THE AVAYA INC.

LONG-TERM CARE INSURANCE PLAN
(Prudential Policies only)
Active Salaried

SUMMARY PLAN DESCRIPTION

Effective 06/1/2012
Last Updated 6/3/2013

Helpful search tools:

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Find Feature: while in a PDF, press 'Control' + 'F' to bring up the find feature and enter the word(s) you're seeking. The find feature will allow you to search the whole document for each reference to your desired topic.

This is a Summary Plan Description (SPD) of the benefits as they were available, to eligible employees from June 1, 2012 until June 30, 2013 under The Avaya Inc. Long-Term Care Insurance Plan (Long-Term Care Plan). More detailed information is provided in the Plan Document. In all instances, the Plan Document will control and govern the operation of the Long-Term Care Plan administered by Prudential Insurance Company of America.

The Board of Directors of Avaya Inc. (or its delegate) reserves the right to modify, suspend or terminate the Long-Term Care Plan at any time. Questions regarding your benefits should be addressed to the **Plan Administrator** (see "Important Contacts"). Because of the many detailed provisions of the Long-Term Care Plan, no one other than the **Plan Administrator** 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.

As of June 30, 2013, Prudential Insurance Company of America no longer underwrites Group Long Term Care policies. Any Prudential Long Term Care policies from June 1, 2012 to June 30, 2013 are unaffected by Prudential's product discontinuation; and this SPD governs over those policies.

Questions regarding your benefits should be addressed to the **Plan Administrator** (see "Important Contacts"). Because of the many detailed provisions of the Long-Term Care Plan, no one other than the **Plan Administrator** 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.

Please note that participation in the Long-Term Care Plan is neither an offer of employment nor a guarantee of employment for any period of time at an **Avaya Participating Company**.

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INTRODUCTION

As of June 30, 2013, Prudential Insurance Company of America will no longer underwrite new policies. If you have chosen to maintain a Long Term Care Policy through Prudential your Long-term Care insurance will continue to provide protection against the high costs associated with nursing home and other assisted living services

This is a Summary Plan Description (SPD) of the Long Term Care benefits as they were available to eligible employees from June 1, 2012 to June 30, 2013 under The Avaya Inc. Long-Term Care Insurance Plan (Long-Term Care Plan). As of June 30, 2013, Prudential Insurance Company of America no longer underwrites Group Long Term Care policies. Any Prudential Long Term Care policies are unaffected by Prudential's product discontinuation; and this SPD and your Certificate of Coverage governs over those Prudential Group Long Term Care policies.

HIGHLIGHTS

Here is a summary of some features of the Long-Term Care Plan, as they existed from June 1, 2012 to June 30, 2013 through Prudential Insurance Company of America.

Plan Features	Summary
Eligibility	If you are an **eligible employee** (a regular, active, full-time or part-time, (not covered by a collective bargaining agreement)) who works for an **Avaya Participating Company**), you and your **eligible family members** are eligible for coverage.
When Coverage Begins	Generally, coverage is effective on the first day of the month following the date the **Insurer** (see "Important Contacts") approves the request for coverage. (see "When Coverage Begins" for further details).
Proof of Insurability	Newly **eligible employees** who enroll within 90 days of their eligibility date do *not* need to provide a Statement of Health as proof of insurability. The employee must be **actively at work** on the effective date of coverage (see "When Coverage Begins" for exceptions). Employees who enroll later, and *all* **eligible family members**, however, must provide a Statement of Health.
When Benefits Start	A 30 Day Benefit Waiting/Elimination Period must be met once during your lifetime before benefits are payable. (see "When Benefits Are Payable").
When Benefits Start	Benefits begin on the first day that **daily benefits** are authorized, and you are receiving covered services, and after you meet any required deductible period (see "When Benefits Are Payable").
When Benefits Stop	Benefits stop when your condition has improved so that you are no longer eligible for benefits, when you reach the **total lifetime benefit**, or when your coverage stops. See "When Coverage Ends" to understand when coverage may stop.
Cost	You pay the full cost of insurance coverage for you and your **eligible family members** under the Long-Term Care Plan.

TERMS YOU SHOULD KNOW

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

Activities of Daily Living: Bathing, Continence, Dressing, Eating, Toileting, Transferring and Severe Cognitive Impairment

Actively at Work:

- Actually present on the job and physically able to perform all duties of your job, and
- Working the minimum scheduled hours in your work week at your regular business establishment, or at some other location to which your job requires you to travel.

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

Daily benefit: the maximum amount of money that you will be paid for each day you are eligible for benefits and receive a covered service. Also referred to as Facility Daily Benefit Amount (FDB).

Domestic Partner: an individual (same-gender or opposite-gender) can be your domestic partner if you satisfy either the government registration requirement or the affidavit requirement and submit the necessary documentation.

> **Government Registration**: an individual is your domestic partner if you satisfy one of the following requirements and submit a copy of the applicable government registration:
>
> - You have complied with any state or local registration process for domestic partners;
> - You reside in a state that recognizes same-gender marriages and you are legally married to your same-gender domestic partner under the laws of that state; or
> - You reside in a state that recognizes same–gender civil unions, and you have legally entered into such a civil union.
>
> Note: An individual will cease to be your domestic partner when a copy of the applicable government documentation terminating your domestic partnership is filed with the **Avaya Health and Benefits Decision Center**.
>
> **Affidavit:** an individual is your domestic partner if you complete and file with the **Avaya Health and Benefits Decisions Center** a notarized Domestic Partner

Affidavit and any other required documentation, and you and your **domestic partner:**

- Reside in the same household as a member of that household,
- Are age 18 or older,
- Have mental sufficiency to enter into a valid contract,
- Are not related to each other by blood,
- Are not legally married to any other person, or the domestic partner of any other person
- Have a close and committed personal relationship with each other and have no such relationship with anyone else, and
- Have joint responsibility for each other's welfare and financial obligations.

Note: An individual will cease to be your **domestic partner** when a notarized Domestic Partner Termination Affidavit is completed and filed with the **Avaya Health and Benefits Decision Center.**

Domestic Partnership: A relationship that is formed by two people, one of whom is an **eligible employee** of the employer.

Eligible employee: a regular, active, full-time or part-time, employee (not covered by a collective bargaining agreement) who works for a **Participating Company**.

