

THE AVAYA INC.

LONG-TERM CARE INSURANCE PLAN

SUMMARY PLAN DESCRIPTION

**Effective 1/1/2007
Last Updated 3/30/2007**

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2007, to **eligible employees** 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.

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, subject to the terms of applicable collective bargaining agreements. 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 Inc. is not bound by statements made by anyone or any entity other than the Plan Administrator or its authorized delegates.

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

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INTRODUCTION

Because long-term care can place enormous emotional and financial burdens on families, Avaya Inc. offers the Avaya Inc. Long-Term Care Insurance Plan (Long-Term Care Plan) to **eligible employees** and their **eligible family members**. Long-term care insurance provides protection against the high costs associated with nursing home and other assisted living services. The Long-Term Care Plan gives you a choice between two types of coverage options: Nursing Home Coverage and Comprehensive Coverage. Once you select your coverage option, there are four **daily benefit** amounts to choose from. The Long-Term Care Plan also offers an option of electing **nonforfeiture coverage**.

HIGHLIGHTS

Here is a summary of some features of the Long-Term Care Plan.

Plan Feature	Summary
Eligibility	If you are an eligible employee (a regular, active, full-time or part-time, represented employee with at least six months of net credited service who works for a 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.
Proof of Insurability	Newly eligible employees who enroll within 90 days of their eligibility date do <i>not</i> 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 <i>all</i> eligible family members , however, must provide a Statement of Health.
Coverage Provided	The Long-Term Care Plan offers two types of coverage options: Nursing Home Coverage and Comprehensive Coverage. Both types cover an initial care advisory visit, nursing home care services, in-patient hospice care services, assisted living facilities and a Transition Expense Benefit. The Comprehensive Coverage also includes services such as home care, adult day care, at-home hospice care, ongoing care advisory services and respite care.
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 waiting 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.
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 a specific meaning 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.

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.

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.

Domestic Partner: an individual (same-gender or opposite-gender) who means each of two people in a Domestic Partnership. A “Domestic Partnership” is formed by two people, one of whom is an **Eligible Employee** or Eligible Retiree of the employer. You both must complete and file with the **Avaya Health and Benefits Decision Center** a notarized Domestic Partner Affidavit in which you both attest that you met all of the following requirements:

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

In addition to the aforementioned requirements, the following criteria must be satisfied if applicable:

- Have complied with any state or local registration process for domestic partners; are the same-gender, reside in a state that recognizes same-gender marriages and are

legally married under the laws of that state; or reside in a state that recognizes same-sex civil unions and have legally entered into such a civil union.

Domestic Partnership: A **Domestic Partnership** 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, represented employee with at least six months of **net credited service** 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, domestic partner**, parents, parents-in-law, stepparents, stepparents-in-law, grandparents, grandparents-in-law, step-grandparents and step-grandparents-in-law.

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.

Nonforfeiture 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 **total lifetime benefit** of either the total amount of premiums paid, or 30 times the daily nursing home benefit, whichever is greater. The adjusted **total lifetime benefit** is not reduced by any benefits paid.

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

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, represented employee with at least six months of **net credited service** 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.

If you are an Avaya Inc. employee who was assigned from Lucent Technologies Inc., and you had coverage under the prior plan on December 31, 2000, the Long-Term Care Plan will count benefits provided under the corresponding Lucent Plan toward the **total lifetime benefit** limitation under 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
- Your parents, parents-in-law, stepparents, stepparents-in-law, grandparents, grandparents-in-law, step-grandparents and step-grandparents-in-law.

An Avaya Inc. employee cannot cover another Avaya Inc. 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 select the type of coverage, the **daily benefit**, and the optional **nonforfeiture 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 90 days 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**. The eligibility date is the first of the month after you complete six months of **net credited service**.

If 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 on which or following the date the Insurer (see “Important Contacts”) approves the request for coverage. For example, if your request is approved January 1, your coverage becomes effective that day. However, if your request is approved January 2, your coverage becomes effective February 1.

