

THE AVAYA INC.

**AFLAC PERSONAL CANCER INDEMNITY COVERAGE
AND PERSONAL ACCIDENT INDEMNITY COVERAGE
FOR SALARIED EMPLOYEES**

SUMMARY PLAN DESCRIPTION

**Effective 1/1/2010
Last Updated 03/31/2011**

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This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2010, to **eligible employees** under The Avaya Inc. AFLAC Personal Cancer Indemnity and AFLAC Personal Accident Indemnity Coverage for Salaried Employees (the Plan). More detailed information is provided in the state specific Outline of Coverage for each Policy.

The Board of Directors of Avaya Inc. (or its delegate) reserves the right to modify, suspend, or terminate the 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 Plan, no one other than the Plan Administrator is authorized to advise you as to your benefits. For this reason, an **Avaya Participating Company** is not bound by statements made by anyone or any entity other than the Plan Administrator or its authorized delegates.

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

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INTRODUCTION

The Avaya Inc. AFLAC Personal Cancer Indemnity Coverage and AFLAC Accident Indemnity Coverage for Salaried Employees (the “Plan”) provide benefits to specific situations for you (the employee) and your **eligible dependents**.

You have the option of purchasing this coverage and it will become effective once approved by the **Insurer** (see Important Contacts).

HIGHLIGHTS

Here is a summary of some features of the Plan.

Plan Feature	Summary
Eligibility	If you are an eligible employee (a regular, active, full-time or part-time salaried employee who works for an Avaya Participating Company), you are eligible to purchase this coverage.
When Coverage Begins	If you are an eligible employee , you are covered under the Plan after your application for coverage is approved by Insurer (see Important Contacts).
Coverage Provided	The coverage provided differs by State. You should contact the Insurer (see Important Contact) to review the coverage and benefits provided in your State.
Information About the Plan	Enrolled participants should call the Insurer (see “Important Contacts”) for information on plan level coverage within your State, when coverage becomes effective, and cost of coverage.
Cost	If you are covered under the Plan, you pay 100% of the cost of coverage. Your contributions are deducted from your pay on an after-tax basis.

TERMS YOU SHOULD KNOW

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

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

Eligible employee: a regular, active, full-time or part-time, salaried employee who works for an **Avaya Participating Company**. Temporary employees are not eligible to participate in the Plan.

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 Plan.

Eligible dependents: Includes the **eligible employee's** spouse, domestic partner, and dependent, unmarried children (as each State has different requirements, refer to your State specific plan guide for more information on eligibility requirements). Eligible dependents must be considered a "covered person" under the policy.

Eligibility for certain coverage is also contingent upon satisfying certain underwriting requirements imposed by AFLAC. If you have previously been diagnosed with a disease for which you seek coverage, your coverage availability may be limited or denied. These limitations are imposed by AFLAC.

PARTICIPATING IN THE PLAN

Who Is Eligible

If you are an **eligible employee** (a regular, active, full-time or part-time salaried employee who works for an **Avaya Participating Company**), you are eligible to enroll yourself and your eligible dependents for coverage. If you enroll, you (and your eligible dependents) are covered when approved by the **Insurer** (see Important Contacts).

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 Plan.

Are dependents eligible for coverage?

If you are an **eligible employee**, coverage may also be available for your **eligible dependents**. The availability of dependent coverage (and the definition of who is an **eligible dependent**) may be subject to underwriting by AFLAC, and may vary based on the AFLAC coverage selected. Dependent coverage may be limited or denied in instances where a dependent or the employee has previously been diagnosed with a disease for which he or she now seeks coverage. Refer to the AFLAC policy(ies) for more information.

How to Enroll for Coverage

Eligible employees can enroll for themselves and their **eligible dependents** in coverage at anytime during the year. You can enroll for coverage by visiting www.enroll.AFLAC.com/avaya or by call 1-877-322-1671.

You do not need to re-enroll each year.

Policy

Once you complete the appropriate forms to apply for coverage and the **Insurer** (see Important Contacts) approves your application, the **Insurer** will send you a policy, which will outline your coverage. If you have questions or concerns about your policy, immediately call the **Insurer** (see “Important Contacts”).

The Cost of Coverage

The amount deducted from your paycheck to pay for Plan coverage will appear on your pay statement. Remember, you pay the entire cost of coverage on an after-tax basis.

