THE AVAYA INC. VISION CARE PLAN FOR SALARIED EMPLOYEES, A COMPONENT OF THE AVAYA INC. HEALTH & WELFARE BENEFITS PLAN FOR SALARIED EMPLOYEES

Plan Number 550

SUMMARY PLAN DESCRIPTION

EyeMed Vision Plan

EFFECTIVE AS OF JUNE 1, 2016
LAST UPDATED OCTOBER 4, 2018

IF THIS SUMMARY PLAN DESCRIPTION HAS BEEN DELIVERED TO YOU BY ELECTRONIC MEANS, YOU HAVE THE RIGHT TO RECEIVE A WRITTEN DOCUMENT AND MAY REQUEST A COPY OF THIS DOCUMENT ON A WRITTEN PAPER DOCUMENT AT NO CHARGE BY CONTACTING THE PLAN ADMINISTRATOR.

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Summary Plan Description

INTRODUCTION

This document, together with the related summaries, booklets, notices, enrollment materials and attachments (each of which are fully incorporated herein by this reference), is a Summary Plan Description ("SPD") of the benefits under the EyeMed Vision Plan ("EyeMed vision"), under The Avaya Inc. Vision Care Plan for Salaried Employees, a component of The Avaya Inc. Health & Welfare Benefits Plan for Salaried Employees ("Plan"), as in effect on June 1, 2016 (unless otherwise noted). If you terminated your employment with, or retired from, Avaya Inc. (the "Company") prior to June 1, 2016, different provisions may apply to you – in this case, you should contact the Plan Administrator for more information.

We urge you to take the time to review this document carefully. You have many choices under the Plan which are important to you and your family. You will obtain the greatest value from the Plan if you understand the benefits available, and the choices you can make, under the Plan. This SDP replaces and supersedes any other summary plan description previously issued to you for the group vision benefits under the Plan.

Please remember that this SPD only summarizes the key provisions of the EyeMed vision benefit program under the Plan. Other benefits may be described in separate booklets. Also, this SPD is not the official Plan document itself. As a summary, this document cannot explain how every Plan provision might apply in your particular situation. If you have any questions about the Plan or how it applies to you, or if you would like to review or order your own copy of the Plan document, please contact the Plan Administrator – the Plan Administrator's contact information may be found in the "General Plan Information" section of this SPD. The Plan Administrator may charge you a reasonable fee for a copy of the Plan document. Unless contrary to applicable law, the Program Document will control in the event of any irreconcilable conflict between or among the plan documents.

Your receipt of this SPD does not necessarily mean that you are eligible for the Plan. You must satisfy the specific eligibility enrollment and participation requirements provided in the Program Document.

GENERAL PLAN INFORMATION

This section contains general information that you may need to know about the Plan.

Name of Plan

EyeMed Vision Plan ("EyeMed vision") (under The Avaya Inc. Vision Care Plan for Salaried Employees, a component of The Avaya Inc. Health & Welfare Benefits Plan for Salaried Employees)

Effective Date

This SPD reflects the Plan as in effect on June 1, 2018 (unless otherwise noted). The Plan was originally effective as of June 1, 2016.

Plan Identification Number

550

Plan Sponsor

Avaya Inc.
4655 Great America Parkway
Santa Clara, CA 95054
E-mail: hwplanadmin@avaya.com
Employer Identification Number: 22-3713430

Plan Administrator

Avaya Inc.
Health & Welfare Plan Administrator
4655 Great America Parkway
Santa Clara, CA 95054
E-mail: hwplanadmin@avaya.com

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator may delegate any or all of its responsibilities to any person, committee or entity from time to time, including to a "**Claims Administrator**."

Insurer and Claims Administrator

First American Administrators, Inc.
C/O EyeMed Vision Care LLC
Attn: OON Claims
P.O. Box 8504
Mason, Ohio 45040-7111
1-866-798-9189

Web site: www.eyemedvisioncare.com

Agent for Legal Service

Any legal actions regarding a claim should be sent to the **Claims Administrator**. All other legal actions should be sent to:

Avaya Inc.
Attn: General Counsel
4655 Great America Parkway
Santa Clara, CA 95054

Plan Year

The 12-month period beginning on each June 1 and ending on the following May 31.

Type of Plan

The Plan is intended to be an "employee welfare benefit plan", within the meaning of Section 3(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), which provides group vision benefits.

Funding Medium

The group vision benefits under the Plan are fully insured and the Company pays for all of the insurance premiums from its general assets, which may include employee payroll contributions. An insurance company, EyeMed Vision Care LLC, has been appointed as the **Claims Administrator**, and it shares responsibility for administering the group vision benefits with the Company. Some or all of the benefit programs provided under the Plan may require contributions from you. If employee contributions are required, such amounts will be determined in accordance with the enrollment materials provided to you. All benefits are paid exclusively by the insurance company pursuant to the terms of the governing insurance contract(s).

Type of Administration

Contract Administration. The Plan Administrator has contracted with EyeMed Vision Care LLC to provide claims administration services for the Plan as the **Claims Administrator** for the group vision benefits. The **Claims Administrator**'s decisions are final and binding and the Company does not have the authority to change the **Claims Administrator**'s decision.

Amendment and Termination

The Board of Directors of Avaya Inc. (or its delegate) reserves the right to modify, suspend or terminate the benefits at any time without the consent of any employee or **participant**. This includes, but is not limited to, reducing or eliminating benefits for any group of employees (and the dependents of each) and adjusting any required employee contributions. Although the Company currently expects to continue the Plan indefinitely, it is not legally bound to do

so, and it reserves the right to terminate the Plan or any feature at any time and for any reason. Upon termination of the Plan (or feature), all elections and reductions in compensation relating to the Plan (or feature) shall terminate. Note that, for this purpose, an insurance contract is not necessarily the same as the Plan. Consequently, termination of an insurance contract does not necessarily terminate the Plan. Questions regarding your benefits should be addressed to the Plan Administrator. Because of the many detailed provisions of the Plan no one else is authorized to advise you as to your benefits. For this reason, **Avaya Participating Companies** are not bound by statements made by anyone or any entity other than the Plan Administrator or its authorized delegates. The Plan Administrator, or its designee, has sole discretionary authority to interpret and construe the provisions of the Plan, to determine eligibility for benefits under the Plan, and to resolve any disputes that arise under the Plan. Benefits under the EyeMed vision benefit program will be paid only if the Plan Administrator decides, in its discretion, that the applicant is entitled to them.

