

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.

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. 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, 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.