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

Eligible family member: includes your **lawful spouse, surviving spouse, domestic partner***, parents, parents-in-law, stepparents, stepparents-in-law of an Employee, Retired Employee, Spouse or Surviving Spouse or the parent or stepparent of a domestic partner, grandparents, grandparents-in-law, step-grandparents and step-grandparents-in-law of an Employee, Retired Employee, Spouse or Surviving Spouse or the parent or stepparent of a domestic partner, siblings or step siblings of an Employee or Retired Employee, Spouse or Surviving Spouse, and adult children 18 years or older who is a natural child, adopted child or stepchild of an Employee or retired Employee, Spouse or Surviving Spouse..

*Due to state regulations, Domestic Partners who are residents of LA are not eligible.

Insurer: The Prudential Insurance Company of America administers the Plan on behalf of Avaya Inc.

Lawful spouse: a person who is recognized as the lawful husband or lawful wife for federal income tax purposes. An **eligible employee** residing in a state that recognizes

common law marriage must satisfy the specific minimum state requirements to be married under common law.

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

Non-forfeiture coverage: an optional feature that allows you to stop making future long-term care premiums after you have been paying premiums for at least three years and your coverage ends due to cancellation or nonpayment of premiums. If you elect this option, you will be entitled to the full **daily benefit**, subject to a **lifetime maximum** of either the total amount of premiums paid, or 30 times the daily nursing home benefit, whichever is greater. The adjusted **lifetime maximum** is not reduced by any benefits paid.

Refund of Premium: upon your death, Prudential may return a percentage of the premium paid for your Coverage. This benefit will be paid even if, at the time of your death, you are receiving benefits and premiums have been waived. Waived premiums are not considered paid premiums and will not be returned under this provision. Prudential will pay the refund to your estate upon receipt of a copy of the death certificate and a written request for such benefits.

Total lifetime benefit: the total dollar amount of benefits available to you or to your **eligible family members** through the Long-Term Care Plan.

PARTICIPATING IN THE PLAN

Who Is Eligible

You are eligible to enroll if you are a regular, active, full-time or part-time, employee (not covered by a collective bargaining agreement) who works for an **Avaya Participating Company**.

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

Your Eligible Family Members

If you are eligible for the Long-Term Care Plan, some of your family members may also be eligible for coverage. Your **eligible family members** may enroll even if you do not. **Eligible family members** are:

- Your **lawful spouse** or **domestic partner***, and

- parents, parents-in-law, stepparents, stepparents-in-law of an Employee, Retired Employee, Spouse or Surviving Spouse or the parent or stepparent of a domestic partner, grandparents, grandparents-in-law, step-grandparents and step-grandparents-in-law of an Employee, Retired Employee, Spouse or Surviving Spouse or the parent or stepparent of a domestic partner, siblings or step siblings of an Employee or Retired Employee, Spouse or Surviving Spouse, and adult children 18 years or older who is a natural child, adopted child or stepchild of an Employee or retired Employee, Spouse or Surviving Spouse.

*Due to state regulations, Domestic Partners who are residents of LA are not eligible.

An **Avaya Participating Company** employee cannot cover another **Avaya Participating Company** employee as a dependent under the Long-Term Care Plan.

When You Enroll

You and your **eligible dependents** may enroll in the Long-Term Care Plan as soon as you are eligible or any time thereafter as long as you remain eligible. However, depending on when you enroll, you may or may not need to provide a Statement of Health as proof of insurability (See “Proof of Insurability”).

When you enroll, you will select your pool of money, which is the Lifetime Maximum based on the daily benefit and whether you want 5 years benefit or 7 years of benefits, choose the inflation protection option you prefer and the optional non-forfeiture coverage (see "How the Plan Works).

Proof of Insurability

If you are an **eligible employee**, proof of insurability is not required if you enroll for coverage within the first 90days following your eligibility date, provided you are **actively at work** on your effective date. However, proof of insurability is always required for **eligible family members**.

If you are an employee and you do not enroll when first eligible, you must provide the **Insurer** (see "Important Contacts") with satisfactory proof of insurability before you can begin to receive long-term care coverage. The proof of insurability includes a Statement of Health, and may require other evidence, such as medical records. If a physical exam is required, you will need to obtain it at your own expense.

You must provide proof of insurability to increase your type of coverage, unless you increase your **daily benefit** during the special opportunity given at least once every five years (see "Special Plan Features").

When Coverage Begins

If you are newly eligible and enroll within 90 days of your eligibility date, your coverage becomes effective on the first day of the month following the date the **Insurer** (see "Important Contacts") receives your completed enrollment form, provided you are **actively at work** on that date. If your form is received on the first day of the month, your coverage is effective that day, provided you are eligible and **actively at work**.

Guaranteed issue coverage for employees who are not actively at work on their effective date will become effective on the first of the month following their return to work (provided they are actively at work on that date).

If you are an employee and you do not enroll during your first opportunity, or if your **eligible family members** enroll, proof of insurability needs to be provided. Coverage becomes effective on the first day of the month next following the date the **Insurer** (see "Important Contacts") approves the request for coverage.

If you are eligible for this coverage other than as an employee, your coverage will be delayed if, on the day your insurance would otherwise begin, you are confined in a health care facility or are receiving Home Care or Hospice Care. Instead it will begin on

the first day of the month following the date you are discharged from such confinement or are not receiving such care.

The Cost of Coverage

You pay the full cost of coverage under the Long-Term Care Plan. The costs are based on:

- The age of the person being covered at the time coverage becomes effective,
- The Pool of Money chosen
- The **inflation protection option** chosen, and
- Election of the optional **non-forfeiture coverage**.

As an employee, you have the option to pay your costs through after-tax payroll deductions or directly to the **Insurer** (see "Important Contacts"). If you opt to pay via Payroll deductions, your deductions will stop when you retire and you will be able to pay your costs directly to the **Insurer**. Retired employees and **eligible family members** must pay premiums directly to the **Insurer** on a monthly, quarterly, semiannual or annual basis. Note that monthly payments must be automatically deducted from a checking account.

Each payment not made by payroll deductions has a grace period of 31 days. If you fail to pay the **Insurer** (see "Important Contacts") within the grace period, your coverage under this Long-Term Care Plan will end on the last day of the month for which the **Insurer** has received full payment.

Costs may only be raised as a result of an increase made on a class-wide basis that has been filed and approved by the States. Your costs cannot be adjusted because of the change in your age or your health status. You will be required to pay the increased premium in order to maintain coverage.

Terminating Your Coverage

You and your **eligible family members** can cancel your Long-Term Care Plan coverage at any time. This cancellation will be effective at the end of the month in which you request cancellation.