You must be **actively at work** on your effective date for coverage to begin. If the effective date is a regularly scheduled day off, a scheduled vacation or a paid holiday, you must have been **actively at work** on the most recent prior day that was a regularly scheduled work day for you, and that was not a scheduled vacation day or paid holiday.

If you are not **actively at work** when coverage is supposed to begin, coverage will begin on the first day of the month after you are **actively at work**, and you will be required to provide proof of insurability.

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 type of coverage chosen (Nursing Home Coverage or Comprehensive Coverage),
- The **daily benefit** chosen, and
- Election of the optional **nonforfeiture coverage**.

As an employee, you pay your costs through after-tax payroll deductions. Payroll deductions will stop when you retire and you will be able to pay your costs directly to the Insurer (see "Important Contacts"). Retired employees and **eligible family members** can pay monthly, quarterly, semiannually or annually directly to the Insurer. 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. Your costs cannot be adjusted because of the change in your age or your health status.

If your coverage became effective before January 1, 1993, under the corresponding plan offered by AT&T Corp., and continued through Lucent Technologies Inc. and then Avaya Inc., the cost for your initial coverage is based on your age on December 31, 1992. If you change your coverage, your cost may change (see "Changing Your 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 Avaya Inc. does not forward costs to the Insurer	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, 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

You and your **eligible family members** can select different types of coverage and **daily benefits** for long-term care services. When you enroll:

- You first select the type of coverage option you want (Nursing Home Coverage or Comprehensive Coverage).
- Then, you select the **daily benefit** you want. The **daily benefit** is the maximum amount of money that you will be paid for each day you are receiving a covered service. Please note that assisted living facilities and home care services are reimbursed up to 60% of the **daily benefit**.
- Finally, you may elect the **nonforfeiture coverage** option, which provides reduced **total lifetime benefits** to covered individuals who have paid premiums for at least three years and elect to stop making payments.

The type of coverage and the **daily benefit** you select determines the maximum benefit (**total lifetime benefit**) you can receive during your lifetime (see “Overview of Long-Term Care Plan Coverage Options”).

Overview of Long-Term Care Plan Coverage Options

Covered Services	Nursing Home Coverage	Comprehensive Coverage
Advisory Visit	<ul style="list-style-type: none"> • One initial care visit 	<ul style="list-style-type: none"> • One initial care visit
Nursing Home Services	<ul style="list-style-type: none"> • Nursing Home Care (all types of care, from skilled to custodial) • In-patient Hospice Care 	<ul style="list-style-type: none"> • Nursing Home Care (all types of care, from skilled to custodial) • In-patient Hospice Care
Home/Community Care Services*	<ul style="list-style-type: none"> • Assisted Living Facility 	<ul style="list-style-type: none"> • Assisted Living Facility • Home Care • Adult Day Care • At-Home Hospice Care • Ongoing Care Advisory Services
Additional Services	<ul style="list-style-type: none"> • Transition Expense Benefit 	<ul style="list-style-type: none"> • Alternate Plan of Service • Respite Care • Transition Expense Benefit

Covered Services	Nursing Home Coverage	Comprehensive Coverage
Coverage Options**	<ul style="list-style-type: none"> • \$80 daily benefit with total lifetime benefit of \$146,000. • \$120 daily benefit with total lifetime benefit of \$219,000. • \$160 daily benefit with total lifetime benefit of \$292,000. • \$200 daily benefit with total lifetime benefit of \$365,000. 	<ul style="list-style-type: none"> • \$80 daily benefit with total lifetime benefit of \$204,400. • \$120 daily benefit with total lifetime benefit of \$306,600. • \$160 daily benefit with total lifetime benefit of \$408,800. • \$200 daily benefit with total lifetime benefit of \$511,000.
<p>* Paid at 60% of daily benefit.</p> <p>** Daily benefits are paid at 100% of charges up to the scheduled amounts listed above. (See "Multiple Services" if more than one covered service is being provided at the same time.)</p> <p>Note: Certain benefits begin after a waiting period (see "Once Your Benefits Are Authorized").</p> <p>A nonforfeiture coverage option is also available to each participant.</p>		

What Is Covered

The Long-Term Care Plan offers two types of coverage options to choose from: Nursing Home Coverage and Comprehensive Coverage.

