AVAYA, INC.
GROUP LONG TERM CARE INSURANCE PROGRAM

SUMMARY PLAN DESCRIPTION

EFFECTIVE DATE: JULY 1, 2013

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INTRODUCTION

Avaya, Inc. (the "Company") is pleased to sponsor the Avaya Group Long Term Care Insurance Program (the "Plan"). This program provides eligible employees with affordable coverage that can help protect them from the high costs of long term care services, including care at home, in the community, in assisted living facilities (including Alzheimer's facilities), and in nursing homes.

Genworth Life Insurance Company ("Genworth Life") is the underwriting company for the Plan and will serve as Benefits and Claims Administrator under the Plan.

This Summary Plan Description ("SPD") summarizes provisions of the Plan in effect on the Effective Date. This SPD and the related materials do not provide all details of the Plan. More specific information is contained in Group Policy Number 13056 issued by Genworth Life. Certificates of insurance issued to each insured person contain details of the coverage under the Plan. Copies of the Group Policy are available for review in the Company's Human Resources department.

If there is any conflict between the terms of this SPD and the Group Policy, the Group Policy will control. If the terms of the Plan change, you will be notified of all material changes.

KEY FACTS TO KNOW

Insurance provided under the Plan is intended to be federally tax-qualified long term care insurance within the meaning of Internal Revenue Code Section 7702B(b), as amended.

WHO IS ELIGIBLE?

A person is eligible to apply for optional coverage on his or her first day of work if he or she is an actively at work, full time employee of the Company.

Actively at work means any employee who is performing the usual duties of his/her job at the usual place of work as required by the Company on a full-time basis at least 30 hours per week. An employee is considered actively at work while on Company approved vacations, holidays, and regularly scheduled days off, or during temporary business closures. An employee is not considered to be actively at work if he or she is unable to perform his or her usual duties due to a sickness, accident or injury; or if he or she is on a leave of absence, a sabbatical or retired from the Company.

In addition, an eligible employee's family members (spouse, parents, grandparents, parents-in-law and grandparents-in-law), between the ages of 18 and 79, may also apply for long term care insurance under the Plan. For the purposes of this Plan, a domestic partner is considered a spouse. A person cannot be eligible in more than one class under the Plan.

All eligible persons must be at least 18 years of age, maintain a permanent United States residence, and have an active Social Security number or tax identification number issued by the United States government.

WHAT COVERAGE IS AVAILABLE?

Two Optional Levels of Coverage:

- Essential Plan
  - 1,095 days approximate benefit duration
  - 60% of the Nursing Facility Maximum (NFM) for Home & Community Care
  - Informal Care included
- Preferred Plan
  - 1,825 days approximate benefit duration
  - 60% of the NFM for Home & Community Care
  - Informal Care included

Five levels of the Nursing Facility Maximum

- $100 per day
- $150 per day
- $200 per day
- $250 per day
- $300 per day

Three Inflation Protection Options

- Future Purchase Option Benefit
- Automatic3% Compound for Life
- Automatic 5% Compound for Life

Optional Non-forfeiture Benefit Rider: An optional Non-forfeiture Benefit Rider is also available for additional premium. The rider allows the insured to retain partial coverage if he or she decides to cancel his or her long term care coverage after it has been in force for more than three years.

WHAT DOES THE PLAN COST?

Premium rates are included in the Information Kit and in the Group Policy. The insured pays the cost for the Optional Long Term Care Insurance. The cost of coverage depends on the options selected and the age of the applicant.

Genworth Life Insurance Company will collect the premium on the policyholder's behalf Insurance will be billed directly to each insured.

KEY THINGS TO DO

To make the most of the Company's Group Long Term Care Insurance Program, consider the sources of income that would be available to your family to pay for care if you can no longer function independently. Considering factors such as your marital status and other financial assets will help you determine the type and amount of insurance you need.

