THE AVAYA INC. FLEXIBLE SPENDING ACCOUNT PLANS, A COMPOENENT OF THE AVAYA INC. HEALTH & WELFARE BENEFITS PLAN

Plan Number 551

SUMMARY PLAN DESCRIPTION ("SPD")

EFFECTIVE AS OF JANAURY 1, 2021

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Introduction to The Avaya Inc. Flexible Spending Account Plans Summary Plan Description

Avaya Inc. (the "Employer") is pleased to sponsor an employee benefit program known as The Avaya Inc. Flexible Spending Account Plans (the "Plan"), a component of the Avaya Inc. Health & Welfare Benefits Plan. There are two types of flexible spending accounts provided under the Plan: a Health Care Flexible Spending Account ("Health Care FSA" or “HCFSA”) and a Dependent Care Flexible Spending Account ("Dependent Care FSA" or “DCFSA”).

The Plan is called a "flexible" spending account plan because you determine the amount of unreimbursed eligible medical and/or dependent day care expenses that you (and where applicable, your eligible family members) will likely incur during the Plan Year and you elect to have the Employer withhold equal amounts from your pay (subject to Plan limitations) *on a pre-tax basis* for reimbursement of such expenses. Any amounts that you elect to have withheld for reimbursement of eligible medical expenses will be credited to the Health Care FSA and any amounts that you elect to have withheld for reimbursement of dependent day care expenses will be credited to the Dependent Care FSA. You must elect wisely because any amounts allocated to a flexible spending account that are not used for expenses incurred during the Plan Year will generally be forfeited. Limited exceptions to the forfeiture rules apply if your Employer offers a Carryover Provision (for the Health Care FSA only). If available, this feature is described in the attached Plan Information Appendix.

Your Employer may offer an additional pre-tax payment option under the Plan. Your Employer may allow you to pay your share of premiums under one or more employee welfare benefit plans sponsored by the Employer on a pre-tax basis (for example, you may elect to pay your share of supplementary AD&D premiums on a pre-tax basis). Any premiums you elect to pay on a pre-tax basis will be credited to your Premium Payment Account (“PPA Account”) and used to pay your share of premiums.

The Plan is beneficial to you because amounts that you elect to have withheld from your pay for reimbursement of eligible medical and/or dependent day care expenses, for pre-tax premium payments are withheld *before* any federal income and employment taxes (e.g., FICA and FUTA) are applied, and in most cases, before any applicable state taxes are applied. If you have unreimbursed medical and/or dependent day care expenses, participation in this Plan will actually increase your take home pay over what your net take home would be if you paid for such expenses with after-tax dollars.

The SPD is divided into six parts: Part I-General Information about the Plan; Part II-Health Care FSA Benefits; Part III-Dependent Care FSA Benefits; Part IV-PPA Account Benefits; Part V-Employment-Related Events Affecting Coverage; and Part VI-the Plan Information Appendix. The first four parts of the SPD are in

Question and Answer format. We encourage you to read the entire SPD, but if you have questions about your rights and obligations under the Plan, please refer to the Table of Contents above for the Question that most resembles your question. Information relating to the Plan that is specific to your Employer is described in the Plan Information Appendix attached to this SPD. You will be referred to the Plan Information Appendix throughout the SPD. In addition, terms that are capitalized throughout are terms that are specifically defined in the SPD or the Plan document.

This SPD and the Plan Information Appendix attached hereto (collectively, the "SPD") describe the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The Plan is also established pursuant to a Plan document into which this SPD has been incorporated. If there is a conflict between the official Plan document and the SPD, the SPD will govern. The effective date of this SPD is set forth in the attached Plan Information Appendix.

If you have any questions regarding the terms of the Plan, the Health Care FSA, the Dependent Care FSA, or the PPA Account, contact the Plan Administrator identified in the Plan Information Appendix. The Plan Administrator's name, address and telephone number appear in the Plan Information Appendix attached to this SPD. Other important information has been provided in the Plan Information Appendix attached to this SPD.

Union Agreement

If you are covered by an applicable collective bargaining agreement, the benefits described in this Summary Plan Description reflect the provisions of The Avaya Inc. Flexible Spending Account Plans (may also be referenced as “The Avaya Inc. Reimbursement Account Plans”) 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 covered by the agreements and to any other employee 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.

Part I: General Information about the Plan

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow Eligible Employees to use pre-tax dollars ("Pre-tax Contributions") to pay for certain otherwise unreimbursed medical and/or dependent day care expenses. The Employer may also elect to use the Plan to allow you to use Pre-tax Contributions to pay for your share of premiums under Employer-sponsored employee benefits.

Q-2. Who can participate in the Plan?

Each Eligible Employee of the Employer who satisfies the Plan's eligibility requirements will be eligible to begin participating in this Plan on the applicable Eligibility Date. The eligibility requirements and the Eligibility Date are identified in the Plan Information Appendix. Those employees who actually participate in the Plan are called "Participants."

For the Health Care FSA only. If you are a Participant in the Health Care FSA option, your Eligible Dependents are also covered. Your Eligible Dependents, for purposes of the Health Care FSA option, are your Spouse (determined in accordance with the federal Defense of Marriage Act) and any other person who qualifies as your dependent under Code Section 105(b). An individual is a "dependent" for purposes of Code Section 105(b) if the individual satisfies any of the following criteria: (i) the individual is a dependent for income tax purposes under Code Section 152 (i.e., qualifies you for a personal exemption); (ii) the individual would qualify as your dependent under Code Section 152 but for the fact that (A) the individual has income in excess of the exemption amount (applicable to "Qualifying Relatives" as defined in Code Section 152), (B) the individual is a dependent of another taxpayer, (C) the individual is married and files a joint return with his or her spouse, or (D) the individual is a "child" as defined in Code Section 152(f)(1) who will not turn age 27 during the year. An individual qualifies as a child as defined by Code Section 152(f)(1) if he/she is any of the following: (i) natural child, (ii) adopted child or child "placed with you for adoption," (iii) step child, or (iv) child placed with you by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction. In addition, a child to whom Code Section 152(e) applies (i.e., a child of divorced or separated parents) is considered a dependent of both parents for the purpose of the Health Care FSA without regard to who claims the child as a dependent on his or her tax return.