ELIGIBILITY AND PARTICIPATION REQUIREMENTS

You are eligible to participate in the EyeMed vision benefit program if you are an "**eligible employee**" and satisfy the eligibility provisions described in the Program Document. You are an "**eligible employee**" if you are a regular full-time or part-time, salaried employee who works for Avaya Inc. and such other affiliates that have elected to participate in the Plan with the prior approval of Avaya Inc. (an "**Avaya Participating Company**").

You are not an "**eligible employee**" if:

- You are a Student Intern.
- You are enrolled in an International Assignee plan and paid from the U.S. payroll of an **Avaya Participating Company**, or you are covered through Aetna Global Benefits under the International Indemnity plan. Instead, you will receive group vision benefits through Aetna Global Benefits. Contact Aetna Global Benefits at the number on your ID card for specific information about group vision benefits.
- You are not paid from the U.S. payroll of an **Avaya Participating Company**, you are employed by an independent company (such as an employment agency), or your services are rendered as part of an agreement excluding participation in benefits.

Enrollment

The timeline for enrollment in Avaya's group vision benefit plans varies by your employment status. Here are some key dates to keep in mind:

Employment Status	Timeline to Enroll	Eligibility Coverage Date
Newly-hired/rehired or newly-eligible active full-time or part-time employees	You have 31 days from your eligibility coverage date to enroll in or waive coverage for yourself and/or your dependents	Date of hire, rehire, or date you enter the eligible class
Current active **eligible employees**	**Annual enrollment** period	January 1st of the following calendar year
	Within 31 days of a **qualified status change** (e.g. birth, adoption, marriage, death of dependent, divorce, involuntary loss of other group health coverage, etc.)	Your coverage eligibility date depends on your **qualified status change**. Coverage typically begins on the date of the event or the first of the month following the event.

For anticipated enrollment periods, such as new hire eligibility and annual enrollment, information will be e-mailed to you from *Avaya Health & Benefits* instructing you to enroll. The e-mail will include information about how to enroll yourself and your **eligible dependents** in the benefits enrollment portal at https://my.adp.com and the date by which you must make your elections. If you have not received an e-mail and your enrollment deadline is nearing, contact the **Avaya Health & Benefits Decision Center** for assistance

(via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.).

For **qualified status changes**, you are responsible for initiating the change within 31 days of the qualifying event (e.g. adding a newborn or dropping a divorced spouse) online by logging in to the benefits enrollment portal at https://my.adp.com or by contacting the **Avaya Health & Benefits Decision Center** (via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.).

If you miss your enrollment deadline(s) you may be negatively impacted for the remainder of the **Plan Year**. See "If You Do Not Enroll (on time)" and "Qualified Status Changes" for more detail.

Your elections are in effect as follows:

- The elections or waivers you make as a newly-hired, rehired, or newly-**eligible employee** are effective for the duration of the calendar year in which you enroll.
- The elections or waivers you make during annual enrollment are in effect for the next full calendar year.
- The elections or waivers you make for a **qualified status change** are effective for the duration of the calendar year in which you make an enrollment change.

How to Enroll or Make Changes to Your Benefits

For most benefits you can make benefit elections for you and your **eligible dependents** online by logging in to the benefits enrollment portal at https://my.adp.com or by contacting the **Avaya Health & Benefits Decision Center** (via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.).

The benefits enrollment portal is available year-round. You will use the portal as a new hire to initially enroll in your benefits, during annual enrollment to update your elections, and/or to make **qualified status changes** during the year. The benefits enrollment portal contains everything you need to make an informed decision, and your personalized enrollment webpage walks you through each of your election choices, benefit by benefit.

For example, when you enroll, you may:

- Change from the vision Default Coverage Waiver (see "Default Coverage Waiver (Vision Only)") to elect coverage,
- Enroll your **eligible dependents** in coverage *(Note: after your election is approved you will be required to submit proof of dependency (i.e. marriage license, Government Registration for **Domestic Partners**, birth certificate, etc.) for each dependent newly added to coverage before their coverage will take effect)*,
- Enroll in or waive each Avaya Inc. benefit separately. You may waive medical coverage and still enroll in dental and/or vision coverage for yourself and your dependents, or you

may cover all your dependents under the vision plan (for example), even if they are not covered under an Avaya Inc. medical or dental plan.

Default Coverage Waiver (Vision Only)

When you view the benefit enrollment portal for the first time, a vision plan Default Coverage Waiver (all vision benefits will automatically be waived) will be selected. It is your responsibility to keep or amend the vision plan Default Coverage Waiver, and review all other benefits you are eligible for, within your 31-day election window. If you do not change the election, or if you fail to enroll altogether, the vision plan Default Coverage Waiver will be in force for the remainder of the **Plan Year**. Your next opportunity to make changes to your benefits will be during the next annual enrollment period or within 31 days of a **qualified status change**.

If You Do Not Enroll (on time)

If you miss your enrollment deadline, your coverage will remain *as is* for the remainder of the **Plan Year**. You will have to wait until the next annual enrollment period to enroll in or change your election, unless you have a mid-year **qualified status change**. For new hires and rehires, this means you will have the Default Coverage Waiver automatically assigned to you (see "Default Coverage Waiver (Vision only)"). For existing employees, this means you will retain your existing election. All applicable payroll contributions will apply.

Similarly, if you do not enroll your **eligible dependent(s)** within 31 days of your hire/rehire/eligibility date or within 31 days of a **qualified status change**, or if you do not submit proper proof of your dependents' eligibility for benefits by the deadline on the dependent verification letter, your dependent(s) will not be **covered** for the remainder of the **Plan Year**. You will have to wait until the next annual enrollment period to enroll your **eligible dependents** and provide proof of dependency, unless you have a mid-year **qualified status change**.

Your Costs

You can find the cost for each benefit online at https://my.adp.com.

Payroll Deductions for Insurance Premiums

Your payroll deductions for benefits are clearly indicated on your pay statement (paystub).

- For new hires/rehires and for benefit changes made during the year (for **qualified status changes**), your deductions/contributions generally begin within 1-2 pay periods (prospectively, as soon as administratively feasible) after your enrollment is received and processed.
- For elections made during annual enrollment your deductions/contributions begin on your first paycheck in January.

