

**THE AVAYA INC.**

**VISION CARE PLAN  
FOR SALARIED EMPLOYEES**

**SUMMARY PLAN DESCRIPTION**

**Effective 1/1/2007  
Last Updated 3/31/2008**

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2007, to **eligible employees** under The Avaya Inc. Vision Care Plan for Salaried Employees (Vision Care Plan).

The Board of Directors of Avaya Inc. (or its delegate) reserves the right to modify, suspend or terminate the Vision Care Plan at any time. Questions regarding your benefits should be addressed to the Plan Administrator (see "Important Contacts"). Because of the many detailed provisions of the Vision Care Plan, no one other than the Plan Administrator is authorized to advise you as to your benefits. For this reason, Avaya Inc. is not bound by statements made by anyone or any entity other than the Plan Administrator or its authorized delegates.

Please note that participation in the Vision Care Plan is neither an offer of employment nor a guarantee of employment for any period of time at Avaya Inc. Avaya Inc. employees are employees at will, which means that they can terminate their employment at any time and for any reason. Likewise, Avaya Inc. may terminate an employee's employment at any time and for any reason.

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## **INTRODUCTION**

The Avaya Inc. Vision Care Plan for Salaried Employees encourages good eye care by offering affordable routine eye exams and prescription lenses (including one necessary eyeglass frame) or prescription contact lenses. You are eligible to use your vision care benefits once in a calendar year.

While you are free to use any provider you wish, your out-of-pocket expenses are generally lower when you go to a provider who participates in the vision care networks.

Coverage for you and your **eligible dependents** begins on your first day of work at a **Participating Company**, if you elect to enroll for coverage within your initial enrollment period.

## HIGHLIGHTS

Here is a summary of some features of the Vision Care Plan.

Plan Feature	Summary
Eligibility	If you are an <b>eligible employee</b> (a regular, active, full-time or part-time, salaried employee who works for a <b>Participating Company</b> ), you are eligible for coverage. You may also enroll your <b>eligible dependents</b> .
When Coverage Begins	Coverage for you and your <b>eligible dependents</b> begins on your first day of work with a <b>Participating Company</b> , if you elect to enroll for coverage within your initial enrollment period.
Coverage Provided	The Vision Care Plan covers routine eye exams and prescription lenses (including one necessary eyeglass frame) or prescription contact lenses.
When Benefits Are Paid	The Vision Care Plan pays benefits for each eligible service or supply once in a calendar year. This applies individually to each person covered under the Vision Care Plan.
Benefits Paid Based on Your Choice of Provider	Benefits are paid based on whether you received services from a network provider available through the Vision Care Plan, or from an out-of-network provider.  While you are free to go to the provider of your choice, your out-of-pocket expenses are generally lower when you go to a network provider.
Cost	You pay 100% of the cost of coverage which varies by level of coverage. Your contributions are deducted on a pre-tax basis.

## **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 that you can better understand your benefits. These terms are printed in **boldface** when they appear to let you know they are defined here.

**Annual enrollment:** the period of time each year designated by the Company in which you can generally make changes in your health care 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 enroll, make changes in your coverage or ask questions about the Vision Care Plan. See “Important Contacts.”

**Calendar year rule:** the Plan covers each eligible service or supply only once in a calendar year. A calendar year begins January 1st and ends December 31st.

**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** and **domestic partnership dependent**.

**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 age 23 must be certified for coverage by the Claims Administrator under The Avaya Inc. Medical Expense Plan for Salaried Employees. 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).

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

**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, 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 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 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.

**Participant:** an **eligible employee** or **eligible dependent** who has been enrolled and is covered under the Vision Care Plan.

**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 vision care coverage for an **eligible employee'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:

<b>Qualified Status Change</b>	<b>Description</b>
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** and/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.

## PARTICIPATING IN THE PLAN

### ***Who Is Eligible***

You are eligible to participate in the Vision Care Plan if you are a regular, active, full-time or part-time, salaried employee 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.

### ***Eligible Dependents***

As a participant in the Vision Care Plan, you may also enroll your **eligible dependents** for vision care coverage.

If you elect to enroll your **domestic partner** and/or **domestic partnership dependents**, you and your **domestic partner** must complete an Affidavit of Domestic Partnership. This affidavit is available on the Avaya Healthy Decisions Web site ([www.AvayaHealthyDecisions.com](http://www.AvayaHealthyDecisions.com)) under the "Reference Materials & Forms" section. Have the agreement notarized and return the affidavit to the **Avaya Health and Benefits Decision Center**.

The **Avaya Health and Benefits Decision Center** can tell you the tax impact of enrolling a **domestic partner** and/or **domestic partnership dependents**. Under IRS regulations, you contribute toward the cost of Vision Care Plan coverage on a pre-tax basis for yourself and for your family members *other than* your **domestic partner** and/or **domestic partnership dependent**. The same tax advantages do not currently apply when you cover your **domestic partner** and/or **domestic partnership dependent**. Under IRS regulations, you cover them with after-tax contributions and the amount of the Company's cost to cover them is reported as taxable income to you each month. This taxable income is subject to both income tax and FICA withholding. The amount of taxable income depends on whom you elect to cover.

### ***Enrollment***

What you need to do to enroll for vision coverage depends on whether you are:

- A newly **eligible employee**,
- An employee changing your existing coverage during an **annual enrollment** period,  
or

- An employee changing your existing coverage level during the year due to a **qualified status change** (see “Changing Your Coverage During the Year”).

### **Newly Hired Employees**

An enrollment letter will be sent to your home address when you first become eligible to participate in the Vision Care Plan. The letter will include information about the Vision Care Plan, how to enroll and the date by which you must make your elections. You can make your enrollment elections online by logging onto the Avaya Healthy Decisions Web site at [www.AvayaHealthyDecisions.com](http://www.AvayaHealthyDecisions.com) or by calling the **Avaya Health and Benefits Decision Center** (see “Important Contacts”).

If you do not enroll by the date specified in the enrollment letter, you will have to wait for the next **annual enrollment** period unless you have a **qualified status change**.

You do not need to re-enroll each year, unless you wish to change your coverage.

### **Annual Enrollment**

During **annual enrollment** each year, you will have an opportunity to select the benefits that best meet your needs for the coming year. You may change the **eligible dependents** you cover and/or elect or decline vision coverage. **Annual enrollment** is held once a year, usually in the fall.

You will receive enrollment information that will explain how to make your **annual enrollment** elections. If you do not elect to make any changes, your current coverage election will continue unless it is being discontinued.

