Avaya Inc. Health Reimbursement Arrangement Plan

for Represented Retirees

Summary Plan Description

Effective January 1, 2017

Last Updated April 1, 2017

You should keep a copy of this Summary Plan Description for future reference. If this Summary Plan Description has been delivered to you by electronic means, you have the right to receive a written summary and may request a copy of this summary on a written paper document at no charge by contacting the Plan Administrator (contact information is provide under the heading "Administrative Information" in this summary).

Caution: *This document, together with the Avaya Inc. Health and Welfare Benefits Plan for Retirees, is the Plan Document for the Avaya Inc. Health Reimbursement Arrangement Plan for Represented Retirees (the "HRA" or "Plan") as in effect on January 1, 2017. This document, together with the summaries, booklets, notices, election materials and attachments issued in connection with the Plan and as in effect from time to time (each of which are fully incorporated herein by this reference), is also intended to serve as the Summary Plan Description for the Plan. If there are any irreconcilable discrepancies between this Plan Document and the summaries, booklets, notices, election materials or attachments, this Plan Document will govern. Nothing in this Plan Document says or implies that any person has a guaranteed right to participate in the Plan, or that the Plan will remain unchanged in future years. Avaya Inc. has the right to suspend, amend, or terminate the Plan and/or any of the benefits provided thereunder at any time in any manner—subject to the terms of applicable collective bargaining agreements and to the extent permitted by law. The Plan Administrator, or its designee, has sole discretionary authority to interpret and construe the provisions of the Plan, to determine eligibility for benefits under the Plan, and to resolve any disputes that arise under the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides, in its discretion, that the applicant is entitled to them.*

The receipt of this Plan Document or related Summary Plan Description does not necessarily mean that you are eligible to participate in the Plan or that you are entitled to any benefits from the Plan. Your rights, if any, are governed by the provisions of the Plan Document as in effect from time to time.

Contents

Introduction

Avaya Inc. ("Avaya" or the "Company") has established the Avaya Inc. Health Reimbursement Arrangement Plan for Represented Retirees (this "HRA" or "Plan"), effective January 1, 2017 (the "Effective Date"). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth herein.

This Plan is intended to permit Eligible Retirees and Eligible Spouses to obtain reimbursement of Medical Care Expenses on a nontaxable basis from his or her HRA Account. This Plan is intended to be a health reimbursement arrangement as defined under IRS Notice 2002-45. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from Participants' gross income under Section 105(b) of the Internal Revenue Code of 1986, as amended (the "Code"). This Plan is intended to be an employer-provided medical reimbursement plan under Sections 105 and 106 of the Code and the regulations issued thereunder.

Many Avaya retirees and their spouses are able to acquire medical insurance through the individual insurance market, using OneExchange, a company dedicated to helping individuals choose the right coverage option from the individual market, if they wish. If an Eligible Retiree or an Eligible Spouse works with OneExchange to purchase health insurance coverage on the individual market, he or she may also be eligible to have a portion of the insurance premiums, and certain other medical expenses, reimbursed on a tax-free basis through this Plan.

Each time "Avaya" appears in this booklet, Avaya Inc. and all of its subsidiaries, divisions, and facilities that have adopted the Plan with Avaya Inc.'s consent are included; provided, however, Avaya Inc. is the only entity authorized to amend or terminate the Plan.

Who Is Eligible to Participate; Termination of Participation

You and your spouse may become a Participant in this Plan if you and your spouse meet this Plan's eligibility requirements, set forth below.

You
If you retire from Avaya, you may become a Participant in this Plan if you meet this Plan's definition of "Eligible Retiree."

How this Plan defines "Eligible Retiree"
You are an "Eligible Retiree" if:

- You are a former non-salaried employee of Avaya whose terms and conditions of employment with Avaya were determined by collective bargaining with a union or affiliate thereof representing you with respect to whom inclusion in the Plan has been provided for in the collective bargaining agreement;

- You terminated employment with Avaya on or before October 15, 2015;

- You and your eligible dependents are not receiving COBRA continuation coverage under The Avaya Inc. Retiree Medical Expense Plan or The Avaya Inc. Medical Expense Plan; and

- You are entitled to receive a service or disability pension under The Avaya Inc. Pension Plan. Refer to the Avaya Inc. Pension Plan summary plan description and plan document for details.

