65KXR1

Helpful Links & Tools to Take Control of Your Health



Taking Control of Your Health	Tool (click link)	Description
What are Flexible Spending Accounts?	Go to the <i>Forms & Plan Documents</i> tile on the home page at https://my.adp.com . Filter on “F” for FSA forms and resources.	An FSA may be used for reimbursement of eligible health care expenses, and child or elder daycare expenses. The amount you decide to contribute to the account for the year is deducted from your salary before income taxes. This reduces your taxable income, saving you money on taxes.
Determine the right amount to contribute to your Flexible Spending Account	https://www.myalex.com/avaya/2021	Now it’s really easy to figure out how much you should contribute to your Health Care and/or Dependent Care Flexible Spending Account with this intuitive online tool. ALEX, our interactive Benefit Advisor (https://www.myalex.com/avaya/2021) can also assist you with this decision! ALEX is best viewed in Google Chrome.
Talk to someone about a personal issue	https://www.MagellanAscend.com	The Employee Assistance Program (EAP) is available 24/7 to help you and your family successfully deal with life’s problems and challenges. The EAP is a prepaid, confidential counseling and referral resource coordinated through Magellan Behavioral Health.
Looking for childcare and eldercare resources?	https://www.MagellanAscend.com	The Family Resource Program provides services to busy parents who are looking for help on issues such as adoption, senior care, and education resources. Additionally, the Family Resource Program offers free tutoring through its Homework Connection program.
Avaya Discount Marketplace	https://avaya.savings.beneplace.com/home	Avaya Discount Marketplace brings you some of the hottest deals of the year.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the following pages, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or call **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

Legal Reminders

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
CALIFORNIA – Medicaid	COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
IOWA - Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884
KENTUCKY – Medicaid and KI-HIPP	NEW HAMPSHIRE – Medicaid
Kentucky Medicaid Website: https://chfs.ky.gov Phone: 1-800-635-2570 Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 1-603-271-5218 Toll-Free: 1-800-852-3345, ext 5218

Legal Reminders

LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
MAINE – Medicaid	NEW YORK – Medicaid
<p>Website: https://www.maine.gov/dhhs/ofa/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofa/applications-forms Phone: -800-977-6740. TTY: Maine relay 711</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
<p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840</p>	<p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>
MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>
MISSOURI – Medicaid	OKLAHOMA – Medicaid and CHIP
<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>
MONTANA – Medicaid	OREGON – Medicaid and CHIP
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>	<p>Website: http://healthcare.oregon.gov/Pages/index.aspx Website: http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>
NEBRASKA – Medicaid	PENNSYLVANIA – Medicaid
<p>Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633; Lincoln: (402) 473-7000; Omaha: (402) 595-1178</p>	<p>Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462</p>
NEVADA – Medicaid	RHODE ISLAND – Medicaid
<p>Website: http://dhcfnv.gov Phone: 1-800-992-0900</p>	<p>Website: http://www.eohhs.ri.gov/ 1-855-697-4347, or 401-462-0311 (Direct RI Share Line)</p>
SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
<p>Medicaid Website: https://www.scdhhs.gov Medicaid Phone: 1-888-549-0820</p>	<p>Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282</p>

Legal Reminders

SOUTH DAKOTA - Medicaid	WASHINGTON - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS - Medicaid	WEST VIRGINIA - Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH - Medicaid and CHIP	WISCONSIN - Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT - Medicaid	WYOMING - Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020 or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Notice of Availability: The Avaya Inc. Medical Expense Plan, a component of the Avaya Inc. Health & Welfare Benefits Plan, Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOU MAY OBTAIN A COPY OF THE PLAN'S NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES THE WAYS THAT THE PLAN USES AND DISCLOSES YOUR PROTECTED HEALTH INFORMATION.