LONG TERM CARE INSURANCE: THIS SECTION DESCRIBES HOW THE PLAN WORKS.

WHAT ARE THE BENEFITS?

Benefits are payable for expenses incurred for

- Care and services during confinement in a **nursing facility or assisted living facility**, up to the Nursing Facility Maximum based on the option selected
- **Home and community care** which includes adult day care, and nurse or therapist services, home health or personal care services, and incidental homemaker and chore care provided in the insured's home, up to 60% of the Nursing Facility Maximum
- **Bed Reservation** is available for temporary absences of up to 60 days per calendar year when room charges are covered in the facility.
- **Home Assistance Benefit** covers: home modifications; assistive devices; supportive equipment; emergency medical response systems; and caregiver training. It pays up to a lifetime limit equal to 90 days of full Nursing Facility Benefits.
- **Hospice Care Benefit** covers services designed to provide palliative care and alleviate discomforts if the insured person is both chronically and terminally ill. Benefits are payable up to the Nursing Facility Maximum for care received in a covered facility, and the limit for the Home and Community Care Benefit when care is received while the insured person is living at home.
- **Informal care** for maintenance or personal care services provided in the insured's home, by someone who does not normally reside there, a daily benefit up to 25% of the Nursing Facility Maximum, up to 30 days per calendar year
- **Respite Care Benefit** provides short-term coverage to relieve the person who normally and primarily provides the insured person with care in their home on a regular, unpaid basis. It pays for up to 30 days per calendar year.
- **Alternate Care Benefit** may, subject to approval and mutual agreement, pay for covered expenses incurred for services, devices or treatments that are Qualified Long Term Care Services not specifically covered under another benefit.

Other Plan benefits include:

- **Care coordination** services are available. Professional care coordinators review the insured's specific situation and develop an appropriate Plan of Care to meet those needs. The cost of this service is not deducted from the Coverage Maximum.
- **International Nursing Facility Benefit**: This benefit will pay for Covered Expenses received while the insured person is outside the United States. Subject to the Coverage Maximum, it pays up to 75% of the Nursing Facility Maximum for confinement in an out-of-country nursing facility. This benefit terminates four years after the date for which it first makes payment.
- **Waiver of Premiums** while the insured is receiving benefits for facility care or home and community care.

BENEFIT INCREASE OPTIONS
The plan provides ways for an insured person to help keep up with the increasing costs of Covered Care over time.

Benefit Increase Options available under the Group Program are:

- **Future Purchase Options:** This benefit will apply if neither of the Automatic options are selected. Every three years the insured is offered the opportunity to increase his or her benefit amounts by 5% compounded annually. The premium for the additional coverage is based on the insured's attained age as of the effective date of the increase. The offer is not made if the insured is in claim, is benefit eligible, is receiving benefits, or is satisfying the Elimination Period.
- **Automatic 5% Compound Benefit Increases**: With this option, the benefit amounts increase automatically each year by 5% compounded annually while the insurance is in effect and premiums are paid. There is an additional premium for this optional inflation protection.
- **Automatic 3% Compound Benefit Increases**: With this option, the benefit amounts increase automatically each year by 3% compounded annually while the insurance is in effect and premiums are paid. There is an additional premium for this optional inflation protection.

WHAT LONG TERM CARE EXPENSES ARE COVERED?

The Plan pays benefits as reimbursement for covered expenses for Covered Care. Covered Care must:
- Constitute Qualified Long Term Care Services; and
- Be provided pursuant to a written Plan of Care prescribed by a Licensed Health Care Practitioner; and
- Occur while coverage is in force and prior to the exhaustion of any benefit limits, and the Coverage Maximum.

CONDITIONS FOR RECEIVING BENEFITS

For an insured to be eligible for benefits,:
- The insured person must be Chronically Ill
- Genworth Life must receive a current eligibility certification for the insured person from a licensed health care professional, and;
- Genworth Life must receive ongoing proof which verifies that the Covered Care the insured person receives is needed due to continually being Chronically Ill.