Your Eligible Spouse
If you are an Eligible Retiree, your spouse may become a Participant in this Plan if he or she meets this Plan's definition of "Eligible Spouse."

Your spouse is an "Eligible Spouse" if:

- You are an Eligible Retiree; and

- Your spouse is legally married to you on the date on which you become an Eligible Retiree or is registered as your "domestic partner" under the laws in which you reside.

Your spouse is not an Eligible Spouse if you, the Eligible Retiree, pass away prior to January 1, 2017 or are not a Participant in this Plan. For details on coverage and reimbursement in the event of an Eligible Retiree's death, see "Survivor Coverage", below.

Note that Avaya may require you to submit paperwork evidencing your relationship with your Eligible Spouse.

Ineligible Participants
The following individuals are not eligible to participate in this Plan. This list is not meant to be a comprehensive list.

- Non-spouse dependents of an Eligible Retiree;
- Children or grandchildren of an Eligible Retiree;
- Individuals that participate in the Avaya Inc. Family Security Program; and
- Class II Dependents, as such term is defined in the Avaya Inc. Medical Expense Plan, which includes the following relatives who meet the eligibility requirements shown below and who were previously covered under The Avaya Inc. Retiree Medical Expense Plan prior to January 1, 2017:
    - Your unmarried dependent children not included as Class I dependents,
    - Your unmarried dependent stepchildren not included as Class I dependents,
    - Your unmarried grandchildren, your unmarried brothers and sisters, and your parents and grandparents, and
    - Your lawful spouse's parents and grandparents.

Survivor Coverage
As of January 1, 2017, an Eligible Spouse will be eligible to receive reimbursements from the HRA Account balance for claims incurred by the Eligible Retiree or Eligible Spouse after the date the Eligible Retiree dies; however, the Eligible Spouse can only continue to submit for reimbursement of claims for six months (i.e., a "run-out period") after date of death for claims incurred by the Eligible Retiree prior to or on the date of the death of the Eligible Retiree. The surviving Eligible Spouse may continue to incur claims after the date of death of the Eligible Retiree to deplete the HRA Account balance. All future HRA allocations will cease at the time of the Eligible Retiree's death.

As of January 1, 2017, an Eligible Retiree will be eligible to receive reimbursements from the HRA Account balance for claims incurred by the Eligible Retiree or Eligible Spouse after the date the Eligible Spouse dies; however, the Eligible Retiree can only continue to submit for reimbursement of claims for six months (i.e., a "run-out period") after date of death for claims incurred by the Eligible Spouse prior to or on the date of the death of the Eligible Spouse. The Eligible Retiree may continue to incur claims after the date of death of the Eligible Spouse. Following the Eligible Spouse's death, future HRA allocations for the Eligible Retiree will be made for the Eligible Retiree with individual coverage only.

If the Eligible Retiree has no Eligible Spouse, the estate can submit claims for six months (run-out period) after date of death for claims incurred by the Eligible Retiree prior to or on the date of death. After the run-out period expires, any unused balance in the HRA Account will be forfeited.

Election and Coverage Start Date
You are eligible to participate in this Plan if:

- Your coverage or your eligibility for coverage under The Avaya Inc. Retiree Medical Expense Plan terminated on December 31, 2016, provided that you opted-in to this Plan with OneExchange prior to this date or following a mid-year qualified status change; or

- Your COBRA continuation and subsequent extended coverage under The Avaya Inc. Medical Expense Plan or The Avaya Inc. Retiree Medical Expense Plan terminated on December 31, 2016, provided that you opted-in to this Plan with OneExchange prior to this date.