Q-3. When does my participation in the Plan end?

You continue to participate in the Plan until the earlier of the date that (i) you elect not to participate in this Plan; (ii) the last day of the month in which you no longer satisfy the eligibility requirements (e.g., you terminate employment); or (iii)

the Plan is terminated or amended to exclude you or the class of employees of which you are a member.

If you cease to satisfy the eligibility requirements during the Plan Year but become eligible for the Plan again during the same Plan Year and more than 30 days after ceasing to satisfy the eligibility requirements, you may make new elections under the Plan. If you cease to satisfy the eligibility requirements during the Plan Year but become eligible for the Plan again during the Plan Year and within 30 days or less after ceasing to satisfy the eligibility requirements, your prior elections will be reinstated and will remain in effect for the remainder of the Plan Year.

Q-4. How do I become a Participant?

You become a Participant in the Plan by (i) completing the designated election form on which you indicate the amount of your pay you wish to have withheld and then allocated to the Health Care FSA, the Dependent Care FSA, and/or the PPA Account, and (ii) timely submitting the election form to the entity/person designated on the election form during one of the enrollment periods described below. You will be provided access to an election method on or before the beginning of the applicable enrollment period.

IMPORTANT: If you want tax-free reimbursement of unreimbursed medical expenses, you must affirmatively elect to participate in the Health Care FSA. If you want tax-free reimbursement of dependent day care expenses, you must affirmatively elect to participate in the Dependent Care FSA.

You cannot become a Participant in this Plan prior to the date you complete and submit your election form.

You may be required to complete an election form via telephone or voice response technology, electronic communication, or any other method prescribed by the Plan Administrator. In order to utilize a telephone system or other electronic means, you may be required to sign an authorization form authorizing issuance of a personal identification number ("PIN") and allowing such PIN to serve as your electronic signature when utilizing the telephone system or electronic means. The Plan Administrator and all parties involved with Plan administration will be entitled to rely on your directions through use of the PIN as if such directions were issued in writing and signed by you.

Q-5. What are the enrollment periods under the Plan?

When you are first hired, you must enroll during the "Initial Enrollment Period" if you want to participate. The enrollment material provided by the Employer (or the Third Party Administrator identified in the Plan Information Appendix) will identify the beginning and end dates of the Initial Enrollment Period. If you make an election during the Initial Enrollment Period, your participation in the flexible

spending account(s) that you elect will begin on the later of your Eligibility Date or the date that your election is received and processed by the entity processing your election form. The election that you make during the Initial Enrollment Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you experience a specified event that will allow a mid-year election change (see below for more details on mid-year election changes).

If you do not make an affirmative election to participate in any of the flexible spending accounts during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year unless you experience an event that allows you to change that election during the Plan Year.

The Plan also has an "Annual Enrollment Period" during which you may enroll (if you did not enroll during the Initial Election Period) or make a new election for the next Plan Year. You will be notified each year of the beginning and end dates of the Annual Enrollment Period. You must make an affirmative election to participate for the next Plan Year for the Health Care FSA and/or Dependent Care FSA. PPA Account elections generally rollover from year to year unless a) the Plan Administrator notifies you otherwise, or b) you make a change to your benefits for a mid-year election change or during the Annual Enrollment Period. The election that you make during the Annual Enrollment Period is effective the first day of the following Plan Year and is irrevocable for the entire Plan Year unless you have experienced an event that allows a mid-year election change.

If you are a current Participant in the Plan and you fail to complete and submit an election form during the Annual Enrollment Period, you will be deemed to have elected not to participate during the next Plan Year.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Appendix.

Q-6. How are the contributions to the flexible spending accounts made under the Plan?

When you become a Participant in the Plan, your share of the contributions for the elected flexible spending accounts (e.g., Health Care FSA, Dependent Care FSA, and/or PPA Account) will be paid with Pre-tax Contributions that you elected on the election form. Pre-tax Contributions are amounts withheld from your gross income before any applicable federal taxes (and in most cases, state taxes) have been deducted.

Q-7. Can I ever change my election during the Plan Year?

You generally cannot change your election to participate in the Plan or vary the Pre-tax Contribution that you have elected to allocate to the Health Care FSA, the Dependent Care FSA and the PPA Account during the Plan Year. That being said, your election to participate in the Plan will automatically terminate if you cease to satisfy the applicable eligibility requirements. Otherwise, you may change your Pre-tax Contribution elections only during the Annual Enrollment Period, and then, only for the coming Plan Year.

There is an important exception to this general rule that you cannot change or revoke your elections during the Plan Year: You may change or revoke your elections during the Plan Year if you submit a written request (or where applicable, an electronic request) for an election change with the Plan Administrator (or the Third Party Administrator identified in the Plan Information Appendix) within 31 days of experiencing one of the following events. Note that not all of the events apply to Health Care FSA elections.In compliance with The Coronavirus Aid, Relief, and Economic Act (CARES Act) employees were able to make changes to the elections of Healthcare FSA or Limited FSA amounts including increasing or decreasing election amounts, making new elections or revoking a current election prospectively for the plan year ending December 31, 2020.The Consolidated Appropriations Act extended this through the 2021 plan year.

1. **Change in Status**. If one or more of the following "Changes in Status" occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other Change in Status events that the Plan Administrator determines are permitted under IRS regulations:

- A change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your spouse);
- A change in the number of your dependents (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent);
- Any of the following events that change the employment status of you, your spouse, or your dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the plan of another employer) or other employee benefit plan of an employer of you, your spouse, or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes

the individual become (or cease to be) eligible for a particular employee benefit;
- An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, or ceasing to be a student); and
- A change in your, your spouse's or your dependent's place of residence.

The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator. With the exception of an election change to the PPA Account and/or the Health Care FSA resulting from birth, placement for adoption or adoption, all election changes are prospective. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage under the Plan. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the Plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Gain of Coverage Eligibility under Another Employer's Plan*. For a Change in Status in which you, your spouse, or your dependent gain eligibility for coverage under another employer's cafeteria plan (or benefit plan) as a result of a change in your marital status or a change in your, your spouse's, or your dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan. You may be required to provide proof that coverage will become effective.