The Avaya Inc. Medical Expense Plan, a component of the Avaya Inc. Health & Welfare Benefits Plan, (the "Plan") provides health benefits to eligible employees of Avaya Inc. (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices you should contact Avaya's Health Plan Administrator, who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights. You can reach this contact person at: 350 Mount Kemble Avenue, Morristown, NJ 07960, or via e-mail at hwplanadmin@avaya.com.

Notice Regarding Well-Being Program

Avaya Well-Being program is a voluntary well-being program available to all employees. The program is administered according to federal rules permitting employer-sponsored well-being programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the well-being program you may be asked to complete a voluntary Health Quality Assessment or "HQA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a voluntary biometric screening, which will include a blood test for

Glucose, HDL Cholesterol, Total Cholesterol, LDL Cholesterol, and Triglycerides. **You are not required to complete the HQA or to participate in the blood test or other medical examinations.**

Employees who choose to participate in the well-being program will receive incentives in the form of gift cards up to a maximum of \$100, subject to applicable taxes, for completing the various activities listed on the Avaya Well-Being Program page of www.aetna.com.

If you are unable to participate in any of the voluntary health related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting your plan administrator at hwplanadmin@avaya.com.

The information from your HQA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the well-being program, such as health coaching, physical activity opportunities, and healthy-habit tracking tools. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the well-being program and Avaya may use aggregate information it collects to design a program based on identified health risks in the workplace, Aetna will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the well-being program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the well-being program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the well-being program

or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the well-being program will abide by the same confidentiality requirements.

The only individuals who will receive your personally identifiable health information are the account management team at Aetna and a Aetna Customer Care Management Unit representatives in order to provide you with services under the well-being program.

In addition, all medical information obtained through the well-being program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the well-being program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Aetna Customer Care Management Unit representatives program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the well-being program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your plan administrator at hwplanadmin@avaya.com

HIPAA Special Enrollment Rights for Medical Plan Coverage

Loss of Eligibility for Other Health Coverage

If you are declining medical plan enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the medical plans under the Avaya Inc. Health & Welfare Benefits Plan, the Avaya Inc. Health & Welfare Benefits Plan for Salaried Employees, the Avaya Inc. Health and Welfare Benefits Plan for Retirees, the Avaya Inc. Health and Welfare Benefits Plan for Salaried Retirees, or any other group health plan(s) that are applicable to your health status and may be maintained by Avaya from time to time (collectively and/or individually, as applicable, the “Plan” or “Health Plan”), or switch health benefit options under the applicable plan, if you or your dependents lose eligibility for that other coverage (or if the employer stops

contributing toward your or your dependents’ other non-COBRA coverage). However, you must request enrollment within 31 days after the date your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage) by contacting the Avaya Health & Benefits Decision Center at **1-800-526-8056 (option 1)**. Loss of eligibility for coverage includes:

- Loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee or partner, termination of employment, reduction in the number of work hours of employment
- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual, and
- In the case of an individual who has COBRA continuation coverage, at the time the COBRA continuation coverage is exhausted.

However, loss of eligibility for other coverage **does not include** a loss of coverage due to:

- The failure of the employee or dependent to pay premiums on a timely basis
- Voluntary disenrollment from a plan, or
- Termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

When coverage begins. If you enroll yourself, your spouse/domestic partner and/or your eligible dependent child(ren) in a group health plan due to a loss of eligibility for coverage event described above, coverage under this plan will begin the date the election is made.

Gaining a New Dependent

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in a medical plan offered by Avaya. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you are not enrolled in the Avaya Inc. Health & Welfare Benefits Plan, the Avaya Inc. Health & Welfare Benefits Plan for Salaried Employees, the Avaya Inc. Health and Welfare Benefits Plan for Retirees, the Avaya Inc. Health and Welfare Benefits Plan for Salaried Retirees, or any other group health plan(s) that are applicable to your health status and may be maintained by Avaya from time to time (collectively and/or individually, as applicable, the “Plan” or “Health Plan”), as an employee, you also must enroll in the plan when you enroll any of these dependents by contacting the Avaya Health & Benefits Decision Center at **1-800-526-8056 (option 1)**. And, if your spouse is not enrolled in the health plan, you may enroll him or her and any other eligible dependents in the plan when you enroll a child due to birth, adoption or placement for adoption.