Before benefits are payable, the Elimination Period must be satisfied. Elimination Period means 90 calendar days, beginning with the first day on which a Covered Expense is incurred, before the insured is entitled to Benefits. Days used to satisfy the Elimination Period do not need to be consecutive; and can be accumulated over time.

Once satisfied, the insured person will never have to satisfy a new Elimination Period for this coverage.

Important Definitions: Other definitions for this coverage can be found in your Certificate of Insurance.

A **Chronically Ill Individual** is a person who has been certified by a Licensed Health Care Practitioner as being unable to perform, without Substantial Assistance from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must be expected to exist for a period of at least 90 days; or a person requiring substantial supervision to protect the person from threats to health and safety due to a Severe Cognitive Impairment.

Activities of Daily Living are bathing, continence, dressing, eating, toileting, and transferring (getting into and out of a bed, chair or wheelchair).

Covered Care means only those Qualified Long Term Care Services for which the insurance pays benefits or would pay benefits in the absence of an Elimination Period.

Covered Expenses means costs incurred for Covered Care. Each benefit defines the Covered Expenses under that benefit. An expense is considered to be incurred on the day on which the care, service or other item forming the basis for it is received by the insured individual.

Nursing Facility Maximum is the maximum amount that will be paid for confinement in a nursing facility, assisted living facility or hospice care facility. This amount is also used to determine other benefit maximums.

Licensed Health Care Practitioner means any of the following who is not a member of the insured person's immediate family:

- A Physician (as defined in Sec. 1861(r)(1) of the Social Security Act);
- A registered professional nurse;
- A licensed social worker; or
- Any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

A **Plan of Care** is a written, individualized plan for care and support services for the insured that specifies:

- The type, frequency and duration of all services required to meet those needs;
- The kinds of providers appropriate to furnish those services; and
- An estimate of the appropriate cost of such services.

Coverage Maximum is the maximum amount of benefits payable to the insured, and is reduced by the amount of claims paid. The Policy Lifetime Maximum is determined by multiplying the Facility Care Maximum by the benefit duration.

Qualified Long Term Care Services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services which are required

Severe Cognitive Impairment is a loss or deterioration in intellectual capacity that: is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests that reliably measure impairment in the person's: short-term or long term memory; orientation as to people, places or time; deductive or abstract reasoning; and judgment as it relates to safety awareness.

WHAT ARE THE EXCLUSIONS AND OTHER LIMITATIONS FOR THE PLAN ?

Exclusions: Benefits are not paid for any expenses incurred for any Covered Care:

1. For which no charge is normally made in the absence of insurance;
2. Provided outside the United States of America, its territories and possessions; except as described in the International Nursing Facility Benefit;
3. Provided by the insured's Immediate Family, unless a benefit specifically states that a member of the Immediate Family can provide Covered Care. We will not consider care to have been provided by a member of the Immediate Family when:
    - He or she is a regular employee of the organization that is providing the services; and
    - Such organization receives payment for the services; and
    - He or she receives no compensation other than the normal compensation for employees in her or his job category;
4. Provided by or in a Veteran's Administration or Federal government facility, unless a valid charge is made to the insured's estate;
5. Provided by any government program (except Medicaid);
6. Resulting from war or any act of war, whether declared or not; if the illness or injury occurs:
    - While you are serving in the military, naval or air forces or any country, combination of countries or international organization;
    - While you are serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization;
    - Outside the Home Area and while you are not in the military, naval or air forces of any country, combination of countries or international organization or in any civilian non-combatant until supporting or accompanying such forces;
7. Resulting from attempted suicide or an intentionally self-inflicted injury;
8. Resulting from participation in a felony, riot, or insurrection;
9. Resulting from the insured's alcoholism or addiction to drugs or narcotics (except for an addiction to a prescription medication when administered in accordance with the advice of a Physician);
10. For which the insured receives, or is eligible to receive, workers' compensation benefits, occupational disease act benefits, or similar benefits.