Coverage for Dependents

Your **eligible dependents** can also participate in the EyeMed vision benefit program if you elect coverage for them. You must enroll your dependents in the same benefit program in which you are enrolled. **Eligible dependents** are defined by Avaya Inc.

Eligible Dependents Include:

- Your **Lawful Spouse or Domestic Partner** (either same-sex or opposite-sex; both parties must complete and file a notarized **Domestic Partner** Affidavit or government registration).
- **Children** To be eligible for coverage, a dependent child must be under 23 years of age. Each child is eligible for coverage through December 31st of the year in which the child reaches age 23. An **eligible dependent** child includes:
    - Your biological and/or legally adopted child, including any child in the formal legal process of adoption, regardless of residence;
    - A stepchild living with you; and
    - A child living with you for whom you or your **lawful spouse** or your **domestic partner** is the legal guardian (this does not include "wards of the state" or "foster children").

  A child, for this purpose, does not include the spouse, **domestic partner**, or child(ren) of a child.

  Coverage for a fully handicapped child may be continued past the age limits shown above. Your child is fully handicapped if:

    - He or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your Plan; and
    - He or she depends chiefly on you for support and maintenance.

  Proof that your child is fully handicapped must be submitted to the **Claims Administrator** no later than 90 days after the date your child reaches the maximum age under your Plan. You must complete an application form available 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.

  Ineligible dependents include a legally separated spouse, a divorced spouse, and a **domestic partner** where the domestic partnership has terminated.

Coverage for a Domestic Partner

To be eligible for coverage, a **domestic partner** must meet the following criteria:

A **domestic partner** is an individual (same-gender or opposite-gender) who certifies, by affidavit or government registration, the following as of the date of enrollment:

- He or she is your sole **domestic partner** and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership.
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
- He or she resides with you in the same residence.
- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she has mental sufficiency to enter into a valid contract.

Coverage for a Domestic Partner's Child(ren)

A **domestic partner's child** is defined as:

- 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.

If You and Your Spouse or Domestic Partner Both Work for an Avaya Participating Company

Avaya Participating Companies have many families -- employees (or retired **Avaya Participating Company** employees) whose **lawful spouse** or **domestic partner**, children (including those of your eligible **Domestic Partner**, if applicable), or parents also are employed by (or retired from) an **Avaya Participating Company**. This may affect your coverage under the EyeMed vision benefit program.

- No one person can receive benefits as a dependent of more than one employee or retiree, or as both a dependent and an employee or retiree. For example, you may not be **covered** as an active **Avaya Participating Company** employee or retiree and a dependent of another **Avaya Participating Company** employee or retiree. Either parent may cover dependent children; however, both parents cannot cover the same child at the same time.
- An **eligible employee** or retiree may cover another salaried **Avaya Participating Company** employee or retiree. Therefore, if your **lawful spouse** or **domestic partner** is an active salaried employee or retiree, you may enroll as his or her dependent under the EyeMed vision benefit program, or he or she may enroll as your dependent, but not both.
- A salaried active **Avaya Participating Company** employee or retiree cannot enroll a represented **Avaya Participating Company** employee or retiree as an **eligible dependent**.
- Only one **Avaya Participating Company** employee or retiree may enroll any given **eligible dependent**. Either you or your **Avaya Participating Company lawful spouse** or **domestic partner**, as an employee or retiree, may cover your dependent children. A

child may not be **covered** by both parents or by both a parent and a **domestic partner** at the same time.

CHANGING YOUR COVERAGE DURING THE YEAR

Outside of annual enrollment, if you want to make changes to your benefits during the year, you have to meet certain criteria to do so. This section discusses those criteria.

Qualified Status Changes

The Internal Revenue Service (IRS) states that you may change coverage during the year if you have a qualified change in status. 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 **lawful 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 **lawful spouse**, or child that affects benefit eligibility.
Work Schedule	A reduction or increase in hours of employment by you, your **lawful 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 a 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 **lawful spouse** or a child that changes your eligibility for the Plan.

The changes you make must be "due to and consistent with" your qualified change in status. For example, adding your new spouse to your vision plan would be "due to and consistent with" getting married.

To be eligible to make a change, qualified status changes must be reported to the Avaya Health & Benefits Decision Center (online by logging in to the benefits enrollment portal at https://my.adp.com, via e-mail at avayaservicecenter@adp.com, or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.) **within 31 days of the event**. You will be asked to provide documentation of the **qualified status change** to add or remove your dependents from the Plan. This documentation should be in writing and should include proof of the event (e.g. a copy of the divorce decree, documentation of domestic partnership, marriage license, birth certificate, adoption agreement or any other legal documentation to support the **qualified status change**).

Avaya Participating Companies consider corresponding changes in **domestic partner** and/or **domestic partner** child(ren) status as a **qualified status change**.

Enrolling Newborns Mid-Year

If you wish to enroll your newborn in the EyeMed vision plan, you must do so within 31 days from the date of birth. If you miss the 31-day window, the newborn will be without coverage. You will have to wait until the next annual enrollment period to enroll your newborn and provide proof of dependency, unless you have a mid-year **qualified status change**.

PERSONAL EVENTS AFFECTING COVERAGE

If You Gain a New Dependent

If you gain a new dependent, (through marriage, birth or adoption), you may enroll your new dependent within 31 days of the date he or she became your dependent by notifying the **Avaya Health & Benefits Decision Center** (see "Qualified Status Changes").

If a Dependent Loses Eligibility for Avaya's Plans

If your **covered dependent** is no longer eligible for coverage under the EyeMed vision benefit program, (e.g. your dependent child ages-out of the Plan, you and your **lawful spouse** divorce, your dependent dies, etc.), you may remove your dependent(s) within 31 days of the date he or she lost eligibility by notifying the **Avaya Health & Benefits Decision Center** (see "Qualified Status Changes").

You must provide notification within 31 days when your dependent no longer qualifies as an **eligible dependent** to make any corresponding changes to your coverage level and ensure that your dependent is sent timely information regarding **COBRA** continuation coverage, if applicable. If you do not provide notification within 31 days of when the dependent loses eligibility, your coverage level and rates will not be retroactively adjusted, but the dependent will be ineligible to claim benefits. If you do not provide notification within 60 days, your dependent will lose all rights to **COBRA** continuation coverage, if applicable.

If a Dependent Loses Eligibility for non-Avaya Coverage

If your **eligible dependent** loses non-Avaya coverage (e.g. due to an involuntary termination of employment and benefits) you may enroll them in Avaya's plans within 31 days of the date he or she lost their coverage by notifying the **Avaya Health & Benefits Decision Center** (see "Qualified Status Changes").