Nursing Home Coverage

After you meet any required waiting period (see "Once Your Benefits Are Authorized"), the Nursing Home Coverage pays benefits for the following services:

- *One Initial Care Advisory Visit.* This is an optional once-in-a-lifetime service at no additional charge. Benefits will be paid for this service after you are authorized for benefits. A professional care advisor will meet with you and your family to help you make decisions about your care. The advisor will:
 - Help assess the need for services,
 - Help develop a comprehensive care plan, and
 - Discuss the plan with you and your family.

For help in finding a professional care advisor, call the Insurer (see "Important Contacts"). If the Insurer has no designated professional care advisor in your area,

you can select your own advisor and be reimbursed up to \$250, based on state regulations, for the one visit.

- *Nursing Home Services.* These include room and board, nursing care, personal care and custodial care as routinely provided by the nursing home. The home must be a licensed nursing facility or a distinct part of a hospital that is licensed as a nursing facility. For benefits to be paid, the facility must satisfy the Insurer's (see "Important Contacts") criteria for a nursing home. The nursing home care benefit is paid up to the full **daily benefit** amount. Nursing home services are defined this way:
 - *Nursing Care.* Services requiring the professional skills of a registered nurse, licensed practical nurse or a licensed vocational nurse who is currently licensed in the state in which he or she is providing services.
 - *Personal Care.* Human assistance with the activities of daily living (see "When Benefits Are Payable") when the patient cannot perform these activities independently. This assistance may be provided to individuals who require custodial care.
- *In-patient Hospice Care.* Health care and support services provided in a licensed hospice facility for individuals who are terminally ill.
- *Assisted Living Facility.* Care can also be received in a licensed assisted living facility. This facility serves the long-term needs of individuals who need more care than can be provided at home, but who do not want or need the degree of care provided at a nursing home. Assisted living facilities provide custodial care under the direction of a nurse. The maximum **daily benefit** for an assisted living facility is 60% of the nursing home **daily benefit**. This feature may vary by state; contact the Insurer (see "Important Contacts") for details.
- *Transition Expense Benefit.* Benefits will be paid up to a scheduled benefit amount for expenses incurred during or after the waiting period if the expense was incurred when the insured was certified as chronically ill. Coverage includes items required to provide qualified long-term care services, such as personal emergency response systems or durable medical equipment. Home modifications that are otherwise qualified long-term care services will not be paid if they increase the value of the insured's living quarters, as determined by the Insurer. Payment of the Transition Expense Benefit is made after the waiting period is fulfilled and the bills are submitted. Payment of the Transition Expense Benefit will not reduce the **total lifetime benefit**. The Transition Expense Benefit is not available if coverage is in nonforfeiture status.

Comprehensive Coverage

After you meet any required waiting period (see “Once Your Benefits Are Authorized”), the Comprehensive Coverage pays for all the services described above in “Nursing Home Coverage,” as well as:

- *Home Care.* You may receive care in the comfort of your home from a nurse, home health aide, homemaker and/or a physical, occupational, respiratory or speech therapist from a licensed home health care agency. You may also receive care from a licensed nurse or therapist who is not from a licensed agency. The maximum **daily benefit** for home care is 60% of the nursing home **daily benefit** (see “Overview of Long-Term Care Plan Coverage Options”).
- *Adult Day Care Center.* This includes nursing care, personal care and custodial care in a qualified adult day care center. The maximum **daily benefit** for adult day care is 60% of the nursing home **daily benefit** amount. Centers that primarily provide recreation or social activities do not qualify as adult day care centers.
- *Ongoing Care Advisory Services.* These include the following services when they are provided through a qualified care management organization: coordinating various types of care, arranging for appropriate services, monitoring your care, helping you to change your care plan as your needs change, and acting as your advocate if you have problems with the care you are receiving. Services must be provided by a registered nurse, a licensed practical nurse or a social worker trained in care advisory services. The maximum **daily benefit** for ongoing care advisory services is 60% of the nursing home **daily benefit**.
- *At-Home Hospice Care.* This includes health care and support services in your home if you are terminally ill. The maximum **daily benefit** for at-home hospice care is 60% of the nursing home **daily benefit**.
- *Alternate Plan of Service.* This means qualified long-term care services, which are not otherwise specifically defined above as a covered service. Benefits will be payable for an Alternate Plan of Service only if the Insurer (see “Important Contacts”) determines, at its sole discretion, that all of the following requirements are met with respect to each Alternate Plan of Service:
 - Service falls within guidelines established by the Insurer (see “Important Contacts”) as an approved Alternate Plan of Service,
 - It effectively meets the insured’s long-term care service needs,
 - It is, for the insured, a cost-effective alternative to services otherwise covered under this Long-Term Care Plan, and

