TERMS YOU SHOULD KNOW

There are several words and phrases that have a specific meaning under the Medical 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.

Acupuncturist: a **provider** carrying all recognized certifications applying to the practice of acupuncture who is licensed to practice acupuncture according to applicable state laws.

Aetna: the **health care company** that administers the Standard and Enhanced **POS** options, **Enhanced Indemnity option**, the **Prescription Drug Program** and the **Mental Health and Chemical Dependency Program.**

Aetna Global Benefits: the company that administers the Medical Plan option for International Assignees, the International **Indemnity option**. Please refer to the detailed benefit information provided by Aetna Global Benefits for more information.

Allowable amount: the portion of a **provider's** charge that is eligible for reimbursement either in full or in part. Any amount by which the **provider's** charge exceeds the allowable amount is not reimbursable under the Medical Plan.

In-network under the **HMO**, Standard or Enhanced **POS**, **Prescription Drug Program,** or **Mental Health and Chemical Dependency Program** and Enhanced **Indemnity option** (**National Advantage Program network providers**), a **network provider's** charge always equals the allowable amount so that no charges above the allowable amount are payable by the participant.

When **non-network providers** are used under the Enhanced **Indemnity option**, **Prescription Drug Program, Mental Health and Chemical Dependency Program**, or the Medical Plan's **out-of-network** Standard or Enhanced **POS** option provisions, the allowable amount for **medically necessary** services is based on **reasonable and customary charges**. Claims are paid based on the schedule in effect on the date on which a service was provided or based on the schedule in effect on the date the claim payment is made, in accordance with the practice of the **health care company** responsible for paying the claim. The **health care company** uses the same industry-accepted pricing schedule to ensure that **out-of-network** reimbursement is consistent with what nine out of ten **providers** in a given geographic area would charge.

The participant is responsible for the portion of the expense that is above the **reasonable and customary charge**. Amounts in excess of the **reasonable and customary charge** do *not* apply toward the annual **deductible** or the **out-of-pocket maximum** as described in the Medical Plan. Any references in the Enhanced **Indemnity option**, Standard or Enhanced **POS** option **out-of-network** or out-of-area

provisions of the Medical Plan to the amount or percentage of the amount that the Medical Plan covers or pays, refers to the **reasonable and customary charge**.

Under the **Mental Health and Chemical Dependency Program network** benefits, the allowable amount for services from Master's degree level counselors will be 75% of what nine out of ten **providers** in a given area would charge.

Alternative care or alternative treatment: a type of care only available **in-network** under the **Mental Health and Chemical Dependency Program**, which is more intensive than **out-patient** treatment, and less intensive than hospitalization. Alternative treatment includes the following types of care: **partial hospitalization**, **residential treatment** and care from a **halfway house** or **group home**.

Ambulance: a vehicle licensed according to state laws, operated for the exclusive purpose of transporting patients with acute medical conditions and equipped to provide paramedic and stabilizing medical services.

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.

Assigned option: the medical option to which you will be automatically assigned if you are eligible and do not enroll in one of the available options. Part-time employees do not have an assigned option and *must* enroll to be **covered** by the Medical Plan.

Avaya Health and Benefits Decision Center: the resource to contact to enroll, make changes in your coverage or ask questions about the Medical Plan options. See "Important Contacts."

Behavioral Health Care Coordinator: Aetna, the resource to call to coordinate the medical care for the treatment of alcoholism, drug abuse and a mental disorder.

Birthing center: a facility for prenatal, delivery and postpartum care that is (a) staffed by certified nurse-midwives; (b) has access to consultation by an obstetrician/gynecologist with admitting privileges at a nearby **hospital**; (c) is accredited by the National Association of Child Bearing Centers or the Joint Commission on the Accreditation of Healthcare Organizations; and (d) is licensed by the state.

Brand name drug: one that has been patented and is produced by only one manufacturer.

Brief counseling: a problem-focused form of individual or family outpatient counseling that (a) seeks resolution of problems in living (e.g., parenting concerns, emotional stress, marital and family distress, alcohol- and drug-related problems) rather than basic character change; (b) emphasizes counselee skills, strengths and resources;

(c) involves setting and maintaining realistic goals that are achievable in a one to five month period; (d) encourages counselees to practice behavior outside the counseling session to promote therapeutic goals; and (e) in which the counselor provides structure, interprets behavior, offers suggestions, and assigns "homework" activities.

