THE AVAYA INC. VOLUNTARY BENEFITS SUMMARY PLAN DESCRIPTION

Active Represented

Updated: 02/27/2021

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INTRODUCTION

This booklet summarizes the main provisions of the Voluntary Benefit Plans (the Plan) offered by Avaya Inc., under the Avaya Inc. Health and Welfare Benefits Plan for Represented Employees, including accident insurance, critical illness insurance, hospital insurance, and legal plan coverage. This booklet, when combined with the Avaya Inc. Summary Wrap Description for Represented Employees, serves as the ERISA-required Summary Plan Description (SPD) for these benefits. It describes the voluntary benefits as they apply to eligible employees. The Summary Wrap Description describes such provisions as eligibility, enrollment, when/how elections can be changed mid-year, when coverage begins and ends, your rights under ERISA, administrative information, etc.

We encourage you to read this booklet carefully and share it with your family. 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. If you have any questions about your benefits, please contact the Plan Administrator – the Plan Administrator's contact information may be found in the "General Plan Information" section of this SPD.

Note that this booklet is only a summary. Complete details of the voluntary benefits offered by Avaya Inc. may be described in a separate legal plan documents as well as any certificates of coverage and insurance policies . With one exception, the official Plan document, certificates, or policies will control in the event of any differences between those documents and this SPD. However, if there is language in the SPD regarding a topic the Plan document is silent on, the language in this SPD will govern with respect to that topic only.

This booklet contains a summary of the provisions of the Plan as of the date of publication. Avaya Inc. reserves the right to change or discontinue these benefits, in whole or in part, at any time in the future.

Avaya Inc. reserves the right to modify, suspend, or terminate the Plan at any time. Questions regarding your benefits should be addressed to the Plan Administrator (or its authorized delegate). Because of the many detailed provisions of the Voluntary Benefits Plan, no one other than the Plan Administrator (or its authorized delegate) is authorized to advise you as to your benefits. For this reason, each Avaya Participating Company is not bound by statements made by anyone or any entity other than the Plan Administrator (or its authorized delegate).

Please note that participation in the Voluntary Benefits Plan is neither an offer of employment nor a guarantee of employment for any period of time at an Avaya Participating Company. Avaya Participating Company employees are employees at will, which means that they can terminate their employment at any time and for any reason. Likewise, each Avaya Participating Company may terminate an employee's employment at any time and for any reason.

GENERAL PLAN INFORMATION

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

Name of Plan
Voluntary Benefits Plan, (under The Avaya Inc. Voluntary Benefits Plan for Represented Employees, a component of The Avaya Inc. Health & Welfare Benefits Plan)

Plan Identification Number
551 – The Avaya Inc. Health & Welfare Benefits Plan for Represented Employees

Plan Sponsor
Avaya Inc.
350 Mount Kemble Avenue
Morristown, NJ 07960
E-mail: hwplanadmin@avaya.com
Employer Identification Number: 22-3713430

Plan Administrator
Avaya Inc.
Health & Welfare Plan Administrator
350 Mount Kemble Avenue
Morristown, NJ 07960
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**."**

Insurer and Claims Administrator
MetLife
MetLife at 1-800-GET-MET8
Web site: https://www.metlife.com/avaya/

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 Avenue
Morristown, NJ 07960

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

Accident Insurance Plan

Overview of Accident Insurance

Accident Insurance, administered by MetLife, is designed to provide you and your covered dependents with coverage for injuries due to an accident, such as dislocations, torn rotator cuff, burns, eye injury, lacerations, emergency dental care and brain injury. This insurance also covers ambulance service, emergency room visits and hospital admissions. Accident Insurance can provide you with valuable benefits to supplement your medical coverage.

There are two Accident Insurance options available to you, the Low Plan or the High Plan.

Accident Insurance does not provide medical coverage and is not a substitute for medical coverage or disability insurance. You should have medical coverage before you enroll for Accident Insurance.

Note about States' Benefit Variations: Please see the "MetLife Certificate of Insurance Accident Insurance Policy" document for benefit variations that may apply to your state.

Accident Insurance At A Glance

Benefit Level	Plan Options	
Employee only Employee + spouse/domestic partner Employee + child(ren) Employee + Spouse or Domestic Partner + Child(ren)	Low Plan	High Plan

Benefits

The Accident Insurance Plan offers certain benefits for the following:

- Accidental injuries
- Medical treatment and services
- Hospitalization, and
- Other costs.

Cost of Coverage

You pay the full cost of Accident Insurance. These costs are set annually and are communicated during the Annual Enrollment period.

Benefits are paid according to a schedule. For most services, the High Plan option pays twice the scheduled amount the Low Plan option pays.

How Accident Insurance Works

Avaya Inc.'s Accident Insurance helps you pay for out-of-pocket costs resulting from an accident.

Here's how Accident Insurance works:

- If you or a covered family member have a covered accident that first occurs while the individual is covered for Accident Insurance, you must send proof of the accident to MetLife.
- MetLife will review the claim. If the claim is approved, MetLife will pay the scheduled benefit for that claim.
- MetLife will never pay more than 100% of the total benefit amount.

What Accident Insurance Covers

Low Plan

The Low Plan pays benefits according to the following schedule

Accidental Injuries		
Fracture Benefit	**Closed Wound**	**Open Wound**
Face or nose (except mandible or maxilla)	$1,000	$2,000
Skull fracture – depressed (except bones of face or nose)	$4,000	$8,000
Skull fracture – non-depressed (except bones of face or nose)	$2,000	$4,000
Lower jaw, mandible (except alveolar process)	$750	$1,500
Upper jaw, maxilla (except alveolar process)	$1,000	$2,000
Upper arm between elbow and shoulder (humerus)	$1,000	$2,000
Shoulder blade (scapula), collarbone (clavicle, sternum)	$750	$1,500
Forearm (radius and/or ulna), hand, wrist (except fingers)	$750	$1,500
Rib	$750	$1,500
Finger, toe	$100	$200
Vertebrae, body of (excluding vertebral processes)	$1,500	$3,000
Vertebral processes	$500	$1,000
Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx)	$1,500	$3,000
Hip, thigh (femur)	$4,000	$8,000
Coccyx	$500	$1,000
Leg (tibia and/or fibula)	$1,500	$3,000
Kneecap (patella)	$500	$1,000
Ankle	$500	$1,000
Foot (except toes)	$500	$1,000
Chip fracture benefit for any of the above	25% of the applicable benefit for the bone involved	
Dislocation Benefit	**Closed Wound**	**Open Wound**
Lower jaw	$750	$1,500
Collarbone (sternoclavicular)	$1,000	$2,000

Collarbone (acromioclavicular and separation)	$750	$1,500
Shoulder (glenohumeral)	$750	$1,500
Rib	$750	$1,500
Elbow	$750	$1,500
Wrist	$750	$1,500
Bone or bones of the hand (other than fingers)	$750	$1,500
Hip	$4,000	$8,000
Knee (except patella)	$2,000	$4,000
Ankle – bone or bones of the foot (other than toes)	$1,000	$2,000
One toe or finger	$100	$200
Partial dislocation benefit for any of the above	25% of the applicable benefit for joint involved	
Burn Benefit	**2nd Degree**	**3rd Degree**
Less than 10%	$75	$1,000
At least 10% but less than 25%	$200	$2,000
At least 25% but less than 35%	$500	$5,000
35% or more	$1,000	$10,000
Skin Graft Benefit	**Benefit**	
Skin Graft for 2nd or 3rd degree burn	50% of the applicable Burn Benefit	
Concussion Benefit	**Benefit**	
Concussion	$250	
Coma Benefit	**Benefit**	
Coma	$7,500	
Ruptured Disc with Surgical Repair Benefit	**Benefit**	
Ruptured Disc with Surgical Repair	$750	
Torn Cartilage in Knee Benefit	**Benefit**	
With surgical repair	$750	
Exploratory Surgery without repair	$150	
Laceration Benefit	**Benefit**	
Repaired without stitches	$50	
Repaired with stitches:		
Total of all lacerations is less than two inches (5.08 cm) long	$100	
Total of all lacerations is two to six inches (5.08 to 15.24 cm) long	$200	
Total of all lacerations is over six inches (over 15.24 cm) long	$400	