- *Dependent Care Flexible Spending Account Benefits.* With respect to the Dependent Care FSA, you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

  Example: employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event

constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

2. **Special Enrollment Rights (NOTE: This applies to Health Care FSA elections only to the extent that the Health Care FSA is not an "excepted benefit" as defined by the Health Insurance Portability and Accountability Act of 1996)**. If you, your spouse and/or a dependent are entitled to special enrollment rights as set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment for yourself or your eligible dependents because of other medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (e.g., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to change your PPA Account and/or Health Care FSA coverage for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within the 31-day election change period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 31 days. A third special enrollment right applies if you or a dependent child lose eligibility for Medicaid or Children's Health Insurance Program ("CHIP") coverage, or if you or a Dependent child become eligible for premium assistance under a State Medicaid or CHIP Program, provided that you request enrollment within 60 days after either event.

3. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment or custody change requires your dependent child (including a foster child who is your tax dependent) to be covered under this Plan, you may change your election to provide coverage for the dependent child identified in the order. If the order requires that another individual (such as your former spouse) cover the dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the dependent child.

4. **Entitlement to Medicare or Medicaid**. If you, your spouse, or a dependent becomes entitled to Medicare or Medicaid, you may cancel that person's PPA Account and/or Health Care FSA coverage. Similarly, if you, your spouse, or a dependent that has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's PPA Account and/or Health Care FSA coverage.

5. **Change in Cost (applies to PPA Account and Dependent Care FSA elections, but not to Health Care FSA elections)**. If you are notified that the cost of your PPA Account and/or Dependent Care FSA coverage under the Plan has *significantly* increased or decreased or will *significantly* increase or decrease during the Plan Year, you may make certain prospective election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and choose another day care provider, or drop coverage altogether if you are unable to find another provider. If the cost significantly decreases, you may revoke your election and make a new election to correspond with the decrease in cost. For *insignificant* increases or decreases in the cost of your PPA Account or Dependent Care FSA coverage, however, your Pre-tax Contributions will change automatically to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

6. **Change in Coverage (applies only to PPA Account and Dependent Care FSA elections, but not to Health Care FSA elections)**. If your coverage under the PPA Account and/or Dependent Care FSA is significantly curtailed, you may revoke your election and either choose another day care provider or drop coverage altogether. Further, if you change day care providers, you may revise your elections to correspond to the new provider. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (i) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (ii) the plan year for this Plan is different from the plan year of the other employer plan.

Additionally, your election(s) may be modified downward during the plan year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code) if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

7. **Approved Leave of Absence**. If you take an approved leave of absence, your elections are subject to the following terms (depending, in part, on the type of leave you take):

- If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your PPA Account and/or Health Care FSA coverage on the same terms and conditions as though you were still active.
- Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions with Pre-tax Contributions withheld from pay you receive while on leave.

- In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your PPA Account and/or Health Care FSA, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave (not to exceed the end of the Plan Year) with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Plan Administrator.
- If your PPA Account and/or Health Care FSA coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the PPA Account and/or Health Care FSA upon return from such leave on the same basis as you were participating prior to the leave, or as otherwise required by the FMLA. Your coverage may be automatically reinstated provided that coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.
- The Employer may, on a uniform and consistent basis, continue your PPA Account and/or Health Care FSA coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.
- If you are commencing or returning from unpaid FMLA leave, your Dependent Care FSA election under this Plan shall be treated in the same manner that elections for non-health plans are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

8. Other Permitted Election Changes. In addition to the foregoing, you will be permitted to change your elections under the Plan to the extent the Plan Administrator determines that such a change is consistent with the Internal Revenue Code and with regulations, rulings, releases and other guidance issued by the IRS.

Q-8. How long will the Plan remain in effect?

Subject to the terms of any collective bargaining agreement between the Employer and your union, the Employer 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 or participant. This includes, but is not limited to, reducing or eliminating benefits for any group of employees (and the dependents of each) and adjusting any required employee contributions. Although the Employer currently expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any feature at any time and for any reason, subject to the terms of any collective bargaining agreement between the Employer and your union. Upon termination of the Plan (or feature), all elections and reductions in compensation relating to the Plan (or feature) shall terminate.

Q-9. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Part II. Health Care FSA Benefits

The following Questions and Answers relate to the Health Care FSA benefits. This section only applies to the extent that you have elected to allocate Pre-tax Contributions to the Health Care FSA.

Q-10. What is the "Health Care Flexible Spending Account"?

The Health Care Flexible Spending Account ("Health Care FSA") is the portion of the Plan that provides for reimbursement of Eligible Medical Expenses incurred by the Participant and his/her Eligible Dependents. If you elect benefits under this portion of the Plan, a non-interest bearing bookkeeping account will be set up to keep a record of Pre-tax Contributions allocated to the account and the reimbursements for Eligible Medical Expenses to which you are entitled during the Plan Year. No actual account is established; it is merely a bookkeeping account.

Q-11. What is the minimum and maximum annual election amount that I may elect under the Health Care Flexible Spending Account?

You may choose any reimbursement amount you desire subject to the minimum and maximum annual Health Care FSA Election Amounts described in the Plan Information Appendix. You should be aware that the IRS imposes an annual dollar limit on your Pre-tax Contributions to the Health Care FSA.

In addition, any change in your election affecting annual contributions to the Health Care FSA will change the maximum available reimbursement for the remainder of the Plan Year. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated claims administrator) will notify you of the applicable method when you make your election change.

Q-12. How are amounts allocated to the Health Care FSA withheld from my pay?

When you enroll online, you specify the amount of reimbursement for Eligible Medical Expenses you wish to pay for with Pre-tax Contributions. Thereafter, an equal pro-rata portion of the annual contribution will be withheld from each paycheck by your Employer.

Q-13. What amounts will be available for reimbursement of Eligible Medical Expenses at any particular time during the Plan Year?

