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 below, 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 dial **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 July 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**GEORGIA – Medicaid**
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	GA HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment- program-hipp** Phone: 678-564-1162, Press 1 GA CHIRPA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra** Phone: 678-564-1162, Press 2
ALASKA – Medicaid	**INDIANA – Medicaid**
The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**	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
ARKANSAS – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)	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 HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp** HIPP Phone: 1-888-346-9562
CALIFORNIA – Medicaid	**KANSAS – Medicaid**
Health Insurance Premium Payment (HIPP) Program Website: **http://dhcs.ca.gov/hipp** Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	Website: **https://www.kancare.ks.gov/** Phone: 1-800-967-4660
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**KENTUCKY – Medicaid**
Health First Colorado Website: **https://www.healthfirstcolorado.com/** Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: **https://hcpf.colorado.gov/child-health-plan-plus** CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): **https://www.mycohibi.com/** HIBI Customer Service: 1-855-692-6442	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: KIHIPP.PROGRAM@ky.gov KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx** Phone: 1-877-524-4718 Kentucky Medicaid Website: **https://chfs.ky.gov/agencies/dms**
FLORIDA – Medicaid	**LOUISIANA – Medicaid**
Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** Phone: 1-877-357-3268	Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp** Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Legal Reminders

MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: **https://www.mymaineconnection.gov/benefits/s/?language=en_US** Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: **https://www.mass.gov/masshealth/pa** Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
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	Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005	Website: **https://www.hhs.nd.gov/healthcare** Phone: 1-844-854-4825
MONTANA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742
NEBRASKA – Medicaid	**OREGON – Medicaid**
Website: **http://www.ACCESSNebraska.ne.gov** Phone: (855) 632-7633; Lincoln: (402) 473-7000; Omaha: (402) 595-1178	Website: **http://healthcare.oregon.gov/Pages/index.aspx** Phone: 1-800-699-9075
NEVADA – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: **http://dhcfp.nv.gov** Phone: 1-800-992-0900	Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx** Phone: 1-800-692-7462 CHIP Website: **https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx** **CHIP Phone: 1-800-986-KIDS (5437)**
NEW HAMPSHIRE – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program** Phone: 1-603-271-5218 Toll-Free for HIPP program: 1-800-852-3345, ext 5218	Website: **http://www.eohhs.ri.gov/** 1-855-697-4347, or 401-462-0311 (Direct RI Share Line)
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Medicaid Website: **https://www.scdhhs.gov** Medicaid Phone: 1-888-549-0820	Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select** **https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs** Medicaid and CHIP Phone: 1-800-432-5924

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 and CHIP**
Website: **https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program** Phone: 1-800-440-0493	Website: **https://dhhr.wv.gov/bms/** Website: **http://mywvhipp.com/** Medicaid Phone: 304-558-1700 CHIP 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: **https://dvha.vermont.gov/members/medicaid/hipp-program** 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, 2024 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 20250 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

Legal Reminders

Notice of Availability: The Avaya LLC Medical Expense Plan, a component of the Avaya LLC 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 LLC Medical Expense Plan, a component of the Avaya LLC Health & Welfare Benefits Plan, (the "Plan") provides health benefits to eligible employees of Avaya LLC (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 Assessment 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 Health Assessment 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 Health Assessment 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 LLC Health & Welfare Benefits Plan, the Avaya LLC Health & Welfare Benefits Plan for Salaried Employees, the Avaya LLC Health and Welfare Benefits Plan for Retirees, the Avaya LLC 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**. 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 LLC Health & Welfare Benefits Plan, the Avaya LLC Health & Welfare Benefits Plan for Salaried Employees, the Avaya LLC Health and Welfare Benefits Plan for Retirees, the Avaya LLC 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**. 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.**

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 LLC Medical Expense Plan (a component of the Avaya LLC 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 LLC Medical Expense Plan (a component of the Avaya LLC 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 LLC'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 LLC (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.

Legal Reminders

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** 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, 2024

Name of Entity/Sender: Avaya LLC
Contact: Avaya HR Benefits
Address: 350 Mount Kemble Avenue, Morristown, NJ 07960
Phone Number: 1-800-526-8056

*The "Avaya Medical Plans" are comprised of the Avaya LLC Medical Expense Plan (a component of the Avaya LLC Health & Welfare Benefits Plan), and the Avaya LLC Medical Expense Plan for Salaried Employees (a component of the Avaya LLC 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: HealthEquity 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 HealthEquity 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 HealthEquity 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, Medicare, 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 LLC
Health and Welfare Plan Administrator
350 Mount Kemble Avenue
Morristown, NJ 07960
Phone: 1-908-953-2385
E-mail: **hwplanadmin@avaya.com**

The Plan Administrator is responsible for administering COBRA continuation coverage.