Elections made during **annual enrollment** are effective on the first day of the following calendar year.

### **Confirmation Statements**

A confirmation statement will be generated after you enroll or change benefits during **annual enrollment** or at any other time during the year. Be sure to review the information carefully and report any discrepancies immediately to the **Avaya Health and Benefits Decision Center** (see “Important Contacts”).

### ***If You and Your Spouse or Domestic Partner Work for a Participating Company***

Only one employee of Avaya Inc. may enroll any given **eligible dependent**. Either you or your **lawful spouse** or **domestic partner** may cover your dependent **children**. A child may not be covered under the Vision Care Plan by both parents at the same time.

### **The Cost of Coverage**

Your payroll deduction amount for benefit coverage including the Vision Care Plan appears on your pay statement. Remember, you contribute toward the cost of Vision Care Plan coverage on a pre-tax basis for yourself and your family members, other than your **domestic partner** and/or **domestic partnership dependents**.

Cost information will be provided through the Avaya Healthy Decisions Web site at [www.AvayaHealthyDecisions.com](http://www.AvayaHealthyDecisions.com).

### **When Employee Coverage Ends**

Vision care coverage ends on the last day of the month in which:

- You retire or die,
- You leave the Company for any reason (including a leave of absence),
- You are no longer considered an **eligible employee**,
- You fail to make the required contributions, or
- The Company you work for ceases to be a **Participating Company**.

Your coverage also ends as follows if either of these events occurs:

- If the Vision Care Plan is terminated, your coverage will end on the termination date.
- If you are laid off, your coverage will end on the last day of the month in which the layoff occurs.

### **When Dependent Coverage Ends**

Dependent coverage under the Vision Care Plan ends when:

- Your coverage ends, or
- On the last day of the month in which your **covered dependent** is no longer an **eligible dependent**.

You must notify the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) when your dependent no longer qualifies as an **eligible dependent**. Information about continuing coverage will be sent to your dependent.

## **Other Reasons Your Coverage Will End**

In addition, when any of the following happens, you will receive written notice that your coverage (and coverage for your **covered dependents**) has ended on the date identified in the notice:

- Fraud or misrepresentation, or because you (or one of your **covered dependents**) knowingly gave the Plan Administrator, **Claims Administrator** or **Avaya Health and Benefits Decision Center** false, material information. Examples include false information relating to a person's eligibility or status as a **covered dependent**.
- You (or one of your **covered dependents**) permitted an unauthorized person to use one of your ID cards, or you (or one of your **covered dependents**) improperly use another person's ID card.
- You (or one of your **covered dependents**) commit acts of physical or verbal abuse that pose a threat to the staff of the Plan Administrator, **Claims Administrator** or **Avaya Health and Benefits Decision Center**.
- You (or one of your **covered dependents**) in any other way materially violates the terms of the Vision Care Plan.

## ***When Coverage Can Be Continued***

Depending on the circumstances under which your vision care coverage ends, you may be able to continue coverage for you and your **eligible dependents** as required by federal law (see "Continuing Your Vision Coverage Through COBRA").

## ***Changing Your Coverage During the Year***

You may change your coverage under the Vision Care Plan during the year only if you have a **qualified status change**. In order to make a change during the year, status changes must be reported to the **Avaya Health and Benefits Decision Center** (see "Important Contacts") within 31 days of the event. If you miss the 31-day deadline, you must wait until the next **annual enrollment** period to make applicable changes to your Vision Care Plan coverage.

Once you enroll in the Vision Care Plan, you must remain in the Vision Care Plan until the end of the calendar year. You cannot terminate your vision care coverage during the year unless you leave the Company for any reason (due to retirement, death, termination or a leave of absence).

## **HOW THE PLAN WORKS**

### ***Understanding the Plan***

The Vision Care Plan offers coverage in two ways:

- Through providers who participate in the EyeMed Vision Care Access Network, or
- Through providers who do not participate in the EyeMed Vision Care Access Network.

When you need vision care services, you decide which provider you want to use. You may use different providers for each service or supply you need. For example, you may use one provider for your eye exam, but obtain your frames and lenses from another provider.

When you go to a network provider, you either pay nothing or an out-of-pocket fee, as shown in the table in the section “Comparison of Vision Care Benefits.”

When you go to an out-of-network provider, you are responsible for paying the provider’s charge in full. To claim benefits, you must submit a claim form. You are then reimbursed up to the amount specified in the schedule of benefits (see “Comparison of Vision Care Benefits”).

Generally, your out-of-pocket expenses are lower when you use an EyeMed Vision Care Access Network provider.

### ***Selecting a Network Provider***

To obtain a listing of network providers, call the **Claims Administrator** (see “Important Contacts”) or visit [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com)

To ensure you receive the maximum benefit, keep in mind that an optometrist or ophthalmologist who performs an eye exam or other service at a retail location may be an independent practitioner and may not be affiliated with the store. Before obtaining service, you should verify the network status of the provider for both the exam and materials (e.g., lenses, frames or contacts).

## **COVERAGE UNDER THE PLAN**

The Vision Care Plan covers:

- One routine eye exam, and
- One of the following:
  - One eyeglass frame fitted with one pair of eyeglass lenses, or
  - Prescription contact lenses or supply of disposable contact lenses.

The benefit permits contact lenses in lieu of frames *and* lenses. The Vision Care Plan pays benefits for the above services and supplies once in a calendar year. This is known as the **calendar year rule**. A calendar year begins January 1st and ends December 31st.

In addition, you will receive other special discounts on a variety of lens options including:

- Basic Polycarbonate
- PSR Scratch-resistant coating
- Anti-Reflective coating
- Ultraviolet 400 coating
- Tints

See “Non-Covered Items/Negotiated Fees,” for network provider charges for these services. If you receive any of the above materials from an out-of-network provider, you are responsible for paying the full cost. Since these items are not **covered** under the Vision Care Plan, you will not receive reimbursement. However, you may be eligible for reimbursement of such non-covered expenses through The Avaya Inc. Health Care Reimbursement Account Plan for salaried employees.

## HOW BENEFITS ARE PAID

The following chart compares how the Vision Care Plan covers both network and out-of-network expenses.