When Coverage Ends

The following chart shows the circumstances under which your Long-Term Care Plan coverage will end.

Circumstance Causing Coverage to End	When Coverage Ends
You cancel your coverage	At the end of the month in which you notify the **Insurer** (see "Important Contacts")
This coverage is replaced by another substantially equivalent group plan, and you become eligible for that coverage	On that date
You die	On that date
You do not pay your costs for coverage or payroll deductions are not forward to the **Insurer** by the **Avaya Participating Company**	On the last day of the month for which a required payment is made to the **Insurer**
You reach your **total lifetime benefit**	On that date

If the Long-Term Care Plan ends, you will be able to continue your coverage directly with the **Insurer** (see "Important Contacts") if:

- The Long-Term Care Plan is not being replaced with a substantially equivalent plan,
- The Long-Term Care Plan is being replaced with a substantially equivalent group plan, but you are not eligible under the new plan, or
- You are no longer an **eligible employee** or **eligible family member** under the Long-Term Care Plan.

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 **eligible family members**) has ended on the date identified in the notice:

- Fraud or misrepresentation with respect to the Long Term Care Plan, or because you (or one of your **eligible family member**) knowingly gave the **Plan Administrator** or **Insurer** false, material information. Examples include false

information relating to a person's eligibility or status as an **eligible family member**.

- You (or one of your **eligible dependents**) in any other way materially violates the terms of the Long-Term Care Plan.

To continue your coverage after the Long-Term Care Plan ends, you must *pay the required premiums directly to the **Insurer*** (see "Important Contacts").

HOW THE PLAN WORKS

Limitations or Conditions on Eligibility for Benefits

You must have a Chronic Illness or Disability while your Coverage is in force. You must undergo an Assessment and be certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability. A Licensed Health Care Practitioner must then develop a Plan of Care, consistent with the certification. The **insurer** (see "Important Contacts") must be provided with satisfactory proof of loss, including a completed claim form and other documentation. Once these requirements are met, the Insurer will review your claim and determine whether benefits are payable.

Benefit Eligibility Criteria

Before incurring Eligible Charges and submitting a claim, you must undergo an assessment and be certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability. A Chronic Illness or Disability is one that meets either definition below.

1. A loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living due to a loss of functional capacity. This inability must be expected to continue for at least 90 consecutive days. This expectation is not a waiting period.
    a. Activities of Daily Living are
        i. Bathing: Washing oneself by sponge bath, either in a tub or shower, including the task of getting into or out of the tub or shower.
        ii. Continence: Ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
        iii. Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
        iv. Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table), by a feeding tube or intravenously.
        v. Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
        vi. and Transferring: Moving into or out of a bed, chair or wheelchair.

2. A Severe Cognitive Impairment that requires Substantial Supervision to protect you from threats to health and safety.

A Licensed Health Care Practitioner must then develop a Plan of Care.

Notice of Claim

If you think you have a Chronic Illness or Disability that is expected to last at least 90 days, either you or your representative must either call the **Insurer**, or send a written notice (see "Important Contacts"). You or your representative must notify the **Insurer** within 20 days of the onset of a potential Chronic Illness or Disability, or as soon as reasonably possible. The address for the Customer Service Center appears on the first page of your Certificate Coverage supplied by the **Insurer** at the onset of your policy.) The notice must include your name and Certificate number.

Certification Process

The **Insurer** will arrange for an Assessment to determine if you have a Chronic Illness or Disability. As part of the Assessment process, you will be interviewed. The Assessment will be based on objective standards of measurement. The Assessment must be made at a time when the chronic nature of the condition can be determined. A Licensed Health Care Practitioner must certify your Chronic Illness or Disability. After your Chronic Illness or Disability is certified, a Plan of Care, acceptable to Prudential, must be developed consistent with your needs. Prudential reserves the right to verify that all of the Benefit Eligibility Criteria have been satisfied and determine if you are eligible for benefits. You will be sent a written notice to confirm the date you become eligible. If you are not eligible, you will be sent a written notice explaining the reasons you are not eligible. You can select your own Licensed Health Care Practitioner to certify your chronic Illness or Disability. If you wish to do so, you should notify us when you call our Long-Term Care Customer Service Center. Prudential will send you an Assessment form that your Licensed Health Care Practitioner must complete and return together with an acceptable Plan of Care to us prior to submitting proof of loss. Prudential must receive proof that a Licensed Health Care Practitioner has certified, in writing, that you have a Chronic Illness or Disability. The certification must occur on or after your Effective Date. Prudential reserves the right to verify that all of the Benefit Eligibility Criteria have been satisfied to determine if you are eligible for benefits.

Claim Forms

When Prudential is notified, you will be sent a claim form. It will be sent no later than 10 working days following the date of your notice. If you do not receive the claim form within this time, you may send us the documentation identified in the Proof of Loss section of your Coverage.

Proof of Loss

For reimbursement of Eligible Charges, your Proof of Loss must include the Provider's bill, together with the completed claim form. Any bill must include all of the following.

1) The name of the person who received the service.
1) The name and address of the Provider who rendered the service.
2) The date(s) of service.
3) Each type of service rendered.
4) The charge for that service.

At your own expense, you must obtain and submit all required documentation to us in English.

If you are submitting Proof of Loss for charges for Qualified Long-Term Care Services rendered by a Nursing Home, Assisted Living Facility, Residential Health Care Facility, Adult Foster Home or Board and Care Facility, or by a vendor providing such services on behalf of the facility, you must submit a written bill that itemizes and separately details each service, cost and expense that you sustained. This bill must include an itemized listing of all services, costs and expenses, including type and date of each, hours of services per day and cost per hour for each date services are provided to you. Charges for room and board or comparable expenses for residence in the facility must be listed separately from any other costs. Prudential reserves the right to require that facility bills be sufficiently itemized to allow us to determine which charges, if any, from a facility may be Eligible Charges under your Coverage. You are responsible for obtaining a sufficiently itemized bill from the facility you use.

If you are submitting Proof of Loss for charges for Qualified Long-Term Care Services rendered by a Nursing Home, Assisted Living Facility, Residential Health Care Facility, Adult Foster Home or Board and Care Facility, or by a vendor providing such services on behalf of the facility, you must submit a written bill that itemizes and separately details each service, cost and expense that you sustained. This bill must include an itemized listing of all services, costs and expenses, including type and date of each, hours of services per day and cost per hour for each date services are provided to you. Charges for room and board or comparable expenses for residence in the facility must be listed separately from any other costs. Prudential reserves the right to require that facility bills be sufficiently itemized to allow us to determine which charges, if any, from a facility may be Eligible Charges under your Coverage. You are responsible for obtaining a sufficiently itemized bill from the facility you use.