If you are eligible to participate in this Plan on January 1, 2017 but were covered by The Avaya Inc. Medical Expense Plan or The Avaya Inc. Retiree Medical Expense Plan under COBRA prior to such date, you are eligible to participate in this Plan on the first day of the calendar month immediately following the date on which you opted-in to this Plan with OneExchange, provided that such election is completed no later than sixty (60) days after your COBRA coverage expires. You must call OneExchange at 1-855-535-7157 (if Medicare-eligible) or 1-844-669-3681 (if non-Medicare eligible) to opt in to this Plan within sixty (60) days of your COBRA expiration.

If you choose not to participate in this Plan when first eligible and, during the Plan year, experience a qualified status change (as defined under federal regulations), you may opt in mid-year, provided you report your qualified status change to OneExchange by calling 1-855-535-7157 (if Medicare-eligible) or 1-844-669-3681 (if non-Medicare eligible) within sixty (60) days of the event. You may be asked to provide documentation of the qualified status change.

Initial Election and Continuing Participation Requirements
In order for an HRA Account to be established and maintained by the Plan Administrator for an Eligible Retiree and Eligible Spouse, where applicable, the following criteria must be met:

- <u>If eligible for Medicare</u>, the Eligible Retiree and/or Eligible Spouse must (1) be covered and remain covered by a medical and prescription drug plan offered through OneExchange, and (2) opt in to this Plan with OneExchange; or

- <u>If not eligible for Medicare</u>, the Eligible Retiree and/or Eligible Spouse must (1) be covered and remain covered under a medical and prescription drug plan offered through OneExchange or an individual/group health insurance plan and (2) opt in to this Plan with OneExchange

Note that the additional participation requirements listed in this section apply to all Participants. If an Eligible Retiree and Eligible Spouse participate in the Plan, both individuals must satisfy

the participation requirements listed above. If you fail to satisfy these requirements at any time, any unused balance in your HRA Account will be forfeited.

When do you become eligible for Medicare?
In general, you become eligible for Medicare based on age (age 65), disability, or end-stage renal disease. (To understand Medicare start dates refer to https://www.mymedicarematters.org/enrollment/am-i-eligible). It is your sole responsibility to know and understand your Medicare options and decide what is best for your personal situation. Avaya does not provide Medicare advice. You should consult your personal advisor if you have any questions.

Relationship between OneExchange and this Plan
Although this Plan is only available to Eligible Retirees and Eligible Spouses, it is important that you keep in mind that neither OneExchange, nor any of the insurance policies that may be available through OneExchange or a public marketplace exchange, are part of this Plan, or of any other employee benefit plan sponsored or administered by Avaya. This means:

- Avaya has no responsibility for the level of benefits provided by any of the insurance policies available through OneExchange or the public marketplace exchanges. If you believe that an insurance company has failed to cover a procedure, medicine or other service that should have been covered, you will need to deal directly with the insurance company involved. Avaya will not have any ability to cause the insurance company to change its decision.

- OneExchange is a privately owned and operated insurance exchange, which is completely independent of Avaya. Representatives of OneExchange are not employed by and do not represent or speak for Avaya, and Avaya does not supervise or oversee the advice provided by OneExchange.

- Avaya does not endorse or recommend any particular insurance plan, program, provider or agent. You are encouraged to investigate individual insurance plans for yourself and make your own informed decision about which individual insurance plan is best for you. It is possible that other insurance policies offered outside of OneExchange may be more suitable for your needs. The insurance plan that you select is your own individual plan and is not sponsored or maintained by Avaya and is not part of any plan or program established or maintained by Avaya.

Under no circumstances whatsoever shall Avaya, the Plan Administrator or any other person or committee affiliated with Avaya, have any responsibility or liability for any advice provided by any representative of OneExchange, or the failure of any insurance plan or policy acquired through OneExchange to provide any coverage.

Benefits Provided by the Plan; Method of Funding

Reimbursements paid by the HRA Account

When you become a Participant in this Plan, an HRA Account will be established by the Plan Administrator for you to receive benefit credits from the Company. The HRA Accounts are just bookkeeping entries with the purpose of keeping track of credited amounts and available reimbursement amounts, and are not literal separate bank or trust accounts.