### **Comparison of Vision Care Benefits**

The following chart compares how the Vision Care Plan covers both In-Network and Out-of-Network expenses:

<b>Benefit</b>	<b>Network Benefit</b>	<b>Out-of-Network Reimbursement</b>
<p><b>Eye Examination</b> Includes a routine complete examination, dilation refraction and prescription for eyeglass lenses.</p> <p><b>Exam Options:</b> Contact lens exams and other additional procedures will be an additional cost to you</p> <p>Standard Contact Lens Fit and Follow-up* Premium Contact Lens Fit and Follow-up**</p>	<p>\$0 Copay</p> <p>Up to \$55 10% off retail price</p>	<p>Up to \$40</p> <p>N/A N/A</p>
<p><b>Lenses</b> Includes one pair of standard, uncoated plastic lenses (single, bi-focal or tri-focal), regardless of size or power.</p>	<p>Covered in full.</p>	<p>Single Vision: \$40 Bi-focal: \$75 Tri-focal: \$100</p>
<p><b>Frames</b> Any available frame at provider location</p>	<p>\$0 Copay, \$120 allowance; you pay 80% of balance over \$120</p>	<p>Up to \$50</p>
<p><b>Contact Lenses</b> In lieu of lenses and frames (covers material only):</p> <p>Conventional</p> <p>Disposables</p> <p>Medically Necessary</p>	<p>\$0 Copay, \$100 allowance; you pay 85% of balance over \$100</p> <p>\$0 Copay, \$100 allowance; you pay amount over \$100</p> <p>\$0 Copay, Paid in Full</p>	<p>Up to \$75</p> <p>Up to \$75</p> <p>Up to \$75</p>

Benefit	Network Benefit	Out-of-Network Reimbursement
<p><b>LASIK and PRK Vision Correction Program</b>                      Your plan includes a discount for laser vision correction procedures. When applicable, members receive a 15% discount off the price of LASIK or PRK procedures, or 5% off any promotional price, whichever is lower. Services are provided through the U.S. Laser Network owned and administered by LCA Vision. Simply call 1-877-5LASER6 to begin the process of receiving your discount</p>	<p>15% off retail price or 5% off promotional pricing.</p>	<p>N/A</p>
<p><b>Replacement Contact Lenses by Mail Program</b>                      Order replacement lenses for competitive prices via the internet and have the contacts mailed directly to your home. The service is for replacement contact lenses only and your core benefit allowance or discount will not apply to the service. We recommend that your initial pair of contact lenses is purchased from your eye care provider to ensure proper fit and follow-up care.</p>	<p>Visit <a href="http://www.eyemedcontacts.com">www.eyemedcontacts.com</a> to access the ordering system or call 800-508-1399</p>	<p>Not covered</p>
<p>*Standard Contact Lens Fitting examples include, but are not limited to, disposable and frequent replacement, etc.                      **Premium Contact Lens Fitting examples include, but are not limited to, toric, multifocal, etc.</p>		

You do not have to use the same provider for each service or supply you need. For example, you can go to a network provider for a vision exam and an out-of-network provider for frames and lenses.

**Value Added Features**

In addition to the vision benefits the Vision Care Plan offers, you may also enjoy additional, value-added features including:

- Continued Eyewear Savings: Save up to 40% off additional complete eyeglass purchases once the funded benefit has been used.
- Replacement Contact Lenses by Mail: As an added convenience, you can order replacement contact lenses directly online and mailed directly to your home. Visit the Web site [www.eyemedcontacts.com](http://www.eyemedcontacts.com) for more details.

## **Non-Covered Items/Negotiated Fees**

### **Eyeglass Lens Options**

The following lens options are not **covered** under the Vision Care Plan. However, the network providers have agreed to limit their charges for the following services and supplies:

<b>Lens Options</b>	<b>Participant Cost</b>
Standard Progressive (add on to bifocals)	\$65.00
Basic Polycarbonate	\$40.00
Scratch Resistant Coating	\$15.00
Anti-Reflective Coating	\$45.00
Ultraviolet 400 Coating	\$15.00
Tints	\$15.00
Other Coatings	80% of charge
Other Lens Options	80% of charge

If you receive any of the above materials from an out-of-network provider, you are responsible for paying the full cost. Since these items are not **covered** under the Vision Care Plan, you will not receive reimbursement. However, you may be eligible for reimbursement of such non-covered expenses through The Avaya Inc. Health Care Reimbursement Account Plan if you are a participant in that Plan.

## **HOW TO CLAIM BENEFITS**

### ***Network Provider***

Network providers submit claim forms for you. Benefits are paid directly to network providers. You can locate a network provider by calling 1-866-723-0513 or going online [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com). You will receive an **Explanation of Benefits (EOB)** showing charges and benefits paid.

### ***Out-of-Network Provider***

Out-of-network providers generally request payment in full at the time of service. To receive reimbursement for the vision care services or supplies of an out-of-network provider, you must submit a claim form to the **Claims Administrator** (see "Important Contacts"). You must complete a request for reimbursement claim form and attach the corresponding receipts. The **Claims Administrator** will pay benefits for covered services or supplies directly to you up to the limits indicated on the benefit chart above, and will send you an **EOB**.

You should submit claims within 90 days of service. In no case are benefits payable for claims submitted later than 15 months from the date of service.

If a claim for benefits is denied, you may appeal the decision (see "Claim Procedures").

## MISCELLANEOUS COVERAGE INFORMATION

### ***If You Use an HMO***

The Vision Care Plan covers any eligible expenses you incur for vision services under a health maintenance organization (HMO) up to the amounts listed in the schedule of benefits (see “Comparison of Vision Care Benefits”). However, you cannot be reimbursed by both the Vision Care Plan and your HMO for the same expense.

### ***Coordination of Benefits***

The Vision Care Plan has a coordination of benefits (COB) provision. This feature is designed to prevent duplicate benefit payments when you or your **covered dependents** participate in more than one group plan.

### **When the COB Provision Applies**

The COB provision applies when you or your **eligible dependents** have vision care coverage in addition to that provided under the Vision Care Plan, such as:

- A group-sponsored insurance or prepayment plan, or
- A government-sponsored plan.

### **When the COB Provision Does Not Apply**

The COB provision described in this section does not apply:

- To benefits under any personal policy (except no-fault or other state-mandated automobile insurance), and
- To two related people, both of whom are employees or retirees of a **Participating Company**, due to the following two rules:
  - One person cannot receive Vision Care Plan benefits as both an employee or retiree of a **Participating Company**, and as an **eligible dependent** of such an employee or retiree.
  - One person cannot receive Vision Care Plan benefits as an **eligible dependent** of more than one employee or retiree of a **Participating Company**.