Torn, Ruptured or Severed Tendon / Ligament / Rotator Cuff Benefit	Benefit
Surgical repair: one tendon/ligament/rotator cuff	$750
Surgical repair: two or more tendons/ligaments/rotator cuffs	$1,500
Exploratory Surgery without repair	$150
Broken Tooth Benefit	**Benefit**
Crown	$200
Extraction	$100
Filling	$25
Eye Injury Benefit	**Benefit**
Eye Injury	$300
ACCIDENT - MEDICAL TREATMENT AND SERVICES BENEFITS	
Ambulance Benefit	**Benefit**
Air Ambulance Benefit	$1,000
Ground Ambulance Benefit	$300
Emergency Care Benefit	**Benefit**
Emergency Room	$150
Physician's Office	$75
Urgent Care	$100
Non-Emergency Initial Care Benefit	**Benefit**
Non-Emergency Room	$100
Medical Testing Benefit	**Benefit**
Medical Testing	$150
Physician Follow-Up Visit Benefit	**Benefit**
Physician Follow-Up Visit	$75
Transportation Benefit	**Benefit**
Transportation	$300
Therapy Services Benefit	**Benefit**
Cognitive behavioral therapy	$35
Occupational therapy	$35
Physical therapy	$35
Respiratory therapy	$35
Speech therapy	$35
Vocational therapy	$35

Pain Management Benefit (for Epidural Anesthesia) Benefit	Benefit
Pain Management Benefit (for Epidural Anesthesia)	$75
Prosthetic Device Benefit	**Benefit**
One device only	$750
More than one device	$1,500
Medical Appliance Benefit	**Benefit**
Brace	$75
Cane	$75
Crutches	$75
Walker – expected use less than 1 year	$150
Walker – expected use 1 year or longer	$300
Walking boot	$75
Wheel chair or motorized scooter – expected use less than 1 year	$200
Wheel chair or motorized scooter – expected use 1 year or longer	$750
Other medical device used for mobility	$750
Medical Appliance Benefit Limit	**Benefit Limit**
Limit for all Medical Appliances combined, per Covered Person, per Accident	$1,000
Blood/Plasma/Platelets Benefit	**Benefit**
Blood/Plasma/Platelets	$400
Inpatient Surgery Benefit	**Benefit**
Cranial Surgery	$1,500
Exploratory Surgery	$150
Hernia repair	$150
Thoracic cavity or abdominal pelvic cavity Surgery	$1,500
Outpatient Ambulatory Surgery Benefit	**Benefit**
Outpatient Ambulatory Surgery	$300
ACCIDENT - HOSPITAL BENEFITS	
Accident - Hospital Admission Benefit	**Benefit**
Non-ICU Hospital Admission	$500
Intensive Care Unit Admission	$1,000
Accident - Hospital Confinement Benefit	**Benefit**
Non-ICU Hospital Confinement	$100
Intensive Care Unit Confinement	$200

Inpatient Rehabilitation Benefit	Benefit
Inpatient Rehabilitation	$150
OTHER BENEFITS	
Health Screening Benefit	**Benefit**
Health Screening	$50
Lodging Benefit	**Benefit**
Lodging	$100

High Plan

The High Plan pays benefits according to the following schedule.

Accidental Injuries		
Fracture Benefit	**Closed Wound**	**Open Wound**
Face or nose (except mandible or maxilla)	$2,000	$4,000
Skull fracture – depressed (except bones of face or nose)	$5,000	$10,000
Skull fracture – non-depressed (except bones of face or nose)	$2,500	$5,000
Lower jaw, mandible (except alveolar process)	$1,000	$2,000
Upper jaw, maxilla (except alveolar process)	$2,000	$4,000
Upper arm between elbow and shoulder (humerus)	$2,000	$4,000
Shoulder blade (scapula), collarbone (clavicle, sternum)	$1,400	$2,800
Forearm (radius and/or ulna), hand, wrist (except fingers)	$1,000	$2,000
Rib	$1,000	$2,000
Finger, toe	$200	$400
Vertebrae, body of (excluding vertebral processes)	$3,000	$6,000
Vertebral processes	$1,000	$2,000
Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx)	$3,000	$6,000
Hip, thigh (femur)	$5,000	$10,000
Coccyx	$750	$1,500
Leg (tibia and/or fibula)	$2,000	$4,000
Kneecap (patella)	$1,000	$2,000
Ankle	$1,000	$2,000
Foot (except toes)	$1,000	$2,000
Chip fracture benefit for any of the above	25% of the applicable benefit for the bone involved	
Dislocation Benefit	**Closed Wound**	**Open Wound**

Lower jaw	$1,000	$2,000
Collarbone (sternoclavicular)	$1,500	$3,000
Collarbone (acromioclavicular and separation)	$1,000	$2,000
Shoulder (glenohumeral)	$1,000	$2,000
Rib	$1,000	$2,000
Elbow	$1,000	$2,000
Wrist	$1,000	$2,000
Bone or bones of the hand (other than fingers)	$1,000	$2,000
Hip	$5,000	$10,000
Knee (except patella)	$2,500	$5,000
Ankle – bone or bones of the foot (other than toes)	$2,000	$4,000
One toe or finger	$200	$400
Partial dislocation benefit for any of the above	25% of the applicable benefit for joint involved	
Burn Benefit	**2nd Degree**	**3rd Degree**
Less than 10%	$100	$1,500
At least 10% but less than 25%	$300	$3,000
At least 25% but less than 35%	$750	$7,500
35% or more	$1,500	$15,000
Skin Graft Benefit	**Benefit**	
Skin Graft for 2nd or 3rd degree burn	50% of the applicable Burn Benefit	
Concussion Benefit	**Benefit**	
Concussion	$500	
Coma Benefit	**Benefit**	
Coma	$12,000	
Ruptured Disc with Surgical Repair Benefit	**Benefit**	
Ruptured Disc with Surgical Repair	$1,500	
Torn Cartilage in Knee Benefit	**Benefit**	
With surgical repair	$1,500	
Exploratory Surgery without repair	$300	
Laceration Benefit	**Benefit**	
Repaired without stitches	$75	
Repaired with stitches:		
Total of all lacerations is less than two inches (5.08 cm) long	$150	

Total of all lacerations is two to six inches (5.08 to 15.24 cm) long	$300
Total of all lacerations is over six inches (over 15.24 cm) long	$700
Torn, Ruptured or Severed Tendon / Ligament / Rotator Cuff Benefit	**Benefit**
Surgical repair: one tendon/ligament/rotator cuff	$1,000
Surgical repair: two or more tendons/ligaments/rotator cuffs	$2,000
Exploratory Surgery without repair	$300
Broken Tooth Benefit	**Benefit**
Crown	$300
Extraction	$150
Filling	$50
Eye Injury Benefit	**Benefit**
Eye Injury	$400
ACCIDENT - MEDICAL TREATMENT AND SERVICES BENEFITS	
Ambulance Benefit	**Benefit**
Air Ambulance Benefit	$1,500
Ground Ambulance Benefit	$400
Emergency Care Benefit	**Benefit**
Emergency Room	$200
Physician's Office	$100
Urgent Care	$200
Non-Emergency Initial Care Benefit	**Benefit**
Non-Emergency Room	$200
Medical Testing Benefit	**Benefit**
Medical Testing	$200
Physician Follow-Up Visit Benefit	**Benefit**
Physician Follow-Up Visit	$100
Transportation Benefit	**Benefit**
Transportation	$500
Therapy Services Benefit	**Benefit**
Cognitive behavioral therapy	$50
Occupational therapy	$50
Physical therapy	$50
Respiratory therapy	$50

