THE AVAYA INC. RETIREE MEDICAL EXPENSE PLAN, A COMPONENT OF THE AVAYA INC. HEALTH AND WELFARE BENEFITS PLAN FOR RETIREES

Plan Number 553

SUMMARY PLAN DESCRIPTION

Aetna Point of Service Medical Plan

EFFECTIVE AS OF JANUARY 1, 2018

IF THIS SUMMARY PLAN DESCRIPTION HAS BEEN DELIVERED TO YOU BY ELECTRONIC MEANS, YOU HAVE THE RIGHT TO RECEIVE A WRITTEN DOCUMENT AND MAY REQUEST A COPY OF THIS DOCUMENT ON A WRITTEN PAPER DOCUMENT AT NO CHARGE BY CONTACTING THE PLAN ADMINISTRATOR.

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Aetna Point of Service Medical Plan
Summary Plan Description

INTRODUCTION

This Summary Plan Description ("Summary") highlights the key features of the group medical benefits under the Aetna Point of Service Medical Plan ("POS"), under The Avaya Inc. Retiree Medical Expense Plan, a component of The Avaya Inc. Health and Welfare Benefits Plan for Retirees ("Plan"), as in effect on January 1, 2018 (unless otherwise noted). If you terminated your employment with, or retired from, Avaya Inc. (the "Company") prior to January 1, 2018, different provisions may apply to you – in this case, you should contact the Plan Administrator for more information. We urge you to take the time to review this Summary carefully. You have many choices under the Plan which are important to you and your family. You will obtain the greatest value from the Plan if you understand the benefits available, and the choices you can make, under the Plan. This Summary replaces and supersedes any other summary plan description previously issued to you for the group medical benefits under the Plan.

The document for the POS benefit program under the Plan is attached to this Summary ("Program Document") in Appendix I. The Program Document provides information regarding the eligibility, participation, benefit levels and claim procedures for the benefit program. This document, together with the Program Document is the "Summary Plan Description" for the POS benefit program under the Plan.

Please remember that this Summary only summarizes the key provisions of the POS benefit program under the Plan. Other benefits may be described in separate booklets. Also, this Summary is not the official Plan document itself. As a summary, this document cannot explain how every Plan provision might apply in your particular situation. If you have any questions about the Plan or how it applies to you, or if you would like to review or order your own copy of the Plan document, please contact the Plan Administrator – the Plan Administrator's contact information may be found in the "General Plan Information" section of this Summary. The Plan Administrator may charge you a reasonable fee for a copy of the Plan document. Unless contrary to applicable law, the Program Document will control in the event of any irreconcilable conflict between or among the plan documents.

Your receipt of this Summary does not necessarily mean that you are eligible for the Plan. You must satisfy the specific eligibility enrollment and participation requirements provided in the Program Document.

GENERAL PLAN INFORMATION

This section contains general information that you may need to know about the Plan.

Name of Plan

Aetna Point of Service Medical Plan ("POS") (under The Avaya Inc. Retiree Medical Expense Plan, a component of The Avaya Inc. Health & Welfare Benefits Plan for Retirees)

Effective Date

This Summary reflects the Plan as in effect on January 1, 2018 (unless otherwise noted). The Plan was originally effective as of January 1, 2004.

Plan Identification Number

553

Plan Sponsor

Avaya Inc.
4655 Great America Parkway
Santa Clara, CA 95054
E-mail: hwplanadmin@avaya.com
Employer Identification Number: 22-3713430

Plan Administrator

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

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator may delegate any or all of its responsibilities to any person, committee or entity from time to time, including to a "Claims Administrator."

Claims Administrator

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Agent for Legal Service

Any legal actions regarding a claim should be sent to the Claims Administrator. All other legal actions should be sent to:

Avaya Inc.
Attn: General Counsel
4655 Great America Parkway
Santa Clara, CA 95054

Plan Year

The 12-month period beginning on each January 1 and ending on the following December 31.

Type of Plan

The Plan is intended to be an "employee welfare benefit plan", within the meaning of Section 3(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), which provides group medical benefits.

Funding Medium

With certain limited exceptions, the Company pays a majority of the costs associated with providing group medical benefits under the Plan through the Avaya Inc. Represented Employees Post-Retirement Benefits Trust, which is a trust set up under Section 501(c)(9) of the Internal Revenue Code. The Bank of New York Mellon is the trustee of this Trust. Although an insurance company has been appointed as the Claims Administrator, it is only responsible for administering the claims under the Plan and does not insure any benefits under the Plan. Some or all of the benefit programs provided under the Plan may require contributions from you. If contributions are required, such amounts will be determined in accordance with the enrollment materials provided to you.

Type of Administration

Contract Administration. The Plan Administrator has contracted with Aetna Life Insurance Company to provide claims administration services for the Plan as the Claims Administrator for the group medical benefits. The Claims Administrator's decisions are

final and binding and the Company does not have the authority to change the Claims Administrator's decision.

Amendment and Termination

Subject to the terms of any collective bargaining agreement between the Company and your union, the Company reserves the right to amend any one or more of the component benefit programs of the Plan at any time without the consent of any employee, retiree or participant. This includes, but is not limited to, reducing or eliminating benefits for any group of employees or retirees (and the dependents of each) and adjusting any required contributions. Although the Company currently expects to continue the POS benefit program indefinitely, it is not legally bound to do so, and it reserves the right to terminate the POS benefit program or any feature at any time and for any reason, subject to the terms of any collective bargaining agreement between the Company and your union. In addition, the Avaya Participating 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. Upon termination of the Plan (or feature), all elections and reductions in compensation relating to the Plan (or feature) shall terminate.