## **The Primary Plan Determines Benefits First**

Under the COB provision, the **Claims Administrator** determines that one plan is primary and determines its benefits first. To claim benefits, submit your claim to the primary plan first. After that plan determines its benefits, submit a claim to the secondary plan(s) along with a copy of the **EOB** statement you received from the primary plan. The secondary plan(s) will then determine if any additional benefits are payable.

- If the Vision Care Plan is the primary plan, it pays its benefits without regard to the secondary plan.
- If the Vision Care Plan is secondary, the Vision Care Plan coordinates benefits with the primary plan. Here is how this works. The **Claims Administrator** first calculates what the Vision Care Plan would have paid if it were the primary plan. Second, the **Claims Administrator** reviews the **EOB** statement you received from the primary plan to determine what the primary plan paid. The Vision Care Plan then pays the difference, up to the amount the Vision Care Plan would have paid if it were the primary plan. Therefore, among the primary and secondary plans, you can receive up to 100% (but not more than 100%) of the allowable amount under the highest paying plan.

## **How the Claims Administrator Determines Which Plan Is Primary**

The **Claims Administrator** determines which plan is primary and which plan(s) is secondary under the following rules:

- If the other plan(s) does not have a COB feature, that plan(s) is considered primary and the Vision Care Plan is considered secondary.
- If both plans have a COB provision, the plan covering a person as an employee is primary, and the plan covering the person as a dependent is secondary.
- For dependent **children**, determination of the primary and secondary plan(s) follows these rules in this sequence:
  - The “birthday rule.” The plan covering the parent whose birthday (month and day) comes first in the year is the primary plan for the **children**, and the plan covering the other parent is the secondary plan for the **children**. The Vision Care Plan uses this rule.
  - The “male-female rule.” For plans that do not use the birthday rule, the father’s group insurance is the primary plan for the **children** and the mother’s group insurance is the secondary plan for the **children**.

- If one parent's plan includes the male-female rule and one parent's plan includes the birthday rule, the male-female rule applies to the extent permitted by law.
- If the parents of dependent **children** are divorced or legally separated, the **Claims Administrator** will determine if there is a court decree or a **Qualified Medical Child Support Order (QMCSO)** establishing financial responsibility for vision care. If it is determined that an order is a **QMCSO**, Avaya Inc. will comply with the terms of that order (see "Important Contacts" for where to submit QMCSOs).
  - If there is such a decree or **QMCSO**, the plan covering the parent who has that responsibility will be the primary plan.
  - If there is no such decree or **QMCSO**, the plan that covers the parent with custody will be the primary plan; the other parent's plan will be secondary.
  - If there is no such decree or **QMCSO** and the parent with custody remarries, that parent's plan remains primary, the stepparent's plan is secondary, and the non-custodial parent's plan is third.
  - If payment responsibilities are still unresolved, the plan that has **covered** the patient for the longest time is the primary plan.

If both parents have coverage through a **Participating Company**, either parent (but not both) may choose to cover the **children**. Claims for the **children** are submitted to the **Claims Administrator** of the parent covering the **children**. The other parent's coverage is not secondary because it does not cover the **children**.

### ***Right of Recovery and Subrogation***

If all or some of the expenses under the Vision Care Plan are not payable (improper payments), or if all or some of the payments made exceed the benefits payable under the Vision Care Plan (excess payments), then those improper or excess payments must be refunded to the Vision Care Plan.

If the refund is due from another person or organization, you or your **covered dependents** must assist the Vision Care Plan in getting the refund when requested. You or your **covered dependents** are still responsible for any improper or excess payments made to you or your **covered dependents** or to providers under the Vision Care Plan.

Failure by you or your **covered dependents**, or any other person or organization that was improperly or excessively paid, to promptly refund the full amount may reduce the amount of any future benefits that are payable to or on behalf of you or your **covered dependents** under the Vision Care Plan.

The Vision Care Plan provides **covered** benefits to you and your **covered dependents** that are not provided by any third party. So, benefits provided under the Vision Care Plan as a result of any illness or injury which gives rise to a claim by you or your **covered dependents** against a third party as the result of or attributable to the negligent or wrongful acts or omission of such third party are excluded and are not **covered** under the Vision Care Plan. If such benefits *have* been paid by the Vision Care Plan, the following shall apply:

- The Vision Care Plan shall be entitled to all of your and your **covered dependents'** rights of recovery against such third party to the extent of the reasonable value of the benefits provided under the Vision Care Plan.
- You and your **covered dependents** agree to reimburse the Vision Care Plan for the reasonable value of all benefits received under the Vision Care Plan out of any actual recoveries you or your **covered dependents** received from any third party (other than the **participant's** family members).
- The Vision Care Plan's subrogation and reimbursement rights apply to any recoveries that may be received or actually are received by you or your covered dependents, including, but not limited to, the following:
  - Any payments made as a result of a settlement, judgment, or otherwise, made by or on behalf of a third party or his or her insurance company, or made under an uninsured or underinsured motorist coverage;
  - Any payments under Workers' Compensation, no-fault or other state mandated motor vehicle insurance; or
  - Any payments made as a result of coverage under any automobile, school or homeowners insurance policy.

You and your **covered dependents** are required to fully cooperate and perform all actions necessary to secure the Vision Care Plan's right of recovery and subrogation, including granting a lien on any monies recovered from a third party, refraining from taking any action or negotiating any agreement with any third party that may prejudice the Vision Care Plan's rights, and from assigning any rights to recover vision care expenses from any tortfeasor or other person or entity to any other party. You or your **covered dependents** shall not incur any expenses on behalf of the Vision Care Plan in pursuit of the Vision Care Plan's rights. No court costs or attorney's fees may be deducted from the Vision Care Plan's recovery without the advance express written consent of the Vision Care Plan.

In the event you or your **covered dependents** fail or refuse to honor these terms, the Vision Care Plan will be entitled to recover any cost incurred in enforcing these terms and conditions.

## Continuing Your Vision Coverage Through COBRA

A federal law known as **COBRA** (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended) requires employers to offer **eligible employees** and their **covered dependents** the opportunity to continue their group health coverage *at their own expense* for a limited period of time if they lose coverage due to a qualifying event. Although not required under **COBRA**, the Vision Care Plan provides continuation coverage to your **domestic partner** and/or **domestic partner dependents**.

### COBRA Coverage

**COBRA** may extend your coverage under the Vision Care Plan for up to 18 months, 29 months or 36 months, depending on the qualifying event. The following chart summarizes who is eligible for **COBRA** continuation coverage, under what circumstances, and how long **COBRA** continuation coverage continues.