Speech therapy	$50
Vocational therapy	$50
Pain Management Benefit (for Epidural Anesthesia) Benefit	**Benefit**
Pain Management Benefit (for Epidural Anesthesia)	$100
Prosthetic Device Benefit	**Benefit**
One device only	$1,000
More than one device	$2,000
Medical Appliance Benefit	**Benefit**
Brace	$150
Cane	$150
Crutches	$150
Walker – expected use less than 1 year	$200
Walker – expected use 1 year or longer	$400
Walking boot	$150
Wheel chair or motorized scooter – expected use less than 1 year	$300
Wheel chair or motorized scooter – expected use 1 year or longer	$1,000
Other medical device used for mobility	$200
Medical Appliance Benefit Limit	**Benefit Limit**
Limit for all Medical Appliances combined, per Covered Person, per Accident	$1,500
Blood/Plasma/Platelets Benefit	**Benefit**
Blood/Plasma/Platelets	$500
Inpatient Surgery Benefit	**Benefit**
Cranial Surgery	$2,000
Exploratory Surgery	$300
Hernia repair	$200
Thoracic cavity or abdominal pelvic cavity Surgery	$2,000
Outpatient Ambulatory Surgery Benefit	**Benefit**
Outpatient Ambulatory Surgery	$400
ACCIDENT - HOSPITAL BENEFITS	
Accident - Hospital Admission Benefit	**Benefit**
Non-ICU Hospital Admission	$1,000
Intensive Care Unit Admission	$2,000
Accident - Hospital Confinement Benefit	**Benefit**

Non-ICU Hospital Confinement	$200
Intensive Care Unit Confinement	$400
Inpatient Rehabilitation Benefit	**Benefit**
Inpatient Rehabilitation	$200
OTHER BENEFITS	
Health Screening Benefit	**Benefit**
Health Screening	$50
Lodging Benefit	**Benefit**
Lodging	$200

Key Terms

Accident means an act or event that:

- Is unforeseen, unexpected and unanticipated
- Is definite as to time and place
- Is not an illness, and
- Occurs while Accident Insurance is in effect.

The term “accident” includes unavoidable exposure to the elements if such exposure was a direct result of an accident.

Injury means any bodily harm:

- That results directly from an accident, and
- Is not specifically excluded as set forth in the section of the Certificate titled Accident - Exclusions.

Illness means:

- A physical illness, physical infirmity or physical disease
- Pregnancy, or
- Infection, but not an infection received through an accidental cut or wound.

What Accident Insurance Does Not Cover

The Accident Insurance Plan will not pay benefits for you or your covered dependents if the loss is caused by the covered individual’s sickness, or the diagnosis or treatment of such sickness, except for the covered individual’s use of:

- any drug, medication or sedative that is taken or used as prescribed by a Physician; or
- an “over the counter” drug, medication or sedative taken as directed.

The Accident Insurance Plan will not pay benefits for you or your covered dependents if the loss is caused or contributed to by:

- the Covered Person’s voluntary use, by any means, of poison, gas, or fumes;

- the Covered Person's suicide or attempted suicide (while sane or insane);
- the Covered Person's intentionally self-inflicted Injury;
- war, whether declared or undeclared; or act of war;
- the Covered Person's active participation in an insurrection, rebellion, riot, or terrorist act;
- the Covered Person's infection, other than infection occurring in an external wound resulting from an Injury that results directly from an Accident;
- food poisoning;
- the Covered Person's operation, while intoxicated, of a motor vehicle involved in the incident. For purposes of this exclusion:
    - intoxicated means that the Insured's blood alcohol level met or exceeded .08%; and
    - motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all-terrain vehicle; or a snow mobile;
- Dental or plastic Surgery for cosmetic purposes, except when such Surgery is performed to:
    - treat an Injury that results directly from an Accident;
    - correct a disorder of normal bodily function or structure that was caused by an Injury that results directly from an Accident for which coverage is not otherwise excluded under this Certificate; or
    - reconstruct a part of the body which was disfigured or removed as a result of an Injury that results directly from an Accident for which coverage is not otherwise excluded under this Certificate;
- The Covered Person's mental illness, or the diagnosis or treatment of such mental illness, except for the Covered Person's use of:
    - any drug, medication or sedative that is taken or used as prescribed by a Physician; or
    - an "over the counter" drug, medication or sedative taken as directed;
- Activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority;
- The Covered Person's travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight;
- The Covered Person parachuting or otherwise exiting from a motorized or non-motorized aircraft while such aircraft is in flight, except for self-preservation;
- The Covered Person riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- The Covered Person participating in any semi-professional or professional competitive athletic activity for which any type of compensation or remuneration is received;
- The Covered Person's employment for wage or profit; or
- The Covered Person bungee jumping, base jumping, hang gliding, para-kiting, sail-gliding, scuba diving deeper than 130 feet; spelunking; or mountaineering including rock climbing using ropes and any other climbing equipment. For the purposes of this exclusion the term mountaineering does not include backpacking, mountain biking, hiking or trail running.

In addition, the Accident Insurance benefits will not pay benefits for:

- a Covered Person while incarcerated in any type of penal or detention facility; or
- any of the following outside of the United States, Canada or Mexico:
    - Medical treatment;
    - Hospital admission or Confinement; or

- Inpatient stay in a Rehabilitation Facility.

How to File an Accident Insurance Claim

To file a claim for reimbursement for services under the Accident Insurance Plan, you must provide notice of a claim and proof of loss by following the steps outlined below:

- **Notice of Claim:** You must provide notice of a claim by writing to or calling MetLife within 20 days after the covered condition (injury) occurs, or as soon as is reasonably possible.
- **Claim Form:** When MetLife receives notice of a claim, they will send a claim form to you and explain how to complete it. You should receive this claim form within 15 days of providing notice of a claim.
- **Proof of Loss:** When you receive the claim form, you must complete it as instructed and return it with the required proof no later than 90 days after the date of the loss. Failure to give such Proof within the time required will neither invalidate or reduce any such claim if it was not reasonably possible to give proof within such time, provided such proof is provided as soon as reasonably possible and in no event, except in the absence of the legal capacity of the claimant, later than one year from the time proof is otherwise required.

Submit the above information:

- By mail: Please call to request a claim form be provided.
- On the website: **https://www.metlife.com/avaya/**

You may call MetLife at 1-800-GET-MET8 to provide notice of a claim only.

Refer to *Claims and Appeal Procedures – Critical Illness Insurance, Accident Insurance and Hospital Indemnity Insurance* in this SPD for additional information on claims and appealing a denied claim.

Critical Illness Insurance Plan

Overview of Critical Illness Insurance

Critical Illness Insurance, administered by MetLife, offers benefits if you or another covered dependent have a serious illness. Critical Illness Insurance can provide you with valuable benefits to supplement your medical coverage.

This benefit is designed to provide a lump sum payment if you or another covered dependent are diagnosed with a covered illness or have a covered surgery. If you choose to enroll in this insurance, you have three levels of coverage: $10,000, $20,000, and $30,000. If elected the spouse is covered at 100% and the Children at 50%.

Critical Illness Insurance does not provide medical coverage and is not a substitute for medical or disability insurance. You should have medical coverage when you enroll for Critical Illness Insurance.

Note about States' Benefit Variations: Please see "The MetLife Certificate of Insurance Critical Illness Policy" document for Critical Illness benefit variations that may apply to your state.

Critical Illness Insurance at a Glance

Benefit Amount	For You	For Your Spouse	For Your Dependent Children
• $10,000 • $20,0000 • $30,000	• See Insured's Certificate or the Group Policyholder's participation file which has been provided by MetLife	• See Insured's Certificate or the Group Policyholder's participation file which has been provided by MetLife	• See Insured's Certificate or the Group Policyholder's participation file which has been provided by MetLife

Cost of Coverage

You pay the full cost of Critical Illness Insurance. Your contributions are based on your age, whether you insure any dependents, and your tobacco user status (i.e., whether or not you use tobacco as reflected in the policy records as of the premium due date). Benefits are paid tax-free because you make your contributions for coverage on an after-tax basis.

Your coverage options are:

- Employee only
- Employee + Spouse/Domestic Partner
- Employee + Child(ren)
- Employee + Spouse/Domestic Partner + Child(ren)

How Critical Illness Insurance Works

Avaya offers Critical Illness Insurance to help you pay for out-of-pocket costs if you or a covered dependent have covered illness or surgery.