Union Agreement

The benefits described in this SPD reflect the provisions of the Plan for represented employees or retirees as referred to in applicable collective bargaining agreements between Avaya Inc. and the unions representing employees of the Avaya Participating Company. Copies of these agreements are distributed or made available to those employees or retirees covered by the agreements and to any other employee or retiree who submits a written request for a copy to the Plan Administrator. A reasonable duplication charge may be made for copies furnished in response to such written request.

ELIGIBILITY AND PARTICIPATION REQUIREMENTS

You are eligible to participate in the POS benefit program if you are an "eligible retiree" and satisfy the eligibility provisions described in the Program Document. You are an "eligible retiree" if you were a former eligible employee of Avaya Inc. or such other affiliates that have elected to participate in the Plan with the prior approval of Avaya Inc. (an "Avaya Participating Company") and who:

- Was covered by a collective bargaining agreement that provides for the benefits provided under the Plan,
- Retired on or after October 15, 2015,
- Was either a represented employee when you terminated from an Avaya Participating Company or transferred to a management position less than 12 months before you terminated from an Avaya Participating Company, and
- Is receiving a service or disability pension under the Avaya Inc. Pension Plan.

You are not an "eligible retiree" if:

- You reside outside of the Aetna Point-Of-Service Medical Plan service area,
- You select a non-Aetna retiree medical plan through Avaya, such as Kaiser. Instead, you will receive medical benefits available through your plan. Contact your carrier for specific information about the coverage available.
- Prior to retiring, you were not paid from the U.S. payroll of an Avaya Participating Company, you were employed by an independent company (such as an employment agency), or your services were rendered as part of an agreement excluding participation in benefits.

Enrollment

The timeline for enrollment in Avaya's group medical benefit plans varies by your status. Here are some key dates to keep in mind:

Status	Timeline to Enroll	Eligibility Coverage Date
Newly-retired	You have 31 days from the date on your retirement eligibility letter from ADP, Avaya's benefit administrator, to enroll in or waive coverage for yourself and/or your dependents	The day after your active medical coverage (as an Avaya Represented employee) ended, provided you make a timely election
Current active eligible retirees	Annual enrollment period	January 1st of the following calendar year
	Within 31 days of a qualified status change (e.g. birth, adoption,	Your coverage eligibility date depends on your qualified status change.

[redacted]	marriage, death of dependent, divorce, involuntary loss of other group health coverage, etc.)	Coverage typically begins on the date of the event or the first of the month following the event.

For anticipated enrollment periods, such as newly-retired or annual enrollment, information will be mailed to you from ADP, Avaya's benefit administrator, instructing you to enroll. The correspondence will include information about how to enroll yourself and your eligible dependents in the benefits enrollment portal at https://my.adp.com and the date by which you must make your elections. If you have not received correspondence from ADP within three (3) weeks of your retirement date, contact the Avaya Health & Benefits Decision Center for assistance (via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.).

For qualified status changes, you are responsible for initiating the change within 31 days of the qualifying event (e.g. adding a newborn or dropping a divorced spouse) online by logging in to the benefits enrollment portal at https://my.adp.com or by contacting the Avaya Health & Benefits Decision Center (via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.).

If you miss your enrollment deadline(s) you may be negatively impacted for the remainder of the Plan Year. See "If You Do Not Enroll (on time)" and "Qualified Status Changes" for more detail.

Your elections are in effect as follows:

- The elections or waivers you make as a new retiree are effective for the duration of the Plan Year in which you enroll.
- The elections or waivers you make during annual enrollment are in effect for the next full Plan Year.
- The elections or waivers you make for a qualified status change are effective for the duration of the Plan Year in which you make an enrollment change.

How to Enroll or Make Changes to Your Benefits

For most benefits you can make benefit elections for you and your eligible dependents online by logging in to the benefits enrollment portal at https://my.adp.com or by contacting the Avaya Health & Benefits Decision Center (via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.).

The benefits enrollment portal is available year-round. You will use the portal as a new retiree to initially enroll in your benefits, during annual enrollment to update your

elections, and/or to make qualified status changes during the year. The benefits enrollment portal contains everything you need to make an informed decision, and your personalized enrollment webpage walks you through each of your election choices, benefit by benefit.

For example, when you enroll, you may:

- Enroll your eligible dependents in coverage *(Note: after your election is approved you will be required to submit proof of dependency (i.e. marriage license, Government Registration for Domestic Partners, birth certificate, etc.) for each dependent newly added to coverage before their coverage will take effect)*,
- Enroll in or waive each Avaya Inc. benefit separately. For example, you may waive medical coverage and still enroll in dental coverage for yourself and your dependents.

Default Coverage Waiver (Medical & Pharmacy Only)

Medical and pharmacy coverage is automatically waived for newly-eligible represented retirees and their dependents. **Your medical and pharmacy election and covered dependents do NOT carryover from the benefits you had as an active represented employee.** Coverage is also waived when you move outside of the service area of the medical plan you used to be covered under. It is your responsibility to keep or amend the medical and pharmacy plan Default Coverage Waiver, and review all other benefits you are eligible for, within your 31-day election window. If you do not change the election, the medical and pharmacy plan Default Coverage Waiver will be in force for the remainder of the Plan Year. Your next opportunity to make changes to your benefits will be during the next annual enrollment period or within 31 days of a qualified status change.