If:	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
You	Become laid off	You and your <b>covered dependents</b>	18 months
	Have a reduction in hours	You and your <b>covered dependents</b>	18 months
	Terminate employment (for reasons other than gross misconduct)	You and your <b>covered dependents</b>	18 months
	Do not return from an <b>FMLA</b> leave of absence	You and your <b>covered dependents</b>	18 months
	Become disabled within the first 60 days of <b>COBRA</b> continuation coverage	You and your <b>covered dependents</b>	Up to 29 months*
	Die	Your <b>covered dependents</b>	36 months
	Become divorced or legally separated	Your <b>covered dependents</b>	36 months
Your <b>covered dependent</b>	Is no longer an <b>eligible dependent</b> (due to age limit, divorce, or legal separation)	Your <b>covered dependent</b>	36 months
	Is no longer an <b>eligible dependent</b> because of your death	Your <b>covered dependent</b>	36 months
	Becomes disabled within the first 60 days of <b>COBRA</b> continuation coverage	You and your <b>covered dependent</b>	Up to 29 months*

\*Includes months of **COBRA** coverage already used.

## **Employee Loses Coverage**

If you lose coverage because of a layoff, termination of employment (for reasons other than gross misconduct), or if you do not return to work after an **FMLA** leave of absence, **COBRA** continuation coverage is available to you and your **covered dependents** for up to 18 months from the date of the qualifying event. If you elect **COBRA** coverage and you acquire a new child (birth, adoption or placement of adoption) during your **COBRA** continuation period, you may enroll that new child in **COBRA** continuation coverage.

You and your **covered dependents** will be notified by the **Avaya Health and Benefits Decision Center** when an event makes continuation of coverages available and sends you election information, including the cost of the coverage. You and each of your **covered dependents** have an independent right to elect **COBRA** continuation coverage. You (or a **covered dependent**) must notify the **Avaya Health and Benefits Decision Center** (within 60 days of the date the notice is sent or coverage is lost, whichever is later) of your decision to continue coverage. If you do not elect continuation coverage during the first 60-day election period and you become eligible for trade adjustment assistance, you may elect continuation coverage during a second 60-day period that begins on the first day of the month in which you are determined to be eligible for such assistance. In this situation, your election must be made within 6 months of your first **COBRA** qualifying event.

If you or your **covered dependent** becomes disabled within the meaning of the Social Security Act during the first 60 days of **COBRA** continuation coverage, you and your **covered dependents** may extend the 18-month continuation period to 29 months. For the 29-month continuation coverage period to apply, you must notify the **Avaya Health and Benefits Decision Center** (see "Important Contacts") 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 the **Avaya Health and Benefits Decision Center** 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.

If one of your **covered dependents** experiences another qualifying event (for example, your child becomes no longer eligible due to age, or you die during the **COBRA** continuation period), the **COBRA** continuation period can be extended for that dependent. You or your **covered dependent** must notify the **Avaya Health and Benefits Decision Center** (see "Important Contacts") within 60 days of the second event. (Note that a second qualifying event is not triggered when you become entitled to Medicare.) This notice should be in writing and should include proof of the second qualifying event. If the **Avaya Health and Benefits Decision Center** 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.

## **Dependent Continuation Coverage**

Each of your **covered dependents** may have the right to **COBRA** continuation coverage for up to 36 months from the date of the qualifying event if he or she loses coverage because:

- You die,
- You and your spouse get divorced or legally separated, or
- He or she is no longer eligible for coverage under the Vision Care Plan (e.g., due to the age limit)

If your **covered dependents** lose coverage because of your death, the **Avaya Health and Benefits Decision Center** will notify them of their right to continue coverage within 44 days. Your **covered dependent** must notify the **Avaya Health and Benefits Decision Center** of their decision to continue coverage within 60 days of the later of this notification or the date benefits terminate.

If you get divorced or legally separated, or if your child no longer meets the eligibility requirements, you or your **covered dependent** must notify the **Avaya Health and Benefits Decision Center** within 60 days of the event. This notice should be in writing and should include proof of the qualifying event (for example, a copy of the divorce decree). If the **Avaya Health and Benefits Decision Center** is not notified within 60 days of the qualifying event, your **covered dependent** will lose the right to elect **COBRA** continuation coverage. After the **Avaya Health and Benefits Decision Center** is notified, your **covered dependent** will be notified of his or her right to continue coverage within 14 days. Within 60 days of the later of this notification or the date benefits terminate, your **covered dependent** must notify the **Avaya Health and Benefits Decision Center** of his or her decision to continue coverage. If the **Avaya Health and Benefits Decision Center** determines that your **covered dependent** is not eligible for **COBRA** continuation coverage, your **covered dependent** will be notified in writing explaining why continuation coverage is not available.

## **When Coverage Ends**

If you and/or your **covered dependent** elect **COBRA** continuation coverage, it takes effect on the date of your qualifying event and continues until the earliest of the following:

- The end of the 18-month, 29-month or 36-month continuation period
- The date Avaya Inc. no longer provides health care coverage to any of its employees

- When there is a significant underpayment of a premium or when premiums for **COBRA** continuation coverage are not paid within the required time
- The date you or your **covered dependents** become **covered** under another group health care plan other than TRICARE (provided pre-existing condition exclusions or limitations under the new group health care plan do not apply)
- With respect to the 11-month extension for disability, the date the person is no longer disabled (you must notify the **Avaya Health and Benefits Decision Center** within 30 days of a determination by the Social Security Administration that you or the **covered dependent** is no longer disabled)

If the **Avaya Health and Benefits Decision Center** determines that your coverage is terminating before the end of the 18-month, 29-month or 36-month period (e.g., when premiums are not being paid within the required time), you will be notified that your coverage is terminating and you will be provided with the reason why and the date your coverage is terminating.

### **COBRA Coverage Cost**

You (or your **covered dependent**) pay the full cost for **COBRA** continuation coverage, plus a 2% administrative fee. If the **COBRA** period is extended to 29 months because you or a **covered dependent** is disabled under the Social Security Act, a 2% administrative fee applies for the first 18 months and a 50% administrative fee applies for you and your **covered dependents** for the next 11 months (from the 19th month through the 29th month).

