

OTHER IMPORTANT INFORMATION

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

Claim Procedures

Participants, their beneficiaries (if applicable) or any individual duly authorized by them, have the right under ERISA and the Medical Plan to file a written claim for benefits with the **Claims Administrator** or Plan Administrator (see “Important Contacts”), as the case may be.

Claims concerning whether you or your dependent is eligible to participate in the Medical Plan are decided by the Plan Administrator (see “Important Contacts”). Claims concerning the amount and extent of benefits are decided by the **Claims Administrator**.

You (or another person) cannot challenge a claim decision in court until the following claim and appeal procedures have been complied with and exhausted.

Initial Claim Decision

When a claim is received, the **Claims Administrator** must decide whether (and/or at what level) the benefit is covered under the Medical Plan, as the case may be. When the medical benefit is provided or denied, you will receive a notice explaining how the coverage level was calculated or why benefits have been denied. How fast this notice must be given to you depends on whether the claim is an **urgent care claim**, a **pre-service claim** or a **post-service claim**. The deadline for this notice is no later than:

- For an **urgent care claim**, 72 hours after the claim is received.
- For a **pre-service claim**, 15 days after the claim is received.
- For a **post-service claim**, 30 days after the claim is received.

The notice will contain the information outlined under the section “Claims Decision Notices”.

If your claim is an **urgent care claim** or a **pre-service claim**, you can be notified of an initial denial decision orally, and a written or electronic notice will be provided no more than 3 days after the oral notice.

Failure to Follow Urgent Care or Pre-Service Claims Procedure

If you fail to follow the procedures for filing an **urgent care claim** or a **pre-service claim**, you will be notified by the **Claims Administrator** of the failure and the proper procedure that you must follow. This notice must be provided no later than 24 hours after the failure for **urgent care claims** or 5 days after the failure for **pre-service claims**. This notice may be oral unless you (or your authorized representative) request a written notice. This notice is triggered when:

- You (or your authorized representative) make a communication that is received by a person or organization unit customarily responsible for handling benefit matters; and
- The communication names a specific participant or covered dependent, a specific medical condition and a specific treatment, service or product for which approval is requested.

Notice of Incomplete Urgent Care Claim

If you (or your authorized representative) submit an **urgent care claim** that is missing necessary information, you will receive a notice from the **Claims Administrator**. This notice will tell you the specific information needed to complete the claim. The notice will be given no later than 24 hours after receiving the claim. You must be given a reasonable time to provide the information but not less than 48 hours. You will be notified of the decision concerning your **urgent care claim** as soon as possible but no later than 48 hours after the earlier of:

- When the Medical Plan receives the requested information, or
- The end of the period you were given to provide the information.

Concurrent Care Claim

At times the **Claims Administrator** may approve a course of treatment that is provided over time or for a specific number of treatments. If the **Claims Administrator** later terminates or reduces the previously approved course of treatment, the **Claims Administrator** will notify you of this decision so you (or your authorized representative) will have sufficient time to appeal that decision before the course of treatment is deemed not covered or coverage is provided at a reduced rate.

If you need to extend a course of treatment and the original request for the treatment was an **urgent care claim**, you should contact the **Claims Administrator** at least 24 hours before the approved course of treatment will expire. If you do so, the **Claims Administrator** will provide you with a notice of its decision concerning the requested extension within 24 hours of your request. If you (or your authorized representative) request an extension later, you will receive a notice of the **Claims Administrator's** decision based on whether that request is an **urgent care claim** or **pre-service claim**.

Appeal Procedures

After the **Claims Administrator** (for benefits) or Plan Administrator (see “Important Contacts”) (for eligibility to participate) denies your claim, you (or your authorized representative) may request a full review if you disagree with the denial. You (or your authorized representative) must submit a written request for review to the **Claims Administrator** (for benefits claims) or the Plan Administrator (for eligibility to participate claims) within 180 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 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;
- Demonstrate that the decision complied with the Medical Plan’s administrative procedures or safeguards; or
- State the Medical Plan’s policy or guidelines regarding the benefits for your diagnosis, whether or not it was relied upon.

Your appeal will be reviewed by someone other than the person who made the first decision on your claim. Upon written request, the **Claims Administrator** must disclose the identity of any medical experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the **Claims Administrator** must consult with a health care professional who has the appropriate training and experience in the field of medicine involved.

After a decision by the **Claims Administrator** or 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:

- For an **urgent care claim**, 36 hours after receiving the appeal.
- For a **pre-service claim**, 15 days after receiving the appeal.
- For a **post-service claim**, 30 days after receiving the appeal.

If you disagree with the first appeal decision, you (or your authorized representative) may request a second appeal in writing no later than 60 days after you receive the first appeal decision. In connection with your second appeal, you (or your authorized

representative) may review relevant documents and submit issues and comments in writing. After a decision by the **Claims Administrator** is made concerning your second appeal, you will be notified of the findings and decision in writing. This notice will be provided no later than:

- For an **urgent care claim**, 36 hours after receiving the appeal.
- For a **pre-service claim**, 15 days after receiving the appeal.
- For a **post-service claim**, 30 days after receiving the appeal.

This decision is final and is not subject to further internal review unless your claim qualifies for the Third Party Appeal Review described in the section “Third Party Appeal Review Process.”

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 Medical 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;
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request;
- If the decision is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the Medical Plan’s terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request;
- 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.