If you are submitting Proof of Loss for the International Coverage benefit, you must also submit a copy of your passport, airline ticket or other proof acceptable to Prudential that you are outside the United States.

A Provider's bill does not need to be submitted for a claim under the Cash Alternative Benefit.

The proof of loss must be sent within 90 days of the date loss begins. Failure to furnish such proof within the time required will not invalidate or reduce any claim if both of the following apply.

1) It was not reasonably possible to furnish the proof within that time; and
2) Proof is furnished as soon as reasonably possible.

Physical Examination

You may be required to have a physical examination to be eligible for benefits. Prudential may do this when and as often as is reasonable, while your claim is pending, at its own expense.

Time of Claim Payment

Benefits are paid within 60 days after Prudential receives satisfactory proof of loss. An explanation of benefits notice that explains the resolution of your claim will be sent to you within 30 days from the date Prudential receives satisfactory proof of loss.

Benefits due and unpaid at your death will be paid to your estate.

At your request, all or a portion of any benefits payable under your Coverage may be paid directly to the eligible Provider if located in the United States. Benefits not assigned will be paid directly to you.

Benefits will be calculated and paid in United States currency. If applicable, any foreign exchange rate will be as determined by Prudential.

Facility of Payment

The **Insurer** may pay benefits to a person whom we deem entitled to the benefits if they would otherwise be paid to your estate or to a person who is a minor or to a person otherwise not competent to give a valid release.

The **Insurer** may pay up to $1,000 under this provision. Any payment made in good faith pursuant to this provision, shall fully discharge the **Insurer** to the extent of such payment.

Late Payments

If benefits are not paid in a timely fashion, Prudential will pay interest on any such late claim payments in accordance with the laws then in effect.

Reassessment

You will be reassessed periodically to determine if you are still eligible for benefits. To comply with federal income tax requirements, you must be certified as having a Chronic Illness or Disability at least once in a 12-month period. Prudential reserves the right to verify that all of the Benefit Eligibility Criteria have been satisfied to determine if you continue to be eligible for benefits.

COVERAGE PROVIDED

What is Covered

Facility Daily Benefit- whichever is applicable to *your* policy	$80, $120, $160, $200 or $300
Assisted Living Facility Daily Benefit	100% of Facility Daily Benefit
Bed Reservation Benefit	Same as Facility Daily Benefit
Bed Reservation Calendar Year Limit	60 Days
Hospice Care	Same as Facility Daily Benefit
Respite Care	Same as Facility Daily Benefit
Respite care Calendar Year Limit	30 Days
Home Care Daily Benefit	60% of Facility Daily Benefit
Cash Alternative Daily Benefit	50% of Home Care Daily Benefit
Home Support Services Lifetime Benefit	60x Facility Daily Benefit
Private Care Consultant Calendar Year Benefit	20x Facility Daily Benefit
International Coverage Facility Daily Benefit	75% of Facility Daily Benefit
International Coverage Home Care Daily Benefit	75% of Facility Daily Benefit
International Coverage Lifetime Benefit Limit	365 Days

How Much You Receive

The **daily benefit** you select determines the maximum amount you can receive each day. The Long-Term Care Plan pays for the actual charge for covered services up to your **daily benefit**. The amount payable per day will not exceed the total for all services you receive in a day. For possible benefit types, see "Overview of Long-Term Care Plan Coverage Options."

Multiple Services

Within a category, any combination of covered services may be received on the same day. All covered services will be considered and benefits will be payable up to your **daily benefit** for that category.

If you receive covered services from more than one category on the same day, all covered services will be considered and total benefits payable for that day will be payable in an amount up to the highest **daily benefit** amount within a single category of covered services. For example, if you receive home care and nursing home services on the same day, you can receive up to the nursing home **daily benefit** for all the covered services you received on that day.

If you have your initial care advisory visit on the same day as one of the above categories, benefits may be payable for both services.

Other Sources of Benefits

The Long-Term Care Plan is designed to provide the type of coverage and **daily benefit** you or your **eligible family member** elects. If other sources cover part or all of your eligible expenses, your benefit from the Long-Term Care Plan will be reduced to reflect those other benefits. In no event will your total benefit payable under the Long-Term Care Plan be greater than it would have been if you had not had the other source of benefits.

Your long-term care benefit will be up to 100% of the amount, reduced, to the extent permitted by law, by:

* Any benefits you received or are eligible to receive from any federal, state or other governmental health plans or law, other than Medicare or Medicaid,

* Any benefits paid or payable through another plan that an **Avaya Participating Company** sponsors or contributes to, such as The Avaya Inc. Medical Expense Plan,

* Any benefits paid or payable by any employer's liability or occupational disease law,

* Any motor vehicle no-fault law, or

* Any benefits paid or payable by any state or federal Workers' Compensation law.

Overview of Long-Term Care Plan Coverage

Overview of Long-Term Care Plan Coverage	
Facility Daily Benefit Amount (FDB)	Your Facility Daily Benefit (FDB) is the maximum dollar amount the plan will pay for any single day's covered expenses; whichever is applicable to *your* policy: $80, $120, $160, $200, OR $300.
Plan Model	Service Reimbursement – Pays a benefit equal to the lesser of the qualified expenses incurred or the applicable Facility Daily Benefit (FDB).
Benefit Eligibility	See "How the Plan Works"
Lifetime Maximum	The Lifetime Maximum is equal to <u>your elected</u> Facility Daily Benefit for Nursing Home Care multiplied by the number of years elected on *your* policy and then multiplied by 365 days. • **5 Years (elected Facility Daily Benefit x 5 x 365)**