The dollar amount that will be credited to your HRA Account each Plan Year will depend on whether you are eligible for Medicare and whether your Eligible Spouse participates in this Plan, as provided below. Whether your Eligible Spouse is eligible for Medicare has no impact on the dollar amount that will be credited to your HRA Accounts.

Non-Medicare Eligible Retirees			
Coverage Tier	**Avaya Contribution**	**Trust Contribution***	**Total Possible HRA Allocation****
Eligible Retiree with individual coverage (either on OneExchange or public marketplace exchange)	$2,200	$4,200	$6,400
Eligible Retiree and Eligible Spouse with coverage (either on OneExchange or other individual/group health coverage)	$4,000	$8,500	$12,500

Medicare Eligible Retirees			
Coverage Tier	**Avaya Contribution**	**Trust Contribution***	**Total Possible HRA Allocation****
Eligible Retiree with individual coverage on OneExchange	$2,200	$200	$2,400
Eligible Retiree and Eligible Spouse with coverage on OneExchange	$4,000	$200	$4,200

Contributed from the Avaya Inc. Represented Employee Benefits Trust. For more information about funding, refer to the section below titled "Funding This Plan."

*****Note that these are the dollar amounts that will be credited to HRA Accounts with respect to the full 2017 and 2018 Plan Years. Accounts will be prorated if an employee becomes retiree-eligible any month other than the first month of the year as described below, or as a result of a qualified status change. Accounts will be prorated if a retiree becomes Medicare eligible on account of the smaller HRA allocation creditable to Medicare eligible retirees. Avaya reserves the right to change the dollar amount of credits to HRA Accounts that are made with respect to any future Plan Year without any prior notice to Participants.***

Your HRA Account will be credited with the applicable dollar amount on the first day of each Plan Year in which you are a Participant in this Plan, or as soon as administratively possible thereafter. If you were not covered by The Avaya Inc. Retiree Medical Expense Plan in the year before you opt in to the Plan, your HRA Account will be credited within two (2) months following your election in the Plan after Avaya is able to verify your eligibility. Any balance in your HRA Account which remains at the end of a Plan Year will be carried over to the subsequent Plan Year while you and/or your Eligible Spouse remain a Participant in this Plan.

If you become a Participant in the middle of a Plan Year, your HRA Account will be credited on the first day of the month after your election with a pro-rata portion of the applicable dollar amount for that Plan Year, pro-rated based on the number of full months during such Plan Year which you will be a Participant in this Plan (assuming for such purpose that you will be a Participant through the end of such Plan Year). A pro-ration process will apply for you if/when you become Medicare-eligible during the plan year on account of the smaller HRA allocation creditable to Medicare eligible retirees.

If both you and your Eligible Spouse participate in this Plan, the entire balance in your joint HRA Accounts can be used for either of your Medical Care Expenses. If the Eligible Spouse of the Eligible Retiree passes away, the Eligible Retiree can continue to use the joint HRA Account balances until their participation in the Plan ceases. No further HRA Account allocation will be made for the deceased spouse. If the Eligible Retiree passes away, the Eligible Spouse can continue to use the joint HRA Account balances until the account is depleted. No further HRA Account allocations will be made to the surviving spouse of a deceased retiree. (For additional details on coverage and reimbursement in the event of an Eligible Retiree's death, see "Survivor Coverage")

If both you and your Eligible Spouse are Eligible Retirees, your joint HRA Accounts will be funded as if one of you were the Eligible Retiree and the other were the Eligible Spouse. In other words, you will not be able to set up two separate Eligible Retiree and/or Eligible Spouse accounts. But, as is the case with all Eligible Spouses participating in the Plan, the entire balance in your joint HRA Accounts can be used for either of your Medical Care Expenses. You will not receive "double funding" if both you and your Eligible Spouse are Eligible Retirees.

Your HRA

You can begin using the balance in your HRA Account once you become a Participant in this Plan. Any balance in your HRA Account which remains at the end of a Plan Year will be carried over to the subsequent Plan Year. If you cease to be a Participant in this Plan, any unused balance in your HRA Account will be forfeited.