The full annual amount of reimbursement you have elected under the Health Care FSA for a Plan Year (reduced by prior reimbursements for that Plan Year) will be available at any time during the Plan Year without regard to how much

you have contributed to the Health Care FSA. If your Employer has adopted a Carryover Provision for the Health Care FSA, any carryover amounts will also be available for reimbursement of Eligible Medical Expenses.

Q-14. How do I receive reimbursement under the Health Care FSA?

When you incur an Eligible Medical Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form either online or via paper form. You may obtain a Request for Reimbursement Form from the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from the service provider (e.g., a receipt, explanation of benefits or "EOB") associated with each expense that indicates the following:

- Name of person receiving service;
- Date service(s) incurred (e.g. the date the prescription was filled, the date a medical procedure was performed. The date an orthodontia adjustment was performed, etc. This is not necessarily the date that the service was paid for.);
- Name of doctor or provider of service(s) (e.g. the name of the doctor who performed the medical procedure, the store from where the prescription or over-the-counter item was purchased). If the expense is for an over-the-counter drug or medicine (other than insulin), a copy of the prescription must be provided or, alternatively, you may submit a receipt from the pharmacy with the RX number;
- Due to the CARES Act, Over the counter drugs and medications may be reimbursed through the Healthcare FSA without a doctor's prescription for the plan year ending December 31, 2020.

- Nature of expense (e.g., what type of service or treatment was provided); and
- The amount of the expense

You may be required to provide additional substantiation to the extent determined necessary to support your claim. The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Medical Expense" you will receive notification of this determination.

You must submit all claims for reimbursement for a Plan Year on or before the last day of the Run-Out Period for that Plan Year. The Run-Out Period is described in the Plan Information Appendix. If your Employer has adopted a Carryover Provision for the Health Care FSA, any available carryover amount will continue to be available for the next Plan Year.

NOTE: If your health plan administrator or insurance carrier automatically submits an Evidence of Benefit (EOB) statement to the Third Party Administrator for processing, you may not have to provide any additional substantiation or certification.

Q-15. What is an "Eligible Medical Expense"?

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your Eligible Dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by Code Section 213(d). Whether an expense is for "medical care" is within the sole discretion of the Plan Administrator; and
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

An "Eligible Dependent" is your legal spouse (in accordance with federal law) and any other individual who is a "dependent" as defined in Code Section 105(b) (i.e., a dependent who is eligible to receive tax-free health coverage under the Code). Coverage for an individual covered as an Eligible Dependent under the Health Care FSA ends on the date that the individual ceases to meet the requirements to be an Eligible Dependent.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and prescribed over-the-counter drugs (and over-the-counter products and devices). Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care," as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third Party Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Over-the-counter drugs and medicines (other than insulin) that are for “medical care” will not constitute an Eligible Medical Expense unless you or your eligible dependents have obtained a prescription from a provider authorized by state law (e.g., a physician). Insulin and over-the-counter products and devices other than drugs or medicines will still constitute an Eligible Medical Expense even if not prescribed by a physician to the extent that they are for medical care.

In addition, certain other expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any Health Care FSA (per IRS regulations):

- Health insurance premiums;
- Expenses incurred for qualified long term care services; and
- Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Appendix and/or enrollment material.

Q-16. When must the expenses be incurred in order to receive reimbursement?

Eligible Medical Expenses must be incurred ***during*** the Plan Year and while a Participant. An expense is incurred when the service or treatment giving rise to the expense has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the Health Care FSA becomes effective, before your Health Care FSA election becomes effective, or after a separation from service (except for expenses incurred during an applicable COBRA continuation period).

If the Employer has adopted a Carryover Provision, you will be able to use amounts allocated to the Health Care FSA that are unused at the end of the Plan Year for expenses incurred during the following Plan Year**. Note that any carryover amounts from a Plan Year cannot be determined and are not available to you until after the last day of the Run-Out Period for that Plan Year. The terms of the Carryover Provision, if adopted, will be described in the Plan Information Appendix.**

Q-17. What if the Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have allocated to the Health Care FSA?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual reimbursement amount that you have elected. Except as otherwise set forth in the Plan Information Appendix, any amount allocated to the Health Care FSA will be forfeited by the Participant if it has not been applied by the end of the Run-Out Period to reimburse expenses incurred during the Plan Year. The Run-Out Period is described in the Plan Information Appendix. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations.

If the Employer has adopted a Carryover Provision, amounts allocated to the Health Care FSA that are unused at the end of the Plan Year (determined as of the last day of the Run-Out Period for that Plan Year) may be used to reimburse Eligible Medical Expenses incurred in the subsequent Plan Year.

Q-18. What happens if a claim for benefits under the Health Care FSA is denied?

If you are denied a benefit under the Health Care FSA, you should proceed in accordance with the claims and appeal procedures set forth in the Plan Information Appendix.

Q-19. What happens to unclaimed Health Care FSA reimbursements?

Any reimbursements under the Health Care FSA that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical Expense was incurred shall be forfeited.

Q-20. What is COBRA continuation coverage?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the Health Care FSA.

<u>When Coverage May Be Continued</u>

If you are a Participant in the Health Care FSA, then you generally have a right to choose continuation coverage under that program for the remainder of the current Plan Year if you lose your coverage because of:

- A reduction in your hours of employment; or
- A voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

If you are the spouse of a Participant, then you generally have the right to choose continuation coverage for the remainder of the current Plan Year for yourself if you lose coverage for any of the following reasons:

- The death of the Participant;
- A voluntary or involuntary termination of the Participant's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; or
- The divorce or legal separation from the Participant.

In the case of a dependent child of a Participant, he or she has the right to choose continuation coverage for the remainder of the current Plan Year if coverage is lost for any of the following reasons:

- The death of the Participant;

- A voluntary or involuntary termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment;
- His or her parents' divorce or legal separation; or
- He or she ceases to be a dependent child.

Those events that entitle you to elect coverage are called "Qualifying Events." Those covered individuals who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries." A child who is born to, or placed for adoption with, the Participant during a period of continuation coverage is also entitled to continuation coverage under COBRA as a Qualified Beneficiary.

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of Health Care FSA reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health Care FSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered dependents (including your spouse) must notify the COBRA Administrator identified in the Plan Information Appendix in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost under the Plan because of the event. When the COBRA Administrator is notified that one of these events has occurred, the COBRA Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's spouse is treated as notice to any covered dependents who reside with the spouse.