Act of War means any act peculiar to military, naval or air operations in time of War.

Home Area means the 50 states of the United States of American, the District of Columbia and Canada.

War includes, but is not limited to, declared war, and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization.

Benefits are payable for Alzheimer's disease, subject to the same exclusions, limitations and provisions otherwise applicable to other Covered Care.

Non-Duplication of benefits: Benefits will be paid only for Covered Care expenses that are in excess of the amount paid or payable under:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- Any other federal, state or other governmental health care program or law except Medicaid.

Pre-Existing Conditions Limitation: We will not pay for Covered Expenses incurred for any care or confinement that is a result of a Pre-Existing Condition when the care or Confinement begins within six (6) months following the initial certificate effective date.

A **Pre-Existing Condition** means a condition (illness, disease, injury or symptom) for which medical advice or treatment was recommended by, or received from, a Health Care Professional within six (6) months prior to your initial Certificate Effective Date.

A **Health Care Professional** includes: a Physician; a Nurse; a physician assistant; a physical, occupational, speech or respiratory therapist; a chiropractor; an acupuncturist; a homeopathic doctor; or a Licensed Health Care Practitioner.

WHEN DOES LONG TERM CARE INSURANCE TAKE EFFECT?

Optional coverage is subject to underwriting approval by Genworth Life, and will take effect upon approval.

However, any optional coverage for an employee will take effect upon such approval only if he or she is actively at work for the prior 30 calendar day period. If this requirement is not met, the effective date of coverage will be deferred until the first day of the billing period on which the employee is actively at work and has been actively at work for the prior 30 calendar day period.

WHEN DOES LONG TERM CARE INSURANCE END?

Coverage ends on the first to occur of:

1. The date the insured dies;
2. The date coverage is cancelled by the insured;
3. The date the policy lifetime maximum is exhausted; or
4. The end of the grace period if the amount of any overdue premium is not received.

If a person ceases to be eligible, he or she can continue coverage under the Plan by paying premiums directly to Genworth Life.

CAN AN INSURED CHANGE COVERAGE OPTIONS??

Long Term Care coverage selections can be changed at any time, as follows:

- To increase the coverage level to a higher option at any time a request must be sent with satisfactory proof of good health. Upon approval, premiums for the additional coverage will be based on the age of the insured on the date the change is effective.
- To decrease the coverage level, proof of good health is not required. The premium for the reduced coverage will be based on the original issue age.

WHAT IF THE INSURED'S EMPLOYMENT STATUS CHANGES?

If the status of employment changes, for example, if the insured employee takes an unpaid leave of absence or goes out on long term disability, coverage will continue as long as premiums are paid when due.

WHAT IF THE INSURED DIES?

Coverage ends at the death of the insured. If the surviving spouse also has coverage, that coverage will remain in place, as long as he or she continues to pay the premiums.

30 DAY REFUND

If the insured is not completely satisfied with the Long Term Care Insurance coverage, he or she may return the certificate within 30 days of receipt of the Certificate of Insurance for a full refund of any premiums paid.

ADMINISTRATIVE INFORMATION

WHAT IS AVAYA's EMPLOYER IDENTIFICATION NUMBER?

The employer identification number assigned to Avaya, Inc. (as the sponsor of this Plan) is 22-3713430

WHO IS THE PLAN ADMINISTRATOR?

The Plan Administrator has the authority to control and manage the operation and administration of this Plan and is the agent for service of legal process.

The Plan Administrator is:
Avaya Inc.
211 Mount Airy Road
Basking Ridge, NJ 07920

Plan administration responsibilities under the Plan have been delegated to the insurance provider, Genworth Life Insurance Company. You can contact them by calling 1-800-416-3624, or in writing at the following address:

Genworth Life Insurance Company
Group Processing Center – Avaya, Inc.
P.O. Box 64010
St. Paul, MN 55164-0010

HOW CAN I ACCESS OFFICIAL PLAN DOCUMENTS?