If You Do Not Enroll (on time)

If you miss your enrollment deadline, your coverage will remain *as is* for the remainder of the Plan Year. You will have to wait until the next annual enrollment period to enroll in or change your election, unless you have a mid-year qualified status change. For existing retirees, this means you will retain your existing election. For new retirees or retirees that move outside of the service area of the medical plan you used to be covered under, this means you will have the Default Coverage Waiver automatically assigned to you (see "Default Coverage Waiver (Medical & Pharmacy Only)".

Similarly, if you do not enroll your eligible dependent(s) within 31 days of your eligibility date or within 31 days of a qualified status change, or if you do not submit proper proof of your dependents' eligibility for benefits by the deadline on the dependent verification letter, your dependent(s) will not be covered for the remainder of the Plan Year. You will have to wait until the next annual enrollment period to enroll your eligible dependents and provide proof of dependency, unless you have a mid-year qualified status change.

Your Costs

If applicable, you can find the cost for each benefit online at https://my.adp.com.

Contributions for Insurance Premiums

Contributions for insurance premiums, if applicable, are clearly indicated on your annual Confirmation Statement sent to you by ADP shortly after Annual Enrollment each year. If contributions are due from you (e.g. for Other Covered Charges elections in excess of the $50,000 default option), PayFlex, our Direct Bill vendor, will contact you for payment. Payment is due by the deadline provided on the correspondence from PayFlex.

Coverage for Dependents

Your eligible dependents can also participate in the POS benefit program if you elect coverage for them. You must enroll your dependents in the same benefit program in which you are enrolled. Eligible dependents are defined by Avaya Inc.

Eligible Dependents Include:

- **Your Lawful Spouse or Domestic Partner** (either same-sex or opposite-sex; both parties must complete and file a notarized Domestic Partner Affidavit or government registration).

- **Children** To be eligible for coverage, a dependent child must be under 23 years of age. Each child is eligible for coverage through December 31st of the year in which the child reaches age 23. An eligible dependent child includes:

    - Your biological and/or legally adopted child, including any child in the formal legal process of adoption, regardless of residence;
    - A stepchild living with you; and
    - A child living with you for whom you or your lawful spouse or your domestic partner is the legal guardian (this does not include "wards of the state" or "foster children").

  A child, for this purpose, does not include the spouse, domestic partner, or child(ren) of a child.

  Coverage for a fully handicapped child may be continued past the age limits shown above. Your child is fully handicapped if:

    - He or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your Plan; and

- He or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to the Claims Administrator no later than 90 days after the date your child reaches the maximum age under your Plan. You must complete an application form available and submit it for approval to the address listed on the form.

No coverage is available for a child over age 23 who is incapacitated for a short time due to illness or accident.

- **Class II Dependents** (must receive less than $12,000 per year in income from all sources, other than the Avaya retiree's support; must live with you or in a nearby household provided by you, and in the case of unmarried dependent stepchildren, live with you throughout the period of coverage; AND must either have been continuously re-enrolled during each Annual Enrollment since January 1, 1996 and continue to be re-enrolled each year (non-grandfathered class II dependents), or have been enrolled before June 1, 1986 and continuously enrolled each plan year thereafter (grandfathered class II dependents).

Class II dependents include:

- Your unmarried dependent child(ren) not included above;
- Your unmarried dependent stepchild(ren) not included above;
- Your unmarried grandchild(ren);
- Your unmarried brothers and sisters;
- Your parents and grandparents;
- Your lawful spouse's parents and grandparents.

Ineligible dependents include a legally separated spouse, a divorced spouse, and a domestic partner where the domestic partnership has terminated.

Coverage for a Domestic Partner

To be eligible for coverage, a domestic partner must meet the following criteria:

A domestic partner is an individual (same-gender or opposite-gender) who certifies, by affidavit or government registration, the following as of the date of enrollment:

- He or she is your sole domestic partner and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership.
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.

- He or she resides with you in the same residence.
- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she has mental sufficiency to enter into a valid contract.

Coverage for a Domestic Partner's Child(ren)

A domestic partner's child is defined as:

- The natural or adopted child of a domestic partner,
- A child whom the domestic partner is in the formal, legal process of adopting, or
- A child living with you for whom the domestic partner is the legal guardian.

If You and Your Spouse or Domestic Partner Work (or Worked) for an Avaya Participating Company

Avaya Participating Companies have many families -- employees (or retired Avaya Participating Company employees) whose lawful spouse or domestic partner, children (including those of your eligible Domestic Partner, if applicable), or parents are also employed by (or retired from) an Avaya Participating Company. This may affect your coverage under the POS benefit program.

- No one person can receive benefits as a dependent of more than one employee or retiree, or as both a dependent and an employee or retiree. For example, you may not be covered as an active Avaya Participating Company employee or retiree and a dependent of another Avaya Participating Company employee or retiree. Either parent may cover dependent children; however, both parents cannot cover the same child at the same time.
- An eligible employee or retiree may cover another represented Avaya Participating Company employee or retiree. Therefore, if your lawful spouse or domestic partner is an active represented employee or retiree, you may enroll as his or her dependent under the POS benefit program, or he or she may enroll as your dependent, but not both.
- A represented active Avaya Participating Company employee or retiree cannot enroll a salaried Avaya Participating Company employee or retiree as an eligible dependent.
- Only one Avaya Participating Company employee or retiree may enroll any given eligible dependent. Either you or your Avaya Participating Company lawful spouse or domestic partner, as an employee or retiree, may cover your dependent children. A child may not be covered by both parents or by both a parent and a domestic partner at the same time.