Center of excellence: a facility that is designated by the **health care company** as a preferable facility to handle selected services of a highly specialized nature, such as organ transplants.

Chemical dependency: both alcoholism and drug dependency, as classified by the International Classification of Diseases of the U.S. Department of Health and Human Services.

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.") See **Class I dependents**, **Class II dependents** and **domestic partnership dependents**.

Chiropractor: a Doctor of Chiropractic (D.C.) who is licensed to provide services in the state in which the service is rendered.

Choice POS II: the **network** of **Aetna providers** used to receive **in-network** benefits under the Standard or Enhanced **POS** option.

Claims Administrator: the **health care company** authorized by Avaya Inc. to administer the Medical 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** through meeting all of the following:

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

To be **covered** as Class I dependents, **children** beyond age 23 must be certified for coverage by the **Claims Administrator**. You must complete an application form available from the 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).

Class II dependents: include the following relatives who meet the eligibility requirements shown below:

- Your unmarried dependent **children** not included as **Class I dependents**,
- Your unmarried dependent stepchildren, not included as **Class I dependents**,
- Your unmarried grandchildren, your unmarried brothers and sisters, and your parents and grandparents, and
- Your **lawful spouse's** parents and grandparents.

To be eligible for coverage as Class II Dependents under the Medical Plan, those relatives must continue to meet the following requirements:

- They receive less than $12,000 per year in income from all sources, other than your (the Avaya Inc. employee's) support,
- They live with you or in a nearby household provided by you, and in the case of unmarried dependent stepchildren, live with you throughout the period of coverage, and
- They either:
  - Have been continuously re-enrolled as a Class II dependent during each **annual enrollment** since January 1, 1996 (through a predecessor plan) and continue to be re-enrolled each year (non-grandfathered Class II dependents), or

- Have been enrolled before June 1, 1986 as a Class II dependent through a predecessor plan and continuously enrolled each plan year thereafter (grandfathered Class II dependents).

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 medical coverage to participants who otherwise would lose coverage due to certain reasons, such as a loss of employment.

Coinsurance: the cost-sharing method by which the Medical Plan pays a percentage of the **provider's covered** charge (for example, 80%) and you pay the remaining percentage (for example, 20%). Your coinsurance is your share of the cost.

Coordination of benefits (COB): a feature of the Medical Plan designed to prevent duplicate benefit payments when you or your **eligible dependents** participate in more than one group plan.

Copayment: a flat dollar amount that you pay for a certain medical service (such as an office visit or supply) as your share of the cost.

Covered: eligible under the terms of the Medical Plan. "Covered" is often used to modify other terms. A covered expense is a medical cost that satisfies all of the rules to be considered for payment under the Medical Plan. A covered person is one who is enrolled and eligible for benefits under the Medical Plan. A covered **provider** is one who is (or which is) eligible to provide services and receive payment under the Medical Plan.

Covered dependent: a **Class I dependent, domestic partner** or **domestic partnership dependent** who is **covered** as the dependent of an **eligible employee**. Other people such as siblings, parents, and grandparents may be **covered** as **Class II dependents** if they are currently enrolled and if they continue to meet the eligibility criteria.

Custodial care: treatment or services generally prescribed by a medical professional that could be rendered safely and reasonably by a person not medically skilled. Custodial care is treatment or services that do not directly treat illness or injury but that are designed mainly to help the patient with daily living activities or are provided primarily for the convenience or comfort of the patient. These activities include but are not limited to:

- Personal care such as help in walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; and dressing

- Homemaking, such as preparing meals or special diets

- Moving the patient

- Acting as a companion or sitter
- Supervising medication that can usually be self administered
- Treatment or services that any person may be able to perform with minimal instruction, including, but not limited to, recording temperature, pulse and respiration, or administration and monitoring of feeding systems.

Custodial care is a type of care provided to a patient whose need for medical care has stabilized and whose current medical condition is not expected to significantly and objectively improve.

Deductible: the amount of eligible expenses you may be required to pay under the Medical Plan each year before benefits for **covered** expenses can begin. Whether a deductible applies, and the amount of the deductible depends upon the Medical Plan option you choose, the type of service or supply you receive, and whether care is received **in-network** or **out-of-network**. There is usually no deductible under the **HMO** option. Some expenses do not count toward the deductible. (See “Expenses You Pay That Do Not Count Toward the Deductible.”)