When coverage begins. In the case of marriage, coverage will begin on the day the election is made in the enrollment system as long as you notify the Company within 31 days of the event. In the case of birth, adoption or placement for adoption, coverage is retroactive to the date of birth, adoption or placement for adoption.

Childrens’ Health Insurance Program Reauthorization Act (CHIPRA)

On April 1, 2009, The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) added two new HIPAA special enrollment rights that will apply to Avaya’s medical and dental plans. If you or your dependent(s) are eligible, but not enrolled in medical or dental coverage, you will be entitled to a special enrollment period if:

- You or your dependent decline enrollment because your dependent is covered under a Medicaid or State child health plan and your dependent’s eligibility for the Medicaid or the State child health plan ends, or
- Your dependent becomes eligible for state premium assistance from a Medicaid or State child health plan with respect to cover under this Plan.

You must request enrollment in the medical and dental plans within 60 days after the date your dependent(s) loses coverage under a Medicaid or a State child health plan or the date your dependent becomes eligible for assistance under Medicaid or a State child health plan where premiums are charged by the plans by contacting the Avaya Health & Benefits Decision Center at **1-800-526-8056 (option 1)**.

When coverage begins. If you enroll yourself and/or your eligible

dependent child(ren) in a group health plan due to a loss of eligibility for coverage event described above, coverage under this plan will begin the date the election is made.

Patient Protection

The Represented POS, Traditional Indemnity, Kaiser HMO, and HMSA PPP medical plans under The Avaya Inc. Medical Expense Plan (a component of the Avaya Inc. Health & Welfare Benefits Plan) generally require designation of a primary care provider. You have the right to designate any primary care provider who participates in your provider’s network and who is available to accept you or your family members. For children, you may designate a pediatrician as your primary care provider. You do not need prior authorization from Aetna, Kaiser, HMSA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on how to select a primary care provider, and for a list of the participating primary care providers, including a list of participating health care professionals who specialize in obstetrics or gynecology, please contact your provider by referencing the ***Important Contacts*** resource in this Guide.

Rights under the Newborns’ and Mothers’ Health Protection Act of 1996

The “Newborns’ and Mothers’ Health Protection Act of 1996” was signed into law on September 26, 1996. The Act affects the amount of time the mother and newborn child are covered for a hospital stay following childbirth. In general, group health plans and health insurance issuers that are subject to the Act may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Care beyond this point must be pre-certified, but prior to the expiration of the 48 hour (or 96 hour) period, the plan may not require pre-certification of any length of stay. Mother or newborn child may leave earlier if the attending physician, in consultation with the mother, decides to discharge the patients earlier.

Under the Act, the time limits affecting the stay begin at the time of delivery, if the delivery occurs in a hospital. If the delivery occurs outside the hospital, the stay begins when the mother or newborn is admitted in connection with the childbirth.

This coverage may be subject to annual deductibles and coinsurance provisions applicable to other such hospital benefits provided under the Avaya Inc. Medical Expense Plan (a component of the Avaya Inc. Health & Welfare Benefits Plan). Please refer to the Summary Plan Descriptions (www.Avaya.com/BenefitAnswers) for deductibles and coinsurance information applicable to the options in which you choose to enroll or, if you are enrolled in an HMO, call your carrier.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under The Women's Health and Cancer Rights Act ("WHCRA") of 1998. If you (or a covered dependent) are receiving mastectomy-related services, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Company Medical Plan.