Third-Party Appeal Review Process

An independent Third-Party Appeal Review Process is available to **eligible employees** and their dependents enrolled in Medical Plan options other than the **HMO** option. The process applies to certain claims for services that have been denied by the Standard or Enhanced **POS** option, Enhanced **Indemnity option**, **Prescription Drug Program** and/or **Mental Health and Chemical Dependency Program** service providers.

Claims are reviewed by Island Peer Review Organization (IPRO), the third-party review administrator. If your claim is eligible for the independent review process, you (or your **covered dependent**) will be notified by the appropriate **Claims Administrator**.

Claims eligible for Third-Party Review must meet *all* of the following:

- The claimant must have exhausted all administrative appeals or processes available through the **Claims Administrator** under the terms of the Medical Plan,
- The claim must relate to an extreme illness or injury,
- The appeal must have been denied either due to a lack of medical necessity or because the claim relates to an **experimental or investigative treatment, drug or device**, as defined in the Medical Plan, and
- The claim must otherwise be payable under the terms of the Medical Plan.

EAP Claim Procedures

The Claims Administrator for the **EAP** is **Magellan**. **Magellan** will generally decide whether your request for **EAP** services is covered under the **EAP** and inform you of its determination during your initial telephone call to request services.

If **Magellan** cannot decide during the initial call, **Magellan** will decide within 5 calendar days of your request for services or of notice to **Magellan** of a circumstance that affects the availability of further **EAP** services. **Magellan** will inform you by telephone of its determination within 1 business day after a decision is made.

If you are receiving an ongoing course of **EAP** counseling, **Magellan** will notify you in advance if **Magellan** intends to terminate or reduce the number of **EAP** sessions that can be provided so that you will have an opportunity to appeal the decision before the termination or reduction takes effect.

If **Magellan** determines that you need **urgent care**, **Magellan** will provide telephonic crisis counseling and make an appropriate referral to your Medical Plan and/or

emergency resources in the community. **Magellan** does not make claim determinations relating to **urgent care**.

Because **Magellan** pays all **EAP providers** directly, you should not pay a **provider** for **EAP** services. In the event that you mistakenly pay a **provider** for **EAP** services, **Magellan** will decide your request for reimbursement within 30 days after receipt of the claim.

If a claim for **EAP** benefits is wholly or partially denied, **Magellan** will provide written notice of the denial to you or your authorized representative. The notice will contain the information outlined under the section "Claims Decision Notices". If **Magellan** denies your claim, you (or your authorized representative) may request a full review if you disagree with the denial. You (or your authorized representative) must submit a written request for review to **Magellan** within 180 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. If your appeal of a denial of claim for **EAP** benefits is wholly or partially denied, **Magellan** will provide written notice of the denial to you or your authorized representative. The notice will contain the information outlined under the section "Claims Decision Notices".

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 Medical 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 Medical Plan, you will have the opportunity to obtain a summary of the Medical Plan's annual financial report. You also may examine all Medical Plan documents governing the Medical 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 also may request assistance and information about your health benefits rights under ERISA and HIPAA (Health Insurance Portability and Accountability Act of 1996) by contacting the Plan Administrator (see "Important Contacts").

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

You also have the right to:

- Continue medical coverage for yourself, spouse, or dependents if there is a loss of coverage under the Medical Plan as a result of a qualifying event under **COBRA**. You or your dependents will have to pay for such coverage. Review this summary plan description and the documents governing the Medical Plan for the rules governing your **COBRA** continuation rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under that plan, when you become entitled to elect **COBRA** continuation coverage, when your **COBRA** continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action by Plan Fiduciaries

You also have the right to expect the fiduciaries -- the people responsible for the operation of the Medical Plan -- to act prudently and in the best interest of those who participate as a whole. The Medical Plan's fiduciaries must act in the best interest of all Medical 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 ignored – in whole or in part – after going through the appeals procedures, you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack of response to your request concerning the qualified status of a **qualified medical child support order (QMCSO)**, you may file suit in federal court.
- If it should happen that the Medical Plan fiduciaries misuse the Medical Plan's money, or 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 Medical 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 Medical Plan, contact the **Claims Administrator** 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

With certain limited exceptions, the Company pays a majority of the costs associated with providing benefits under The Avaya Inc. Medical Expense Plan for Salaried Employees through the Avaya Inc. Health Plans Benefit Trust, which is a trust set up under Section 501(c)(9) of the Internal Revenue Code. State Street Bank and Trust Company is the trustee of this Trust.

Benefits Cannot Be Assigned

Assignment or alienation of any benefits provided by the Medical Plan will not be permitted or recognized, except as otherwise required by applicable law. This means that benefits provided under the Medical 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 Medical Plan, but reserves the right to amend or terminate the Medical Plan at any time by the resolution of the Board of Directors or its properly authorized designee. In addition, the Company does not guarantee the continuation of any medical benefits during employment or during retirement nor does it guarantee any specific level of benefits or contributions.

Plan Administrator and Claims Administrator

The Plan Administrator and **Claims Administrator** have the full discretionary authority and power to control and manage all aspects of the Medical Plan, to determine eligibility for Medical Plan benefits, to interpret and construe the terms and provisions of the Medical Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Medical Plan as they may deem appropriate in accordance with the terms of the Medical Plan and all applicable laws.

Plan Sponsor

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