If You Die While Covered Under an Avaya Inc. Plan

Your **covered dependents** have the option of continuing coverage under **COBRA** for up to 36 months if they make the required contributions.

If You Move

A move does not impact the benefits provided under the EyeMed vision benefit program.

EMPLOYMENT-RELATED EVENTS AFFECTING COVERAGE

If Your Employment Status Changes

Since your options are based, in part, on your employment status, it is possible that a change in your employment status may affect your coverage. If a change in your employment status requires that you change your vision plan and you fail to make a selection within the 31-day window, your and your **eligible dependents**', as applicable, vision coverage will be waived for the remainder of the **Plan Year**. Your next opportunity to make changes to your benefits will be during the next annual enrollment period or within 31 days of a **qualified status change**.

If you change from Part-Time to Full-Time

Vision benefit coverage is NOT impacted by a change from part-time to full-time status.

If you change from Full-Time to Part-Time

Vision benefit coverage is NOT impacted by a change from full-time to part-time status.

If you change from Salaried to Represented

Your group vision benefit coverage will end on the last day of the month in which your status changes and you will become eligible to participate in the vision plan offered to represented employees.

If Your Employment Terminates

Refer to the "Loss of Benefits" section of this booklet.

When your employment terminates, you will receive information at your home address about your rights to continue coverage (as applicable) under **COBRA** (see "Continuing Coverage through COBRA").

If You Are Laid Off

For group vision benefit coverage, depending upon your years of Net Credited Service and/or your job title and the type of layoff, part of your cost for **COBRA** coverage may be paid by the **Avaya Participating Company**. Your Force Management Program package will provide the details.

When you are laid off, you will receive information at your home address about your rights to continue coverage (as applicable) under **COBRA** (see "Continuing Coverage through COBRA").

If You Retire

Refer to the "Loss of Benefits" section of this booklet.

When you retire, you will receive information at your home address about your rights to continue coverage (as applicable) under **COBRA** (see "Continuing Coverage through COBRA").

If You Transfer

If you transfer to another **Avaya Participating Company**, it will not affect your participation in the Plans. If you transfer to a non-**Avaya Participating Company**, refer to the "Loss of Benefits" section of this booklet.

If You Are Rehired

Refer to the "Enrollment" section of this booklet.

If you Become Disabled

Your participation may be affected if you become disabled. Your length of service and the duration of your disability determine what happens to your coverage during a disability. Refer to the "If you Become Disabled" section of the *Avaya Inc.* ***Summary Wrap Description*** *for Salaried Employees* located at https://www.avaya.com/benefitanswers.

CONTINUING 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.

COBRA enables you or your dependents to continue group vision benefit coverage.

COBRA may extend health plan coverage 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 **covered dependents**	18 months
You	Have a reduction in hours	You and your **covered dependents**	18 months
You	Are terminated from employment (for reasons other than gross misconduct)	You and your **covered dependents**	18 months
You	Do not return from an FMLA leave of absence (or state equivalent)	You and your **covered dependents**	18 months
You	Become disabled within the first 60 days of **COBRA** continuation coverage	You and your **covered dependents**	Up to 29 months*
You	Die	Your **covered dependents**	36 months
You	Become divorced, legally separated, or there is a dissolution of your domestic partnership	Your **covered dependents**	36 months
Your **covered dependents**	Is no longer an **eligible dependent** (due to age limit, divorce, or legal separation or this is a dissolution of your domestic partnership)	Your **covered dependents**	36 months
Your **covered dependents**	Is no longer an **eligible dependent** because of your death	Your **covered dependents**	36 months
Your **covered dependents**	Becomes disabled within the first 60 days of **COBRA** continuation coverage	Your **covered dependents**	Up to 29 months*

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

COBRA applies to the health plan options you and your dependents are **covered** under at the time of your loss of active coverage. The group vision benefit plan you have at the time of your loss of coverage as an active employee is your option as a **COBRA** Qualified Beneficiary. Although not required under **COBRA**, the plans provide continuation coverage to **Domestic Partner** and/or **Domestic Partner** Child(ren).

Loss of Coverage

You and your **covered dependents** will be notified when an event makes continuation of coverage available. Avaya's **COBRA** vendor, WageWorks, will send 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 WageWorks (within 60 days of the date the notice is sent or coverage is lost, whichever is later) of the 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 six months of your first **COBRA** qualifying event.

If you elect **COBRA** coverage and you acquire a new dependent (e.g. through marriage, birth, adoption, etc.) during your **COBRA** continuation period, you may enroll that new dependent in **COBRA** continuation coverage with required documentation (i.e. marriage, birth or adoption certificate).

COBRA May Be Extended

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 WageWorks by phone at 1-800-526-2720 within 60 days of the determination of your disability by the Social Security Administration and within the initial 18-month continuation coverage period. This notice should be in writing and should include a copy of the Social Security Administration's disability determination. If WageWorks determines that you or your **covered dependents** are not eligible for an extension of the **COBRA** continuation period, you will be provided a written explanation of why extended **COBRA** continuation coverage is not available.

If one of your **covered dependents** experiences another qualifying event (for example, your child is no longer eligible for coverage due to age, you die during the **COBRA** continuation period, etc.), the **COBRA** continuation period can be extended for that dependent. You or your **covered dependent** must notify WageWorks by phone at 1-800-526-2720 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 WageWorks determines that your **covered dependent** is not

eligible for an extension of the **COBRA** continuation period, the dependent 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 **lawful spouse** get divorced or legally separated, or there is a dissolution of your domestic partnership, or
- He or she is no longer eligible for coverage under the Plan (e.g., due to reaching the age limit)

If your **covered dependents** lose coverage because of your death, WageWorks will notify them of their right to continue coverage within 44 days. Your **covered dependent** must notify WageWorks by phone at 1-800-526-2720 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 WageWorks by phone at 1-800-526-2720 within 60 days of the event. Notice should also be provided to WageWorks in writing and should include proof of the qualifying event (for example, a copy of the divorce decree). If WageWorks is not notified within 60 days of the qualifying event, your **covered dependent** will lose the right to elect **COBRA** continuation coverage. After your notice is received, 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 WageWorks of his or her decision to continue coverage. If WageWorks 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 COBRA Coverage Ends

If you and/or your **covered dependent(s)** elect **COBRA** continuation coverage, it takes effect on the date of the 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 the **Avaya Participating Company** 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 eligible for Medicare, if after the date your **COBRA** coverage begins. Note that coverage will still be available for family members who are not Medicare-eligible.