- It is not provided by a member of the insured's immediate family.

The benefit payable for an Alternate Plan of Service will be the lesser of:

- The actual cost of the services provided, or
 - The benefit for the most closely related defined covered service, as determined by the Insurer (see "Important Contacts").
- **Respite Care.** Respite care allows your usual care provider the chance to take some time off. You can choose to continue to be cared for at home or, if you would like, in a nursing home. Respite care services include care from an unlicensed care provider, such as a family member, neighbor, or friend. The Long-Term Care Plan covers up to 21 days of respite care in a calendar year. Respite care is reimbursed up to the full nursing home **daily benefit**.

See "Multiple Services" if more than one covered service is being provided at the same time.

Daily Benefit and Total Lifetime Benefit

Once you choose the coverage option you want, you must decide which **daily benefit** you want. You can choose one of the following amounts:

- \$80
- \$120
- \$160
- \$200

Together, your choice of **daily benefit** and coverage option determine the daily and **total lifetime benefit** you can receive for covered services. The **total lifetime benefit** is the total amount available to you through the Long-Term Care Plan (see "Overview of Long-Term Care Plan Coverage Options").

For the Nursing Home Coverage, the **total lifetime benefit** is a dollar amount that will provide a minimum of five years of coverage. For the Comprehensive Coverage, the **total lifetime benefit** will provide a minimum of seven years of coverage.

However, benefits may last longer than you expect because they are based on the *dollar amounts of the benefits you receive*, not on the number of days. For example, if

you choose the \$200 **daily benefit** and your care in a nursing home is only \$100 per day, the benefit will last twice as long.

If you enrolled in the corresponding plan offered by AT&T Corp. before January 1, 1996, have been continuously enrolled through Lucent Technologies Inc. and then Avaya Inc., and did not increase your **daily benefit** (e.g., \$60, \$100, \$140), your **daily benefit** and cost will remain as originally elected.

Nonforfeiture Coverage

After you choose your type of Long-Term Care Plan coverage and your **daily benefit**, you may elect whether or not to take the optional **nonforfeiture coverage**.

This feature provides that after you pay premiums for at least three years, if you elect to stop making payments you will be entitled to coverage equal to the full **daily benefit**, subject to a **total lifetime benefit** of either the total amount of premiums paid or 30 times the **daily benefit**, whichever is greater. The adjusted **total lifetime benefit** is not reduced by any benefits paid.

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").

Changes You Can Request

The guidelines for requesting a change in your Long-Term Care Plan coverage are summarized in the following chart.

Change	When	Proof of Insurability	When Effective
<ul style="list-style-type: none"> Switch from Nursing Home Coverage to Comprehensive Coverage, or Increase daily benefit. 	Any time	Required*	If approved, on the first day of the month in which the Insurer approves your request.
<ul style="list-style-type: none"> Switch from Comprehensive Coverage to Nursing Home Coverage, Decrease daily benefit, or Add/remove the nonforfeiture coverage option. 	Any time	Not needed	On the first day of the month after receipt of your request by the Insurer.
<p>* Also see “Special Plan Features” for an exception to increasing your daily benefit.</p> <p>If your request for a change is denied, the Insurer will provide the reason for the denial (see “Claim Denial and Appeal Procedures”).</p>			