Your HRA Account balance can be used to reimburse yourself for the insurance premium on your medical and prescription drug insurance policy, including Medicare premiums, or can be used for most Medical Care Expenses. For purposes of this Plan, a "Medical Care Expense" is an expense, incurred by you (or your Eligible Spouse) on or after the date in which you (and your Eligible Spouse, as applicable) have opted-in to this Plan, for medical care (as defined in Section 213 of the Code, as modified by the exclusions below) (generally, this includes expenses related to the diagnosis, care, mitigation, treatment or prevention of disease which are deductible for federal income tax purposes). Some examples of Medical Care Expenses that are eligible for reimbursement under this Plan include:

- Medications that are prescribed by a doctor, or insulin;
- Dental out-of-pocket expenses;
- Dermatology;
- Physical therapy;
- Birth control pills;
- Chiropractor treatments;
- Hearing aids; and
- Wheelchairs

Some examples of items that are *not* eligible for reimbursement under this Plan (despite the fact that they may fall within the definition of medical care expenses as defined in Section 213 of the Code) include:

- Baby-sitting and child care;
- Dental premiums;
- Long-term care premiums and services;
- Vision care out-of-pocket expenses and premiums
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items are and are not Medical Care Expenses, consult IRS Publication 502, "Medical and Dental Expenses," under the headings "What Medical Expenses Are Includible" and "What Expenses Are Not Includible," but also consider the exclusions listed above.

Medical Care Expenses may be reimbursed from your HRA Account only to the extent that you or your Eligible Spouse are not reimbursed for the expense through the insurance plan you purchased through OneExchange or by any other accident or health plan.

Only Medical Care Expenses incurred while you are a Participant in this Plan may be reimbursed from your HRA Account. Similarly, only Medical Care Expenses while your Eligible Spouse is a Participant in this Plan may be reimbursed from your HRA Account. However, you are entitled to obtain reimbursement from your HRA Account for Medical Care Expenses incurred by or on behalf of your spouse. Medical Care Expenses are "incurred" when the medical care is provided, not when you or your Eligible Spouse are billed, charged, or pay for the expense.

Thus, a Medical Care Expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may *not* be reimbursed from an HRA Account:

- expenses incurred for qualified long term care services;
- expenses incurred *prior to the date* that you (or your Eligible Spouse, as applicable) became a Participant in this Plan;
- expenses incurred *after the date* that you (or your Eligible Spouse, as applicable) cease to be a Participant in this Plan; and
- expenses that have been reimbursed by another health plan or for which you plan to seek reimbursement under another health plan.

Filing a Claim for Reimbursement

In order to be reimbursed from your HRA Account, you must first pay the Medical Care Expense and then submit a reimbursement form to the Claims Submissions Agent within the timeframe required by this Plan. This Plan does not provide for direct payment to insurance companies or other medical providers. A reimbursement claim for a Medical Care Expense can be filed with the Claims Submissions Agent at any time during which you (and your Eligible Spouse, as applicable) are participating in the Plan, subject to any run-out period rules described in this SPD and as long as there are monies in the HRA Account in which the Medical Care Expense was incurred.

The Plan's Claim Submissions Agent is OneExchange:

Willis Towers Watson
P.O. Box 981155
El Paso, TX 79998-1155
Fax: 855-321-2605

The reimbursement form must be mailed or faxed to the Claims Submission Agent, along with bills, invoices, or other written statements from an independent third party (e.g., a hospital, physician, or pharmacy), showing that Medical Care Expenses have been incurred and the amount of such Medical Care Expenses. The completed reimbursement form must contain the following: (a) the name of the individual(s) on whose behalf the Medical Care Expenses were incurred, (b) the date the Medical Care Expenses were incurred, (c) the nature of the Medical Care Expenses; and (d) the amount incurred. You can obtain a reimbursement form from OneExchange. Your claim is deemed filed when it is received by the Claims Submission Agent.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received.