- With respect to the 11-month extension for disability, the date the person is no longer disabled you must notify WageWorks that you or the **covered dependent** is no longer disabled

If WageWorks 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, WageWorks is legally required to provide a 45-day grace period for this initial **COBRA** payment. No further extension will be permitted. After the initial payment, subsequent payments are due by the first of the month for the coverage period which is being paid. WageWorks is legally required to provide you with a 30-day grace period for these payments. No further extension is permitted. Payments received after the 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.

COBRA for a Military Leave of Absence

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to **eligible employees** who enter military service. The terms “Uniformed Services” or “Military Service” mean the Armed Forces (i.e., Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

If you lose coverage because you enter into active military duty covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you and your **covered dependents** are eligible for **COBRA** continuation coverage. Under USERRA, however, you and your **covered dependents** are only required to pay the regular employee contribution for the first 30 days of coverage, and the duration of the continuation coverage is 24 months instead of 18 months.

Special rules apply if your active military duty is in connection with "Operation Enduring Freedom". In that case, the **Avaya Participating Company** provides you and your **covered dependents** with continued coverage under the vision benefit plan, as applicable, for the first 60 months of your military leave of absence. To receive this continued coverage, you must pay the regular employee contribution. This coverage satisfies the Plan obligation to provide you with **COBRA** continuation coverage. As a result, if you lose coverage at the end of your military leave of absence because you do not return to the **Avaya Participating Company**, then you (and your **covered dependents**) will have no right to **COBRA** continuation coverage, so long as you were on military leave for at least 18 months.

If You Have Questions

Questions concerning **COBRA** continuation coverage rights should be addressed to WageWorks by phone at 1-800-526-2720. For more information about your rights under ERISA, **COBRA**, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 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 Employee Benefits Security Administration. You may also visit their website at www.dol.gov/ebsa.

Keep the COBRA Administrator Informed of Address Changes

In order to protect your family's rights, you should keep WageWorks informed of any changes in the addresses of family members. You may contact WageWorks by phone at 1-800-526-2720. You should also keep a copy, for your records, of any notices you send to WageWorks.

SUMMARY OF PLAN BENEFITS

Benefits

Group vision benefits are provided under the Plan and are fully insured. The full cost associated with the group vision benefits are paid from employee payroll contributions. You should read the Program Documents for each benefit program to understand your benefits. All benefits are paid exclusively by the insurance company pursuant to the terms of the governing insurance contract(s).

Qualified Medical Child Support Orders:

A **Qualified Medical Child Support Order** ("QMCSO") is an order by a court for one parent to provide a child or children with health care coverage under a group health plan. The Plan Administrator will comply with the terms of any **qualified medical child support order** it receives and will:

1. Establish reasonable procedures to determine whether medical child support orders are QMCSOs as defined under Section 609 of ERISA;
2. Promptly notify you and any alternate recipient (as defined in Section 609(a)(2)(C) of ERISA) of the receipt of any medical child support order, and the Plan's procedures for determining whether medical child support orders are QMCSOs; and
3. Within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a QMCSO and will notify you and each alternate recipient of such determination.

The Plan Administrator is permitted to modify your election under the Plan to provide coverage under an accident or health plan for a child or foster child who is your dependent if a judgment decree or order resulting from divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires coverage for the child. You are permitted to revoke your election under the Plan for the **Plan Year** and make a new election to provide for or cancel coverage for the child if the order requires the spouse, former spouse or other individual to provide coverage for the child. The Plan Administrator, in its sole discretion, shall determine whether the order qualifies as a QMCSO in accordance with procedures established for such purpose. Your new election shall take effect as of the effective date provided in the QMCSO procedures established by the Plan Administrator.

You may obtain a copy of the Plan's QMCSO procedures from the Plan Administrator free of charge upon request.

Loss of Benefits

Coverage for active employees ends on the last day of the month in which any of the following events occur:

- You retire or die;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage;

- You do not make any required contributions;
- You become **covered** under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under the Plan, if your Plan contains such a maximum benefit; or
- Your employer notifies EyeMed Vision Care LLC that your employment is ended.

Generally, your dependent's coverage will end on the:

- Date your coverage ends;
- Last day of the month in your which your **covered dependent** is no longer an **eligible dependent**; or
- Last day of the year in which your dependent turns age 23.

If your **covered dependent** is no longer eligible for coverage under the EyeMed vision benefit program, (e.g. your dependent child ages-out of the Plan, you and your **lawful spouse** divorce, your dependent dies, etc.), you must remove your dependent(s) within 31 days of the date he or she lost eligibility by notifying the **Avaya Health & Benefits Decision Center** (see "Qualified Status Changes" and "If a Dependent Loses Eligibility for Avaya's Plans").

If the EyeMed vision benefit program is discontinued or the Plan is terminated, coverage for you and your **eligible dependents** will end on the termination date, not the last day of the month.

When your coverage ends, you and your **eligible dependents** may be eligible for **COBRA** continuation coverage (see "Continuing Coverage through COBRA").

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

PLAN ADMINISTRATION

The Plan is administered by the Company (as the "Plan Administrator") and EyeMed Vision Care LLC. EyeMed Vision Care LLC, the **Claims Administrator**, is the contact for all claims questions.

Benefits Cannot Be Assigned

Assignment or alienation of any benefits provided by the EyeMed vision benefit program will not be permitted or recognized, except as otherwise required by applicable law. This means that benefits provided under the EyeMed vision benefit program 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 Administrator

The Plan Administrator has the power and authority in its sole and absolute discretion to control and manage the operation and administration of the Plan and shall have all powers necessary to accomplish these purposes. The Plan Administrator will administer the Plan in accordance with established policies, interpretations, practices, and procedures and in accordance with the requirements of ERISA, the Plan and applicable laws. Unless otherwise delegated to EyeMed Vision Care LLC, the Plan Administrator will have absolute discretion with respect to the Plan, including the power to:

1. Interpret the terms of the Plan, including eligibility determinations;
2. Determine factual questions that arise in the course of administering the Plan;
3. Adopt and enforce rules and regulations regarding the administration of the Plan;
4. Determine the conditions under which benefits become payable under the Plan and to determine the person or persons to whom such benefits will be paid; and
5. Make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan.