An employee or covered dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

Each Qualified Beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) within 60 days from the date you would lose coverage as a result of a Qualifying Event or the date you are sent notice of your right to elect continuation coverage, whichever is later and send it to the COBRA Administrator identified in the Plan Information Appendix of this SPD. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day Grace Period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Health Care FSA until the end of the Plan Year in which the Qualifying Event occurs. However, continuation coverage may end earlier for any of the following reasons on the dates indicated:

- The first day of the month following the month for which you made a timely and complete premium payment (Note if your payment is insufficient by the lesser of 10% of the required COBRA premium, or $50, you will be given 30 days to cure the shortfall);
- The date that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation *after you have elected COBRA continuation coverage*;
- The date that you first become entitled to Medicare *after you have elected COBRA continuation coverage*; or

- The date the Employer no longer provides group health coverage to any of its employees.

If You Have 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.

Continuation of Participation for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. The terms “Uniformed Services” or “Military Service” mean the Armed Forces (i.e., Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If your military leave is for less than 31 days, you may continue your participation in the Plan on an after-tax basis for as long as you are on leave.

If you lose coverage because you enter into active military duty covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA) that is longer than 31 days, you and your covered dependents are eligible for

COBRA continuation coverage. You will be charged up to the full contribution plus a 2% administrative fee.

If you choose not to continue your participation in the Plan while on military leave, you are entitled to reinstated participation with no waiting periods or exclusions when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home and an eight-hour rest period if you are on a military leave of less than 31 days,
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days, or
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

Keep the COBRA Administrator Informed of Address Changes

In order to protect your family's rights, you should keep WageWorks informed of any changes in the addresses of family members. You may contact WageWorks by phone at 1-800-526-2720. You should also keep a copy, for your records, of any notices you send to WageWorks.

Q-21. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the Health Care FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate privacy notice that outlines the Employer's health privacy policies.

Q-22. How does the Health Care FSA interact with other plans sponsored by my Employer?

Typically, a Health Care FSA is the payer of last resort. This means the Health Care FSA cannot reimburse expenses that are reimbursable from any other source.

Q-23. How long will the Health Care FSA remain in effect?

Although the Employer expects to maintain the Health Care FSA indefinitely, it has the right to modify or terminate the program at any time and for any reason.

Other Important Health Care FSA Information

ERISA Rights

The Health Care FSA Plan is an ERISA welfare benefit plan. As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all Plan Participants shall be 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 work-sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report (if any). The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue Group Health Plan Coverage. You may continue health care coverage for yourself, spouse or dependent children if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your eligible dependents will have to pay for such coverage. You should review the COBRA section of this SPD for more information concerning 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 the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 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 that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration ("EBSA") listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Order (QMCSO)

(NOTE: This applies to Health Care FSA elections and only to the extent that the Health Care FSA is not an "excepted benefit" as defined by the Health Insurance Portability and Accountability Act of 1996)

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 Avaya Health and Benefits Decision Center free of charge upon request by calling 1-800-526-8056 (option 1), M−F, 8 AM to 8 PM ET and Sat, 8 AM to 5 PM ET, or via e-mail: avayaservicecenter@adp.com.

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

The Plan will not set employee contributions on the basis of genetic information. The Plan may not require an employee (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.

Plan is Not an Employment Contract

The Plan is not intended to be, and should not be construed as, a contract for or of employment between you and the Employer for any specific period of time.

Part III. Dependent Care FSA Benefits

The following Questions and Answers relate to the Dependent Care FSA benefits. This section only applies to the extent that you have elected to allocate Pre-tax Contributions to the Dependent Care FSA.

Q-24. What is the "Dependent Care FSA"?

The Dependent Care FSA is the portion of the Plan that provides for reimbursement of Eligible Day Care Expenses incurred by the Participant. If you elect benefits under this portion of the Plan, a non-interest bearing bookkeeping account will be set up to keep a record of Pre-tax Contributions (and where applicable, any non-elective Employer contributions) allocated to the account and the reimbursements for Eligible Day Care Expenses to which you are entitled during the Plan Year. No actual account is established; it is merely a bookkeeping account.

Q-25. What is the minimum and maximum annual election amount that I may elect under the Dependent Care FSA?

You may choose any reimbursement amount you desire subject to the minimum and maximum annual Dependent Care FSA Election Amount described in the Plan Information Appendix. You should be aware that there is an overall statutory maximum on your Dependent Care Election Amount.

In addition, the amount of reimbursement that you receive cannot exceed the lesser of your or your spouse's earned income (as defined in Code Section 32). To the extent permitted by applicable law, your spouse will be deemed to have earned income for purposes of the dependent Care FSA of $250 ($500 if you have two or more Qualifying Individuals (as defined in Q-30), for each month that your spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time student (as defined by Code Section 21).

Q-26. How are amounts allocated to the Dependent Care FSA withheld from my pay?

When you enroll, you specify the amount of reimbursement for Eligible Day Care Expenses you wish to pay for with Pre-tax Contributions. Thereafter, an equal pro-rata portion of the annual contribution, reduced by any non-elective Employer Contributions (if any) allocated to your Dependent Care FSA sub-account, will be withheld from each paycheck by your Employer.

Q-27. What amounts will be available for reimbursement of Eligible Day Care Expenses at any particular time during the Plan Year?

Under the Dependent Care FSA, you may be reimbursed only up to the amount of your Dependent Care FSA sub-account balance at the time the request for reimbursement is processed.

Q-28. How do I receive reimbursement under the Dependent Care FSA?

When you incur an Eligible Day Care Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form either online or via paper form. You may obtain a Request for Reimbursement Form from the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from the service provider (e.g., an invoice) associated with each expense that indicates the following:

- The provider name;
- The provider contact information;
- The dependent name;
- Service dates (beginning and end);
- A description of the service and
- The expense amount

The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Day Care Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Day Care Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Day Care Expenses prior to the end of the Run-Out Period. The Run-Out Period is described in the Plan Information Appendix.

Q-29. What are "Eligible Day Care Expenses"?