The initial **COBRA** payment (which includes payment for coverage back to the date regular coverage ended) is due when you elect **COBRA**. However, the Vision Care Plan is legally required to provide you with a 45-day grace period for this initial **COBRA** payment. No further extension will be permitted. After the initial payment, payments are due by the first of the month for the coverage period which is being paid. The Vision Care Plan is legally required to provide you with a 30-day grace period for these payments. No further extension is permitted. Payments received after your 30- or 45-day grace period will result in an automatic loss of all **COBRA** coverage rights. Once **COBRA** coverage is lost, it cannot be reinstated. There are no exceptions.

## **If You Have Questions**

Questions concerning your **COBRA** continuation coverage rights should be addressed to the **Avaya Health and Benefits Decision Center** (see “Important Contacts”). For more information about your rights under ERISA, including **COBRA**, the Health Insurance Portability and Accountability 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 the EBSA Web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA Web site.)

## **Keep Your Plan Informed of Address Changes**

In order to protect your family’s rights, you should keep the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the **Avaya Health and Benefits Decision Center**.

## **SERVICES NOT COVERED UNDER THE PLAN**

The following services and supplies are not **covered** under the Vision Care Plan:

- Drugs or any other medication
- Medical or surgical treatment
- Special or unusual treatment, such as orthoptics, vision training, subnormal vision aids, aniseikonic lenses or tonography
- Services or supplies not prescribed by a licensed physician, optometrist or ophthalmologist
- Nonprescription lenses or contact lenses
- Experimental or investigational treatment, drugs or devices
- Tinted, photochromic, oversized, photosensitive, high index or antireflective lenses, whether or not those lenses are medically necessary, although network providers will limit their charges for these non-covered items (see “Non-Covered Items/Negotiated Fees”)
- Services or supplies available from any government agency or covered by any governmental plan
- Replacement of broken or lost frames or lenses within a calendar year (including contact lenses)
- Contact lens care kits, cleaning solutions, lens insurance, and extra fittings. Note that lens cleaning solutions are eligible expenses under the Avaya Inc. Health Care Reimbursement Account Plan for salaried employees.
- Services or supplies for which no obligation to pay exists or for which no charge would be made in the absence of the Vision Care Plan’s benefits
- Vision exams or any materials furnished for any condition, disease, ailment or injury arising out of or in the course of employment
- Vision exams performed and lenses and frames ordered before the individual became eligible for coverage under the Vision Care Plan, or after termination of the individual’s coverage under the Vision Care Plan

- Services or supplies **covered** under any other Company-provided medical benefit program or by Workers' Compensation laws, or to the extent covered by a Company safety lens program
- Two pairs of glasses, in lieu of bifocals or trifocals
- Any eye examination, or any corrective eyewear, required by the Company as a condition of employment
- Services rendered or materials purchased outside the United States or Canada, unless the individual resides in the United States or Canada and the charges are incurred while on a business or pleasure trip.

Remember, you may be eligible for reimbursement of expenses not **covered** by the Vision Care Plan through The Avaya Inc. Health Care Reimbursement Account Plan for salaried employees.

## **EMPLOYMENT-RELATED EVENTS**

Your coverage under the Vision Care Plan will end if certain events occur.

### ***If You Change Your Employment Status***

Changes in your employment status, such as going from full-time to part-time, generally do not affect your participation in the Vision Care Plan.

If your job classification is changed to represented, it will affect your eligibility for Vision Care Plan benefits as follows:

- Coverage under the Vision Care Plan will end on the last day of the month in which your status changes.
- Your job classification change to a represented position will make you eligible to participate in the vision care plan offered to represented employees.

### ***If You Terminate Employment***

If you terminate employment for any reason, coverage under the Vision Care Plan ends on the last day of the month in which you terminate. You may be able to continue coverage for yourself and your **covered dependents** through **COBRA** (see “Continuing Your Vision Coverage Through COBRA”).

### ***If You Retire***

Your coverage under the Vision Care Plan ends on the last day of the month in which you retire. You may be able to continue coverage for yourself and your **covered dependents** through **COBRA** (see “Continuing Your Vision Coverage Through COBRA”).

### ***If You Leave the Company and Are Rehired***

If you leave the Company and then are rehired as an **eligible employee**, you and your **eligible dependents** may enroll for coverage as of your first day of work with a **Participating Company** (see “When Coverage Begins” and “Enrollment”).

### ***If You Become Disabled***

You are eligible for coverage under the Vision Care Plan during any period you are eligible to receive benefits under The Avaya Inc. Short-Term Disability Plan for Salaried Employees.

You are not eligible for coverage under the Vision Care Plan during any period you are eligible to receive benefits under The Avaya Inc. Long-Term Disability Plan for Salaried Employees. You may be able to continue coverage for yourself and your **covered dependents** through **COBRA** for a limited period of time (see “Continuing Your Vision Coverage Through COBRA”).

Your coverage under the Vision Care Plan will automatically resume on your first day of work upon your return, if you elect to enroll for coverage (see “When Coverage Begins” and “Enrollment”).

### ***If You Take an Approved Leave of Absence***

If you are on an approved leave of absence, you can continue vision care coverage for yourself and your **covered dependents**. You and your **covered dependents** will be notified of any continuation rights available under **COBRA**.

If you are eligible for an **FMLA** leave under The Family and Medical Leave Act of 1993, as amended, Avaya Inc. will comply with this legislation.

### ***If Both You and Your Spouse Work for the Company***

No one person can receive benefits as a dependent of more than one employee, or as both a dependent and an employee. For example, you may not be **covered** as an active Avaya Inc. employee and a dependent of another Avaya Inc. employee. Either spouse may cover dependent **children**; however, both parents cannot cover the same child at the same time.

## PERSONAL EVENTS AFFECTING COVERAGE

### ***If You Get Married***

See “If You Gain a New Dependent.”

### ***If You Gain a New Dependent***

If you gain a new dependent (for example, through marriage, birth, adoption or by acquiring a **domestic partner** or **domestic partnership dependent**), you may enroll your new dependent if you do so within *31 days of the date he or she became your dependent*. Contact the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) for additional information. If you enroll the dependent *within* the specified 31-day time frame, he or she is **covered** from the date he or she became your dependent. *If you do not enroll the new dependent within 31 days, you will not be permitted to elect coverage for the dependent until the next **annual enrollment** period, unless you experience another applicable **qualified status change**.*

### ***If a Dependent Loses Eligibility***

See “Continuing Your Vision Coverage Through COBRA”.