The descriptions of the benefits in this summary are subject to the provisions of the official Plan documents and other governing instruments. Copies of the official Plan documents as well as the latest annual reports of Plan operations are available for your review during normal working hours at:

Avaya Inc.
211 Mount Airy Road
Basking Ridge, NJ 07920

CAN THE PLAN BE CHANGED, REPLACED OR TERMINATED?

The Company expects and intends to continue the benefits described in this summary, but reserves the right to terminate, amend or replace the Plan in whole or in part at any time and for any reason.

The Certificate Is Guaranteed Renewable. This means you have the right, subject to the terms of the group policy, to continue this coverage until the benefits are exhausted, by paying the premium on time.

The insurer cannot change any of the terms of the coverage, except that, in the future, Genworth Life may increase the premiums you pay.

If the Company stops sponsoring this program, you have the right to continue the coverage by paying the premiums yourself. You will be sent a notice giving you the option to continue to maintain your coverage at its existing level.

HOW IS THE PLAN FUNDED?

Benefits under the Plan are funded through insurance. Participants pay the full cost of the plan they select.

WHAT ARE THE CLAIMS AND APPEALS PROCEDURES?

Payment of claims under the Plan will be made by the Claims Administrator, Genworth Life Insurance Company. Claims for benefits under the Plan are to be submitted to Genworth Life Insurance Company as provided in the Claim Payments section of the Certificate of Insurance.

Contact the Claims Administrator with any questions regarding a claim or need for claim forms.

Notify Genworth Life Insurance Company within 30 days of the date the covered loss starts or as soon as reasonably possible thereafter.

Upon receipt of a notice of claim, the claim forms needed to file proof of loss will be sent. If the claim forms are not received within 15 days, proof of loss can be filed without them with a letter describing the nature and extent of the loss and the covered expense for which claim is made. If the claim is for a continuing loss, written proof of loss must be given to Genworth Life Insurance Company within 90 days after the end of each monthly period for which benefits may be payable. For any other loss, written proof must be given within 90 days after the date of such loss. Unless the insured is not legally capable, the required proof must always be given to Genworth Life Insurance Company no later than 1 year from the time specified.

Genworth Life Insurance Company must receive updates to the insured's Plan of Care on an ongoing basis.

Once the Elimination Period is satisfied, benefit payments will be made on a monthly basis after receipt of claim as long as the insured remains eligible to receive benefits. When a claim is paid, a notice showing the total amount of benefits that have been paid to date will be sent.

No action may be brought to recover under the Plan until 60 days after proof of loss has been given. No action can be brought more than 3 years from the date written proof of loss was required to be given.

APPEALS

If a claim under the Plan is denied in whole or in part, the insured will receive written notice. This notice will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure.

Within 180 days after denial, the insured may submit a written request for reconsideration of the claim. Documents or records in support of the appeal should accompany any such request. The insured may review pertinent documents and submit issues and comments in writing. Genworth Life will review the claim and provide, within 60 days, a written response to the appeal. In the written response, Genworth Life will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based.

Genworth Life Insurance Company has the exclusive right to interpret the appropriate Plan provisions. Decisions of Genworth Life Insurance Company are conclusive and binding.

WHAT ARE MY RIGHTS UNDER ERISA?

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive information about the Plan and its benefits.

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising 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 the above rights.

If you request materials from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case the court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 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 Employee Benefits Security Administration or visiting their web site at www.dol.gov/ebsa/.

HIPAA PRIVACY SUMMARY

The Plan may disclose information concerning your coverage under the Plan to the Plan Sponsor in accordance with privacy standards under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

HIPAA PERMITTED DISCLOSURES FOR THE PLAN

The Plan may disclose information concerning your coverage under the Plan to the Plan Sponsor only under these circumstances.