Information concerning the cost of coverage is provided by the **Insurer** (see Important Contacts) or at www.enroll.AFLAC.com/avaya.

When Coverage Begins

If you are an **eligible employee**, you may enroll yourself (and your **eligible dependents** in the Plan at any time. Your policy will be effective on the date that AFLAC issues a policy.

If you do not change your AFLAC election during Annual Enrollment, your election from one year will continue for the following year. Your deductions will be adjusted to reflect the new cost of coverage from year to year.

When Coverage Ends

Your coverage under the Plan ends when:

- You fail to make the required contributions,
- You elect not to participate in the Plan,
- With respect to your covered dependent(s), when they no longer qualify as **eligible dependents** as defined in the policy(ies); or
- Any other earlier termination date specified in the AFLAC policy(ies).

BENEFITS

The Plan pays benefits to you in a number of situations. Please call the **Insurer** (see Important Contacts) or visit www.enroll.AFLAC.com/avaya to receive a detailed brochure on the benefits provide in the State in which you reside.

AFLAC supplemental health benefits generally pay a specified fixed amount for cancer, hospitalization, and certain specified diseases described in the policy and any Riders you select. Accident coverage provides indemnity benefits for certain specified accidental occurrences, and disability benefits provide payments upon certain disabling injuries or illnesses.

Note, under some policies disability benefits may only be payable for disabilities attributable to accidental injuries. See your individual policy for a comprehensive description of the AFLAC supplemental benefits.

Limitations and Exclusions

There are key limitations and exclusions under each policy. You must refer to your policy to review these limitations and exclusions. All benefits available under the policy will be determined by AFLAC.

Filing a Claim

If you are covered under the Plan and are ready to claim benefits, contact the **Insurer** (see Important Contacts) for the appropriate paperwork to complete.

EMPLOYMENT-RELATED EVENTS

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

If You Change Your Job Classification

If your job classification is changed to represented, you will no longer be covered by this benefit.

If Your Employment Terminates

If your employment terminates for any reason, your coverage under the Plan will remain active as long as you continue to pay the premium directly to the **Insurer** (see Important Contact). You should call the **Insurer** regarding the process of paying your premium if this situation occurs to ensure that your coverage does not lapse.

If You Take an Approved Leave of Absence

If you are on an approved unpaid leave of absence, you may be able to continue coverage under the Plan by paying the premium directly to the **Insurer** (see Important Contacts). You should call the **Insurer** regarding the process of paying your premium if this situation occurs to ensure that your coverage does not lapse.

PERSONAL EVENTS

If You Get Married

See “If You Gain a New Dependent” below.

If You Gain a New Dependent

If you gain a new **eligible dependent** (for example, through marriage, birth, adoption, or by acquiring a **domestic partner** or **domestic partnership dependent**) while you are enrolled, you may enroll your new **eligible dependent** at any time.

If You Retire

See “If Your Employment Terminates.”

If You Die

See “If Your Employment Terminates.”

IMPORTANT CONTACTS

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

Contact / Service Provided	Contact Information
<p>American Family Life Assurance Company of Columbus (“AFLAC”): AFLAC is the Insurer and processes claims and pays benefits</p>	<p>AFLAC insures and underwrites the coverage under the Plan, and administers the Plan on behalf of Avaya Inc.</p> <p>Address for submitting claims: <i>Refer to your Policy</i></p> <p><i>Telephone number: 8:00 am to 8 pm ET</i> 877-322-1671 for enrollment 800-992-3522 for questions regarding active policies TDD:800-622-2345 Web site: www.enroll.AFLAC.com/avaya to enroll. www.AFLAC.com – for questions on active policies.</p>
<p>Plan Administrator: Contact for eligibility related documents.</p>	<p>Avaya Inc. Health and Welfare Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920</p> <p>E-mail: hwplanadmin@avaya.com</p>

CLAIMS and APPEALS PROCESS

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

Claim Procedures

Claims must be filed directly with AFLAC. Specific instructions for filing your claim with AFLAC are included in each AFLAC supplemental benefit policy in which you enroll.