### ***If Your Physically or Mentally Handicapped Child Reaches Age 23***

If your physically or mentally handicapped child is incapable of self-support when he or she reaches age 23, coverage may be continued beyond that age, if the child is fully dependent on you for support at that time. You must apply for this coverage. It is not automatic. To apply for coverage, contact your medical health care claims administration at the telephone number printed on your medical ID card prior to the child's 23rd birthday.

### ***If You Die While Covered Under the Vision Plan***

If you die while **covered** under the Vision Care Plan, your **covered dependents** have the option of continuing coverage under **COBRA** for up to 36 months if they make the required contributions. For more information about continuing coverage under **COBRA**, see “Continuing Your Vision Coverage Through COBRA.”

### **Qualified Status Changes**

Between **annual enrollment** periods, coverage type changes are allowed for certain **qualified status changes**. The type of change you can make (e.g., a change in coverage category) depends on the event.

To make a change, call the **Avaya Health and Benefits Decision Center** (see “Important Contacts”). You may only make a change in coverage that is consistent with your **qualified status change**. For example, if you marry, you may elect to change your coverage from “individual” coverage to “two-person” coverage.

Changes must be made *within* 31 days of the qualifying event or you will have to wait until the next **annual enrollment** period to make the change.

### ***If You Have a Change in Dependent Status***

You must update your dependent information whenever you have a change in dependent status, for example, if your dependent no longer meets the eligibility requirements (see “Participating in the Plan”). To update dependent information, contact the **Avaya Health and Benefits Decision Center** (see “Important Contacts”).

## IMPORTANT CONTACTS

Following is a list of contacts and resources, including specific responsibilities for each.

Contact / Service Provided	Address / Telephone Number
<p><b>Avaya Health and Benefits Decision Center:</b></p> <p>Contact for questions concerning eligibility and enrollment including <b>COBRA</b>.</p>	<p><i>Telephone number:</i> 1-800-526-8056 (option 1); TDD: 1-800-952-0450 Monday through Friday, 8 am to 8 pm, Eastern time</p> <p>Web site: <a href="http://www.AvayaHealthyDecisions.com">www.AvayaHealthyDecisions.com</a></p>
<p><b>Claims Administrator:</b></p> <p>Contact by phone for:</p> <ul style="list-style-type: none"> <li>• Locations of network providers</li> <li>• Your eligibility status for exams, lenses and frames</li> <li>• Other vision care-related matters</li> <li>• Claim forms</li> </ul> <p>Contact by mail:</p> <ul style="list-style-type: none"> <li>• To submit claims for benefits</li> <li>• For legal actions regarding a claim for benefits</li> </ul>	<p>EyeMed Vision Care. administers the Vision Care Plan on behalf of Avaya Inc.</p> <p><i>Telephone number:</i> 1-866-723-0513 Monday through Saturday, 8 am to 11 pm, Eastern time Sunday, 11 am to 8 pm, Eastern time</p> <p>EyeMed Vision Care Attn: OON Claims P.O. Box 8504 Mason, Ohio 45040-7111</p> <p>Web site: <a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a></p>
<p><b>Domestic Relations Matters Group:</b></p> <p>Contact for matters relating to a <b>Qualified Medical Child Support Order (QMCSO)</b>.</p>	<p>Domestic Relations Matter Group Aon Corporation 270 Davidson Avenue 7th Floor Somerset, NJ 08873</p>
<p><b>Plan Administrator:</b></p> <p>Contact for all legal actions, except for legal actions regarding a claim for benefits. Legal actions regarding a claim for benefits should be directed to the <b>Claims Administrator</b> at the above address.</p>	<p>Avaya Inc. Vision Care Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920</p> <p>E-mail: <a href="mailto:hwplanadmin@avaya.com">hwplanadmin@avaya.com</a></p>

## **OTHER IMPORTANT INFORMATION**

This section contains administrative information about the Vision Care Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

### ***Claim Procedures***

Participants, their beneficiaries (if applicable) or any individual duly authorized by them, have the right under ERISA and the Vision Care Plan to file a written claim for benefits with the **Claims Administrator** or Plan Administrator (see “Important Contacts”), as the case may be.

The Plan Administrator (see “Important Contacts”) has the final authority to decide whether you are eligible to participate in the Vision Care Plan. The **Claims Administrator** has the authority to decide the amount and extent of benefits that are payable to you.

You (or another person) cannot challenge a claim decision in court until the following claim and appeal procedures have been complied with and exhausted.

### **Claim Processing**

When the vision benefit is provided or denied, you will receive a notice explaining how the coverage level was calculated or why benefits have been denied. This notice will be provided within 30 days after the **Claims Administrator** or Plan Administrator (see “Important Contacts”), as the case may be, receives the claim.

If the **Claims Administrator** or Plan Administrator, as the case may be, needs more than 30 days to make a decision, a representative will notify you in writing within the initial 30-day period and explain why more time is required. An additional 15 days (for a total of 45 days) may be taken if the **Claims Administrator** or Plan Administrator, as the case may be, sends this notice. The extension notice will include the date by which the **Claims Administrator’s** or Plan Administrator’s, as the case may be, decision will be sent.

### **Appeal Procedures**

After the **Claims Administrator** or Plan Administrator (see “Important Contacts”), as the case may be, denies your claim, you (or your authorized representative) may request a full review by the **Claims Administrator** or Plan Administrator (see “Important Contacts”), as the case may be, if you disagree with the denial. You (or your authorized representative) must submit a written request for review within 180 days after you receive the denial notice. In connection with your appeal, you (or your authorized representative) may review relevant documents and submit issues and comments in writing.

The relevant documents that must be made available to you upon request include documents, records and other information that:

- Were relied on in deciding your benefit claim;
- Were submitted, considered or generated in the course of deciding your benefit claim;
- Demonstrate that the decision complied with the Vision Care Plan's administrative procedures or safeguards; or
- State the Vision Care Plan's policy or guidelines regarding the benefits for your diagnosis, whether or not it was relied upon.

If you want to appeal a decision on eligibility for benefits, send your appeal to the Plan Administrator (see "Important Contacts"). All other appeals should be sent to the **Claims Administrator** (see "Important Contacts").

Your appeal will be reviewed. Someone other than the person who made the first decision on your claim must make this review. The **Claims Administrator** (see "Important Contacts") must disclose the identity of any vision or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the **Claims Administrator** must consult with a health care professional who has the appropriate training and experience in the field of medicine involved.

After a decision by the **Claims Administrator** or Plan Administrator (see "Important Contacts"), as the case may be, is made concerning your appeal, you will be notified of the findings and decision in writing. This notice will be provided no later than 60 days after receiving the claim.

