

TERMS YOU SHOULD KNOW

There are several words and phrases that have a specific meaning under the Vision Care Plan. This section explains those terms so you can better understand your benefits. These terms are printed in **boldface** when they appear to let you know they are defined here.

24-month rule: the Vision Care Plan covers each eligible service or supply only once in a 24-month period. Depending on the type of service or supply, the 24 months begin on the earlier of:

- The date of your vision exam, or
- The date you order prescription lenses, eyeglass frames or contact lenses.

Annual enrollment: the period of time each year designated by the Company in which you can generally make changes in your benefits for reasons other than a **qualified status change**. Elections made during annual enrollment are effective on the first day of the following calendar year.

Avaya Health and Benefits Decision Center: the resource to call to make changes in your coverage or ask questions about the Vision Care Plan. See "Important Contacts."

Children: include your biological children and/or legally adopted children (including those who are in the formal legal adoption process), stepchildren living with you and children living with you for whom you, your **lawful spouse** or your **domestic partner** is the legal guardian (excluding "wards of the state" or "foster children").

Claims Administrator: the company authorized by Avaya Inc. to administer the Vision Care Plan.

Class I dependents: include your **lawful spouse** and each unmarried child through December 31st of the year in which the child reaches age 23.

To be eligible, a child must be:

- Your biological child and/or your legally adopted child, including any child in the formal legal process of adoption, regardless of residence,
- A stepchild living with you, or
- A child living with you for whom you or your **lawful spouse** is the legal guardian. This does not include "wards of the state" or "foster children."

Class I dependents also include each unmarried child of any age who is determined to be eligible by the applicable medical Claims Administrator by meeting all of the following criteria:

- Incapable of self support,
- Physically or mentally handicapped, and
- Fully dependent on you for support.

To be covered as Class I dependents, **children** beyond the age of 23 years must be certified for coverage by the applicable medical Claims Administrator under The Avaya Inc. Medical Expense Plan. You must complete an application form available from your applicable medical Claims Administrator, and submit it for approval to the address listed on the form.

No coverage is available for a child over age 23 who is incapacitated for a short time due to illness or accident (e.g., a broken leg).

COBRA: an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. This refers to federal legislation that governs the offer of temporary continued vision coverage to participants who otherwise would lose coverage due to certain reasons, such as a loss of employment.

Covered: eligible under the terms of the Vision Care Plan. “Covered” is often used to modify other terms. A covered expense is a vision cost that satisfies all of the rules to be considered for payment under the Vision Care Plan. A covered person is one who is enrolled and eligible for benefits under the Vision Care Plan.

Covered dependent: a **Class I dependent, domestic partner** or **domestic partnership dependent** who is **covered** as the dependent of an employee.

Domestic Partner: an individual (same-gender or opposite-gender) is your domestic partner if you both complete and file with the **Avaya Health and Benefits Decision Center** a notarized Domestic Partner Affidavit in which you both attest that you met all of the following requirements:

- Reside in the same household,
- Are age 18 or older,
- Have mental sufficiency to enter into a valid contract,
- Are not related to each other by blood,
- Are not legally married to any other person,

- Have a close and committed personal relationship with each other; intend to continue such relationship indefinitely; and have no such relationship with anyone else, and
- Have joint responsibility for each other's welfare and financial obligations.

In addition to the aforementioned requirements, the following criteria must be satisfied if applicable:

- Have complied with any state or local registration process for domestic partners; are the same-gender, reside in a state that recognizes same-gender marriages and are legally married under the laws of that state; or reside in a state that recognizes same-sex civil unions and have legally entered into such a civil union.

Domestic partnership dependent: is the natural or adopted child of a **domestic partner**, a child whom the **domestic partner** is in the formal, legal process of adopting, or a child living with you for whom the **domestic partner** is the legal guardian.

Eligible dependents: your eligible **Class I dependents**, eligible **domestic partner** and eligible **domestic partnership dependents**.

Eligible employee: a regular, active, full-time or part-time, represented employee with at least six months of **net credited service** who works for a **Participating Company**.

Individuals who are not paid from the U.S. payroll of a **Participating Company**, who are employed by an independent company (such as an employment agency), or whose services are rendered pursuant to an agreement excluding participation in benefit plans are not eligible to participate in the Vision Care Plan.

Explanation of Benefits (EOB): a benefit statement sent to you by the Claims Administrator (see "Important Contacts") that provides detailed payment information for each service or supply you receive under the Vision Care Plan.

FMLA: the Family and Medical Leave Act of 1993, as amended.

Lawful spouse: a person who is recognized as the lawful husband or lawful wife for federal income tax purposes. An **eligible employee** residing in a state that recognizes common law marriage must satisfy the specific minimum state requirements to be married under common law.

Net credited service: your current continuous service plus all service credited under the service bridging rules (including mandatory portability, if applicable) of The Avaya Inc. Pension Plan and The Avaya Inc. Pension Plan for Salaried Employees.

Participating Company: Avaya and such other companies that have elected to participate in the Vision Care Plan, with the prior approval of Avaya.

Qualified Medical Child Support Order (QMCSO): a judgment, decree, or order issued by a court or a certain administrative process that requires medical plan coverage for a participant’s child and that has been determined to be qualified under the Internal Revenue Code of 1986, as amended. Avaya Inc. has a policy to comply with the requirements of a QMCSO.

Qualified status change: as permitted under federal regulations, qualified changes in status include the following:

Qualified Status Change	Description
Marital Status	A change in your legal marital status, including marriage, death of your spouse, divorce, legal separation or annulment.
Number of Family Members	Events that change the number of eligible family members, including birth, adoption, placement for adoption or death.
Employment Status	A termination or commencement of employment by you, your spouse or child.
Work Schedule	A reduction or increase in hours of employment by you, your spouse or a child, including a switch between part-time and full-time, or the start of or return from an unpaid leave of absence.
Family Member Meets or No Longer Meets the Eligibility Requirements	An event that causes a member of your family to meet or no longer meet the Plan’s eligibility requirements for coverage. This may include a child reaching the maximum age for coverage.

Avaya Inc. also considers corresponding changes in **domestic partner** or **domestic partnership dependents** as a qualified status change.

The Internal Revenue Service states that you may change coverage during the year if you have a qualified change in status. Qualified status changes must be reported to the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) within 31 days of the event.

Reasonable and customary: the fee determined by the **Claims Administrator** on the basis of:

- The fees usually charged most patients for a similar service, and
- The range of fees charged by providers with similar training and experience for the same or similar services within the locality.