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 changing the type of coverage from Nursing Home Coverage to Comprehensive Coverage, you will pay the cost of the new option based on your age at the time the change is effective. Proof of insurability is required to make this change.
- If you are decreasing your **daily benefit** or are changing the type of coverage from Comprehensive Coverage to Nursing Home Coverage, you will pay the cost of the new type of coverage based on the age used to determine your previous **daily benefit** or the Comprehensive Coverage. Proof of insurability is not required.
- If you are increasing the **daily benefit** within your current type of coverage (for example, if you have Nursing Home Coverage and 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 five years (see “Special Plan Features”).

- If you are adding the **nonforfeiture coverage** option, your premium will be based on your age on your original effective date for your coverage and on dates when coverage changes became effective under the Long-Term Care Plan. Proof of insurability is not required. The required three-year vesting period begins on the date the **nonforfeiture 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 **total lifetime benefit** 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:

- *Bed reservation benefit.* If you require hospitalization while you are in the nursing home, hospice or Assisted Living Facility, the Long-Term Care Plan will continue to pay to hold your bed in the nursing home for up to ten days per hospital stay.
- *Opportunity for increase.* At least once every five years, you and your participating **eligible family members** will be notified of the opportunity to increase your **daily benefit**. Proof of insurability will not be required for this increase as long as you have not received **daily benefits** during the six months before the effective date of the increase. The increase in your **daily benefit** will also increase your **total lifetime benefit**. If you have received any benefits, only the remaining portion of the **total lifetime benefit** will increase by the same percentage rate. The cost for this incremental increase will be based on your or your participating family member's age on the effective date of the change. This feature may vary by state; contact the Insurer (see "Important Contacts") for details.
- *Portability.* You and your participating **eligible family members** can continue coverage even after you retire or leave employment with Avaya Inc. In that case, your costs must be paid directly to the Insurer (see "Important Contacts").
- *Cost 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 waiting 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.* If you have elected the Comprehensive Coverage, have been a Long-Term Care Plan participant for at least

four years, and you die, your estate may receive a portion of the premiums you paid. The amount returned is a percentage of the premiums you paid up to age 65, reduced by any benefits paid. This feature may not be available in every state; contact the Insurer (see “Important Contacts”) for details.

The percentage available for refund is:

Number of Complete Years Covered Under the Comprehensive Plan	Percentage Available for Refund (before reduction for benefits paid)
1 – 3	0%
4	20%
5 – 19	Increases by 5% annually to 95%
20	100%

If you increase your coverage over time, the percentage returned will be applied separately for any incremental coverage amounts you have purchased. For example, if you have been covered under the Comprehensive Coverage for 20 years and had one increase four years ago, the amount returned would be 100% of the premiums paid for the original amount of coverage plus 20% of the premiums paid for the increase. No premiums paid after age 65 will be returned.

When Benefits Are Payable

For you to receive benefits, the Insurer (see “Important Contacts”) must authorize benefits in advance. To be authorized to receive benefits, you must be unable to perform, without substantial assistance from another individual, at least two out of six of the following activities of daily living for a period of 90 days because of a loss of functional capacity:

- *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.
- *Dressing:* Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- *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.
- *Transferring:* Moving into or out of a bed, chair or wheelchair.

- *Toileting*: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- *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).

Your need for assistance may be due to physical disabilities, severe cognitive impairments or both.

You, your doctor or someone acting on your behalf will need to contact the Insurer (see “Important Contacts”) to certify that you are incapable of performing these activities on your own. The Insurer must approve the request for benefits and, in doing so, may also need you to authorize access to your medical records. In evaluating your request for benefits, the Insurer may take into account:

- Your inability to perform the activities of daily living, and
- Your severe cognitive impairment.

You should obtain authorization from the Insurer (see “Important Contacts”) as soon as it appears that you will need services covered by the Long-Term Care Plan. Otherwise, you may not be eligible for benefits. You must be authorized for benefits, be certified as chronically ill, and be receiving covered services for benefits to be paid.