Overview of Long-Term Care Plan Coverage	
	$146,000, $219,000, $292,000, $365,000 or $547,500 • **7 Years (elected Facility Daily Benefit x 7 x 365)** $204,400, $306,600, $408,800, $511,000 or $766,500
Covered Services/Benefit Payout:	. **Covered Expenses up to:**
• Nursing Home	• 100% of Facility Daily Benefit
• Assisted Living Facility/Residential Care Facility	• 100% of Facility Daily Benefit
• Home Care and Adult Day Care	• 60% of Facility Daily Benefit You must satisfy the Benefit Waiting/Elimination Period before benefits are payable.
Cash Alternative Benefit	Under this provision, at your option, your Coverage will pay a monthly fixed benefit to you in lieu of reimbursement for Eligible Charges for Home Care as stated above. The Cash Alternative Daily Benefit is payable for each day in the month in which you have a Chronic Illness or Disability, after you satisfy the Benefit Waiting/Elimination Period. The Cash Alternative Benefit is equal to 50% of your daily benefit for Home Care. The Cash Alternative Benefit is subject to the following: 1) You must meet the Benefit Eligibility Criteria. 2) You can only elect this benefit on a monthly basis. 3) It is in lieu of any other Institutional Care or Home Care benefits payable for that month. These benefits are subject to the Benefit Waiting/Elimination Period and reduce your Lifetime Maximum.
Informal Care Benefit	The Cash Alternative Benefit above may be used for informal care services.
Bed Reservation	While you are receiving Long-term care services in a Nursing Home, you may incur charges for Bed Reservation by that facility to retain your bed while you are absent from that facility for any reason. **Benefits for Eligible Charges will be paid up to 60 days per calendar year**. You must satisfy the Benefit Waiting/Elimination Period before benefits are payable.

Overview of Long-Term Care Plan Coverage	
Hospice Care	Provides coverage for Hospice Care. Benefits for Eligible Charges will be paid up to **100% of the Facility Daily Benefit for institutional and non-institutional care.** The Benefit Waiting/Elimination Period does not apply to Hospice Care benefits.
Respite Care	Will pay up to the Facility Daily Benefit for each day Respite Care is received up to 30 days per calendar year. The Benefit Waiting/Elimination Period does not apply before benefits are payable.
Private Care Consultant	Provides coverage for a Private Care Consultant to provide information, resources or to coordinate your long-term care services. You must first meet the Benefit Eligibility Criteria in order to use this benefit. Benefits for Eligible Charges will be paid up to 20 times the Facility Daily Benefit per calendar year. No Benefit Waiting/ Elimination Period applies to Private Care Consultant benefits. Benefit does NOT reduce the Lifetime Maximum.
Home Support Services Benefit	The **Home Support Benefit** allows the insured to be reimbursed for expenses for Assistive Devices or Technology, Caregiver Training, Durable Medical Equipment, (not covered by Medicare), Emergency Medical Response System, Home Modifications and Transportation Services, (for medically necessary health care) which will enable the insured to remain independent at home. Benefits for eligible charges will be paid up to 60 times the Facility Daily Benefit. No Benefit Waiting/Elimination Period applies to Home Support Benefits.
Alternate Plan Benefit	Due to emerging trends on the delivery of long-term care, this plan takes into account the current institutional and home care settings that are available. Prudential will consider a claim for benefits for long- term care services received in an alternate setting or non-institutional services designed to help an eligible person remain independent in his or her home. You must satisfy the Benefit Waiting/Elimination Period before benefits are payable.
Coordination of Benefits	The purpose of this Long-Term Care Coverage is to help you pay for covered expenses, but not to pay for more than you actually

Overview of Long-Term Care Plan Coverage	
	incur. To do this, Prudential coordinates its payments with certain other coverages you may have that provide benefits for the same services covered by this Long-Term Care Coverage.
Waiting / Elimination Period	A 30 Day Benefit Waiting/Elimination Period must be met once during your lifetime before benefits are payable. This Plan has one combined Benefit Waiting/Elimination Period for all covered services to which it applies. This is a period, counted in calendar days, which begins on the date you are certified as having a Chronic Illness or Disability and continues as long as you have a Chronic Illness or Disability. You do not need to incur charges to satisfy the Benefit Waiting/Elimination Period. The Benefit Waiting/Elimination Period can be satisfied over multiple periods of Chronic Illness or Disability.
Benefits Paid During Deductible Period	The following benefits are available during the deductable or waiting period: • Home Support Benefit • Respite Care • Private Care Consultant • Information and Referral Services • Hospice Care.

Premium Refund Available at Death	If you die before the age of 74, a portion of the premiums may be refunded to your spouse, if applicable, otherwise to your estate. The percentage of premiums to be refunded is based on your age at death. The refund will be the total premiums you paid (including any premiums paid on your behalf by your employer) times the percentage below and then reduced by any benefits paid by Prudential. Age and Percent of Premium: Age 64 and Under: 100%, 65 – 90% 70 – 40% 66 – 80% 71 – 30% 67 – 70% 72 – 20% 68 – 60% 73 – 10% 69 – 50% 74 – 0% Only premiums paid since the effective date of your Prudential coverage will be taken into account in determining the benefit payable and no credit will be provided for premiums paid while covered under the MetLife plan .
International Benefit	Benefits for Eligible Charges for care you receive outside the United States will be paid up to 75% of your Facility Daily Benefit or 75% of the Home Care Daily Benefit, according to the services you use. Payment of International Coverage benefits is limited to 365 days during which Eligible Charges are incurred over the lifetime of the Coverage. Benefits will be paid in U.S. currency. You must satisfy the Benefit Waiting/Elimination Period before benefits are payable.

CHANGING YOUR COVERAGE

You can change your type of coverage and **daily benefit** amount at any time. To make a change, you must contact the **Insurer** (see "Important Contacts").

You may make a written request to change your Coverage while it is in force. If you choose to add additional benefits, you must complete another Enrollment Form and any applicable Evidence of Insurability Form. These forms can be obtained by calling the Insurer (see "Important Contacts"). The **Insurer** will review your request and determine whether you are accepted for the additional benefits. If your request is denied, you will be sent a written notice that explains why you were not accepted. You are not required to provide evidence of insurability if you are decreasing your Coverage. If you change your Coverage, your premium will be adjusted. You will be sent a new Schedule of Benefits confirming the Effective Date of the new Coverage.

How Changes Affect Your Cost

When you change your coverage, your cost will change on the date your new type of coverage or new **daily benefit** amount takes effect. Here is how your cost will be affected:

- If you are decreasing your **daily benefit**, you will pay the cost of the new type of coverage based on the age used to determine your previous **daily benefit**. Proof of insurability is not required.

- If you are increasing the **daily benefit** within your current type of coverage (for example, if you increase from $80 to $120) the cost for this incremental increase will be based on your age on the effective date of the change. Proof of insurability is required to make this change, unless you increase your **daily benefit** during the special opportunity given at least once every 3 years (see "Special Plan Features").

- If you are adding the **non-forfeiture coverage** option, the premium f*or the additional coverage* will be based on your age as of the date of your application and on dates when coverage changes became effective under the Long-Term Care Plan. Proof of insurability is required for the additional coverage. The required three-year vesting period begins on the date the **non-forfeiture coverage** option is added and only premiums paid after the date of purchase will be counted toward the reduced **total lifetime benefit**.