Any determination made by the Plan Administrator will be final, conclusive and binding on all parties.

The Plan Administrator may delegate all or any portion of its authority to any person or entity.

Duties of the Plan Administrator

The Plan Administrator will (i) administer the Plan in accordance with its terms, (ii) decide disputes which may arise relative to a Plan **participant's** rights, (iii) keep and maintain the Plan documents and all relevant records pertaining to the Plan, (iv) arrange for the payment of claims, (v) establish and communicate procedures to determine whether a medical child support order is qualified under Section 609 of ERISA, and (vi) perform all necessary reporting as required by ERISA.

Claims Administrator

The Plan Administrator has contracted with EyeMed Vision Care LLC to provide claims administration services for the Plan as its **Claims Administrator** and insurer for the group vision benefits. EyeMed Vision Care LLC, not the Company, is responsible for determining and paying claims. EyeMed Vision Care LLC is responsible for determining eligibility for a benefit and the amount of any benefits payable under the EyeMed vision benefit program and providing the claims procedures to be followed and the claims forms to be used by eligible individuals with respect to the group vision benefits. As a fiduciary for benefit determinations for the group vision benefits, EyeMed Vision Care LLC, to the fullest extent permitted by law, has the discretionary authority to interpret the EyeMed vision benefit program in order to make benefit determinations. EyeMed Vision Care LLC also has authority to require eligible individuals to furnish it with such information as it determines necessary for the proper administration of the EyeMed vision benefit program. The **Claims Administrator**'s decisions are final and binding and the Company does not have the authority to change the **Claims Administrator**'s decision.

Plan Administrator Compensation

The Plan Administrator serves without additional compensation; however, all expenses for administration, including compensation for hired services, will be paid by the Plan to the extent not paid by the Company in its sole and absolute discretion.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the employees and their dependents and defraying reasonable expenses of plan administration. These duties must be carried out with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation and in accordance with Plan documents to the extent that they are consistent with ERISA.

The Named Fiduciary

The Plan Administrator is the "named fiduciary" with respect to the Plan. A named fiduciary can appoint others, such as EyeMed Vision Care LLC, to carry out fiduciary responsibilities under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will not be liable for any act or omission of such person unless either (i) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures, or (ii) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

HIPAA Notice of Privacy Practices

The Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you

would like a copy of the Plan's Notice of Privacy Practices, please contact the Plan Administrator.

Limitations Period for Filing Suit

Unless specifically provided otherwise under a Program Document, insurance contract or pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures. Claims and appeals procedures are provided in the Program Document.

HOW THE PLAN WORKS

Understanding the Plan

The EyeMed vision benefit program 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 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 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.

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 EyeMed vision benefit program 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 EyeMed vision benefit program pays benefits for the above services and supplies once every 12 months from the date of your last examination or lenses/frame purchase.

In addition, you will receive other special discounts on a variety of lens options. 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 EyeMed vision benefit program, you will not receive reimbursement. However, you may be eligible for reimbursement of such non-**covered** expenses through The Avaya Inc. Flexible Spending Account Plans for Salaried Employees, if you participate in that plan.

HOW BENEFITS ARE PAID

Comparison of Benefits

The following chart compares how the EyeMed vision benefit program covers both in-network and out-of-network expenses:

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$0 Copay	Up to $40
Frames	$0 Copay; $120 allowance; 20% off balance over $120	Up to $50
Standard Plastic Lens		
Single Vision	$0 Copay	Up to $40
Bifocal	$0 Copay	Up to $75
Trifocal	$0 Copay	Up to $100
Standard Progressive Lens	$65 Copay	Up to $75
Premium Progressive Lens	$65 Copay, 80% of charge less $120 allowance	Up to $75
Lenticular	$0 Copay	Up to $100
Lens Options		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lens Fit and Follow-Up[1]		
Standard Contact Lens Fit & Follow-Up	Up to $55	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Contact Lenses		
Conventional	$0 Copay; $100 allowance; 15% off balance over $100	Up to $75
Disposable	$0 Copay; $100 allowance; plus balance over $100	Up to $75
Medically Necessary	$0 Copay; Paid-in-Full	Up to $200
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchase and 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency		
Examination	Once every 12 months (from last date of service)	
Lenses or Contact Lenses	Once every 12 months (from last date of purchase)	
Frame	Once every 12 months (from last date of purchase)	
Additional Discounts	40% off complete pair of prescription eyeglasses	N/A
	20% off non-prescription sunglasses	N/A
	20% off remaining balance beyond plan coverage	N/A

[1] Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.

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.

Non-Covered Items/Negotiated Fees

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 EyeMed vision benefit program, you will not receive reimbursement. However, you may be eligible for reimbursement of such non-**covered** expenses through The Avaya Inc. Flexible Spending Account Plans for Salaried Employees, if you participate in that plan.

Laser Vision Benefit

You are entitled to a 15% discount on retail pricing or a 5% discount on promotional pricing on LASIK and PRK treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a LasikPlus Center, which is part of the U.S. Laser Network, and you elect to obtain pre-operative and post-operative care not from the LasikPlus Center provider, the other provider may charge additional fees for the pre-operative and post-operative care which you will be responsible for and such fees are not subject to the 15% discount on retail pricing or the 5% discount on promotional pricing.

Accessing the Laser Vision Benefit

1. To locate the nearest U.S. Laser Network provider, you must call 1-877-5LASER6.
2. After you have located a U.S. Laser Network provider, you should contact the U.S. Laser Network provider and identify yourself as an EyeMed Member. You should schedule a consultation with a U.S. Laser Network provider to determine if you are a good candidate for laser vision correction.
3. If it is determined that you are a good candidate for laser vision correction, you should schedule a treatment date with a U.S. Laser Network provider.
4. To activate the benefit, you must call the U.S. Laser Network again at 1-877-5LASER6 with your scheduled treatment date.
5. At the time the treatment is scheduled, you will be responsible to remit an initial refundable deposit to U.S. Laser Network. (If you should decide not to have the treatment, the deposit will be returned. Otherwise, the deposit will be applied to the total cost of the treatment.)
6. At the time you remit the deposit, U.S. Laser Network will issue you an authorization number confirming the EyeMed discount. This authorization number will be sent to your U.S. Laser Network provider prior to treatment.
7. On the day of the treatment, it is your responsibility to pay, or arrange to pay, the balance of the fee.
8. After the treatment, you should follow all post-operative instructions carefully. In addition, you are responsible for scheduling any required follow-up visits with a U.S. Laser Network provider to ensure the best results from the laser vision correction.