If your claim is denied
If a claim is denied—in whole or in part—you (or your Eligible Spouse who is a Participant in the Plan, as applicable) are entitled to a full review. For more information about the process for reviewing denied claims, see the "Appealing Denied Reimbursement Claims" section of this Plan.

If you misrepresent a claim
When you file a claim for reimbursement, you certify that the statements you make on the claim form are complete and accurate to the best of your knowledge. If you misrepresent information or file a fraudulent claim, you will be required to repay any amounts that were paid to you from your HRA Account based on that claim to the Company.

When Coverage Ends

Under certain circumstances, your participation in this Plan may end.

Your participation in this Plan ends on the last day of the month in which the earliest of the following occurs:

- You or any member of your family submits a falsified, altered, or fraudulent claim;
- You cease to be an Eligible Retiree; or
- You die.

Your spouse's participation in this Plan ends on the last day of the month in which the earliest of the following occurs:

- You, your spouse or any member of your family submits a falsified, altered, or fraudulent claim;
- Your spouse ceases to be an Eligible Spouse; or
- Your spouse dies.

Coverage will also end if Avaya discontinues this Plan, or amends this Plan so that you are no longer eligible.

If you have questions
Questions concerning this Plan should be addressed to the Plan Administrator or to OneExchange. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep this Plan informed of address changes
In order to protect your family's rights, you should keep the Avaya Health & Benefits Decision Center and OneExchange informed of any changes in your address and phone number. You should also keep a copy, for your records, of any notices you send. The Avaya Health & Benefits Decision Center can be reached at 1-800-526-8056 (option 1). OneExchange can be reached at 1-855-535-7157 (if Medicare-eligible) or 1-844-669-3681 (if non-Medicare eligible).

Administrative Information

This Plan is governed by ERISA (the Employee Retirement Income Security Act of 1974). This section provides important legal and administrative information you may need such as:

- how to contact the Plan Administrator;
- information about the Claims Submission Agent and how to contact them;
- what to do if a claim is denied: and
- your rights under ERISA.

If you have any questions about any of the following, contact the Plan Administrator or OneExchange.

Plan Administrator
Avaya is the Plan Administrator of this Plan. The Plan Administrator has full authority to interpret and administer this Plan, and its decisions are final and binding on all parties. No person has the right to any benefits under this Plan unless the Plan Administrator, or a person to whom the Plan Administrator has delegated the authority, determines that the benefit is payable.

You may contact the Plan Administrator at:

Avaya Inc.
Plan Administrator
4655 Great America Parkway
Santa Clara CA 95054
E-mail: hwplanadmin@avaya.com

The Plan Administrator, or its designee, has such powers and duties as it considers necessary or appropriate to discharge its duties. The Plan Administrator has sole discretionary authority to interpret and construe the provisions of this Plan and to decide all matters hereunder. Without limiting the generality of the foregoing, the Plan Administrator shall have the discretionary authority to determine eligibility for benefits under the Plan, to prescribe procedures to be followed and the forms to be used by Eligible Retirees and Eligible Spouses to opt in and submit claims pursuant to this Plan, to prepare and distribute information explaining this Plan and the benefits under this Plan (including the HRA Accounts) in such manner as the Plan Administrator determines to be appropriate, to request and receive from all Eligible Retirees and Eligible Spouses such information as the Plan Administrator determines from time to time is necessary for the proper administration of this Plan and to resolve any disputes that arise under the Plan. Benefits under this Plan will be paid only if the Plan Administrator decides in its sole discretion

that the applicant is entitled to them. Decisions of the Plan Administrator shall be final and binding.

The Plan Administrator may rely upon the information submitted by a Participant as being proper under this Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator. The Plan Administrator, subject to Avaya's approval, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of this Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of Avaya.

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for the Plan Administrator's own willful misconduct or willful breach of this Plan. Unless otherwise determined by Avaya and permitted by law, any Plan Administrator who is also an Avaya employee shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid by Avaya. The Plan Administrator shall be bonded to the extent required by ERISA.