The Plan Administrator (see “Important Contacts”) has the final authority to decide whether you are eligible to participate in the Plan. The **Insurer** 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 Plan benefits are provided or denied in whole or in part, 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 (see “Important Contacts”), 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 include:

- The specific reason or reasons for the decision;
- The specific 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

Any denial, in whole or in part, of a claim for benefits will be provided by AFLAC in accordance with the individual policy provisions. You will receive notice of a denial as soon as reasonably possible but no later than 30 days (for medical) or 45 days (for disability claims) after AFLAC receives the claim (filed in accordance with the AFLAC supplemental policy). In special circumstances, an extension of time may be needed to make a decision (e.g., we may need additional information). In that case, AFLAC may take a 15-day extension (for medical claims) or two 30-day extensions (for disability claims). You will receive written notice of the extension before the end of the 30/45 day period (whichever is applicable).

Generally, your denial will consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the specific Plan provisions upon which the denial is based, (iii) a description of any additional information you might be required to provide and explanation of why it is needed, and (iv) an explanation of the Plan's claim review procedure.

You, your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to AFLAC. You may submit with your appeal any comments, documents, records and issues that you believe support our claim (even if you have not previously submitted such documentation). You may have representation throughout the review procedure. An appeal must be filed with AFLAC in accordance with the claim filing procedures described in your denial letter within 180 days of receipt of the written notice of denial of a claim. The full, fair and independent review will be held and a decision rendered by the Claims Administrator, no later than 60 days (if for a medical claim) or 45 days (if for a disability claim) after receipt of your written appeal. In addition, the Claims Administrator may take a 45 day extension for any disability claims for reasons beyond the Claims Administrator's control. The decision after your review will be in writing and will include information similar to that which was included in your first denial letter.

You may request, free of charge, and at any time during the appeal process, all documents that are relevant (as defined by ERISA) to your claim. If your claim is denied, in whole or in part, you have the right to bring an action in federal court in accordance with ERISA 502(a). You cannot take any legal action until you have exhausted the Plan's claims review procedures described above.

If you wish to have a third party file the appeal on your behalf, you must have them submit with the written appeal a written authorization executed by you. If the third party is an individual other than your treating provider, then the authorization must comply with the applicable terms of the Health Insurance Portability and Accountability Act ("HIPAA").

All claims decisions are made solely by AFLAC.

YOUR RIGHTS UNDER ERISA

It is the policy of each **Avaya Participating Company** to provide meaningful benefits -- above and beyond your paycheck. Part of this additional protection is provided through the 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 Summary Plan Description describing your benefits under the Plan, you will have the opportunity to obtain a summary of the Plan's annual financial report. You also may examine all Plan documents governing the 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 (see "Important Contacts").

Prudent Action by Plan Fiduciaries

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

The **Avaya Participating Company** may not 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 ignored -- 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 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 Plan, contact the **Insurer** (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 source of funds for the Plan is your elected payroll deduction.

Benefits May Not Be Assigned

Assignment or alienation of any benefits provided by the Plan will not be permitted or recognized, except as otherwise required by applicable law. This means that benefits provided under the 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 Documents Govern

This Summary Plan Description was designed to describe the key features of the Plans for salaried employees in easy-to-understand terms. It is less technical than the Policies. However, it is the Policies and contracts that determine your rights.

Plan May Be Amended or Terminated

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

ADMINISTRATIVE INFORMATION

Plan Name	The official Plan Name is The Avaya Inc. AFLAC Personal Cancer Indemnity Coverage and AFLAC Accident Indemnity Coverage For Salaried Employees which is a part of The Avaya Inc. Health & Welfare Benefits Plan for Salaried Employees.
Plan Sponsor	The Plan Sponsor is Avaya Inc.
Plan Administrator	The Plan Administrator is: Avaya Inc. H&W Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920 E-mail: hwplanadmin@avaya.com
Type of Administration	The Plan is underwritten by AFLAC (the Insurer). The applicable AFLAC insurance policies govern the operation of the Plan at all times.
Insurer	The Insurer is the American Family Life Assurance Company of Columbus ("AFLAC"): Address for submitting claims: <i>Refer to your "Policy"</i> <i>Telephone number: 877-322-1671</i> TDD: 800-622-2345 Web site: www.enroll.AFLAC.com/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 a "health & welfare" plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Plan Number	The Plan Number is 550.
Employer Identification Number	The Employer Identification Number is 22-3713430.