However, if benefits would otherwise be authorized and it is not reasonably possible to obtain authorization before services begin, the Insurer (see “Important Contacts”) may pay benefits beginning with the first day you received covered services after all required waiting periods have been completed.

You will be notified of the Insurer’s (see “Important Contacts”) decision within ten business days after it receives all the necessary information about your case. The Insurer cannot authorize benefits if you do not provide the necessary information. For more details on the information that must be provided, call the Insurer.

The notice will indicate the day your benefit period begins (see “Once Your Benefits Are Authorized”). It will also outline the concurrent review process (see “Concurrent Review”). If benefits are authorized, you may wish to schedule an initial care advisory visit with a professional care advisor. This is an optional, one-time service covered by the Long-Term Care Plan (see “What Is Covered”). If authorization is denied, see “Claim Denial and Appeal Procedures.”

You, your doctor and your family will decide what care is appropriate for you. The Insurer (see “Important Contacts”) provides *only* authorization for benefits, not medical advice about care.

Once Your Benefits Are Authorized

Once you have been authorized for long-term care benefits:

- Your benefit period begins on the first day that **daily benefits** are authorized and you are receiving services that would be covered under the Long-Term Care Plan. A benefit period will end if 180 consecutive days have passed during which you have not received authorized covered services.
- Each benefit period begins with a *waiting period*. During the waiting period, *benefits are not payable*. The waiting periods for the two coverage options are as follows:

Kind of Services	Waiting Period*
<p>Nursing Home Coverage:</p> <ul style="list-style-type: none"> • Initial Care Advisory Visit • Nursing Home Care, In-patient Hospice Care, Assisted Living Facility and Transition Expense Benefit 	<p>None</p> <p>60 days of receiving covered services**</p>
<p>Comprehensive Coverage:</p> <ul style="list-style-type: none"> • Initial Care Advisory Visit • Nursing Home, In-patient Hospice Care, Assisted Living Facility and Transition Expense Benefit • Home Health Care, Adult Day Care, Ongoing Care Advisory Services, At-Home Hospice Care, Alternate Plan of Service • Respite Care 	<p>None</p> <p>30 days of receiving covered services**</p> <p>30 days of receiving covered services**</p> <p>30 days of receiving covered services**</p>
<p>* Covered services received before benefits are authorized do not count toward the waiting period. Once you have fulfilled the waiting period, you will not have to fulfill another, unless you have not received authorized covered services for more than 180 consecutive days.</p> <p>** Under the Nursing Home Coverage, the waiting period is 60 days of covered services. Under the Comprehensive Coverage, the waiting period is 30 days of covered services. Only days in which a covered service is received count toward the waiting period. For example, if you receive home care services three days per week, only those three days are counted toward the 30-day waiting period, not all seven days of the week.</p>	

If you are receiving more than one kind of covered service, the waiting periods for each will run at the same time, rather than one after the other. If you received services

before your authorization, they do not count toward the waiting period. Benefits are paid for covered services received only after the waiting period.

Concurrent Review

When you are receiving covered services, the Insurer (see “Important Contacts”) will review your case from time to time to see that you continue to meet the standards for benefits. The Insurer may review your records, or contact you, your doctor or someone else familiar with your condition. If it is determined that you are no longer eligible for benefits, you will be notified. In no event will your benefit eligibility be ended before the date of notification.

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.”

For your initial care advisory visit, you will receive benefits up to the amount charged if you visit with a professional care advisor designated by the Insurer (see “Important Contacts”). If there are no designated professional care advisors in your area, you may receive benefits up to \$250, based on state regulations, with a professional who is not designated by the Insurer.

How Benefits Are Paid

You will be reimbursed for covered services after the Insurer (see “Important Contacts”) has reviewed your claim. You can have payment made directly to your provider, if you wish and if the provider agrees. You should submit your claim and accompanying proof no later than 90 days after the end of the calendar year in which you received the services. However, if the Insurer is satisfied that claims are submitted late for reasons beyond your control, and were submitted as soon as reasonably possible, eligible claims will not be reduced or denied because of the delay.