CHANGING YOUR COVERAGE DURING THE YEAR

Outside of annual enrollment, if you want to make changes to your benefits during the year, you have to meet certain criteria to do so. This section discusses those criteria.

Qualified Status Changes

The Internal Revenue Service (IRS) states that you may change coverage during the year if you have a qualified change in status. As permitted under federal regulations, qualified changes in status include the following:

Qualified Status Change	Description
Marital Status	A change in your legal marital status, including marriage, death of your spouse, divorce, legal separation, or annulment.
Number of Family Members	Events that change the number of eligible family members, including birth, adoption, placement for adoption, or death.
Employment Status	A termination or commencement of employment by your spouse or child that affects benefit eligibility.
Work Schedule	A reduction or increase in hours of employment by your spouse or a child, including a switch between part-time and full-time, or the start of or return from an unpaid leave of absence.
Family Member Meets or No Longer Meets the Eligibility Requirements	An event that causes a member of your family to meet or to no longer meet a Plan's eligibility requirements for coverage. This may include a child reaching the maximum age for coverage.
Residence or Worksite	A change in the place of residence or worksite of you, your spouse or a child that changes your eligibility for the Plan.

The changes you make must be "due to and consistent with" your qualified change in status. For example, adding your new spouse to your medical plan would be "due to and consistent with" getting married.

To be eligible to make a change, qualified status changes must be reported to the Avaya Health & Benefits Decision Center (online by logging in to the benefits enrollment portal at https://my.adp.com, via e-mail at avayaservicecenter@adp.com, or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.) **within 31 days of the event**. You will be asked to provide documentation of the qualified status change to add or remove your dependents from the Plan. This documentation should be in writing and should include

proof of the event (e.g. a copy of the divorce decree, documentation of domestic partnership, marriage license, birth certificate, adoption agreement or any other legal documentation to support the qualified status change).

Avaya Participating Companies consider corresponding changes in domestic partner and/or domestic partner child(ren) status as a qualified status change.

Note: A qualified status change does not permit you to change your medical plan option (e.g. Kaiser HMO to Aetna POS). You may only make a change to your medical plan option during annual enrollment or if you move out of an HMO service area (if enrolled in the HMO at the time of the event).

Enrolling Newborns Mid-Year

Under the POS benefit program, newborn children are automatically covered during the first 31 days of life. If you wish to continue benefits coverage beyond the first 31 days, you must enroll your newborn in the appropriate plans within 31 days from the date of birth. If you miss the 31-day window, the newborn may be without coverage.

Special Enrollment Rights

Aside from a qualified status change, you may be able to enroll under the special enrollment rules provided by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which apply when an individual initially declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you initially declined coverage because you had other health care coverage that you have now lost through no fault of your own (or if the employer stops contributing towards your or your dependents' other coverage); or (ii) since initially declining coverage you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. In the former case, you must have given (in writing) the alternative coverage as your reason for waiving coverage under the medical care program when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the medical care program within 31 days after you lose your alternative coverage (or if the employer stops contributing towards your or your dependents' other coverage) or the date of your marriage or the birth, adoption, or placement for adoption of your child.

If you fail to make a valid enrollment election within 31 days period, you will not be eligible to make another enrollment election until the next open enrollment period or the next time a special enrollment right is triggered.

If you or an eligible dependent (i) lose coverage under Medicaid or Children's Health Insurance Program ("CHIP") due to a loss of eligibility, and (ii) become eligible for a premium subsidy under Medicaid or CHIP, a special enrollment will be permitted. Enrollment must be requested within the 60 day period after the loss of Medicaid or

CHIP. This enrollment right is not available if the loss of coverage was due to non-payment of the required premiums.

Contact the Plan Administrator for details about special enrollment rights under the Plan.

PERSONAL EVENTS AFFECTING COVERAGE

If You Gain a New Dependent

If you gain a new dependent, (through marriage, birth or adoption), you may enroll your new dependent within 31 days of the date he or she became your dependent by notifying the Avaya Health & Benefits Decision Center (see "Qualified Status Changes").

If a Dependent Loses Eligibility for Avaya's Plans

If your covered dependent is no longer eligible for coverage under the POS benefit program, (e.g. your dependent child ages-out of the Plan, you and your spouse divorce, your dependent dies, etc.), you may remove your dependent(s) within 31 days of the date he or she lost eligibility by notifying the Avaya Health & Benefits Decision Center (see "Qualified Status Changes").

You must provide notification within 31 days when your dependent no longer qualifies as an eligible dependent to make any corresponding changes to your coverage level and ensure that your dependent is sent timely information regarding COBRA continuation coverage, if applicable. If you do not provide notification within 31 days of when the dependent loses eligibility, your coverage level and rates will not be retroactively adjusted, but the dependent will be ineligible to claim benefits. If you do not provide notification within 60 days, your dependent will lose all rights to COBRA continuation coverage, if applicable.

If a Dependent Loses Eligibility for non-Avaya Coverage

If your eligible dependent loses non-Avaya coverage (e.g. due to an involuntary termination of employment and benefits) you may enroll them in Avaya's plans within 31 days of the date he or she lost their coverage by notifying the Avaya Health & Benefits Decision Center (see "Qualified Status Changes").