Plan Sponsor
Avaya is the sponsor of this Plan and Avaya's address is:

Avaya Inc.
4655 Great America Parkway
Santa Clara CA 95054

Plan Name Identification Number
When dealing with or referring to this Plan in terms of claim appeals or other correspondence, you will receive a more rapid response if you identify this Plan fully and accurately. To identify this Plan, you need to use Avaya's employer identification number (EIN): 22-3713430. You also need to know this Plan's official name and number: The official name of this Plan is the Avaya Inc. Health Reimbursement Arrangement Plan for Represented Retirees, and this Plan's number is *553.*

Plan Year
January 1 through December 31.

Agent For Service of Legal Process
The agent for service of legal process on this Plan is:

Avaya Inc.
4655 Great America Parkway
Santa Clara CA 95054
Attention: Assistant General Counsel

Legal process for this Plan may also be served on the Plan Administrator at the address listed above.

Type of Administration
The Plan Administrator pays applicable benefits from a combination of a predetermined amount from Avaya's general assets and from the Avaya Inc. Represented Employees Benefits Trust. The Plan Administrator may delegate all or some of its duties to a third party administrator from time to time.

Company and Participant Contributions
The Company funds the full dollar amount that is credited to each HRA Account based on Plan provisions. There are no required Participant contributions for benefits under this Plan.

Funding This Plan
All of the amounts payable under this Plan shall be paid from a combination of a predetermined amount from Avaya's general assets and from the Avaya Inc. Represented Employees Benefits Trust. Nothing herein will be construed to require the Company or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Company from which any payment under this Plan may be made.

Plan Amendments
Avaya expects to continue the Plan, but reserves the right to amend or terminate the Plan, in whole or in party, at any time for any reason by the resolution of Avaya's Board of Directors or its properly authorized designee. In addition, Avaya does not guarantee the continuation of any benefits during employment or during retirement nor does it guarantee any specific level of benefits or contributions.

Code and ERISA Compliance
It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

No Guarantee of Tax Consequences
Neither the Plan Administrator nor Avaya makes any commitment or guarantee that any amounts paid to or for your benefit under this Plan will be excludable from your gross income for federal, state, or local income tax purposes. It is your obligation to determine whether each payment under this Plan is excludable from your gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if you have any reason to believe that such payment is not so excludable.

Situations Affecting Your Plan Benefits

Certain situations could affect your benefits.

Assignment of Benefits
You cannot assign your benefits or claims under this Plan. Any attempt to assign your benefits will not be recognized, except as required by law.

Appealing Denied Reimbursement Claims

Reimbursement Claims Appeals

Initial Claim Decision: Within 30 days after the Claims Submission Agent receives your reimbursement claim, the Company will reimburse you for your Medical Care Expenses (if the Claims Submission Agent approves the claim), or the Claims Submission Agent will notify you that your claim has been denied. The 30-day time period may be extended for an additional 15 days for matters beyond the control of the Claims Submission Agent, including in cases where a reimbursement claim is incomplete. The Claims Submission Agent will provide written notice of any extension, including the reasons for the extension, and will allow you 45 days in which to complete an incomplete reimbursement claim.

Note: These procedures apply only to questions of whether a particular expense was eligible to be reimbursed from your HRA Account. Any claim related to whether an expense should be covered by an insurance policy obtained through OneExchange (or otherwise) must be addressed to the insurance company that issued the policy. The insurance policies purchased through OneExchange (or otherwise) are not employee benefit clans provided by Company, and Company has no authority over, or responsibility for, the benefits provided by such policies.

Appealing a Denial: If you disagree with the decision of the Claims Submission Agent relating to your reimbursement claim, you may request a full review of the decision. You must submit your appeal request within 180 days after you receive the denial notice; if you do not submit your request within this 180-day period, you lose your right to appeal. In connection with your appeal, you or your representative can receive reasonable access to and copies (free of charge) of all documents, records and other information relevant to your reimbursement claim. You may also submit written comments, documents, records and other information relating to your reimbursement claim. If you want to appeal a decision related to ***medical benefits,*** send your appeal to the claims department of ***the insurance company that issued you the medical policy.***

If your claim is related to eligibility, COBRA or anything other than a determination of medical benefits, you should direct your appeal to the Plan Administrator.