1. The Plan may inform the Plan Sponsor whether you are enrolled or disenrolled from the Plan.

2. The Plan may disclose summary health information to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining premium quotes from insurers, or to modifying, amending, or terminating the Plan. Summary health information is information that summarizes reimbursement history, claims, appeals, or types of reimbursement claims without identifying you.

3. The Plan may disclose protected health information ("PHI") to the Plan Sponsor for Plan administration functions that the Plan Sponsor performs for the Plan, as limited by 45CSR 164.504(f)(2). Employees of the Plan Sponsor perform certain administrative functions necessary for the management and operation of the Plan. The Plan Sponsor has certified to the Plan that its practices and terms concerning privacy for PHI incorporate the terms of this Summary. The Plan Sponsor has agreed to abide by the terms of this Summary. The Plan's Notice of Privacy Practices also permits the Plan to disclose your PHI to the Plan Sponsor as described in this Summary.

RESTRICTIONS ON PLAN SPONSOR'S USE OR DISCLOSURE OF PHI

The following restrictions apply to the Plan Sponsor's use and disclosure of your PHI.

- The Plan Sponsor will only use or disclose your PHI for Plan administration purposes, as required by law, or as permitted under HIPAA regulations. See the Plan's Notice of Privacy Practices for more information about permitted uses and disclosures of PHI under HIPAA.

- If the Plan Sponsor discloses any of your PHI to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to keep your PHI private and confidential as required by the HIPAA regulations and to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.

- The Plan Sponsor will not use or disclose your PHI for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor, unless the Plan Sponsor has received your written authorization for such use or disclosure.

- The Plan Sponsor will promptly report to the Plan any use or disclosure of your PHI that it becomes aware of that is inconsistent with the uses or disclosures allowed in this Summary.

PLAN SPONSOR'S RESPONSIBILITIES TO PARTICIPANT AND THE PLAN

The Plan Sponsor will allow you or the Plan to inspect and copy any PHI about you that is in the Plan Sponsor's custody and control. HIPAA regulations set forth the rules that you and the Plan must follow in this regard. There are some exceptions.

- The Plan Sponsor will amend, or allow the Plan to amend, any portion of your PHI to the extent permitted or required under the HIPAA regulations.
- With respect to certain disclosures, the Plan Sponsor will keep a disclosure log. The disclosure log will go back to the original effective date of the Plan. You have a right to see the disclosure log. The Plan Sponsor does not have to include disclosures for certain Plan-related purposes, such as claims reimbursement or coordination of flexible health reimbursement benefits. The Plan's business associate(s) will likewise track disclosures required by HIPAA.
- The Plan Sponsor will make its internal practices, books, and records relating to its use and disclosure of your PHI from the Plan available to the Plan and to the U. S. Department of Health and Human Services for determining compliance with the HIPAA Privacy Rule.
- The Plan Sponsor will, if feasible, return or destroy all of your PHI in its custody or control that the Plan Sponsor has received from the Plan or from any business associate when the Plan Sponsor no longer needs such information to administer the Plan. If it is not feasible for the Plan Sponsor to return or destroy your PHI, the Plan Sponsor will limit the use or disclosure of any PHI that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

PLAN SPONSOR EMPLOYEES TO WHOM ACCESS TO PHI IS GRANTED FOR PURPOSES LISTED ABOVE

The following classes of employees under the control of the Plan Sponsor may be given access to your protected health information for the purposes set forth in this document:

Officers of Human Resources	Human Resources Privacy Officer
Benefits Office Employees	Corporate Privacy Officer
Human Resources Generalists	Vice President for Financial Affairs
Assistant Directors of Human Resources	Risk Management Office Employees
Information Technology/Technical Support Employees	Information Technology Billing Operations
System Auditors	

This list includes every class of employees under the control of the Plan Sponsor who may receive your PHI. If any of these employees use or disclose your PHI in violation of the rules that are set out in this summary, the employees will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to you.