How Changes Affect Your Total Lifetime Benefit

When you change your type of coverage or your **daily benefit**, your **lifetime maximum** also changes. Any long-term care benefits you previously received under the Long-Term Care Plan will count toward your revised **total lifetime benefit**.

SPECIAL PLAN FEATURES

You should be aware of these special Long-Term Care Plan features:

Restoration of Benefits

All benefits paid under this Coverage are deducted from your Lifetime Maximum (unless otherwise indicated). However, your Lifetime Maximum may be restored. If as a result of a reassessment, you are no longer considered to have a Chronic Illness or Disability for at least six (6) consecutive months, your Lifetime Maximum will be restored to the level then in effect prior to claim.

Future Purchase Inflation Protection

Prudential will increase your coverage amounts by 5% compounded annually every three (3) years without providing proof of good health. Premium rates for the additional coverage amounts will be based on your then current age at the then current premium rates in effect. You have the right to convert to Automatic Inflation protection one time during the lifetime of the insurance plan. Premium rates for the Automatic Inflation protection will be based on your then current age at the current premium rates in effect. This benefit will be included in the base plan only if you have not elected the Automatic Inflation option.

Automatic Compound Inflation Protection Optional Benefit

This benefit option will allow benefits to increase automatically by 5% compounded annually while your premiums are level based on original issue age. If this option is not elected, Prudential will offer a periodic inflation increase at least every three years.

There is an additional cost for this option.

Waiver of Premium

After you meet the Benefit Eligibility Criteria and satisfy the required Benefit Waiting/Elimination Period, the premiums for your Coverage will be waived. Premiums will be waived beginning the first day of the month following the date you satisfy the Benefit Waiting/Elimination Period. Premiums will again become due as of the first day of the month following the month in which you no longer meet the Benefit Eligibility Criteria.

Direct Bill Modal Premium Discounts

5.00% for Annual Mode and 1.67% for Semi Annual Mode

Non-Forfeiture Benefit

Optional for new enrollees- When you choose your type of Long-Term Care Plan coverage and your **daily benefit**, you also elect whether or not to take the optional **non-forfeiture coverage**.

This feature provides that if you stop paying premiums on or after the third anniversary of your Effective Date, you may be entitled to receive benefits under this provision. No benefits will be paid if either of the following apply: a) Your insurance ended prior to your third anniversary. b) You have already received benefits that equal or exceed the total amount of premiums paid for your Coverage. If you are entitled to a benefit, this benefit will be equal to the greater of the following:

1) 30 times the Facility Daily Benefit at the time of lapse, up to your remaining Lifetime Maximum.
2) The total amount of premiums paid for your Coverage, less the sum of all benefits paid on your behalf while your Coverage was in effect.

Contingent Non-Forfeiture

This feature applies only if your coverage does not include the Non-Forfeiture provision described above. This feature automatically provides a Non-Forfeiture Benefit if premium rates are increased by Prudential by more than certain allowable percentages. In that event, you will be able to: 1) continue coverage at current benefit levels by paying the new premium amount; 2) lapse your coverage and retain a reduced lifetime maximum with no further premium payments; or 3) decrease your coverage and keep the policy in effect on a premium paying basis. The contingent benefit and the threshold amounts are described in the 2000 NAIC Long-Term Care Insurance Model Regulation.

Bed reservation benefit

While you are receiving Long-Term Care services in a Nursing Home, you may incur charges for Bed Reservation by that facility to retain your bed while you are absent from the facility for any reason. Charges for Bed Reservation are Eligible Charges if:

1. The charge for Bed Reservation is a separate, customary facility charge that would be made in the absence of insurance.

2. You would be required to pay such charge in the absence of insurance.

3. The charge is incurred while you are receiving benefits under this Certificate for care in a Nursing Home.

Benefits for these Eligible Charges will be paid up to the Facility Daily Benefit. This benefit is subject to a Bed Reservation Calendar Year limit of 60 days. Benefits will not be paid for Home Care for the same day on which a Bed Reservation benefit is paid Bed Reservation benefits are subject to the Elimination Period and reduce your Lifetime Maximum.

Guaranteed Purchase Option

Every three years on the Anniversary Date of the Effective Date of your Coverage, while your coverage is in effect, Prudential will increase your benefits. You will be notified of this increase at least 60 days prior to the Anniversary Date. You will not have to provide proof of good health to receive this increase. All increases will occur even if you meet the Benefit Eligibility Criteria at the time of the increase. These increases will occur without taking any action. If you want to decline any increase, you must notify Prudential in writing, within 30 days of receipt of the notification.

With each increase, your benefits that provide coverage for Eligible Charges up to a specified dollar amount per day, per Calendar Year or per lifetime will be increased by 5% compounded annually over the three-year period. Amounts are rounded. The number of days during a Calendar Year for which benefits are payable for Bed Reservation and Respite Care shall remain the same. The number of days during a lifetime for which benefits are payable for International Coverage shall remain the same. You will receive a new Schedule of Benefits following each increase, listing your increased benefits.

Increases to your lifetime maximum: The increase to your Lifetime Maximum will be the increase to your Facility Daily Benefit times the benefit period multiplier, where the benefit period multiplier is the Lifetime Maximum at issue divided by the Facility Daily Benefit at issue.

This benefit will terminate if any of the following events occur.

1. Your Coverage lapses because we did not receive the full modal premium from the policyholder or the person acting on the policyholder's behalf when due.
2. You elect to convert to Automatic Inflation protection.

If your Coverage ends and is later reinstated, increases will be made as if your Coverage had remained in effect. If your Coverage lapses for non-payment of premium and coverage continues under the Non-Forfeiture Benefit, no increases will be made after the due date of the unpaid premium. If you elect a lesser Lifetime Maximum under the Contingent Non- Forfeiture Provisions, no additional increases will be made.

Conversion to Automatic Inflation Protection

You have a right to convert to Automatic Inflation protection if available under the Group Contract. You may elect to convert to Automatic Inflation one time only on an anniversary Date, without having to provide additional evidence of insurability. The premium for the Automatic Inflation protection will be based on your age at the time you elect to convert. If you wish to exercise this option, you should contact Prudential at the Contact Address or phone number.

Portability

Allows you to continue your coverage at the same premium rate* if you retire, leave your job or the Group Contract Holder withdraws sponsorship of the Group Contract and does not replace it within 31 days of the date the coverage would otherwise end. This applies as long as you have not exhausted your Lifetime Maximum Benefits.