Your appeal will be reviewed by someone other than the person who made the first decision on your claim. The Claims Submission Agent will disclose the identity of any medical or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the Claims Submission Agent will consult with a health care professional who has the appropriate training and experience in the field of medicine involved. After a decision is made concerning your appeal, you will be notified of its findings and decision in writing. This notice will be provided no later than 60 days after receiving the appeal.

No person eligible for benefits under this Plan has a right to seek review of a denial of benefits-or to bring any action to enforce a claim for benefits in any court, prior to filing a claim for benefits and exhausting all rights described under this section, or more than 12 months after the date the claimant submitted his or her last required appeal. Except as may be otherwise required by law, the final decisions of the Claims Submission Agent and the Plan Administrator will be final and binding on all parties.

Claims/Appeals 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 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 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.
- For denial of a claim on appeal, ***other than a claim for medical benefits,*** a description of the procedures for the second level of appeal.
- A statement of your right to bring suit under ERISA if your claim is denied following a final appeal.

Second Level Appeal

If you disagree with the decision of the reimbursement claim you have the right to a second level appeal. Second level appeals should be sent to the Plan Administrator.

Avaya Inc.
Plan Administrator
4655 Great America Parkway
Santa Clara CA 95054
E-mail: hwplanadmin@avaya.com

Your appeal will be reviewed by the Avaya Employee Benefits Committee. The Committee will disclose the identity of any medical or vocational experts who were consulted in connection with your claim. After a decision is made concerning your appeal, you will be notified of its findings and decision in writing. This notice will be provided no later than 60 days after receiving the appeal. This decision of the second level appeal will be final and binding.

Your ERISA and Other Legal Rights

As a Participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Participants in this Plan shall be entitled to:

Receive Information About This Plan and Benefits Provided Hereunder

- Examine (without charge) at the Plan Administrator's office and at other specified locations—such as work sites and union halls (as applicable)—all Plan documents. These may include insurance contracts, collective bargaining agreements (as applicable) and copies 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 Employee Benefits Security Administration (EBSA).

- Obtain, upon written request to the Plan Administrator, copies of all Plan documents and other Plan information governing the operation of this Plan, including the most recent annual report (Form 5500 series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for these copies.

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

Continue Group Health Care Coverage

- Continue health care coverage under COBRA for yourself or your Eligible Spouse if there is a loss of coverage under this Plan as a result of a qualifying event as required by COBRA. You or your Eligible Spouse may have to pay for such coverage. Review this Plan on the rules governing your COBRA continuation coverage rights.

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 this Plan. The people who operate this Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Participants in this Plan and their beneficiaries.

No one, including Avaya or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from this Plan or exercising your ERISA rights.

Enforcing Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why and to obtain copies of the 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 materials from this 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 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

- If you have a claim for benefits under this Plan, which is denied or ignored—in whole or in part after going through the appeals procedure—you may file suit in a state or federal court. In addition, if you disagree with this Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court.

- If it should happen that plan fiduciaries misuse this 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 a federal court.

If you file suit against this Plan, 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 this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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 Employee Benefits Security Administration Brochure Request Line at 1-866-444-EBSA (3272), on the Internet at http://www.dol.gov/ebsalpublications/main.html, or by contacting the EBSA field office nearest you.

HIPAA Privacy
As a Participant in this Plan, your "protected health information" is subject to safeguard under the privacy provisions of the Health Insurance Portability and Accountability Act, as amended (HIPAA). Under HIPAA, this Plan has adopted policies that restrict the use and disclosure of your protected health information. Generally, use and disclosure is limited to payment and health care operation functions and only the "minimum necessary" information may be used or disclosed.

This is only a brief summary of HIPAA. As a Participant, you will receive or have received a separate "privacy notice" that describes the important uses and disclosures of protected health information and your rights under HIPAA. If you need a copy of this notice, you should contact the Plan Administrator.