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 additional 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. The child must otherwise meet the definition of an eligible child as a **Class I dependent.**

Please note that states regulate the **HMOs**, and that some states do not offer **domestic partner** coverage or have special requirements about the time you must have been with your **domestic partner**, coverage of your **domestic partner's children**, and **COBRA** continuation coverage. If you are considering **domestic partner** coverage under an **HMO**, you must check with the **HMO** for any such requirements.

Effective date: the date upon which coverage under the Medical Plan starts or takes effect.

Elective care: care that can be postponed for 10 days or more without undue risk to the patient.

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

Eligible employee: a regular, active, full-time or part-time, salaried employee who works for a **Participating Company**. Temporary employees or student interns are not considered regular employees.

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 Medical Plan. International Assignees who are paid from the U.S. payroll of a **Participating Company** will be eligible for coverage through **Aetna Global Benefits**, and are subject to modified plan benefits.

Emergency: a life-threatening medical condition suddenly and unexpectedly manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could result in: (a) permanently placing the patient's health in jeopardy; (b) causing serious and/or permanent impairment of a bodily part or function; (c) causing serious and/or permanent dysfunction of any body organ or part; and (d) causing severe pain. See "Emergency Care" in the **Mental Health and Chemical Dependency Program** for the definition of emergency as it applies to a mental health condition rather than a physical condition.

The following examples are generally emergencies:

- Apparent poisoning
- Convulsions
- Excessive uncontrolled bleeding
- Severe chest pain
- Severe or multiple injuries, including fractures
- Shortness of breath or difficulty breathing
- Sudden loss of consciousness

The following examples are generally *not* considered to be emergencies:

- Childbirth, unless an unexpected complication such as premature birth occurs
- Colds, sore throat, cough
- Diarrhea
- Earaches
- Minor cuts
- Moderate fever
- Rashes
- Sprains
- Vomiting

Employee Assistance Program or **EAP:** the program that helps **eligible employees** and **eligible dependents** resolve personal problems, such as family conflict, drug or alcohol abuse, stress, marital discord, personal finances, and other personal problems through confidential assessment and **brief counseling** and/or referrals.

Experimental or investigative treatment, drug or device: medical, surgical and psychiatric procedures, treatments, devices, drugs and drug treatments not approved by governmental agencies such as the Food and Drug Administration (FDA), and not accepted as standard, tested and accepted effective practice by the medical community

at large at the time the service is rendered, as determined by the **health care company**.

Extended care facility: an institution other than a **hospital** that is licensed according to state laws to provide **in-patient** medical services, and that is accredited by the Joint Commission on the Accreditation of Healthcare Organizations or approved by Medicare. An extended care facility provides direct medical treatment, and must have a professional nursing staff and operate under the supervision of a **physician**. An extended care facility is not primarily a place for rest, for the aged, for **custodial care**, or for the treatment of **mental illness** or **chemical dependency**. The term extended care facility encompasses facilities that go by names such as **skilled nursing facilities**, convalescent facilities, intermediate care facilities, sub-acute care facilities and rehabilitation centers, provided they meet all of the conditions given here.

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

Generic drug: a drug that does not bear the trademark of the original manufacturer. It must have the same active ingredients as their **brand name drug** counterpart. Generic drugs usually cost less than **brand name drugs**.

Group homes and halfway houses: settings for care that are **covered** under the **in-network** benefits of the **Mental Health and Chemical Dependency Program**. Group homes and halfway houses are residences that provide a structured living environment, deliver treatment by **mental health and chemical dependency professionals**, and afford the patient opportunities to transition into daily life activities for the purpose of recovery from mental health conditions or **chemical dependency**. Adult patients typically leave the group home or halfway house during the day to engage in outside activities such as work or school, and return at night.

HMO: see **Health Maintenance Organization**.

Halfway houses: see **group homes and halfway houses**.

Health care company: any company authorized by Avaya Inc. to provide services under the Medical Plan.

Health Maintenance Organization (HMO): a **network** of **hospitals**, doctors, and other medical **providers** who provide services through an HMO option. When you follow your HMO's rules for care, you usually pay no **deductibles** and file no claim forms. See "HMO Option" for more information.