If You or a Covered Dependent Become Eligible for Medicare While Covered on the Plan

If you or a covered dependent are eligible for Medicare (age 65 or older or under age 65 with a qualified disability or End-Stage Renal Disease), you must enroll in Medicare Parts A and B to receive the maximum benefits allowed under the Plan. To enroll in Medicare, contact your Social Security office. Regardless of your enrollment status in Medicare, your coverage with Avaya continues, but will be secondary to Medicare coverage. This means that Medicare becomes the primary payer and the Plan becomes the secondary payer.

When Medicare is the primary payer, benefits under the Plan are processed using the Aetna Traditional Indemnity Medical Plan benefit levels, even for those

covered under the POS benefit program. For more detailed information, see the "*When You Have Medicare Coverage*" section of the attached Booklet.

In addition to contacting your Social Security office to enroll in Medicare, please also contact the Avaya Health & Benefits Decision Center (via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.) within 31 days of your or your covered dependent's Medicare eligibility date to notify them of your Medicare eligibility status.

The Avaya Health & Benefits Decision Center mailed a Notice of Creditable Coverage with your Annual Enrollment letter. You may need to provide this Notice to enroll in Medicare. If you did not receive this notice, you can print a copy at https://my.adp.com. If you do not have access to the Internet, you can call the Avaya Health & Benefits Decision Center at 1-800-526-8056 (option 1) to request a copy.

Medicare Part B Reimbursement While Covered Under an Avaya Inc. Plan

Avaya will reimburse up to $46 per month (paid once annually in your pension check no later than the beginning of the next calendar year) for Medicare Part B premiums for Medicare-eligible retired employees who are eligible for a service or disability pension under The Avaya Inc. Pension Plan and have not waived participation in the Plan. **This reimbursement is for retirees only** (it does not apply to Medicare-eligible dependents), and will be processed annually as designated by Avaya.

The reimbursement is non-taxable if you provide proof (copy of your Medicare card, or a copy of a payment stub showing payment for your Medicare Part B premiums) that you are currently receiving Medicare Part B benefits. If proof of Medicare Part B premium payment is not provided, your reimbursement will be deemed taxable income. Contact the Avaya Health & Benefits Decision Center (via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.) for more information or to provide proof of receipt of Medicare Part B benefits.

If You Die While Covered Under an Avaya Inc. Plan

Coverage for your enrolled dependents continues under COBRA for six months after your date of death as long as your surviving dependents make an election under COBRA. If you paid for your coverage prior to your death, your surviving dependents must pay the same amount to continue coverage under COBRA. After six months, your covered dependents (except Class II dependents) have the option of continuing coverage under COBRA for up to another 30 months (for a total of 36 months) if they make the required contributions. Class II dependents are not eligible to continue coverage under COBRA after the first six months. For more information about continuing coverage under COBRA, see "Continuing Coverage through COBRA".

If You Move

A move may require a change in your coverage option or the health care company that administers your benefits. This is considered a qualified status change. **It is up to you to notify the Avaya Health & Benefits Decision Center of your home residence change within your 31-day window** (see "Qualified Status Changes").

If your move requires that you change your enrollment option and you fail to make a selection within the 31-day window, you and your dependents, as applicable, will lose medical and pharmacy benefit coverage for the remainder of the Plan Year. See the section "Default Coverage Waiver (Medical & Pharmacy Only)" for details. Your next opportunity to make changes to your benefits will be during the next annual enrollment period or within 31 days of a qualified status change.

OTHER COVERED CHARGES (OCC)

What are Other Covered Charges (OCC)?

Before managed care and comprehensive medical insurance, insurance companies often grouped medical coverage into three categories: basic, surgical and major medical. Hospital benefits (i.e., hospital room and board) were provided through basic coverage; surgical benefits (i.e., surgery, surgical facility, anesthesia) were provided through surgical coverage and ancillary benefits (i.e., physician office visits, X-ray/lab, private duty nursing) were provided through major medical coverage. Three separate insurance companies may have provided these categories of coverage. Major medical benefits were typically reimbursed at 80% of R&C (reasonable and customary).

Who is covered by OCC?

Effective January 1, 2017, represented retirees that retired after October 15, 2015 and their eligible dependents actively receiving indemnity-level benefits from Aetna, under Avaya's retiree medical plans, are covered by OCC.

What is the OCC limit?

OCC coverage is subject to a lifetime benefit cap of $50,000 per person, with the first $3,500 in benefits per year excluded from the $50,000. Retirees have an opportunity to purchase (or update) additional lifetime benefit amounts for themselves and their eligible dependents at the time of their retirement and at the time they first become eligible to receive indemnity-level benefits (e.g. attaining Medicare-eligibility); this is referred to as "OCC Buy-Up Coverage." Retirees may elect their and their dependents' OCC coverage up to $100,000, $150,000 or $250,000. All OCC enrollees must have the same level of coverage.

What benefits apply toward the OCC limit?

The following chart summarizes the OCC benefits that apply toward the OCC limit.