Here's how Critical Illness Insurance works:

- If you or a covered dependent have a covered condition that first occurs while you or your dependent are covered for Critical Illness Insurance, you must send proof of the condition to MetLife.
- MetLife will review the claim. If the claim is approved, MetLife will pay the benefit for that condition.
- MetLife will never pay more than 100% of the total benefit amount.

What Critical Illness Insurance Covers

Critical Illness Schedule of Insurance

For additional information about the covered condition categories described below (e.g., benign tumor, cancer, or any other condition listed in the Critical Illness Schedule of Insurance), please refer to the "MetLife Certificate of Critical Illness Insurance" for more information.

Covered Condition Category: **Benign Tumor**	Percent of Benefit Amount Paid for Initial Occurrence	Percent of Benefit Amount Paid for Recurrence
Benign Brain Tumor	**50%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**100%** (of the Initial Benefit Amount payable no more than 1 time per Covered Person)
Cancer	Percent of Benefit Amount Paid for Initial Occurrence	Percent of Benefit Amount Paid for Recurrence
Invasive Cancer	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person per Occurrence of each Separate and Unrelated Invasive Cancer)	**100%** (of the Initial Benefit Amount payable no more than 1 time per Covered Person)
Non-Invasive Cancer	**25%** (of the Benefit Amount payable no more than 1 time per Covered Person per Occurrence of each Separate and Unrelated Non-Invasive Cancer)	**100%** (of the Initial Benefit Amount payable no more than 1 time per Covered Person)
Skin Cancer	**10%** (of the Benefit Amount, but not less than $250; payable no more than 1 time per Covered Person)	**None**
Cardiovascular Disease	Percent of Benefit Amount Paid for Initial Occurrence	Percent of Benefit Amount Paid for Recurrence
Cardiovascular Disease treated with: Coronary Artery Bypass Graft	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**100%** (of the Initial Benefit Amount payable no more than 1 time per Covered Person)

Functional Loss	Percent of Benefit Amount Paid for Initial Occurrence	Percent of Benefit Amount Paid for Recurrence
Coma	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**100%** (of the Initial Benefit Amount payable no more than 1 time per Covered Person)
Loss of: Ability to Speak; Hearing; or Sight	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Paralysis of 2 or more limbs	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**100%** (of the Initial Benefit Amount payable no more than 1 time per Covered Person)
Heart Attack	Percent of Benefit Amount Paid for Initial Occurrence	Percent of Benefit Amount Paid for Recurrence
Heart Attack	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**100%** (of the Initial Benefit Amount payable no more than 1 time per Covered Person)
Sudden Cardiac Arrest	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Infectious Disease	Percent of Benefit Amount Paid for Initial Occurrence	Percent of Benefit Amount Paid for Recurrence
Bacterial Cerebrospinal Meningitis	**25%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Diphtheria	**25%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Encephalitis	**25%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Legionnaire’s Disease	**25%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Malaria	**25%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Necrotizing Fasciitis	**25%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Osteomyelitis	**25%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Rabies	**25%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**

Tetanus	**25%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Tuberculosis	**25%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
COVID-19	**25%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Kidney Failure	Percent of Benefit Amount Paid for Initial Occurrence	Percent of Benefit Amount Paid for Recurrence
Kidney Failure	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Major Organ Transplant	Percent of Benefit Amount Paid for Initial Occurrence	Percent of Benefit Amount Paid for Recurrence
Major Organ Transplant (for other than Bone Marrow Transplant)	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Major Organ Transplant (for Bone Marrow Transplant)	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Progressive Disease	Percent of Benefit Amount Paid for Initial Occurrence	Percent of Benefit Amount Paid for Recurrence
ALS	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Alzheimer's Disease	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Multiple Sclerosis	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
muscular dystrophy	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Parkinson's Disease (Advanced)	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**
Systemic Lupus Erythematosus (SLE)	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**None**

Stroke	Percent of Benefit Amount Paid for Initial Occurrence	Percent of Benefit Amount Paid for Recurrence
Stroke	**100%** (of the Benefit Amount payable no more than 1 time per Covered Person)	**100%** (of the Initial Benefit Amount payable no more than 1 time per Covered Person)

Summary of Supplemental Benefits

BENEFIT	BENEFIT AMOUNT	BENEFIT MAXIMUM
Health Screening Benefit	For You: $50 per day For Your Spouse: $50 per day For Your Dependent Child: $50 per day	MetLife will pay the Health Screening Benefit: 1 time per Covered Person, per Calendar Year
Second Opinion Benefit	$500 per evaluation or consultation An additional $250 if the Evaluation Center is located more than 100 miles from the Covered Person's Primary Residence	MetLife will pay the Second Opinion Benefit for 5 second opinion(s) per Covered Person per lifetime

Key Terms

Benefit Amount means the amount MetLife uses to determine the benefit payable for a Covered Condition.

Clinical Diagnosis means a Diagnosis based on the study of symptoms and diagnostic test results.

Covered Condition means those conditions or treatments listed in the Schedule for which a benefit is payable as described in this Certificate. A Covered Condition does not include Supplemental Benefits.

Covered Person means You and, if insured under the Group Policy for the insurance described in this Certificate, Your Dependents.

Hospital means a short-term, acute care, general facility which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic services and therapeutic services for Diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine;
- has facilities for major Surgery either on its premises or through a contractual arrangement with another Hospital;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

What Critical Illness Insurance Does Not Cover

The exclusions that appear below apply to all Covered Conditions and benefits set forth in the MetLife certificate of insurance. Please note that certain covered conditions have additional exclusions that are set forth in the benefit provisions of the certificate of insurance.

MetLife will not pay benefits for any Covered Condition for a Covered Person caused by, or that takes place during:

- the Covered Person's active participation in an insurrection, rebellion, or riot;
- the Covered Person's intentionally self-inflicted injury;
- the Covered Person's suicide or attempted suicide (while sane or insane);
- war, whether declared or undeclared; or act of war; or
- activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority.

In addition, MetLife will not pay benefits for:

- any Covered Condition for which Diagnosis is made outside the United States, Canada or Mexico unless the Diagnosis is confirmed in the United States, in which case the Covered Condition will be deemed to Occur on the date the Diagnosis is made outside the United States, Canada or Mexico.

Intoxicants and Controlled Substances

MetLife will not be liable for any loss sustained or contracted in consequence of the Covered Person's being intoxicated (including but not limited to intoxication due to cannabis use) or under the influence of any controlled substance unless administered on the advice of a Physician.

Illegal Occupation or Commission of a Felony

MetLife will not be liable for any loss to which a contributing cause was the commission of or attempt to commit a felony by the Covered Person whose injury or sickness is the basis of claim, or to which a contributing cause was such Covered Person's being engaged in an illegal occupation.

How to File a Critical Illness Insurance Claim

To file a claim for reimbursement for services under the Critical Illness Insurance Plan, you must provide notice of a claim and proof of loss by following the steps outlined below:

- **Notice of Claim:** You must provide notice of a claim by writing to or calling MetLife within 20 days after the covered condition occurs, or as soon as is reasonably possible.
- **Claim Form:** When MetLife receives notice of a claim, they will send a claim form/s to you and explain how to complete it. You should receive this claim form/s within 15 days of providing notice of a claim.
- **Proof of Loss:** When you receive the claim form, you must complete it as instructed and return it with the required proof no later than 90 days after the date of the loss. Failure to give such proof within the time required will neither invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of the legal capacity of the claimant, later than one year from the time proof is otherwise required.

Submit the above information:

- By mail: Please call to request a claim form be provided.
- On the website: **https://www.metlife.com/avaya/**

You may call MetLife at 1-800-GET-MET8 to provide notice of a claim only.

Refer to *Claims and Appeal Procedures – Critical Illness Insurance, Accident Insurance and Hospital Indemnity Insurance* in this SPD for additional information on claims and appealing a denied claim.