You may be reimbursed for work-related dependent day care expenses ("Eligible Day Care Expenses"). In other words, the expenses have to be incurred in order for you and your spouse (if applicable) to work or look for work. Generally, an expense must meet all of the following conditions for it to be an Eligible Day Care Expense:

1. The expense is incurred for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

2. Each individual for whom you incur the expense is a "Qualifying Individual." A "Qualifying Individual" is:

- An individual that you can claim on your federal income tax return as a "Qualifying Child" (as defined in Code Section 152(a)(1)) and who is age 12 or under, or
- A spouse or other tax "Dependent" (as defined generally in Code Section 21) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year. For purposes of this Dependent Care FSA only, a "Dependent" under Code Section 21 means an individual who is your tax dependent as defined in Code Section 152 or any individual who would otherwise qualify as your tax dependent under Code Section 152 but for the fact that (i) the individual has income in excess of the exemption amount set forth in Code Section 151(d); (ii) the individual is a child of a Participant who is a tax dependent of another taxpayer under Code Section 152; or (iii) the individual is married and files a joint return with his/her spouse. In addition, a child to whom Section 152(e) applies (a child of divorced or separated parents who resides with one or both parents for more than half the year and receives over half of his/her support from one or both parents) may only be the qualifying individual of the "custodial parent" (as defined in Code Section 152(e)(3)) without regard to which parent claims the child as a dependent on his or her tax return.

3. The expense is incurred for the custodial care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your spouse, if applicable) to be gainfully employed or look for work. Whether the expense enables you (and your spouse if applicable) to work or look for work is determined on a daily basis. Normally, an allocation must be made for all days for which you (and your spouse, if applicable) are not working or looking for work; however, an allocation is not required for temporary absences beginning and ending within the period of time for which the day care center requires you to pay for day care. Expenses for overnight stays or overnight camp are not Eligible Day Care Expenses. Expenses that are primarily for education, food and/or clothing are not considered to be for "custodial" care. Consequently, tuition expenses for kindergarten (or its equivalent) and above do not qualify as custodial care. However, summer day camps are considered to be for custodial care even if they provide primarily educational activities.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The day care is not provided by a "child" (as defined in Code Section 152(f)(1)) of yours who is under age 19 the entire year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent. Moreover, the day care cannot be provided by the Participant's Spouse or the parent of the Qualifying Individual.

7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 503 for further guidance as to what is or is not an Eligible Day Care Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for Eligible Day Care Expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

Q-30. When must the expenses be incurred in order to receive reimbursement?

Eligible Day Care Expenses must be incurred ***during*** the Plan Year and while a Participant. An expense is "incurred" when the service or treatment giving rise to the expense has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective, before your Dependent Care FSA election becomes effective, or after a separation from service.

Q-31. What if the Eligible Day Care Expenses I incur during the Plan Year are less than the annual amount I have allocated to the Dependent Care FSA?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Day Care Expenses you have incurred and the annual reimbursement amount that you have elected. Except as otherwise set forth in the Plan Information Appendix, any amount allocated to the Dependent Care FSA shall be forfeited by the Participant if it has not been applied by the end of the Run-Out Period to reimburse expenses incurred during the Plan Year. The Run-Out Period is described in the Plan Information Appendix. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations.

Q-32 What happens if a claim for benefits under the Dependent Care FSA is denied?

If you are denied a benefit under the Dependent Care FSA, you should proceed in accordance with the claims and appeal procedures set forth in the Plan Information Appendix.

Q-33. What happens to unclaimed Dependent Care FSA reimbursements?

Any Dependent Care FSA reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Day Care Expense was incurred shall be forfeited.

Q-34. Will I be taxed on the Dependent Care FSA reimbursement I receive?

You will not normally be taxed on your Dependent Care FSA reimbursement, provided that your family's aggregate dependent day care reimbursement (under this Dependent Care FSA and/or another employer's Dependent Care FSA) does not exceed the statutory limits set forth in the Plan Information Appendix below. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-35. If I participate in the Dependent Care FSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Day Care Expenses not reimbursed under this Dependent Care FSA may be eligible for the dependent care credit.

Q-36 Does the Employer provide a company match for participants in the Dependent Care FSA?

Yes. If you are a Dependent Care FSA participant, you will receive a match of $0.25 for every $1.00 you contribute to your Dependent Care FSA. For example, if you contribute $4,000 to your Dependent Care FSA, the Avaya Participating Company will contribute $1,000 to your account for a combined total of $5,000. The Dependent Care FSA match is done on a per-paycheck basis.

Part IV. PPA Account Benefits

The following Questions and Answers relate to the PPA Account benefits. This section only applies to the extent that your Employer offers the PPA Account option and you have elected to allocate Pre-tax Contributions to the PPA Account.

Q-37. What is the "PPA Account"?

The PPA Account is the portion of the Plan that allows you to use Pre-tax Contributions to pay your share of premiums under various employee welfare benefit plans sponsored by your Employer (for example, your Employer's supplementary AD&D plan). If you elect benefits under this portion of the Plan, a non-interest bearing bookkeeping account will be set up to keep a record of Pre-tax Contributions (and where applicable, any non-elective Employer contributions) allocated to the account and used to pay premiums under one or more employee welfare benefit plans sponsored by your Employer. No actual account is established; it is merely a bookkeeping account.

Q-38. What is the maximum amount that I may elect under the PPA Account?

You may allocate any amount to your PPA Account, subject to the maximum annual PPA Account limit described in the Plan Information Appendix. You should be aware that there is no overall statutory maximum on your PPA Account.

Q-39. How are amounts allocated to the PPA Account withheld from my pay?

When you enroll, you specify the amount of premiums you wish to pay for with Pre-tax Contributions. Thereafter, an equal pro-rata portion of the annual contribution, reduced by any non-elective Employer Contributions (if any) allocated to your PPA Account, will be withheld from each paycheck by your Employer.

Q-40. Do I receive reimbursement under the PPA Account?

No. The Pre-tax Contributions allocated to your PPA Account are automatically applied to your share of premiums under one or more employee welfare benefit plans sponsored by your Employer. You do not need to submit claims, or otherwise seek reimbursement from the PPA Account.