If you receive any of the above services from an **out-of-network provider**, you are responsible for paying the full cost. Since these services are not **covered** under the EyeMed vision benefit program, you will not receive reimbursement. However, you may be eligible for reimbursement of such non-**covered** expenses through The Avaya Inc. Flexible Spending Account Plans for Salaried Employees, if you participate 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 1-866-798-9189 or going online 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** (see "Important Contacts") 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 "Claims and Appeals Process").

MISCELLANEOUS COVERAGE INFORMATION

If You Use an HMO

The EyeMed vision benefit program 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 Benefits"). However, you cannot be reimbursed by both the EyeMed vision benefit program and your HMO for the same expense.

Coordination of Benefits

The EyeMed vision benefit program 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 EyeMed vision benefit program, 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 an **Avaya Participating Company**, due to the following two rules:
    - One person cannot receive EyeMed vision benefit program benefits as both an employee or retiree of an **Avaya Participating Company**, and as an **eligible dependent** of such an employee or retiree.
    - One person cannot receive EyeMed vision benefit program benefits as an **eligible dependent** of more than one employee or retiree of an **Avaya Participating Company**.

The Primary Plan Determines Benefits First

Under the COB provision, the **Claims Administrator** (see "Important Contacts") 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 you received from the primary plan. The secondary plan(s) will then determine if any additional benefits are payable.

- If the EyeMed vision benefit program is the primary plan, it pays its benefits without regard to the secondary plan.
- If the EyeMed vision benefit program is secondary, EyeMed vision benefit program coordinates benefits with the primary plan. Here is how this works:

  The **Claims Administrator** (see "Important Contacts") first calculates what the EyeMed vision benefit program would have paid if it were the primary plan. Second, the **Claims Administrator** (see "Important Contacts") reviews the EOB you received from the primary plan to determine what the primary plan paid. The EyeMed vision benefit program then pays the difference, up to the amount the EyeMed vision benefit program 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** (see "Important Contacts") 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 EyeMed vision benefit program 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 child(ren), 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 child(ren), and the plan covering the other parent is the secondary plan for the child(ren). The EyeMed vision benefit program 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 child(ren) and the mother's group insurance is the secondary plan for the child(ren).
  - 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 child(ren) are divorced or legally separated, the **Claims Administrator** (see "Important Contacts") 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, the **Avaya Participating Company** 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 an **Avaya Participating Company**, either parent (but not both) may choose to cover the child(ren). Claims for the child(ren) are submitted to the **Claims Administrator** (see "Important Contacts") of the parent covering the child(ren). The other parent's coverage is not secondary because it does not cover the child(ren).

Right of Recovery and Subrogation

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

If the refund is due from another person or organization, you or your **covered dependents** must assist the EyeMed vision benefit program 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 EyeMed vision benefit program.

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 EyeMed vision benefit program.

The EyeMed vision benefit program provides **covered** benefits to you and your **covered dependents** that are not provided by any third party. So, benefits provided under the EyeMed vision benefit program 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 EyeMed vision benefit program.

If such benefits *have* been paid by the EyeMed vision benefit program, the following shall apply:

- The EyeMed vision benefit program 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 plan.
- You and your **covered dependents** agree to reimburse the EyeMed vision benefit program for the reasonable value of all benefits received under the EyeMed vision benefit program out of any actual recoveries you or your **covered dependents** received from any third party (other than the **Participant's** family members).

- The EyeMed vision benefit program'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 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.
    - Any payments made as a result of coverage under any automobile, school or homeowner's insurance policy.

You and your **covered dependents** are required to fully cooperate and perform all actions necessary to secure the EyeMed vision benefit program'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 EyeMed vision benefit program'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 EyeMed vision benefit program in pursuit of the EyeMed vision benefit program's rights. No court costs or attorney's fees may be deducted from the EyeMed vision benefit program's recovery without the advance express written consent of the EyeMed vision benefit program.

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

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the **Avaya Health & 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 & Benefits Decision Center** (see "Important Contacts").

SERVICES AND MATERIALS NOT COVERED UNDER THE PLAN

Benefits are not provided from services or materials arising from:

1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
2) Aniseikonic lenses;
3) Medical and/or surgical treatment of the eye, eyes or supporting structures;
4) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment;
5) Safety eyewear;
6) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
7) Plano (non-prescription) lenses;
8) Non-prescription sunglasses;
9) Two pair of glasses in lieu of bifocals;
10) Services or materials provided by any other group benefit plan providing vision care;
11) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order;

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered - fund as a Bifocal lens. Standard Progressive lens covered - fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

Remember, you may be eligible for reimbursement of such non-**covered** expenses through The Avaya Inc. Flexible Spending Account Plans for Salaried Employees, if you participate in that plan.

CLAIMS AND APPEALS PROCESS

This section contains administrative information about the EyeMed vision benefit program 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 EyeMed vision benefit program 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 EyeMed vision benefit program. The **Claims Administrator** (see "Important Contacts") 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 (see "Important Contacts"), 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 (see "Important Contacts"), 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 (see "Important Contacts"), as the case may be, decision will be sent.

Claims Decision Notices

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

- The specific reason or reasons for the decision;
- The specific EyeMed vision benefit program 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 EyeMed vision benefit program'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.

Appeal Procedures

After the **Claims Administrator** or Plan Administrator (see "Important Contacts"), as the case may be, denies your claim - all or in part - 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 EyeMed vision benefit program's administrative procedures or safeguards; or
- State the EyeMed vision benefit program'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** (see "Important Contacts") 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.

IMPORTANT NOTICES

Uniformed Services Reemployment Rights

If you take leave to perform qualifying military service, you may qualify to elect continuation coverage for yourself and any **covered eligible dependents** pursuant to a Federal law called the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Continuation coverage rights under USERRA are similar to **COBRA** continuation coverage rights, but not identical.

In order to qualify for USERRA continuation coverage, you must be performing duty on a voluntary or involuntary basis in qualifying military service. Qualifying military service includes active duty, active and inactive duty for training, National Guard duty under Federal law and a period for which you are absent for an examination to determine your fitness to perform those duties. Qualifying military service also includes a period for which you are absent to perform funeral honors duty as authorized by law and services as an intermittent disaster-response appointee of the National Disaster Medical System. Qualifying military service (also referred to as "uniformed services") means the following: Armed Forces; Army National Guard; Air National Guard when engaged in active duty for training, inactive duty training, or fulltime National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President in time of war or national emergency.