Hospital Indemnity Plan

Overview of Hospital Indemnity Insurance

Hospital Indemnity Insurance, administered by MetLife, offers benefits if you or another covered dependent are admitted to the hospital due to a serious injury or sickness resulting from an accident or sickness. Hospital Indemnity Insurance can provide you with benefits in addition to your medical coverage.

This benefit is designed to provide a lump sum payment for a hospital admission and a cash benefit for a hospital stay for a covered injury or sickness. If you choose to enroll in this insurance, you have two plans to choose from: The Low Plan or the High Plan. Note, residents of New Hampshire are provided a separate plan (including a low plan and a high plan option) from all other residents of U.S. states. For more information is provided in the detailed sections below or consult the "MetLife Certificate of Insurance Hospital Indemnity Policy" document for more details.

Hospital Indemnity Insurance does not provide medical coverage and is not a substitute for medical coverage or disability insurance. You should have medical coverage when you enroll for Hospital Indemnity Insurance.

Note about States' Benefit Variations: Please see the "MetLife Certificate of Insurance Hospital Indemnity Policy" document for benefit variations that may apply to your state.

Hospital Indemnity Insurance at a Glance

Schedule of Benefits for U.S. Residents Plans (excluding New Hampshire residents)

Hospital Benefits	Low Plan Benefit	High Plan Benefit
Admission Benefit	• $750 for the day of admission. No more than 1 time per covered, person per calendar year (combined limit for accident and sickness).	• $1,500 for the day of admission. No more than 1 time per covered, person per calendar year (combined limit for accident and sickness).
Confinement Benefit	• $150 per day, for no more than 30 days per covered person, per calendar year (combined limit for accident and sickness).	• $300 per day, for no more than 30 days per covered person, per calendar year (combined limit for accident and sickness).
Confinement Benefit for Newborn Nursery Care	• $25 per day, for no more than 2 days per newborn baby.	• $50 per day, for no more than 2 days per newborn baby.
Inpatient Rehabilitation Benefit	• $150 per day, for no more than 30 days per covered person, per calendar year.	• $300 per day, for no more than 30 days per covered person, per calendar year.

Schedule of Benefits for New Hampshire Residents Only Plans

Hospital Benefits - Accident	Low Plan Benefit	High Plan Benefit
Hospital Admission Benefit • Non-Intensive Care Unit (ICU) Admission • ICU Admission	• $750 for the day of admission. No more than 1 time per covered person per calendar year. • $750 for the day of admission. No more than 1 time per covered person per calendar year.	• $1,500 for the day of admission. No more than **1 time per covered person per calendar year.** $1,500 for the day of admission. No more than 1 time per covered person per calendar year.
Hospital Confinement Benefit • Non-Intensive Care Unit (ICU) Admission • ICU Admission	• $150 per day, for no more than 30 days per covered person. • $150 per day, for no more than 30 days per covered person.	• $300 per day, for no more than 30 days per covered person. • $300 per day, for no more than 30 days per covered person.
Inpatient Rehabilitation Benefit	• $150 per day, for no more than 30 days per covered person per year.	• $300 per day, for no more than 30 days per covered person per year
Hospital Benefits - Sickness	**Low Plan Benefit**	**High Plan Benefit**
Hospital Admission Benefit • Non-Intensive Care Unit (ICU) Admission • ICU Admission	• $750 for the day of admission. No more than 1 time per covered person per calendar year. • $750 for the day of admission. No more than 1 time per covered person per calendar year.	• $1,500 for the day of admission. No more than 1 time per covered person per calendar year. • $1,500 for the day of admission. No more than 1 time per covered person per calendar year.
Hospital Confinement Benefit • Non-Intensive Care Unit (ICU) Admission • ICU Admission	• $150 per day, for no more than 30 days per covered person. • $150 per day, for no more than 30 days per covered person.	• $300 per day, for no more than 30 days per covered person. • $300 per day, for no more than 30 days per covered person.

Cost of Coverage

You pay the full cost of Hospital Indemnity Insurance. Benefits are paid tax-free because you make your contributions for coverage on an after-tax basis.

Your coverage options are:

- Employee only
- Employee + spouse / domestic partner
- Employee + child(ren)
- Employee + spouse / domestic partner + child(ren)

These costs are set annually and are communicated during the Annual Enrollment period.

How Hospital Indemnity Insurance Works

Avaya offers Hospital Indemnity Insurance to help you pay for out-of-pocket costs if you or a covered dependent are hospitalized due to a covered injury or sickness.

Here's how Hospital Indemnity Insurance works:

- If you or a covered family member are admitted to the hospital for a covered injury or sickness while you or your dependent are covered for Hospital Indemnity Insurance, you must send proof of the admission to MetLife. You must also send proof of the length of the hospital stay for the covered injury or sickness.
- MetLife will review the claim(s). If the claim(s) is approved, MetLife will pay the benefit for the hospital admission and hospital stay.
- MetLife will never pay more than the 100% of the scheduled benefit amount for the hospital admission or hospital stay.

Key Terms

Accident – an act or event that:

- Is unforeseen, unexpected, and unanticipated;
- Is definite as to time and place; and
- Occurs when the individual is covered for Hospital Indemnity Insurance.

The term "accident" includes unavoidable exposure to the elements if such exposure was a direct result of an accident.

Complications of Pregnancy – means diseases or conditions, the diagnoses of which are distinct from pregnancy and not associated with normal pregnancy or Routine Childbirth, but are adversely affected or caused by pregnancy, such as: acute nephritis; nephrosis; cardiac decompensation; non-elective or emergency Caesarean section; ectopic pregnancy which is terminated; a spontaneous termination of pregnancy when a viable birth is not possible; puerperal infection; eclampsia; hyperemesis gravidarum and pre-eclampsia requiring Confinement; toxemia; missed abortion; or disease of the vascular, hemopoietic, nervous or endocrine systems.

The term Complications of Pregnancy does not include: false labor; occasional spotting; doctor prescribed rest during the period of pregnancy; morning sickness; multiple gestation pregnancy; elective abortion; or conditions of comparable severity associated with management of a difficult pregnancy.

Confined or Confinement – means the assignment to a bed as a resident inpatient in a Hospital (including an Intensive Care Unit of a Hospital) on the advice of a Physician or confinement in an observation area within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician.

Covered Person – means You and, if insured under the Group Policy for the insurance described in this Certificate, Your Dependents.

Emergency Room – means an area within a Hospital that is dedicated to the provision of emergency care. This area must:

- be staffed and equipped to handle trauma;
- be supervised and provide treatment by Physicians; and
- provide care seven days per week, 24 hours per day.

The term Emergency Room includes short stay observation units or clinical decision units within a Hospital that assess, within a period of less than 20 continuous hours, whether to discharge or admit patients.

Hospice Facility – means a facility, unit of a facility, public or private agency, or unit of a public or private agency that:

- is separate from a Hospital or is a separately designated unit within a Hospital; and
- meets federal certification requirements as a hospice, or is comparably licensed under the laws where it is located, to provide care or management of persons who are diagnosed with a Terminal Illness.

Hospital – means a short-term, acute care, general facility which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine;
- has facilities for major Surgery either on its premises or through contractual arrangement with another Hospital;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts or alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

The term Hospital does not include a separate unit of a Hospital that is licensed as a hospice facility, nursing home, skilled nursing facility, assisted living facility, rehabilitation facility or an outpatient Surgery facility.

Injury – means any bodily harm.

Intensive Care Unit or **ICU** – means a place which:

- is a specifically dedicated area of a Hospital that is restricted to patients who are critically ill or injured and who require intensive, comprehensive monitoring and care;
- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under close observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis; and
- has a Physician assigned to the intensive care unit on a full-time basis.

The term Intensive Care Unit includes Hospital units with the following names: intensive care unit; coronary care unit; neonatal intensive care unit; pulmonary care unit; burn unit; or transplant unit.

Newborn Nursery Care – means routine well baby care provided to a newborn baby while Confined immediately following a Covered Person's childbirth of such baby.