Q-41. May I use the PPA Account to pay premiums for individual insurance coverage?

No. The purpose of the PPA Account is to enable you to use Pre-tax

Contributions to pay your share of premiums under one or more employee welfare benefit plans sponsored by your Employer. IRS rules do not permit you to use the PPA Account to pay premiums for other insurance coverage, including individual insurance coverage.

Q-42. What if I allocate too much to the PPA Account?

The amounts you allocate to your PPA Account are automatically used to pay your share of premiums under one or more employee welfare benefit plans sponsored by your Employer. Your PPA Account will have a zero balance at the end of each Plan Year, and no amounts will be forfeited as might be the case for unused amounts in a Health Care FSA or a Dependent Care FSA.

Q-43. What happens if a claim for benefits under the PPA Account is denied?

In the unlikely event that you are denied a benefit under the PPA Account, you should proceed in accordance with the claims and appeal procedures set forth in the Plan Information Appendix.

Part V: Employment-Related Events Affecting Coverage

If Your Employment is Terminated

Your eligibility to make pre-tax contributions to the Plan ends if your employment with an Avaya Participating Company ends for any reason. However, you may still be able to submit claims through the Plan (see "RUN-OUT PERIOD FOR PLAN YEAR EXPENSES" for more details), or you may be eligible for Health Care FSA continuation under COBRA (see "Q-20. What is COBRA continuation coverage?" for more details).

If You Become Disabled

Your participation in the Plan may be affected if you become disabled. The duration of your disability determines the effect it will have on your participation.

Disabilities/Effect on Coverage

If you become disabled as determined under The Avaya Inc. Sickness and Accident Disability Benefit Plan, your eligibility to make contributions to the Plan may continue for the remainder of that calendar year, or until you are no longer eligible for those disability benefits, whichever comes first. However, if your contributions cease for any reason, you may still be able to submit claims through the Plan (see "RUN-OUT PERIOD FOR PLAN YEAR EXPENSES" for more details), or you may be eligible for Health Care FSA continuation under COBRA (see "Q-20. What is COBRA continuation coverage?" for more details). If you return to work during the same calendar year, your contributions will automatically resume for the remainder of that calendar year.

Different rules apply after you become eligible for long-term disability benefits. Your eligibility to make pre-tax contributions to the Plan ends when you become eligible for long-term disability benefits under The Avaya Inc. Long-Term Disability Plan. However, you may still be able to submit claims through the Plan (see "RUN-OUT PERIOD FOR PLAN YEAR EXPENSES" for more details), or you may be eligible for Health Care FSA continuation under COBRA (see "Q-20. What is COBRA continuation coverage?" for more details).

If You Take an Approved Leave of Absence

Refer to "Q-7. Can I ever change my election during the Plan Year?".

If You Change from Represented to Salaried

Your coverage under the Plan will end on the last day of the month in which your status changes. If offered under the Salaried benefit package, you will become eligible to participate in the flexible spending account plan offered to salaried employees. Expenses incurred through the end of the month in which you

remained a Represented employee can be submitted through April 15th of the following calendar year under The Avaya Inc. Flexible Spending Account Plans for reimbursement.

Part VI: Plan Information Appendix

This Plan Information Appendix provides information specific to The Avaya Inc. Flexible Spending Account Plans, a component of the Avaya Inc. Health & Welfare Benefits Plan.

I. EMPLOYER/PLAN SPONSOR INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:		Avaya Inc. 2605 Meridian Parkway Suite 200 Durham, NC 27713 1-866-462-8292 e-mail: hwplanadmin@avaya.com
2. Employer's federal tax identification number:		22-3713430
3. Adopting Employers participating in the Plan:		Such other affiliates that have elected to participate in the Plan with the prior approval of Avaya Inc. (an "Avaya Participating Company")
4. Effective Date of the Plan:		January 1, 2018 – December 31, 2018 (unless otherwise noted). The Plan was originally effective as of January 1, 2014.
5. Effective Date of Amendment/Restatement (if different from 4):		September 10, 2018
6. All subsequent Plan Years:		January 1 – December 31
7. Name, address, and telephone number of the Plan Administrator: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD.		Benefits Manager for Avaya Inc. 350 Mount Kemble Ave Morristown, NJ 07960 1 (866) 462-8292 e-mail: hwplanadmin@avaya.com

8. Name, address, and telephone number of the Claims Administrator:		WageWorks P.O. Box 34740 Louisville, KY 40232 1-800-678-6684
9. 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 350 Mount Kemble Ave Morristown, NJ 07960
10. Plan Number:		551 (for the Health Care FSA only)
11. Funding Medium:		The source of funds for the Plan is your elected payroll deduction and general operating assets of the Avaya Participating Company. The Avaya Participating Company pays the cost of administering these plans. Any amounts left in the Plan after all claims are paid out are considered forfeited balances. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations. 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. There is no special fund, trust or insurance from which benefits are paid.
12. Type of Administration:		Contract Administration. The Plan Administrator has contracted with WageWorks to provide claims administration services for the Plan as the Claims Administrator for the flexible spending account benefits. The Claims Administrator's decisions are final and binding and the Employer does not have the authority to change the Claims Administrator's decision.
12. Third-Party Administrator:		**For Enrollment/Eligibility:** Avaya Health & Benefits Decision Center 1-800-526-8056, option 1 M−F, 8 AM to 8 PM ET and

		Sat, 8 AM to 5 PM ET e-mail: avayaservicecenter@adp.com website: https://my.adp.com **For Claims & Plan Information:** WageWorks 1-800-678-6684 1-866-643-2219 (fax) M−F, 6 AM to 6 PM MT website: https://myspendingaccount.wageworks.com/
13. COBRA Administrator:		WageWorks P.O. Box 34740 Louisville, KY 40232

II. ELIGIBILITY, EFFECTIVE DATE OF COVERAGE, and ELECTIONS

(a) The Flexible Spending Account Plan

Each Employee who meets the eligibility requirements noted below in II.(b) and II.(c), who enrolls by the date specified in their enrollment materials, and who is eligible for coverage or participation under any of the Benefit Plans will be eligible to participate in this Plan on their first day of work as a newly-eligible employee ("Eligible Employee"), the effective date of their status change, or on January 1st following an Annual Enrollment election ("Eligibility Date").