If this Creditable Coverage notice has been delivered to you by electronic means, you have the right to receive a written notice and may request a copy of this notice on a written paper document at no charge by contacting the person listed below. Also, if you are the employee participant under Avaya Inc.'s group health plan, you are responsible for providing a copy of this notice to each of your Medicare Part D eligible dependents covered under the plan.

Notice of Creditable Coverage - Prescription Drug Coverage and Medicare About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Avaya Inc. (Avaya) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Avaya has determined that the prescription drug coverage offered by the Avaya Medical Plans* for employees and retirees is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan. A copy of the notice is available at <https://my.adp.com> under the *Forms & Plan Documents* tile on the home page > *Disclosure - Creditable Coverage Certificate*.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Avaya coverage will be affected. Details on the level of benefits can be found in the Summary Plan Descriptions for the Avaya Medical Plans* which are available online at www.avaya.com/benefitanswers.

If you do decide to join a Medicare drug plan and drop your current Avaya coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Avaya and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Call the Avaya Health & Benefits Decision Center at **1-800-526-8056 (option 1)** for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Avaya changes. You also may request a copy of this notice at any time.

Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2020

Name of Entity/Sender: Avaya Inc.

Contact: Avaya HR Benefits

Address: 350 Mount Kemble Avenue, Morristown, NJ 07960

Phone Number: 1-800-526-8056 (option 1)

*The "Avaya Medical Plans" are comprised of the Avaya Inc. Medical Expense Plan (a component of the Avaya Inc. Health & Welfare Benefits Plan), the Avaya Inc. Retiree Medical Expense Plan (a component of the Avaya Inc. Health and Welfare Benefits Plan for Retirees), and the Avaya Inc. Medical Expense Plan for Salaried Employees (a component of the Avaya Inc. Health & Welfare Benefits Plan for Salaried Employees).

General Notice of COBRA Continuation Coverage Rights

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage in most cases.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: WageWorks at 1-800-526-2720.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. You must contact WageWorks at 1-800-526-2720 within 60 days of the determination of your disability by the Social Security Administration and within the initial 18-month continuation coverage period. This notice should be in writing and should include a copy of the Social Security Administration's disability determination. If WageWorks determines that you or your Covered Dependents are not eligible for an extension of the COBRA continuation period, you will be provided a written explanation of why extended COBRA continuation coverage is not available.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period^[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Avaya Inc.
Health and Welfare Plan Administrator
350 Mount Kemble Avenue
Morristown, NJ 07960
Phone: 1-908-953-2385

The Plan Administrator is responsible for administering COBRA continuation coverage.

Important Contacts

Print this contact list and post it at your work or home

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If your BENEFIT question relates to...	and this Provider...	call this number...	or log on to this website...
Enrollment or Mid-Year Status Changes	Avaya Health & Benefits Decision Center	1-800-526-8056, option 1 M-F, 8 AM - 8 PM ET, SAT 8 AM - 5 PM ET email: avayaservicecenter@adp.com	https://my.adp.com
Medical & Pharmacy	Aetna	1-877-508-6927 M-F, 8 AM - 6 PM ET	https://www.aetna.com
	Express Scripts Pharmacy Manager (for Aetna medical members)	1-877-505-3213 24 hours/day, 7 days/week	https://www.express-scripts.com/consumer/site/login
	Aetna Health (medical cost transparency tool)	1-877-508-6927 M-F, 8 AM - 6 PM ET	https://www.aetna.com
	Kaiser	<p>California 1-800-464-4000 24 hours/day, 7 days/week</p> <p>Colorado 1-303-338-3800 M-F, 8 AM - 6 PM</p> <p>Georgia 1-888-865-5813 M-F, 7 AM - 7 PM</p> <p>Pacific Northwest <u>Portland</u> 1-503-813-2000 M-F, 8 AM - 6 PM <u>Outside of Portland</u> 1-800-813-2000 M-F, 8 AM - 6 PM</p> <p>Maryland <u>D.C. Metro Area</u> 1-301-468-6000 M-F, 7:30 AM - 5:30 PM <u>Outside D.C. Metro Area</u> 1-800-777-7902 M-F, 7:30 AM - 5:30 PM</p>	https://www.kp.org
HMSA	<p>Oahu 1-808-948-6079 M-F 8 AM - 5 PM HST</p> <p>Neighbor Islands 1-800-776-4672 M-F 8 AM - 5 PM HST</p>	https://hmsa.com/	