Rehabilitation Facility – means a facility that:

- provides rehabilitation care services on an inpatient basis;
- is separate from a Hospital or is a separately designated unit within a Hospital; and
- maintains all required licenses and certifications.

Sickness – means:

- A physical sickness, physical infirmity, or physical disease; or
- Pregnancy

What Hospital Indemnity Insurance Covers

If you or a covered dependent are admitted to the hospital due to an accident or sickness as defined above (see "Key Terms" section), MetLife will pay the scheduled benefit for the option you enrolled in:

U.S. Residents Plans (excluding New Hampshire residents)

Hospital Admission Benefit

If a you or a covered dependent are admitted for confinement to a hospital for treatment of an injury or sickness, MetLife will pay the admission benefit shown on the schedule of benefits for the day of admission, subject to all of the following:

- The admission must occur on or after the date that coverage took effect for you or a covered dependent.
- The admission benefit is not payable for emergency room treatment or outpatient treatment.
- MetLife will only pay the admission benefit for a you or a covered dependent for one Hospital admission at a time, even if the admission is caused by more than one injury or sickness or a combination of injury and sickness.
- For hospital admission for treatment of an injury, the admission must occur within 180 days after the accident occurs.
- MetLife will only pay an admission benefit for a newborn baby who is born in a hospital if, due to a sickness or injury, the newborn baby is admitted to the intensive care unit.
- If a you or a covered dependent is admitted to a hospital and is then transferred to another hospital, MetLife will not pay an additional admission benefit.
- MetLife will pay the admission benefit no more than the number of times shown on the schedule of benefits.

Hospital Confinement Benefit

If you or a covered dependent are confined in a hospital for treatment of an injury or sickness, MetLife will pay the confinement benefit shown on the schedule of benefits for each day of confinement, subject to all of the following:

- The confinement must begin while coverage is in effect for you or a covered dependent. For confinement for treatment of an injury, the confinement must begin within 180 days after the accident occurs.
- If a you or a covered dependent are confined in a hospital and is then transferred to another hospital, MetLife will treat the transfer as a continuation of the prior confinement.
- MetLife will only pay one confinement benefit per covered person, per day.
- MetLife will pay the confinement benefit for no more than the number of days shown on the schedule of benefits.
- For a newborn baby who is receiving newborn nursery care and is not confined for treatment of a physical illness, infirmity, disease or Injury, MetLife will pay the confinement benefit for newborn nursery care shown on the schedule of benefits for such baby, while confined, up to the number of days shown on the schedule of benefits. If a newborn baby is confined for treatment of a physical illness, infirmity, disease or Injury, MetLife will pay the confinement benefit instead of the confinement benefit for newborn nursery care.

Inpatient Rehabilitation Benefit

If you or a covered dependent are transferred to a rehabilitation facility, as a resident inpatient, immediately after a period of confinement for treatment of an injury or sickness for which MetLife paid an admission benefit or confinement benefit, MetLife will pay the inpatient rehabilitation benefit shown on the schedule of benefits for the period of the continuous stay, subject to all of the following:

- For treatment of an injury, you or a covered dependent's inpatient stay in the rehabilitation facility must start within 365 days after the accident occurs.
- If you or a covered dependent are discharged from the rehabilitation facility and, within 14 days is again admitted to a rehabilitation facility as a resident inpatient for treatment of the same or related injury or sickness, MetLife will treat the subsequent rehabilitation facility stay as a continuation of the previous stay.
- MetLife will not pay the inpatient rehabilitation benefit for any day for which MetLife paid an admission benefit or a confinement benefit.
- MetLife will only pay one inpatient rehabilitation benefit per covered person, per day.
- MetLife will pay the inpatient rehabilitation benefit for no more than the number of days shown on the schedule of benefits.

New Hampshire Residents Only Plans

Accident – Hospital Admission Benefit

If a covered person is admitted to a hospital for treatment of an injury, MetLife will pay the Accident - Hospital Admission benefit shown in the schedule of benefits that applies to the type of hospital admission, subject to all of the following:

- The injury must result directly from an accident.
- In order for the Accident - Hospital Admission benefit to be payable for a non-ICU Hospital admission, admission must occur within 180 days after the accident occurs.
- In order for the Accident - Hospital Admission benefit to be payable for an Intensive Care Unit admission, admission to the Intensive Care Unit must occur within 180 days after the accident occurs.
- This benefit does not apply to emergency room treatment, outpatient treatment, or a stay of less than 20 hours in an observation area.

- MetLife will only pay one Accident - Hospital Admission benefit per covered person, per accident. If the covered person moves from or to an Intensive Care Unit after initial admission to a hospital, MetLife will not pay an additional Accident - Hospital Admission benefit.

Accident – Hospital Confinement Benefit

If a covered person is confined in a hospital for treatment of an injury, MetLife will pay the Accident - Hospital Confinement benefit shown in the schedule of benefits that applies to the type of hospital confinement for each day the covered person is confined in the hospital, subject to all of the following:

- The injury must result directly from an accident.
- In order for the Accident - Hospital Confinement benefit to be payable for a non-ICU hospital confinement, the initial confinement must begin within 180 days after the accident occurs.
- In order for the Accident - Hospital Confinement benefit to be payable for an Intensive Care Unit Confinement, the initial confinement must begin within 180 days after the accident occurs.
- For a non-ICU hospital confinement, the accident - hospital confinement benefit is payable for up to 30 days per covered person, per accident, and may be used over a two-year period following the date of the accident.
- For an Intensive Care Unit Confinement, the hospital confinement benefit is payable for up to 30 days per covered person, per accident, and may be used over a two-year period following the date of the accident.
- MetLife will pay the Accident – Hospital Confinement benefit for only one hospital confinement at a time, even if the confinement is caused by more than one accident.
- MetLife will only pay one Accident – Hospital Confinement benefit per day. If the covered person has a non-ICU hospital confinement and an Intensive Care Unit Confinement on the same day, MetLife will only pay the accident - hospital confinement benefit that applies to Intensive Care Unit confinement.
- If a covered person exhausts the Accident – Hospital Confinement benefit that applies to confinement in an Intensive Care Unit and remains confined in an Intensive Care Unit, the covered person may still be eligible for the Accident – Hospital Confinement benefit that applies to a non-ICU hospital confinement.

Inpatient Rehabilitation Benefit

If a covered person is transferred to a rehabilitation facility immediately after a period of confinement for treatment of an injury for which MetLife paid an Accident – Hospital Confinement benefit, MetLife will pay the Inpatient Rehabilitation benefit shown in the schedule of benefits, subject to all of the following:

- The injury must result directly from an accident.
- MetLife will pay the Inpatient Rehabilitation benefit for each day of the covered person’s continuous stay as a resident inpatient in a rehabilitation facility, up to a maximum stay of 15 days per covered person, per accident but not to exceed 30 days per calendar year.
- The covered person’s inpatient stay in the rehabilitation facility must start within 365 days after the accident.
- After the covered person is discharged from the rehabilitation facility, MetLife will not pay the Inpatient Rehabilitation benefit for a subsequent admission to a rehabilitation facility for treatment of the same injury for which MetLife already paid the Inpatient Rehabilitation benefit.

- MetLife will not pay the Inpatient Rehabilitation benefit for any day for which MetLife paid an Accident – Hospital Confinement benefit.

Sickness – Hospital Admission Benefit

If a covered person is admitted to a hospital for treatment of a sickness, MetLife will pay the sickness - Hospital Admission benefit shown in the schedule of benefits that applies to the type of the hospital admission, subject to the all of following:

- This benefit does not apply to emergency room treatment, outpatient treatment, or a stay of less than 20 hours in an observation unit.
- MetLife will only pay one sickness – Hospital Admission benefit per covered person, per sickness. If the covered person moves from or to an Intensive Care Unit after initial admission to a hospital, MetLife will not pay an additional sickness - Hospital Admission benefit.
- MetLife will pay the Sickness – Hospital Admission benefit no more than 1 time per covered person, per calendar year.