Benefit	Indemnity Coverage
Semiprivate hospital Room & Board beyond 120 days (or beyond 30 days for treatment of mental and nervous conditions and alcohol or drug detox)	100% of the Reasonable & Customary charge after the deductible
Extended Care Facility stays beyond 120 days	80% of the Reasonable & Customary charge after the deductible
Home Health Care Services beyond 200 visits	80% of the Reasonable & Customary charge after the deductible
Physician office or home visits related to an illness	80% of the Reasonable & Customary charge after the deductible

Benefit	Indemnity Coverage
Chiropractor Visits	Limited to 60 visits per year
Private Duty Nursing	100%. Limited to 200 visits/shifts per year
Physical Therapy	80% of the Reasonable & Customary charge after the deductible
Blood and blood derivatives	80% of the Reasonable & Customary charge after the deductible
Artificial limbs and eyes (excluding replacements)	80% of the Reasonable & Customary charge after the deductible
Rental of durable medical equipment	80% of the Reasonable & Customary charge after the deductible
Local ambulance services	80% of the Reasonable & Customary charge after the deductible
Routine mammograms for women's preventive health screening	80% of the Reasonable & Customary charge after the deductible

With the exception of routine mammograms for women's preventive health screening, all of the above benefits are subject to medical necessity. All of the benefits, except Private Duty Nursing, are subject to the deductible.

Are there contributions for OCC coverage?

Represented retirees that retired after October 15, 2015 and their eligible dependents, as applicable, are covered with $50,000 of OCC coverage provided at no cost when enrolled in, and receiving, indemnity-level benefit coverage through an Aetna retiree medical plan offered by Avaya. OCC benefits are tied to enrollment in an Aetna retiree medical plan. If not enrolled in an Aetna retiree medical plan through Avaya at the time of indemnity-level benefit coverage eligibility (e.g. attaining Medicare-eligibility), OCC benefits (including the $50,000 benefit at no cost) are waived.

Retirees have the option to purchase 'Buy-Up' OCC coverage. The annual cost to buy-up is shown in the table below. Retirees will not be billed for the additional OCC coverage until the indemnity-level benefit coverage applies. The amount shown as "coverage" includes the basic $50,000 in addition to the buy-up coverage purchased.

Coverage Per Person	Annual Cost (each), Billed Each January
$ 100,000	$ 9.00
$ 150,000	$ 18.00
$ 250,000	$ 27.00

How to use the buy-up OCC coverage

Should you have any questions about your OCC eligibility or benefits, please call Aetna customer service at 877-508-6927.

CONTINUING COVERAGE THROUGH COBRA

A federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended) requires employers to offer eligible retirees' covered dependents (excluding Class II dependents) the opportunity to continue their group health coverage *at their own expense* for a limited period of time if they lose coverage due to a qualifying event.

COBRA enables your dependents to continue group medical and pharmacy benefit coverage.

COBRA may extend health plan coverage for up to 18 months, 29 months or 36 months, depending on the qualifying event. The following chart summarizes who is eligible for COBRA continuation coverage, under what circumstances, and how long COBRA continuation coverage continues:

If	Qualifying Event	Who is eligible for COBRA Coverage	Duration of COBRA Coverage
You	Die	Your covered dependents	36 months
You	Become divorced, legally separated, or there is a dissolution of your domestic partnership	Your covered dependents	36 months
Your covered dependents	Is no longer an eligible dependent (due to age limit, divorce, or legal separation or this is a dissolution of your domestic partnership)	Your covered dependents	36 months
Your covered dependents	Is no longer an eligible dependent because of your death	Your covered dependents	36 months
Your covered dependents	Becomes disabled within the first 60 days of COBRA continuation coverage	Your covered dependents	Up to 29 months*

COBRA applies to the active health plan options your dependents are covered under at the time of their loss of coverage for one of the reasons listed above. Although not required under COBRA, the plans provide continuation coverage to Domestic Partner and/or Domestic Partner Child(ren).

Note: If your spouse or Domestic Partner enrolls in COBRA for medical and pharmacy coverage, they are ineligible for the Avaya Inc. Health Reimbursement Arrangement Plan for Represented Retirees, (if applicable).

Dependent Continuation Coverage

Each of your covered dependents may have the right to COBRA continuation coverage for up to 36 months from the date of the qualifying event if he or she loses coverage because:

- You die,
- You and your lawful spouse get divorced or legally separated, or there is a dissolution of your domestic partnership, or
- He or she is no longer eligible for coverage under the Plan (e.g., due to reaching the age limit)

If your covered dependents lose coverage because of your death, WageWorks will notify them of their right to continue coverage within 44 days. Your covered dependent must notify WageWorks by phone at 1-800-526-2720 of their decision to continue coverage within 60 days of the later of this notification or the date benefits terminate.

If you get divorced or legally separated, or if your child no longer meets the eligibility requirements, your covered dependent must notify WageWorks by phone at 1-800-526-2720 within 60 days of the event. Notice should also be provided to WageWorks in writing and should include proof of the qualifying event (for example, a copy of the divorce decree). If WageWorks is not notified within 60 days of the qualifying event, your covered dependent will lose the right to elect COBRA continuation coverage. After your notice is received, your covered dependent will be notified of his or her right to continue coverage within 14 days. Within 60 days of the later of this notification or the date benefits terminate, your covered dependent must notify WageWorks of his or her decision to continue coverage. If WageWorks determines that your covered dependent is not eligible for COBRA continuation coverage, your covered dependent will be notified in writing explaining why continuation coverage is not available.