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Dental	Aetna PPO and DMO	1-877-508-6927 M-F, 8 AM - 6 PM ET	https://www.aetna.com
Vision	EyeMed	1-866-723-0513 M-Sa, 7:30 AM - 11 PM ET SU, 11 AM - 8 PM ET	https://www.eyemedvisioncare.com/member
Employee Assistance Program (EAP) and Family Resources	Magellan	1-877-804-9753 24 hours/day, 7 days/week	https://www.magellanascend.com (register or enter as a guest and then enter 877-804-9753 as Avaya's toll free number)
Well-Being Program	Aetna	1-877-508-6927 M-F, 8 AM to 6 PM ET	https://www.aetna.com
Life and AD&D Insurance	MetLife	<u>Basic Life & AD&D Coverage</u> 1-888-466-8659 <u>Supplementary Life Coverage</u> 1-800-523-2894 M-F, 9 AM - 5 PM ET	
Voluntary Benefits – Critical Illness, Accident and Hospital Indemnity	MetLife	1-800-GETMET-8 (1-800-438-6388)M-F, 8 AM - 10:30 PM ET Sa-Su 8 AM - 8 PM	https://www.metlife.com/avaya
Flexible Spending Accounts (FSA)	WageWorks	1-800-678-6684 1-866-643-2219 (fax) M-F, 6 AM - 6 PM MT	https://myspendingaccount.wageworks.com/
COBRA Continuation Coverage	WageWorks	1-800-526-2720 -or- 1-800-526-8056, option 1 M-F, 8 AM- 8 PM ET	https://benedirect.wageworks.com
Pension	Pension Service Center	1-844-868-6236 M-F, 9 AM - 6 PM ET	www.upointhr.com/avaya
401(k)	Fidelity	1-877-208-0783 M-F, 8:30 AM - 12 AM ET (excluding NYSE holidays)	www.401k.com
Long Term Care Insurance	Genworth	1-800-416-3624 M-F, 8 AM - 8 PM ET SU 12 PM - 9 PM ET	www.genworth.com/groupltc (Enter Group ID: avaya ; Code: groupltc)
	MetLife	1-800-438-6388 M-F, 8 AM - 11 PM ET	
	Prudential	1-800-732-0416 M-F, 8 AM - 8 PM ET e-mail: ltc4me@prudential.com	

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International Travel Assistance (Medical & Security)	International SOS	1-215-942-8226 24 hours/day, 7 days/week	www.internationalsos.com Membership Number: 11BCMA000028
FMLA, Disability, Avaya Leaves of Absence	Sedgwick	1-855-282-9211 M-F, 8 AM - 9:30 PM ET	
Group Legal	MetLife Legal Plans	1-800-821-6400 M-F, 8 AM - 8 PM ET	http://www.info.legalplans.com Access Code: 9903852 (Base Plan) Access Code: 9903853 (Base + Parents Plus)

This Guide is the Summary of Material Modifications for The Avaya Inc. Medical Expense Plan, The Avaya Inc. Dental Expense Plan, The Avaya Inc. Vision Care Plan, The Avaya Inc. Flexible Spending Account Plans, The Avaya Inc. Business Travel Accident Insurance Plan for salaried and represented employees, and The Avaya Inc. Group Legal Services Plan. This Summary of Material Modifications supplements the Summary Plan Descriptions posted on www.Avaya.com/BenefitAnswers. You should retain this document with the Summary.