Sickness – Hospital Confinement Benefit

If a covered person is confined in a Hospital for treatment of a sickness, MetLife will pay the Sickness - Hospital Confinement benefit shown in the schedule of benefits that applies to the type of hospital confinement for each day the covered person is confined in the hospital for treatment of a sickness, subject to all of the following:

- For a non-ICU hospital confinement, the Sickness - Hospital Confinement benefit is payable for up to 30 days per covered person, per sickness.
- For an Intensive Care Unit Confinement, the Sickness - Hospital Confinement benefit is payable for up to 30 days per covered person, per sickness.
- MetLife will pay the Sickness - Hospital Confinement benefit for only one hospital confinement at a time, even if the Confinement is caused by more than one sickness.
- MetLife will only pay one Sickness - Hospital Confinement benefit per day. If the covered person has a non-ICU hospital confinement and an Intensive Care Unit Confinement on the same day, MetLife will only pay the Sickness - Hospital Confinement benefit that applies to Intensive Care Unit Confinement.
- If a covered person exhausts the Sickness - Hospital Confinement benefit that applies to confinement in an Intensive Care Unit and remains confined in an Intensive Care Unit, the covered person may still be eligible for the Sickness - Hospital Confinement benefit that applies to a non-ICU hospital confinement.

What Hospital Indemnity Insurance Does Not Cover

U.S. Residents Plans (excluding New Hampshire residents)

Exclusions

MetLife will not pay benefits for any loss due to an Accident or Sickness for a Covered Person caused by:

- the Covered Person’s voluntary use, by any means, of:
  - poison, gas, or fumes;
- the Covered Person’s suicide or attempted suicide (while sane or insane);
- the Covered Person’s intentionally self-inflicted injury;

- war, whether declared or undeclared; or act of war;
- the Covered Person's active participation in an insurrection, rebellion or riot;
- dental procedures or Surgery except as the result of an Accident causing Injury to a sound natural tooth;
- cosmetic Surgery, except when such Surgery is performed to:
    - treat an Injury or Sickness;
    - correct a disorder of normal bodily function or structure that was caused by an Injury or Sickness for which coverage is not otherwise excluded under this Certificate; or
    - reconstruct a part of the body which was disfigured or removed as a result of an Injury or Sickness for which coverage is not otherwise excluded under this Certificate;
- the Covered Person's mental illness, or the diagnosis or treatment of such mental illness, except for the Covered Person's use of:
    - any drug, medication or sedative that is taken or used as prescribed by a Physician; or
    - an "over the counter" drug, medication or sedative taken as directed; or
- activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority.

In addition, MetLife will not pay benefits for:

- a Covered Person while incarcerated in any type of penal or detention facility; or
- any of the following outside of the United States, Canada or Mexico:
    - any medical or healthcare treatment, services or transportation; or
    - any inpatient admission or stay in any medical or health care facility.

New Hampshire Residents Only Plans

Accident Exclusions

MetLife will not pay benefits for any loss for a Covered Person caused by the Covered Person's Sickness, or the diagnosis or treatment of such Sickness.

MetLife will not pay benefits for any loss for a Covered Person caused by:

- the Covered Person's voluntary use, by any means, of poison, gas, or fumes;
- the Covered Person's suicide or attempted suicide (while sane or insane);
- the Covered Person's intentionally self-inflicted injury;
- war, whether declared or undeclared; or act of war;
- the Covered Person's active participation in an insurrection, rebellion or riot;
- the Covered Person's infection;
- food poisoning;
- the Covered Person's operation, while intoxicated, of a motor vehicle involved in the incident. For purposes of this exclusion:
    - intoxicated means that the Insured's blood alcohol level met or exceeded .08%; and
    - motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all-terrain vehicle; or a snow mobile;

- dental or plastic Surgery for cosmetic purposes, except when such Surgery is performed to:
    - treat an Injury that results directly from an Accident;
    - correct a disorder of normal bodily function or structure that was caused by an Injury that results directly from an Accident for which coverage is not otherwise excluded under this Certificate; or
    - reconstruct a part of the body which was disfigured or removed as a result of an Injury that results directly from an Accident for which coverage is not otherwise excluded under this Certificate;
- the Covered Person's mental illness, or the diagnosis or treatment of such mental illness, except for the Covered Person's use of:
    - any drug, medication or sedative that is taken or used as prescribed by a Physician; or
    - an "over the counter" drug, medication or sedative taken as directed;
- activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority;
- the Covered Person's travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight;
- the Covered Person parachuting or otherwise exiting from a motorized or non-motorized aircraft while such aircraft is in flight, except for self-preservation;
- the Covered Person riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- the Covered Person participating in any semi-professional or professional competitive athletic activity for which any type of compensation or remuneration is received; or
- the Covered Person bungee jumping, base jumping, hang gliding, para-kiting, sail-gliding, scuba diving deeper than 130 feet; spelunking; or mountaineering including rock climbing using ropes and any other climbing equipment. For the purposes of this exclusion the term mountaineering does not include backpacking, mountain biking, hiking or trail running.

In addition, MetLife will not pay benefits for:

- a Covered Person while incarcerated in any type of penal or detention facility; or
- any of the following outside of the United States, Canada or Mexico:
    - Hospital admission or Confinement; or
    - inpatient stay in a Rehabilitation Facility.

Sickness Exclusions

MetLife will not pay benefits under this Sickness – Hospital Benefits section of the Certificate for any Covered Person's Sickness that is caused by:

- the Covered Person's voluntary use, by any means, of poison, gas, or fumes;
- the Covered Person's suicide or attempted suicide (while sane or insane);
- the Covered Person's intentionally self-inflicted injury;
- war, whether declared or undeclared; or act of war;
- the Covered Person's active participation in an insurrection, rebellion or riot;
- dental or plastic Surgery for cosmetic purposes, except when such Surgery is performed to:
    - treat a Sickness;
    - correct a disorder of normal bodily function or structure that was caused by a Sickness for which coverage is not otherwise excluded under this Certificate;

- reconstruct a part of the body which was removed or disfigured as a result of a Sickness for which coverage is not otherwise excluded under this Certificate;

- the Covered Person's mental illness, or the diagnosis or treatment of such illness;
- the Covered Person's alcoholism, drug addiction, chemical dependency or complications thereof;
- activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority; or
- routine, vaginal delivery of a child or children or delivery of a child or children by non-emergency Cesarean section.

In addition, MetLife will not pay benefits under this Sickness – Hospital Benefits section of this Certificate for:

- a Covered Person while incarcerated in any type of penal or detention facility;
- any Hospital admission or Confinement outside the United States, Canada or Mexico; or
- routine nursing or well baby care for a newborn child.

Additional Exclusions for Injury and Sickness

If a Covered Person is Confined for both an Injury and Sickness at the same time, MetLife will only pay benefits for the admission and Confinement under the Accident – Hospital Benefits section, and not this section. In this case, if the Covered Person exhausts the benefits under the Accident – Hospital Benefits section for Hospital Confinement and remains Confined for treatment of a Sickness, the Covered Person may still be eligible for the Sickness – Hospital Confinement Benefit under this section.

How to File a Hospital Indemnity Insurance Claim

To file a claim for reimbursement for services under the Hospital Indemnity Insurance Plan, you must provide notice of a claim and proof of loss by following the steps outlined below:

- **Notice of Claim:** You must provide notice of a claim by writing to or calling MetLife within 20 days after the covered condition occurs, or as soon as is reasonably possible.
- **Claim Form:** When MetLife receives notice of a claim, they will send a claim form/s to you and explain how to complete it. You should receive this claim form/s within 15 days of providing notice of a claim.
- **Proof of Loss:** When you receive the claim form, you must complete it as instructed and return it with the required proof no later than 90 days after the date of the loss. Failure to give such proof within the time required will neither invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of the legal capacity of the claimant, later than one year from the time proof is otherwise required.

Submit the above information:

- By mail: Please call to request a claim form be provided.
- On the website: **https://www.metlife.com/avaya/**

You may call MetLife at 1-800-GET-MET8 to provide notice of a claim only.

Refer to *Claims and Appeal Procedures – Critical Illness Insurance, Accident Insurance and Hospital Indemnity Insurance* in this SPD for additional information on claims and appealing a denied claim.