When COBRA Coverage Ends

If your covered dependent(s) elect COBRA continuation coverage, it takes effect on the date of the qualifying event and continues until the earliest of the following:

- The end of the 18-month, 29-month or 36-month continuation period
- The date the Avaya Participating Company no longer provides health care coverage to any of its employees and/or retirees
- When there is a significant underpayment of a premium or when premiums for COBRA continuation coverage are not paid within the required time
- The date your covered dependents become covered under another group health care plan other than TRICARE (The civilian health care component of the Military

Health System) (provided pre-existing condition exclusions or limitations under the new group health care plan do not apply)

- The date your covered dependents become eligible for Medicare, if after the date their COBRA coverage begins. Note that coverage will still be available for family members who are not Medicare-eligible.
- With respect to the 11-month extension for disability, the date the person is no longer disabled your covered dependent must notify WageWorks that they are no longer disabled

If WageWorks determines that your dependent's coverage is terminating before the end of the 18-month, 29-month or 36-month period (e.g., when premiums are not being paid within the required time), they will be notified that their coverage is terminating and they will be provided with the reason why and the date their coverage is terminating.

COBRA Coverage Cost

Your covered dependent(s) pay the full cost for COBRA continuation coverage, plus a 2% administrative fee. If the COBRA period is extended to 29 months because your covered dependent is disabled under the Social Security Act, a 2% administrative fee applies for the first 18 months and a 50% administrative fee applies for your covered dependents for the next 11 months (from the 19th month through the 29th month).

The initial COBRA payment (which includes payment for coverage back to the date regular coverage ended) is due when your covered dependent(s) elect COBRA. However, WageWorks is legally required to provide a 45-day grace period for this initial COBRA payment. No further extension will be permitted. After the initial payment, subsequent payments are due by the first of the month for the coverage period which is being paid. WageWorks is legally required to provide your covered dependent(s) with a 30-day grace period for these payments. No further extension is permitted. Payments received after the 30- or 45-day grace period will result in an automatic loss of all COBRA coverage rights. Once COBRA coverage is lost, it cannot be reinstated. There are no exceptions.

COBRA Questions?

Questions concerning COBRA continuation coverage rights should be addressed to WageWorks by phone at 1-800-526-2720. For more information about your rights under ERISA, COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, contact the nearest area 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. You may also visit their website at www.dol.gov/ebsa.

Keep the COBRA Administrator Informed of Address Changes

In order to protect your family's rights, keep WageWorks informed of any changes in the addresses of family members. Contact WageWorks by phone at 1-800-526-2720 and keep a copy, for your records, of any notices sent to WageWorks.

SUMMARY OF PLAN BENEFITS

Benefits

Group medical benefits are provided under the Plan. With certain limited exceptions, the Company pays a majority of the costs associated with providing group medical benefits under the Plan through the Avaya Inc. Health Plans Benefit Trust, which is a trust set up under Section 501(c)(9) of the Internal Revenue Code. Bank of New York Mellon is the trustee of this Trust. You should read the Program Documents for each benefit program to understand your benefits. In addition, please see the Benefit Plan booklet and Schedule of Benefits included in the Summary for the POS benefit program in Appendix I.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order ("QMCSO") is an order by a court for one parent to provide a child or children with health care coverage under a group health plan. The Plan Administrator will comply with the terms of any qualified medical child support order it receives and will:

1. Establish reasonable procedures to determine whether medical child support orders are QMCSOs as defined under Section 609 of ERISA;
2. Promptly notify you and any alternate recipient (as defined in Section 609(a)(2)(C) of ERISA) of the receipt of any medical child support order, and the Plan's procedures for determining whether medical child support orders are QMCSOs; and
3. Within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a QMCSO and will notify you and each alternate recipient of such determination.

The Plan Administrator is permitted to modify your election under the Plan to provide coverage under an accident or health plan for a child or foster child who is your dependent if a judgment decree or order resulting from divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires coverage for the child. You are permitted to revoke your election under the Plan for the plan year and make a new election to provide for or cancel coverage for the child if the order requires the spouse, former spouse or other individual to provide coverage for the child. The Plan Administrator, in its sole discretion, shall determine whether the order qualifies as a QMCSO in accordance with procedures established for such purpose. Your new election shall take effect as of the effective date provided in the QMCSO procedures established by the Plan Administrator.

You may obtain a copy of the Plan's QMCSO procedures from the Plan Administrator free of charge upon request.

Special Rule for Mental Health Coverage

A federal law called the Mental Health Parity Act ("MHPA") requires that group health plans offering both medical/surgical and mental health benefits generally can no longer set annual or aggregate lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits. In addition, a plan that does not impose an annual or aggregate lifetime dollar limit on medical/surgical benefits generally may not impose such a limit on mental health benefits. The Plan intends to operate in accordance with MHPA to the extent applicable (if at all). For answers to specific questions regarding MHPA benefits, contact the Plan Administrator. Additional state laws may be applicable as more fully described in other materials detailing your medical benefits.

Loss of Benefits

Coverage for retirees ends on the last day of the month in which any of the following events occur:

- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You fail to make any required contributions;
- You become covered under another plan offered by your former employer;
- You have exhausted your overall maximum lifetime benefit under your health Plan, if your Plan contains such a maximum benefit; or
- The company you retired from ceases to be an Avaya Participating Company.

Generally, your dependent's coverage will end on the:

- Date your coverage ends;
- Last day of the month in your which your covered dependent is no longer an eligible dependent; or
- Last day of the year in which your dependent turns age 23.

If your covered dependent is no longer eligible for coverage under the POS benefit program, (e.g. your dependent child ages-out of the Plan, you and your spouse divorce, your dependent dies, etc.), you must remove your dependent(s) within 31 days of the date he or she lost eligibility by notifying the Avaya Health & Benefits Decision Center (see "Qualified Status Changes" and "If a Dependent Loses Eligibility for Avaya's Plans").