*The **Insurer** (see "Important Contacts") has the right to change premium rates in the future, but only on a class basis.

You and your participating **eligible family members** can continue coverage even after you retire or leave employment with an **Avaya Participating Company**. In that case, your costs must be paid directly to the **Insurer** (see "Important Contacts"). If any of the following situations occur, you may keep your Coverage in effect.

- If the person through whom you have your Coverage leaves the Contract Holder, you must notify Prudential in writing within 60 days of this change in status if such change requires an adjustment to your billing method.
- If you become divorced or your Spouse dies, you must notify Prudential in writing within 60 days of the final judgment of divorce or the death that you want to continue your Coverage. Prudential will then adjust the billing method and/or amount, if necessary, to reflect your change in status.
- If you cease to meet the definition of a Domestic Partner, you must notify Prudential in writing within 60 days of this change in status. Prudential will then adjust the billing method and/or amount, if necessary, to reflect your change in status.
- If the Contract Holder withdraws sponsorship of the Contract and does not replace it within 31 days of the date Coverage would otherwise end, Prudential will offer you the opportunity to convert coverage to an individual policy, without providing evidence of insurability. You will be eligible to convert if you have been continuously insured under the Group Contract for at least six months immediately prior to termination. The converted policy will provide benefits identical to or substantially equivalent to or in excess of those provided under the Group Contract from which conversion is made.

If your premiums are being waived when any of the above events occur, you must still notify Prudential in writing as described above. You will not have to send premiums as

long as your premium payments were current before the waiver period. Notice should be sent to Prudential at the Contact Address.

Premium waiver

If you are authorized for or are receiving benefits for covered services, your monthly cost will be waived. The waiver begins the first day of the month in which you meet your deductible period requirements and you are chronically ill. Costs will resume on the first day of the month after you are no longer authorized for benefits.

Return of premiums in the event of your death

Upon your death, Prudential may return a percentage of the premium paid for your Coverage. This benefit will be paid even if, at the time of your death, you are receiving benefits and premiums have been waived. Waived premiums are not considered paid premiums and will not be returned under this provision. Prudential will pay the refund to your estate upon receipt of a copy of the death certificate and a written request for such benefits. If your Coverage also includes a Return of Premium (upon lapse) benefit, and Coverage ends because of your death, return of premium benefits will be determined under this benefit per the Certificate of Coverage.

WHAT IS NOT COVERED

Your Coverage is designed to provide benefits to pay for your Qualified Long-Term Care Services. Your Coverage does not provide benefits for any of the following:

1. Work-connected Conditions Charge. A charge covered by a worker's compensation law, occupational disease law or similar law.
2. Illness, treatment or medical conditions arising out of
    a. War or an act of war, whether declared or undeclared, if the illness or injury occurs while you are serving in the military, naval or air forces of any country, combination of countries or international organization; and
    b. As a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the illness or injury occurs while you are serving in such forces and is outside the home area, while you are insured
    c. Your participation in a riot or insurrection, or the commission of or attempt to commit a felony; or
    d. Alcoholism and drug addiction.
3. Treatment provided in a government facility, unless payment of the charge is required by law or services provided by any law or governmental plan under which you are covered. This does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
4. Charges for services or supplies for which no charge would be made in the absence of insurance.
5. Charges for care or treatment provided outside the United States except as described in the International Coverage benefit.
6. Charges arising from intentionally self-inflicted injury or attempted suicide.

Non-Duplication of Medicare Benefits

Benefits under your Coverage are not payable for expenses for Qualified Long-Term Care Services to the extent that:

1. Such expenses are reimbursable under Medicare; or
2. Such expenses would be reimbursable under Medicare but for the application of a deductible or coinsurance amount.

EMPLOYMENT-RELATED EVENTS AFFECTING COVERAGE

Your coverage under the Long-Term Care Plan will end if certain events occur.

If You Change Your Job Classification

If your job classification is changed, your participation in the Long-Term Care Plan does not change.

If Your Employment is Terminated

Your eligibility to make payroll deducted contributions to the Long-Term Care Plan ends if your employment with a **Participating Company** ends for any reason. However, you are able to continue your coverage by paying the required premiums directly to the **Insurer** (see "Important Contacts"). The **Insurer** will automatically send you a direct billing package.

If You Are Laid Off

See "If Your Employment is Terminated."

If You Become Disabled

If you become eligible for benefits under The Avaya Inc. Sickness and Accident Disability Benefit Plan, payroll deducted contributions to the Long-Term Care Plan will continue for the duration that you continue on an **Avaya Participating Company's** payroll.

If you become eligible for benefits under The Avaya Inc. Long-Term Disability Plan, you are able to continue your coverage by paying the required premiums directly to the **Insurer** (see "Important Contacts"). The **Insurer** will automatically send you a direct billing package.

If You Take an Approved Leave of Absence

Your eligibility to make payroll deducted contributions to the Long-Term Care Plan ends if you are on an approved unpaid leave of absence with an **Avaya Participating Company.** However, you are able to continue your coverage by paying the required premiums directly to the **Insurer** (see "Important Contacts"). The **Insurer** will automatically send you a direct billing package. If reinstated within the same Plan Year, you need to call the **Insurer** to have payroll deductions resumed.

PERSONAL EVENTS AFFECTING COVERAGE

If You Gain a New Dependent

If you gain a new dependent through marriage or domestic partnership, you may be able to enroll your **eligible family members** in the Long-Term Care Plan, subject to proof of insurability. Contact the **Insurer** (see "Important Contacts").

If You Lose a Dependent

If you lose a dependent through divorce, dissolution of domestic partnership, your dependent, provided he or she is a participating **eligible family member**, is able to continue coverage by paying the required premiums directly to the **Insurer** (see "Important Contacts"). Contact the **Insurer** immediately to notify them of the loss of a dependent and the **Insurer** will send a direct billing package (if not already direct billed).

If You Die

If you die, your participating **eligible family members** will be able to continue coverage by paying the required premiums directly to the **Insurer** (see "Important Contacts"). The **Insurer** will automatically send your **eligible family members** a direct billing package.

If You Retire

Your eligibility to make payroll-deducted contributions to the Long-Term Care Plan ends upon your retirement. However, you are able to continue your coverage by paying the required premiums directly to the **Insurer** (see "Important Contacts"). The **Insurer** will automatically send you a direct billing package if you are enrolled at the time of retirement.