Home health care agency: an organization licensed according to state laws to provide skilled nursing and certain other health services on a visiting basis in the patient's home. The agency must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations or be Medicare approved in order to be **covered** under the Medical Plan.

Hospice: an organization licensed according to state laws to provide care to terminally ill patients. A hospice may be either an agency that performs its services in the patient's home, or a facility into which the patient is admitted.

Hospital: a facility providing **in-patient** and **out-patient** care for the diagnosis and treatment of acute illness and injury. Under the **Mental Health and Chemical Dependency Program**, hospital means an acute general hospital with a psychiatric and/or **chemical dependency** unit, an acute psychiatric facility or an acute **chemical dependency** facility. The facility must be licensed according to state law and be staffed by **physicians** (and qualified **mental health or chemical dependency professionals** under the **Mental Health and Chemical Dependency Program**) and maintain 24-hour nursing services. A hospital is not primarily a place for rest or **custodial care**, a nursing home, convalescent home, home for the aged or similar institution nor does it include confinement in a **residential treatment** facility under the **Mental Health and Chemical Dependency Program**.

Indemnity option: a Medical Plan option (Enhanced Indemnity or International Indemnity) for which an annual **deductible** generally applies to **covered** services. (Certain services do not require you to pay a **deductible**.) You pay the percentage of **covered** expenses that applies. Unless you use a **National Advantage Program network provider**, you file claim forms to be reimbursed. See "How the Indemnity Options Work."

In-network: the benefit choice in which you access the services of contracted **network providers** according to the rules of the option or program under which you are enrolled. For the Standard or Enhanced **POS** option, you are encouraged to select a **PCP** so you have the opportunity to work with one physician who can coordinate your health care needs. Your care under the **Mental Health and Chemical Dependency Program** is coordinated by the **Behavioral Health Care Coordinator**. For the **Prescription Drug Program**, it means using a participating retail or the mail-order pharmacy.

In-patient: a patient who is confined in a **hospital** or other health care facility as a registered bed patient for at least 18 (out of 24) hours and incurs room and board charges. In-patient care refers to the care rendered to an in-patient. An in-patient facility is a facility that provides such care.

Lawful spouse: a person who is 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.

Magellan Health Services or **Magellan:** the **health care company** that administers the **EAP Program**.

Medically necessary: (medical necessity) the determination of medical necessity is made by the applicable **health care company**. Care is considered medically necessary if:

- It is accepted by the health care profession in the U.S. as appropriate and effective for the condition being treated,
- It is based upon recognized standards of the health care specialty involved,
- It represents the most appropriate level of care: the frequency of services, the duration of services, and the site of services, depending on the seriousness of the condition being treated (such as in the **hospital** or in the **physician's** office), and
- It is not experimental or investigative.

Mental health and chemical dependency professional: a psychiatrist (M.D.), a licensed psychologist (Ph.D.) or one of the following Master's degree-level **providers**: a clinical social worker; a marriage, family, and/or child counselor; a licensed professional counselor; a certified alcoholism counselor; a certified **chemical dependency** counselor; or a registered nurse with a specialty in psychiatric and mental health nursing. The **provider** must carry all recognized certifications appropriate to his or her specialty and, where state law requires, be licensed in the state in which he or she practices. The particular certification may differ in various areas of the country.

Mental Health and Chemical Dependency Program: the program that provides benefits for treatment of mental health and **chemical dependency** conditions to individuals **covered** under the Standard or Enhanced **POS** option or Enhanced **Indemnity option**.

Mental health emergency: a mental health condition that appears or increases suddenly, and is accompanied by severe symptoms. Without immediate treatment, a mental health emergency condition would result in: (a) the person harming him- or herself, or others; (b) severe diminishment or long-term damage to the state of the person's mental health; or (c) permanent physical impairment of bodily parts or functions as a consequence of the mental health emergency.

Mental illness: for the purpose of determining benefits under the Medical Plan, means a condition that meets either of the following two requirements: (a) it is classified as a mental illness in the latest edition of the International Classification of Diseases of the U.S. Department of Health and Human Services; or (b) it is a condition generally accepted by health care professionals in the U.S. as one that requires psychiatric treatment and will respond to such treatment.

