

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

Covered Services	Nursing Home Coverage	Comprehensive Coverage
Coverage Options**	<ul style="list-style-type: none"> <li>• \$80 <b>daily benefit</b> with <b>total lifetime benefit</b> of \$146,000.</li> <li>• \$120 <b>daily benefit</b> with <b>total lifetime benefit</b> of \$219,000.</li> <li>• \$160 <b>daily benefit</b> with <b>total lifetime benefit</b> of \$292,000.</li> <li>• \$200 <b>daily benefit</b> with <b>total lifetime benefit</b> of \$365,000.</li> </ul>	<ul style="list-style-type: none"> <li>• \$80 <b>daily benefit</b> with <b>total lifetime benefit</b> of \$204,400.</li> <li>• \$120 <b>daily benefit</b> with <b>total lifetime benefit</b> of \$306,600.</li> <li>• \$160 <b>daily benefit</b> with <b>total lifetime benefit</b> of \$408,800.</li> <li>• \$200 <b>daily benefit</b> with <b>total lifetime benefit</b> of \$511,000.</li> </ul>
<p>* Paid at 60% of <b>daily benefit</b>.</p> <p>** <b>Daily benefits</b> 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 <b>nonforfeiture coverage</b> 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"> <li>Switch from Nursing Home Coverage to Comprehensive Coverage, or</li> <li>Increase <b>daily benefit</b>.</li> </ul>	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"> <li>Switch from Comprehensive Coverage to Nursing Home Coverage,</li> <li>Decrease <b>daily benefit</b>, or</li> <li>Add/remove the <b>nonforfeiture coverage</b> option.</li> </ul>	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 <b>daily benefit</b>.</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:

<b>Number of Complete Years Covered Under the Comprehensive Plan</b>	<b>Percentage Available for Refund (before reduction for benefits paid)</b>
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><b>Nursing Home Coverage:</b></p> <ul style="list-style-type: none"> <li>• Initial Care Advisory Visit</li> <li>• Nursing Home Care, In-patient Hospice Care, Assisted Living Facility and Transition Expense Benefit</li> </ul>	<p>None</p> <p>60 days of receiving covered services**</p>
<p><b>Comprehensive Coverage:</b></p> <ul style="list-style-type: none"> <li>• Initial Care Advisory Visit</li> <li>• Nursing Home, In-patient Hospice Care, Assisted Living Facility and Transition Expense Benefit</li> <li>• Home Health Care, Adult Day Care, Ongoing Care Advisory Services, At-Home Hospice Care, Alternate Plan of Service</li> <li>• Respite Care</li> </ul>	<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.