IMPORTANT CONTACTS

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

Contact / Service Provided	Contact Information
Insurer: Approves or denies claims and interprets the Long-Term Care Plan	The Prudential Insurance Company administers the Plan on behalf of Avaya Inc. *Address for submitting claims:* The Prudential Insurance Company of America PO Box 8519, Philadelphia, PA 19176-8519 Fax: 877-874-6573 *Telephone Number:* Tel 800-732-0416 Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern time TDD: **877-542-4778** *E-mail:* ltc4me@prudential.com Web site: www.prudential.com\\gltcweb\\avaya
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 **Insurer** at the above address.	Avaya Inc. Long-Term Care Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920 E-mail: hwplanadmin@avaya.com

CLAIMS AND APPEALS

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

Claim Denial and Appeal Procedures

Participants, their beneficiaries (if applicable) or any individual duly authorized by them have the right under ERISA and the Long-Term Care Plan to file a written claim for benefits with the **Insurer** (see "Important Contacts").

The Plan Administrator (see "Important Contacts") has the final authority to decide whether you are eligible to participate in the Long-Term Care Plan. The **Insurer** (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 long-term care 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 90 days after the **Insurer** or Plan Administrator (see "Important Contacts"), as the case may be, receives the claim.

If the **Insurer** or Plan Administrator, as the case may be, needs more than 90 days to make a decision, a representative will notify you in writing within the initial 90-day period and explain why more time is required. An additional 90 days (for a total of 180 days) may be taken if the **Insurer** or Plan Administrator, as the case may be, sends this notice. The extension notice will include the date by which the **Insurer**'s or Plan Administrator's, 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 Long-Term Care Plan provisions upon which the benefit decision is based;

- A statement that you are entitled to receive upon request (and free of charge) reasonable access to, and copies of, all document, records and other information relevant to your claim;

- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary;

- 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 **Insurer** or Plan Administrator (see "Important Contacts"), as the case may be, denies your claim, all or in part, you, your dependent or your authorized representative may request a full review by the **Insurer** or Plan Administrator, as the case may be, if you disagree with the denial. You, your dependents, or your authorized representative must submit a written request for review within 60 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; or

- Demonstrate that the decision complied with the Long-Term Care Plan's administrative procedures or safeguards.

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 **Insurer** (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.

After a decision by the **Insurer** or the Plan Administrator, 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.

If special circumstances cause the **Insurer** or Plan Administrator, as the case may be, to need more than 60 days to make a decision, a representative will notify you in writing within the initial 60-day period and explain why more time is required. An additional 60 days (for a total of 120 days) may be taken if the **Insurer** or Plan Administrator, as the case may be, sends this notice.

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

YOUR RIGHTS UNDER ERISA

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

Right to Receive Information About the Plan and Its Benefits

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

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

Prudent Action by Plan Fiduciaries

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

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

Enforce Your Rights

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

- If you request a copy of plan documents or the latest annual report (Form 5500 Series) from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials – unless the materials were not sent for reasons beyond the control of the Plan Administrator.

- If you have a claim for benefits that is denied or ignore – in whole or in part – after going through the appeals procedures, you may file suit in a state or federal court.

- If you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court.

- If you file suit against the Long-Term Care Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees – if, for example, it finds your claim is frivolous.

If You Have Questions

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

ADDITIONAL INFORMATION

Plan Funding and Payment of Benefits

The Long-Term Care Plan is insured by the **Insurer** (see "Important Contacts"). The **Avaya Participating Company** forwards the contributions it receives from employees through payroll deductions for the Long-Term Care Plan to the **Insurer**. Costs not collected through payroll deductions are paid directly to the **Insurer**. The expenses of administering the Long-Term Care Plan and benefit payments are the responsibility of the **Insurer**.

Plan Document Governs

This Summary Plan Description was designed to describe the Avaya Inc. Long-Term Care Insurance Plan in easy-to-understand terms. It is less technical than the Plan Document. However, the Plan Document and contract determine your rights and the rights of your **eligible family members** under the Long-Term Care Plan. In all instances, the Long-Term Care Plan Document governs.

Benefits Cannot Be Assigned

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

Plan May Be Amended or Terminated

The **Avaya Participating Company** expects to continue the Long-Term Care Plan, but reserves the right to amend or terminate the Long-Term Care Plan at any time by the resolution of the Board of Directors of Avaya Inc. or its properly authorized designee, subject to the terms of the insurance contract. Certain provisions of the Long-Term Care Plan are subject to approval by state insurance departments. In addition, the **Avaya Participating Company** does not guarantee the continuation of any long-term care benefits during employment or at or during retirement nor does it guarantee any specific level of benefits or contributions.

Plan Administration

The Plan Administrator has the full discretionary authority and power to control and manage all aspects of the Long-Term Care Plan, to determine eligibility for Long-Term Care Plan benefits, to interpret and construe the terms and provisions of the Long-Term Care Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Long-Term Care Plan as they may deem appropriate in accordance with the terms of the Long-Term Care Plan, the contract, applicable collective bargaining agreements and all applicable laws.

Plan Sponsor

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

ADMINISTRATIVE INFORMATION

Plan Name	The official Plan Name is The Avaya Inc. Long-Term Care Insurance Plan.
Plan Sponsor	The Plan Sponsor is Avaya Inc.
Plan Administrator	The Plan Administrator is: Avaya Inc. Long-Term Care Plan 211 Mount Airy Road Basking Ridge, NJ 07920 E-mail: hwplanadmin@avaya.com
Type of Administration	The Plan is administered on behalf of Avaya Inc. by Metropolitan Life Insurance Company (MetLife).
Insurer	Claims under the Long-Term Care Plan are administered on behalf of Avaya Inc. by the **Insurer**: The Prudential Insurance Company of America PO Box 8519 Philadelphia, PA 19176-8519 *Telephone Number:* 1-800-732-0416 TDD: 1-877-542-4778 Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern *Fax*: 877-874-6573 *E-mail*: ltc4me@prudential.com *Web site*: www.prudential.com/gltcweb/avaya
Agent for Service of Legal Process	Legal actions regarding a claim for benefits should be sent to the **Insurer**. All other legal actions should be sent to the Plan Administrator.
Plan Records and Plan Year	The Plan and all its records are maintained on a calendar year basis, beginning on January 1st and ending on December 31st of each year.
Type of Plan	The Plan is considered a “health & welfare” plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Plan Identification Number	The Plan Identification Number is 526.
Employer Identification Number	The Employer Identification Number is 22-3713430.