Benefit Limits

Maximum **daily benefits** and **total lifetime benefits** are limited in some situations as explained in this section.

Multiple Services

The Comprehensive Coverage provides three categories of covered services:

- Nursing home services
- Home/community care services
- Respite care

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 Avaya Inc. 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.

What Is Not Covered

The Long-Term Care Plan does not cover:

- Care specifically provided for detoxification of or rehabilitation for alcohol or drug abuse (chemical dependency), except drug abuse sustained at the hands of or while being treated by a physician for an injury or sickness.
- Any service or supply received outside the United States or its territories.
- While a participant in the Long-Term Care Plan, illness, treatment or medical condition arising out of:
 - War or act of war (whether declared or undeclared);
 - Participation in a felony, riot or insurrection;
 - Service in the armed forces or auxiliary units;
 - Attempted suicide (while sane or insane) or intentionally self-inflicted injury; or
 - Aviation (this applies only to non-fare paying passengers).
- Treatment provided in a government facility, unless otherwise required by law.
- Any care provided while in a hospital, except for confinement in a distinct part of the hospital that is licensed as a nursing home or hospice.
- Any service provided by your immediate family, unless the service is a covered service when provided by an informal caregiver.
- Any service or supply to the extent that such expenses are reimbursable under Medicare, or would be so reimbursable but for the application of a deductible, coinsurance or copayment amount. This exclusion will not apply in those instances where Medicare is determined to be secondary payor under applicable law.
- Services for which no charge is normally made in the absence of insurance.

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 to salaried, your participation in the Long-Term Care Plan does not change.

If You Terminate Your Employment

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 You Terminate Your Employment."

If You Become Disabled

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 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 Avaya Inc.'s payroll.

If You Take an Approved Leave of Absence

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 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, 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, 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, coverage will end of the day of your death. 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	Address / Telephone Number
<p>Insurer: Approves or denies claims and interprets the Long-Term Care Plan</p>	<p>Metropolitan Life Insurance Company (MetLife) administers the Plan on behalf of Avaya Inc.</p> <p><i>Address for submitting claims:</i> MetLife Long-Term Care Group P.O. Box 937 Westport, CT 06881-0937</p> <p><i>Telephone Number:</i> 1-800-GET-MET8 (1-800-438-6388), Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern time TDD: 1-800-638-1004</p> <p><i>E-mail:</i> ltcinfo@metnotices.com</p> <p><i>Web site:</i> http://avayaltc.metlife.com</p>
<p>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.</p>	<p>Avaya Inc. Long-Term Care Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920</p> <p><i>E-mail:</i> hwplanadmin@avaya.com</p>

OTHER IMPORTANT INFORMATION

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.

Appeal Procedures

After the Insurer or Plan Administrator (see “Important Contacts”), as the case may be, denies your claim, 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.

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 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.

Your Rights Under ERISA

It is Avaya Inc.'s policy to provide meaningful benefits -- above and beyond your paycheck. Part of this additional protection is provided through the 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 the Company may dismiss you or discriminate against you to prevent you from obtaining benefits or exercising any of your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without

charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

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

Plan Funding and Payment of Benefits

The Long-Term Care Plan is insured by the Insurer (see “Important Contacts”). Avaya Inc. 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 SPD 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.

Union Agreement

The benefits described in this SPD reflect the provisions of the Long-Term Care Plan as referred to in applicable collective bargaining agreements between the Company and the unions representing employees of the Company. Copies of these agreements are distributed or made available to those employees covered by the agreements and to any other employee who submits a written request for a copy to the Plan Administrator. A reasonable duplication charge may be made for copies furnished in response to such written request.

Plan May Be Amended or Terminated

The 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 and applicable collective bargaining agreements. Certain provisions of the Long-Term Care Plan are subject to approval by state insurance departments. In addition, the 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: MetLife Long-Term Care Group P.O. Box 937 Westport, CT 06881-0937 <i>Telephone Number:</i> 1-800-438-6388; TDD: 1-800-638-1004
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 31 st 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.