Morbid obesity: obesity that has become a direct and immediate threat to a person's life.

National Advantage Program (NAP): a **network** of **providers** offered in many areas of the country. When you are **covered** under the Enhanced or International **Indemnity option** and you elect to receive medical care from **providers** in the National Advantage Program, charges are generally lower and guaranteed to be within the **allowable amount**. If you are **covered** under the Standard or Enhanced **POS** option, you may use a NAP **provider** under the **out-of-network** provisions (if you are not using a **Choice POS II network provider**).

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 for Salaried Employees and The Avaya Inc. Pension Plan.

Network: the **providers** in a given area who participate with the **health care company**. Network **providers** offer services to members enrolled with that **health care company** at a **prenegotiated rate**. A network **provider** means a **provider** who participates in the network.

Non-network: refers to a **physician**, **hospital** or other health care **provider** that has not signed a **network provider** agreement with your **health care company**.

Non-tobacco user: have not used any tobacco products at any time during the 12-month period before enrollment. This includes cigarettes, cigars, pipes, chewing tobacco, and snuff. If you misrepresent your tobacco-user status, this will be considered a violation of Avaya's Code of Conduct.

Occupational therapy: treatment to increase a patient's use of fine motor skills to enable him or her to apply them to the tasks required in daily living, after those skills have been impaired by illness, injury or birth defect.

Out-of-network: the benefit choice in which you access services without following the rules of the program for accessing contracted **network providers**. For the Standard or Enhanced **POS** option, this means obtaining services from a **provider** who does not participate in **Aetna's Choice POS II network**. For the **Mental Health and Chemical Dependency Program**, it means obtaining services without an authorization from the **Behavioral Health Care Coordinator**. For the **Prescription Drug Program**, it means using a pharmacy not identified as a **participating pharmacy**.

Out-of-pocket maximum: the limit on the amount you spend for **covered** medical expenses in **copayments** and/or **coinsurance**. Some charges do not count toward this maximum.

Out-patient: a patient who is treated in a **hospital** or other health care facility for less than 18 hours, and who does not incur a room and board charge. Out-patient care refers to the care rendered to an out-patient. An out-patient facility is one that provides such care.

Out-patient medical facilities: any medical diagnosis or treatment facility that does not offer overnight care, has a staff of medical professionals (including nurses), is operated under the direction of a **physician** and is licensed according to state law. **Covered** facilities include medical laboratories, **out-patient** surgical centers, **birthing centers**, **urgent** care facilities and **out-patient** rehabilitation facilities. It does *not* include a **physician's** office.

PCP: see **Primary care physician**.

POS: see **Point-of-Service**.

Partial hospitalization: a type of alternative care **covered** under the **in-network** benefits of the **Mental Health and Chemical Dependency Program**. Partial hospitalization means **out-patient** care delivered on a daily basis in a **hospital** or other facility. The facility must have both **physicians** and nurses on staff and be authorized to administer medications. Partial hospitalization is typically a less intense level of care than **in-patient** care, but more intense than intensive **out-patient** care.

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

Participating pharmacy: a pharmacy that is a participating retail pharmacy under the **Prescription Drug Program**.

Physical therapy: treatment to increase the patient's use of large-muscle motor skills, such as those needed for walking, after those skills have been impaired by illness, injury or birth defect.

Physician: a legally qualified physician who is licensed to practice medicine in the state in which the care is provided and is **covered** under the Medical Plan. Under the **Mental Health and Chemical Dependency Program**, care must be sought from a **provider** who is a psychiatrist or another M.D. (doctor of medicine) or D.O. (doctor of osteopathy) **provider** who is certified in the treatment of mental health and/or **chemical dependency**.

Point-of-Service (POS): a medical option that provides a higher level of coverage when you use **in-network providers.** However, you may go **out-of-network** and use any health care **provider** you wish. Your cost is usually higher for **out-of-network** care.

Post-service claim: a medical benefit claim other than a **pre-service claim** or **urgent care claim**.

Precertification: the process by which a **health care company** or precertification company reviews requested treatment in advance and advises you as to how benefits would be paid. In most instances, precertified care is **covered** by the Medical Plan

benefits and **medically necessary** care that is not precertified is paid at a reduced level, or not **covered** at all. The need for precertification applies only to certain procedures.