Individuals who are not paid from the U.S. payroll of an Avaya Participating Company, who are employed by an independent company (such as an employment agency) or whose services are rendered pursuant to an agreement excluding participation in benefit plans, are not eligible to participate in the Plan.

The Employee's commencement of participation in the Plan is conditioned on the Employee properly completing and submitting a Salary Reduction Agreement as summarized in the SPD. Eligibility for coverage under any given Benefit Plan shall be determined not by this Plan but by the terms of that Benefit Plan.

(b) Health Care FSA

Each Employee who is a regular, active, full-time or part-time, represented employee with at least six months of net credited service with an Avaya Participating Company and are covered by a collective bargaining agreement that provides for participation in the Flexible Spending Account benefit program ("Eligible Employee") shall be eligible to participate in the Health Care FSA on their Eligibility Date.

(c) Dependent Care FSA

Each Employee who is a regular, active, full-time or part-time, represented employee with at least six months of net credited service with an Avaya Participating Company and are covered by a collective bargaining agreement that provides for participation in the Flexible Spending Account benefit program ("Eligible Employee") shall be eligible to participate in the Dependent Care FSA on their Eligibility Date.

(d) PPA Account

Each Employee who is a regular, active, full-time or part-time, represented employee with at least six months of net credited service with an Avaya Participating Company and are covered by a collective bargaining agreement that provides for participation in the Flexible Spending Account benefit program ("Eligible Employee") shall be eligible to participate in the PPA Account on their Eligibility Date.

III. BENEFIT PACKAGE OPTION(S) PROVIDED UNDER THE PLAN

The Employer elects to offer to eligible Employees the following Benefit Package Option(s) subject to the terms and conditions of the Plan and the terms and conditions of the Benefit Package Option(s). These component Benefit Package Option(s) are specifically incorporated herein by reference. The maximum Pre-Tax Contributions a Participant can contribute via the Salary Reduction Agreement is the aggregate cost of the applicable Benefit Package Option(s) selected. It is intended that such Pre-tax Contribution amounts will, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes.

(a) Benefit Package Option(s): The following Benefit Package Option(s) are made available under the Plan to all those eligible Employees who make an appropriate election.

1. Health Care Flexible Spending Account
2. Dependent Care Flexible Spending Account
3. Premium Payment Account

(b)(1) Health Care FSA Election Amount. Your maximum Health Care FSA election amount is the amount of Pre-tax Contributions you elect to make to the Health Care FSA, not to exceed $2,550 per Plan Year per Participant. The IRS sets a maximum for Pre-tax Contributions to the Health Care FSA Account per Plan Year and may increase this amount from time to time for cost-of-living adjustments. The Plan may allow the IRS maximum for Pre-tax Contributions or may choose a maximum amount that is less than the IRS maximum. The minimum reimbursement amount that may be elected under the Health Care FSA is $300 per Plan Year per plan Participant.

(b)(2) Interaction With HRA. See below regarding this Health Care FSA's rules with respect to coordination with a Health Reimbursement Arrangement Account ("HRA"):

Does the Employer sponsor an HRA?	No, not for Active Represented employees
Does this Health Care FSA or the HRA pay first with respect to any expenses that are covered by both the HRA and Health Care FSA?	N/A

(c) Dependent Care FSA Election Amount. Your maximum Dependent Care Election amount under the Dependent Care FSA shall not exceed the lesser of the amount elected under the Plan or $4,000 ($5,000 including the Avaya Participating Company match) per Plan Year per household (or $2,500, including the Avaya Participating Company match, for married filing separate returns), pursuant to the terms of the Dependent Care FSA described in Part III of the SPD. The minimum reimbursement amount that may be elected under the Dependent Care FSA is $300 per Plan Year per household.

(d) Contributions to Premium Payment Account. Your maximum annual contribution to the PPA Account shall not exceed the total amount of required employee premium contributions under one or more employee welfare benefit plans sponsored by the Employer.

IV. QUALIFIED RESERVIST DISTRIBUTIONS

Does this Health Care FSA include Qualified Reservist Distributions?	No

V. RUN-OUT PERIOD FOR PLAN YEAR EXPENSES

The Employer has established a Run-Out Period for the Health Care FSA and Dependent Care FSA that follows the end of the Plan Year during which you are allowed to submit reimbursement requests for expenses that were incurred in the prior Plan Year.

(a) The Run-Out Period for active employees is April 15th of the following calendar year.

(b) The Run-Out Period for Participants whose coverage is terminated during the Plan Year is April 15th of the following calendar year.

VI. CLAIMS AND APPEAL PROCEDURES

If you are denied a benefit under this Plan, you should proceed in accordance with the following claims review procedures.

Step 1: *Notice is received from Third Party Administrator.* If your claim is denied, you will receive written notice from the Third Party Administrator that your

claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party Administrator, the Third Party Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Third Party Administrator, review it carefully. The notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- A right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an appeal.* If you do not agree with the decision of the Third Party Administrator, you may file a written appeal. You should file your appeal with the Third Party Administrator no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing no later than 30 days after receipt of the appeal by the Third Party Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Third Party Administrator.

Step 6: *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision, you may file a written appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the Third Party Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Other Important Information Regarding Your Appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- The Plan Administrator is required to give the Participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination;
- You cannot file suit in federal court until you have exhausted these appeals procedures, however, you have the right to file suit under ERISA Section 502 following an adverse appeal decision; and
- Each Participant has the right to request and obtain documents, records and other information as it pertains to their Benefit Plan(s).

VII. CARRYOVER PROVISION

The Employer has established a Carryover Provision for the Health Care FSA that allows amounts unused at the end of the Plan Year (determined as of the last day of the Run-Out Period for that Plan Year) to be used to reimburse Eligible Medical Expenses incurred during the subsequent Plan Year. Under IRS rules, the maximum carryover amount is $550.

VIII. ELECTRONIC PAYMENT CARDS

The Employer does not permit Participants to use an electronic payment cards to pay for Eligible Expenses at the point of service.