If you qualify for USERRA continuation coverage, you may continue coverage for yourself and any **covered eligible dependents** for whom you elect coverage for up to 24 months from the date your coverage would end because of your leave. Your USERRA coverage will end earlier than the end of the 24 month period if:

1. You fail to pay the required premiums on a timely basis as described in the enclosed brochure;
2. You fail to return to work within the time required under USERRA; or
3. You lose your USERRA rights because you are dishonorably discharged or because of other conduct specified in USERRA.

COBRA coverage and USERRA coverage begin at the same time and run concurrently – in other words, the coverage periods run at the same time. **COBRA** coverage can continue for up to 18 months and is subject to extension and early termination in certain circumstances that do not apply under USERRA.

The rules and procedures regarding **COBRA** coverage generally apply to USERRA coverage (i.e., election procedures, premium payment procedures, etc.), except to the extent inconsistent with USERRA requirements.

If you would like to receive additional information about USERRA, contact the Plan Administrator.

Genetic Information Non-Discrimination Act of 2008 ("GINA")

The Plan will not set employee contributions on the basis of genetic information. The Plan may not require an employee (or dependent) to undergo a genetic test except in very limited circumstances. The Plan is generally prohibited from collecting genetic information regarding its **participants**. The Plan intends to comply with GINA.

Leave Under Family Medical Leave Act ("FMLA")

If you take a leave of absence for your own serious health condition or to care for family members with a serious health condition or to care for newborn or adopted child, you may be able to continue your health coverage under the Plan. During FMLA leave, you will continue to have group vision benefit coverage: (a) if you had such coverage before taking the leave, and (b) your coverage will be under the same terms as if you had continued to work. You will need to pay your share of the group health plan contributions while on leave. If you choose not to continue your group vision benefits coverage while on leave, your coverage will be reinstated when you return to work, subject to Plan provisions.

Plan is Not an Employment Contract

The Plan is not intended to be, and should not be construed as, a contract for or of employment between you and the Company for any specific period of time.

Statement of ERISA Rights

Your Rights Under ERISA

As a **participant** in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan **Participants** are entitled to –

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts (if any), and a copy of the latest annual report (Form 5500 series as required) and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information including insurance contracts (if any), and copies of the latest annual report (Form 5500 series as required) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies; and
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each **participant** with a copy of this summary annual report.

COBRA and HIPAA Rights

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan, particularly the rules governing your **COBRA** continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan **participants**, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan **participants**. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, 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 the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a 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 from the 31st day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. No action at law or in equity may be brought to recover under the Plan until the appeal rights herein provided have been fully exercised and the Plan benefits requested in such appeal have been denied in whole or in part. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in State or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the Court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, **COBRA**, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security

Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 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 Employee Benefits Security Administration. You may also visit their website at www.dol.gov/ebsa.

IMPORTANT CONTACTS

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

Contact / Service Provided	Contact Information
Avaya Health & Benefits Decision Center: Contact for questions concerning eligibility and enrollment including **COBRA**.	*Telephone number:* 1-800-526-8056 (option 1); TDD: 1-800-952-0450 Monday - Friday, 8am to 8pm, ET and Saturday, 8am to 5pm, ET E-mail: avayaservicecenter@adp.com
Claims Administrator: Contact by phone for: • Locations of **network providers** • Your eligibility status for exams, lenses and frames • Other vision care-related matters • Claim forms Contact by mail: • To submit claims for benefits • For legal actions regarding a claim for benefits	EyeMed Vision Care LLC administers the EyeMed vision benefit program on behalf of Avaya Inc. First American Administrators, Inc. handles the out-of-network claim adjudication duties for EyeMed Vision Care LLC. *Telephone number:* 1-866-798-9189 Monday - Saturday, 8am to 11pm, ET Sunday, 11am to 8pm, ET First American Administrators, Inc. Attn: OON Claims P.O. Box 8504 Mason, Ohio 45040-7111 Web site: www.eyemedvisioncare.com Group number: 1006366
Plan Administrator: 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 **Claims Administrator** at the above address.	Avaya Inc. Health & Welfare Plan Administrator 4655 Great America Parkway Santa Clara, CA 95054 E-mail: hwplanadmin@avaya.com

GLOSSARY

There are several words and phrases that have specific meanings under the EyeMed vision benefit program. 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 Avaya Participating 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 & Benefits Decision Center: the resource to call to enroll, make changes in your coverage or ask questions about the EyeMed vision benefit program. See Important Contacts.

Avaya Participating Company or Companies: Avaya Inc. and such other companies that have elected to participate in the EyeMed vision benefit program with the prior approval of Avaya Inc.

Child(ren): See Coverage for Dependents.

Claims Administrator: the company authorized by Avaya Inc. to administer the EyeMed vision benefit program. See Important Contacts.

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. See Continuing Coverage through COBRA.

Covered: eligible under the terms of the EyeMed vision benefit program. "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 EyeMed vision benefit program. A covered person is one who is enrolled and eligible for benefits under the EyeMed vision benefit program.

Covered dependent: See Coverage for Dependents

Domestic partner: See Coverage for Dependents

Domestic partner's child: See Coverage for Dependents

Eligible dependents: See Coverage for Dependents

Eligible employee: A regular full-time or part-time, salaried employee who works for Avaya Inc. and such other affiliates that have elected to participate in the Plan with the prior approval of Avaya Inc. (an "Avaya Participating Company").

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 EyeMed vision benefit program.

Lawful spouse: See Coverage for Dependents

Network Provider: the providers in a given area who participate in the vision network. Network providers offer services to members enrolled with the EyeMed vision benefit program at a pre-negotiated rate.

Out-of-Network Provider: refers to providers that have not signed a network provider agreement with the vision carrier.

Participant: an eligible employee or eligible dependent who has been enrolled and is covered under the EyeMed vision benefit program.

Plan Year: is the period of time from June 1st to May 31st.

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. The Avaya Participating Company has a policy to comply with the requirements of a QMCSO.

Qualified status change: See Qualified Status Changes

Summary Wrap Description: means the Avaya Inc. Summary Wrap Description for Salaried Employees.