Prenegotiated rate: a rate for medical services to which a **network provider** and the **health care company** has contractually agreed. **Network providers** agree to accept the prenegotiated rate as payment in full. This rate is usually less than their normal charge for that service.

Prescription Drug Program: the program that provides prescription drug benefits to individuals **covered** under the Standard or Enhanced **POS** option or Enhanced **Indemnity option**.

Pre-service claim: a medical benefit claim that requires approval before you can receive the medical care.

Primary care physician (PCP): a **network physician** under the **HMO,** or Standard or Enhanced **POS** option who:

- Qualifies as a participating **provider** in general practice, internal medicine, family practice or pediatrics, and

- Has been selected by you as authorized by your **health care company** to provide your primary health care.

Private duty nursing: nursing services provided in the home by a private duty nurse who holds a valid, recognized nursing certificate and is licensed according to state law in the state in which services are received.

Provider: a person, such as a **physician**, physical therapist or **chiropractor**; an organization, such as a **home health care agency**; or a facility, such as a **hospital**, that provides health care services or supplies.

Qualified Medical Child Support Order (QMCSO): a judgment, decree or order issued by a court or a certain administrative process that requires medical coverage for an **eligible employee's** child and that has been determined to be qualified under the Internal Revenue Code of 1986, as amended. It is the policy of Avaya Inc. to comply with the requirements of a QMCSO (see "Important Contacts").

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 to no longer meet the Plan's eligibility requirements for coverage. This may include a child reaching the maximum age for coverage.
Residence or Worksite	A change in the place of residence or worksite of you, your spouse or a child.

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

The Internal Revenue Service (IRS) states 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 charge: the fee determined by the **Claims Administrator** on the basis of:

- The fees a **provider** usually charges 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 geographic region.

For the **Prescription Drug Program**, the reasonable and customary charge is consistent with the cost of prescriptions obtained from **participating pharmacies**.

Rehabilitation therapy: services provided by a physical therapist, speech therapist or occupational therapist. Rehabilitation services may be provided in a **hospital**, **extended care facility** or through a **home health care agency**. However, the need for

rehabilitation cannot be the primary reason for **hospital** confinement. Rehabilitation therapists may work independently or be on the staff of a **hospital**, **extended care facility** or **home health care agency**.

Residential treatment: a type of care **covered** under the **in-network** benefits of the **Mental Health and Chemical Dependency Program**. Residential treatment means 24-hour-a-day **in-patient** care in a facility that provides sub-acute care, which is less intense than the treatment typically offered by a **hospital**. The facility must provide regular treatment activities under the supervision of licensed and certified mental health professionals, with both **physician**/psychiatrist and nursing services available on either a staff or contracted basis. A residential treatment facility is not solely or principally an alternate residence or a place of rest. On the contrary, measurable improvement, the reasonable likelihood of future improvement, and active family or guardian participation in the treatment are important criteria for authorization of continued treatment.

Skilled nursing facility: a facility that provides continuous skilled nursing care on an **in-patient** basis. It must be licensed in accordance with state and local law and be accredited by the Joint Commission on the Accreditation of Healthcare Organizations or approved by Medicare. A skilled nursing facility is not primarily a place for rest, for the aged, for **custodial care**, or for the treatment of **mental illness** or **chemical dependency**.

Specialist: a **physician** in any generally accepted medical or surgical sub-specialty who provides medical care.

Speech therapy: therapy services that assist in the correction of communication abilities that have been acutely impaired by illness, injury or birth defect.

Tobacco user: any use of tobacco products at any time during the 12-month period before enrollment, constitutes tobacco use. This includes cigarettes, cigars, pipes, chewing tobacco, and snuff.

Urgent: a medical condition that manifests itself by acute symptoms of sufficient severity that postponing treatment for more than 48 hours would:

- Place the patient's life in jeopardy,
- Cause serious, permanent impairment of a bodily part or function, or
- Cause severe pain.

Care that is needed to treat such a condition is called urgent care. Care rendered after the urgent situation has passed is not urgent care.

An urgent care facility is freestanding and not connected to a **hospital**. An urgent care facility is designed to respond to urgent medical conditions and perform minor surgical procedures.

Urgent care claim: a medical benefit claim where applying the non-urgent care time frames (i) could seriously jeopardize your health or ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain without the care or the treatment that is the subject of the claim.