This decision is final and is not subject to further internal review.

### **Claims Decision Notices**

The notice given to you concerning the decision on either your initial claim or your appeal will include:

- The specific reason or reasons for the decision;
- The specific Vision Care Plan provisions upon which the benefit decision is based;
- A statement that you are entitled to receive upon request (and free of charge) reasonable access to, and copies of, all document, records and other information relevant to your claim;

- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary;
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request;
- If the decision is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the Vision Care Plan's terms to your vision circumstances), or a statement that such an explanation will be provided free of charge upon request;
- For an initial claim, a description of the appeal procedures; and
- A statement that the claimant has the right to bring a civil action under ERISA Section 502(a) following a denial upon appeal.

### ***Your Rights Under ERISA***

It is Avaya Inc.'s policy to provide meaningful benefits -- above and beyond your paycheck. Part of this additional protection is provided through the Vision Care Plan. You are entitled to certain rights and protection under ERISA. These rights are described in this section.

#### **Right to Receive Information About the Plan and Its Benefits**

It is your right to know about your benefits. Therefore, in addition to this SPD describing your benefits under the Vision Care Plan, you will have the opportunity to obtain a summary of the Vision Care Plan's annual financial report. You also may examine all Vision Care Plan documents governing the Vision Care Plan and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor. These documents are available for you to examine without charge in the Plan Administrator's office.

You can receive a copy of any of these documents, for a reasonable charge, by making a written request to the Plan Administrator.

You also have the right to:

- Continue vision coverage for yourself, spouse, or dependents if there is a loss of coverage under the Vision Care Plan as a result of a qualifying event under **COBRA**. You or your dependents will have to pay for such coverage. Review this summary plan description and the documents governing the Vision Care Plan for the rules governing your **COBRA** continuation rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under that plan, when you become entitled to elect **COBRA** continuation coverage, when your **COBRA** continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **Prudent Action by Plan Fiduciaries**

You also have the right to expect the fiduciaries -- the people responsible for the operation of the Vision Care Plan -- to act prudently and in the best interest of those who participate as a whole. The Vision Care Plan's fiduciaries must act in the best interest of all Vision Care Plan **participants**.

No one, including the Company may dismiss you or discriminate against you to prevent you from obtaining benefits or exercising any of your rights under ERISA.

### **Enforce Your Rights**

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of plan documents or the latest annual report (Form 5500 Series) from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials – unless the materials were not sent for reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits that is denied or ignore – in whole or in part – after going through the appeals procedures, you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack of response to your request concerning the qualified status of a **qualified medical child support order (QMCSO)**, you may file suit in federal court.
- If it should happen that the Vision Care Plan fiduciaries misuse the Vision Care Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court.
- If you file suit against the Vision Care Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees – if, for example, it finds your claim is frivolous.

### **If You Have Questions**

For answers to questions about the Vision Care Plan, contact the **Claims Administrator** or the Plan Administrator (see "Important Contacts"). If you have any questions about this statement of your rights, or about your rights under ERISA, contact the nearest Regional or District Office of the U.S. Department of Labor, Employee Benefits Security Administration (EBSA), listed in your telephone directory; or contact the Division of Technical Assistance and Inquiries, U.S. Department of Labor, EBSA, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA or visit the EBSA Web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA Web site.)

### ***Plan Funding and Payment of Benefits***

You (the Avaya Inc. employee) pay the full cost associated with benefits under The Avaya Inc. Vision Care Plan for Salaried Employees.

### ***Benefits Cannot Be Assigned***

Assignment or alienation of any benefits provided by the Vision Care Plan will not be permitted or recognized, except as otherwise required by applicable law. This means that benefits provided under the Vision Care Plan are not subject to sale, assignment, anticipation, alienation, attachment, garnishment, levy, execution or any other form of transfer. Generally, state and local laws will not be recognized unless permitted by or under applicable federal law, such as ERISA.

***Plan May Be Amended or Terminated***

The Company expects to continue the Vision Care Plan, but reserves the right to amend or terminate the Vision Care Plan at any time by the resolution of the Board of Directors or properly authorized designee. In addition, the Company does not guarantee the continuation of any vision benefits during employment, nor does it guarantee any specific level of benefits or contributions.

***Plan Administrator***

The Plan Administrator has the full discretionary authority and power to control and manage all aspects of the Vision Care Plan, to determine eligibility for Vision Care Plan benefits, to interpret and construe the terms and provisions of the Vision Care Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Vision Care Plan as deemed appropriate in accordance with the terms of the Vision Care Plan, the contract, and all applicable laws.

***Plan Sponsor***

The Plan Sponsor may allocate or delegate its responsibilities for the administration of the Vision Care Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Vision Care Plan, including discretionary authority to interpret and construe the terms of the Vision Care Plan, to direct disbursements, and to determine eligibility for Vision Care Plan benefits.

## ADMINISTRATIVE INFORMATION

<b>Plan Name</b>	The official Plan Name is The Avaya Inc. Vision Care Plan for Salaried Employees which is a part of The Avaya Inc. Health & Welfare Benefits Plan for Salaried Employees.
<b>Plan Sponsor</b>	The Plan Sponsor is Avaya Inc.
<b>Plan Administrator</b>	The Plan Administrator is:  Avaya Inc. Vision Care Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920  E-mail: <a href="mailto:hwplanadmin@avaya.com">hwplanadmin@avaya.com</a>
<b>Type of Administration</b>	The Plan is underwritten by:  Fidelity Security Life Insurance Company 3139 Broadway Kansas City, MO 64141
<b>Claims Administrator</b>	Claims under the Vision Care Plan are administered on behalf of Avaya Inc. by the <b>Claims Administrator</b> :  EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040
<b>Agent for Service of Legal Process</b>	Legal actions regarding a claim for benefits should be sent to the <b>Claims Administrator</b> . All other legal actions should be sent to the Plan Administrator.
<b>Plan Records and Plan Year</b>	The Plan and all its records are maintained on a calendar year basis, beginning on January 1st and ending on December 31st of each year.
<b>Type of Plan</b>	The Plan is considered a "health & welfare plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
<b>Trustee</b>	State Street Bank and Trust Company is the trustee of the Avaya Inc. Health Plans Benefit Trust. State Street Bank and Trust Company is located at 200 Newport Avenue, North Quincy, MA 02171.
<b>Plan Number</b>	The Plan Number is 550.
<b>Employer Identification Number</b>	The Employer Identification Number is 22-3713430.