Your coverage ends on your date of death. Coverage for your enrolled dependents continues under COBRA for six months after your date of death as long as your surviving dependents make an election under COBRA (see "If You Die While Covered Under an Avaya Inc. Plan" and "Continuing Coverage through COBRA").

If the POS benefit program is discontinued or the Plan is terminated, coverage for you and your eligible dependents will end on the termination date, not the last day of the month.

Other Reasons Your Coverage Will End

In addition, when any of the following happens, you will receive written notice that your coverage (and coverage for your covered dependents) has ended on the date identified in the notice:

- Fraud or misrepresentation with respect to the POS benefit program, or because you (or one of your eligible/covered dependents) knowingly gave the Plan Administrator, Claims Administrator or Avaya Health & Benefits Decision Center false, material misinformation. Examples include false information relating to a person's eligibility or status as an eligible/covered dependent.
- You (or one of your eligible/covered dependents) permitted an unauthorized person to use one of your ID cards, or you (or one of your eligible/covered dependents) improperly use another person's ID card.
- You (or one of your eligible/covered dependents) commit acts of physical or verbal abuse that pose a threat to the staff of the Plan Administrator, Claims Administrator, Insurer or Avaya Health & Benefits Decision Center.
- You (or one of your eligible/covered dependents) in any other way materially violates the terms of the Plan.

PLAN ADMINISTRATION

The Plan is administered by the Company as the "Plan Administrator." Aetna Life Insurance Company, the Claims Administrator, is the contact for all claims questions.

Plan Administrator

The Plan Administrator has the power and authority in its sole and absolute discretion to control and manage the operation and administration of the Plan and shall have all powers necessary to accomplish these purposes. The Plan Administrator will administer the Plan in accordance with established policies, interpretations, practices, and procedures and in accordance with the requirements of ERISA, the Plan and applicable laws. The Plan Administrator will have absolute discretion with respect to the Plan, including the power to:

1. Interpret the terms of the Plan, including eligibility determinations;
2. Determine factual questions that arise in the course of administering the Plan;
3. Adopt and enforce rules and regulations regarding the administration of the Plan;
4. Determine the conditions under which benefits become payable under the Plan and to determine the person or persons to whom such benefits will be paid; and
5. Make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan.

Any determination made by the Plan Administrator will be final, conclusive and binding on all parties.

The Plan Administrator may delegate all or any portion of its authority to any person or entity.

Duties of the Plan Administrator

The Plan Administrator will (i) administer the Plan in accordance with its terms, (ii) decide disputes which may arise relative to a Plan participant's rights, (iii) keep and maintain the Plan documents and all relevant records pertaining to the Plan, (iv) pay or arrange for the payment of claims, (v) establish and communicate procedures to determine whether a medical child support order is qualified under Section 609 of ERISA, and (vi) perform all necessary reporting as required by ERISA.

Claims Administrator

The Plan Administrator has contracted with Aetna Life Insurance Company to provide claims administration services for the Plan as its Claims Administrator for the group medical benefits. The Claims Administrator's decisions are final and binding and

the Company does not have the authority to change the Claims Administrator's decision. Although Aetna Life Insurance Company is an insurance company, Aetna Life Insurance Company only provides claims administration services to the Plan. Aetna Life Insurance Company is not an insurer under the Plan.

Plan Administrator Compensation

The Plan Administrator serves without additional compensation; however, all expenses for administration, including compensation for hired services, will be paid by the Plan to the extent not paid by the Company in its sole and absolute discretion.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the employees/retirees and their dependents and defraying reasonable expenses of plan administration. These duties must be carried out with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation and in accordance with Plan documents to the extent that they are consistent with ERISA.

The Named Fiduciary

The Plan Administrator is the "named fiduciary" with respect to the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will not be liable for any act or omission of such person unless either (i) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures, or (ii) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

HIPAA Notice of Privacy Practices

The Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the Plan Administrator.

Limitations Period for Filing Suit

Unless specifically provided otherwise under a Program Document or pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures. Claims and appeals procedures are provided in the Program Document.

IMPORTANT NOTICES

Women's Health and Cancer Rights Act of 1998

If your medical coverage under the Plan includes coverage for mastectomy-related services, then you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. To obtain more information on WHCRA benefits, including the deductibles and coinsurance that apply, contact the Plan Administrator.

Genetic Information Non-Discrimination Act of 2008 ("GINA")

The Plan will not set contributions on the basis of genetic information. The Plan may not require a retiree (or dependent) to undergo a genetic test except in very limited circumstances. The Plan is generally prohibited from collecting genetic information regarding its participants. The Plan intends to comply with GINA.

Statement of ERISA Rights

Your Rights Under ERISA:

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants are entitled to –

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts (if any), and a copy of the latest annual report (Form 5500 series as required) and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information including insurance contracts (if any), and copies of the latest annual report (Form 5500 series as required) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies; and
- 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.

COBRA and HIPAA Rights:

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary and the documents governing the Plan, particularly 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 an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants. 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 benefit or exercising your rights under ERISA.

Enforce Your Rights:

If your claim for a benefit is denied or ignored, 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. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (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 from the 31st 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. No action at law or in equity may be brought to recover under the Plan until the appeal rights herein provided have been fully exercised and the Plan benefits requested in such appeal have been denied in whole or in part. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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 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 this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area 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. You may also visit their website at www.dol.gov/ebsa.

APPENDIX I

Aetna Point of Service Medical Plan
Summary Plan Description