Legal Plan

Overview of the Legal Plan

As part of the **Avaya Health and Welfare Benefits Plan for Represented Employees,** the Company offers you the opportunity to enrol in its Legal Plan, giving you access to a network of participating attorneys for consultation and advice on legal situations, such as creating or updating a will, disputing a charge that is not yours on your credit card bill, adopting a child, selling or buying a house, or resolving a legal dispute with a neighbor. The services are provided through participating law firms, and participating lawyers are called Plan Attorneys. This summary provides general information about the plan, who is eligible to receive benefits under the plan, what those benefits are, how to obtain benefits and what your rights are under ERISA.

The Legal Plan offers you and your eligible dependents access to affordable, convenient legal services from Plan Attorneys. The attorneys in the network are called “Plan Attorneys.” The Legal Plan is administered by MetLife Legal Plans.

Cost of Coverage

The Avaya Participating Company pays the full cost to provide you with coverage under the Basic Legal Services Plan. You do not pay anything for this coverage. However, there may be other costs associated with use of the Legal Services Plan that you are obligated to pay. If you elect the Plus Parents Plan you are responsible for the additional monthly cost.

- You will be required to pay certain costs related to authorized covered services even when you use a Participating Law Firm. Some examples of these expenses include payment to a third party (someone other than your attorney), fines, filing fees, title insurance, title search and court costs.
- If you are authorized to use a non-Participating Law Firm, benefits for covered services will be limited to a set fee schedule. You will be responsible for paying attorney fees that exceed the schedule and all other costs.
- Due to federal income tax laws, you ~~may~~ will be taxed on the imputed income for the premium cost, paid by the Avaya Participating Company, for the coverage. Thus, the Avaya Participating Company may permit you to waive coverage for an entire year (see “Enrollment Is Automatic Unless You Waive Coverage”).

These costs are set annually and are communicated during the Annual Enrollment period.

How the Legal Plan Works

With the Legal Plan, when you need services, you may contact the MetLife Legal Plan either online or by phone to receive a case number. Be prepared to give the last four digits of your Social Security Number (SSN) and zip code. If you are a spouse or an eligible dependent child of an eligible person, or a parent (or parent-in-law under the Plus Parent buy up option), you will need the last four digits of the SSN and zip code of the employee through whom you are eligible.

- Go to info.legalplans.com to login, enter the last four digits of your Social Security Number and zip code. You will go to a page that is specific for member services, and then select “Obtain Case Number.”
- Call MetLife Legal Plan’s Client Service Center toll-free at (800) 821-6400 between 8 a.m. and 8 p.m., Monday to Friday, ET. The Client Representative will:
  - Verify your eligibility for services
  - Make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage)

- Give you a case number (you will need a new case number for each new case you have)
- Give you the telephone number of a Plan Attorney most convenient to you, and
- Answer any questions you have about the Legal Plan.

You then call the Plan Attorney to schedule an appointment at a time convenient for you. Evening and Saturday appointments may be available.

If you choose, you may select your own attorney. If there are no Plan Attorneys available in your area, you will be asked to select your own attorney. In both of these cases, you will need to file a claim and the MetLife Legal Plan will reimburse you for these non-Plan Attorney's fees in accordance with a set fee schedule.

For services to be covered, you or your eligible dependents, or parent or parent-in law under the Plus Parents buy up option, must have obtained a case number and retained an attorney and the attorney must begin work on the covered legal matter while you are an eligible member of the Legal Plan.

Plan Confidentiality, Ethics and Independent Judgment

Your use of the Legal Plan and the legal services provided are confidential. The Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Avaya Inc. will know nothing about your legal issue or the services you use under the Legal Plan. The Plan Administrator will have access only to limited statistical information needed for orderly administration of the Legal Plan.

No one will interfere with your Plan Attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the Legal Plan are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the plan and he or she will not receive any further instructions, direction, or interference from anyone else connected with the Plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. MetLife Legal Plans or the law firm providing services under the Plan is responsible for all services provided by the attorneys.

You should understand that the plan has no liability for the conduct of any Plan Attorney. You have the right to file a complaint Legal Plan with the state bar concerning attorney conduct pursuant to the plan. You have the right to retain at your own expense any attorney authorized to practice law in your state.

Plan Attorneys will refuse to provide services if a matter is clearly without merit, frivolous, or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, call MetLife Legal Plans at **1-800-821-6400**. We will review your complaint and respond within two business days of your call.

What the Legal Plan Covers

MetLife Legal Plan offers you and your eligible dependents a comprehensive range of personal legal services. Please carefully review the description of covered services below so you understand what the Legal Plan covers, as well as any limitations that apply or conditions that must be met. Throughout this section "you" refers to you or your eligible covered dependent, unless otherwise noted.

For services to be covered, you or your eligible dependent must have obtained a case number and retained an attorney, and the attorney must begin work on the covered legal matter while you are an eligible participant in the Legal Plan.

NOTE: There may be dollar or hour maximums for some or all of the services covered by this Legal Plan. You can request a fee reimbursement packet from MetLife before engaging an attorney for services covered under the Legal Plan. To request a packet you should contact the client service center at **1-800-821-6400.**

Type of Legal Service	Legal Plan Benefit
Advice and Consultation (also included in Plus Parents)	
Office Consultation and Telephone Advice You have the opportunity to discuss any personal legal problems (unless specifically excluded by the Legal Plan) with an attorney either through an office consultation or by telephone. The Plan Attorney will explain your rights, outline options and recommend a course of action. The Plan Attorney will also identify any further coverage available under the Legal Plan and will represent you if you request to be represented. If representation is covered by the Legal Plan, you will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the Legal Plan, the Plan Attorney will provide a written fee statement in advance. You can choose whether to retain the Plan Attorney at your expense, seek other counsel or do nothing. *There are no restrictions on the number of times per year you may use this service; however, for a non-covered matter, this service is not intended to provide you with ongoing access to a Plan Attorney to obtain advice that would allow you to represent yourself. For non-covered matters that are not otherwise excluded, this benefit provides four hours of attorney time and services per year. The Covered Person is responsible to pay fees beyond the 4 hours. No more than a combined maximum total of four hours of attorney time and service are provided for the member, spouse and qualified dependents annually.*	
Financial Matters	
Debt Matters	
Debt Collection Defense This benefit covers attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial, if necessary, and motion to vacate a default judgment. *These services do not include counter-, cross- or third-party claims, bankruptcy, any action arising out of family law matters, including support and post-decree issues, or any matter where the creditor is affiliated with the sponsor or employer.*	
Identity Theft Defense This service covers consultations with an attorney regarding potential creditor actions resulting from identity theft, attorney services as needed to contact creditors, credit bureaus and financial institutions, defense services for specific creditor actions over disputed accounts, including limiting creditor harassment and representation in defense of any action that arises out of the identity theft, such as foreclosure, repossession, or garnishment, up to and including trial if necessary, and online help and information about identity theft and prevention. *These services do not include counter-claims, cross-claims, bankruptcy, any action arising out of divorce or post-decree matters, or any matter where the creditor is affiliated with the sponsor or employer.*	

Type of Legal Service	Legal Plan Benefit
Identity Management Services (also included in Plus Parents) This service provides the Covered Person with access to LifeStages Identity Management Services provided by CyberScout, LLC. These services include both proactive services when the Covered Person believes his or her personal data has been compromised and resolution services to assist the Covered Person in recovering from account takeover or identity theft with unlimited assistance to fix issues, handle notifications, and provide victims with credit and fraud monitoring. Theft support, fraud support, recovery and replacement services are also covered. For more information on identity theft protection, please visit http://www.legalplans-idtheft.com/.	
Type of Legal Service	**Legal Plan Benefit**
Document Preparation (included in Plus Parents)	
Affidavits This service covers the preparation of any affidavit in which you (or the Parent) are making the statement.	
Deeds This service covers the preparation of any deed for which you (or the Parent) are either the grantor or grantee.	
Demand Letters This service covers the preparation of letters that demand money, property or some other property interest of yours (or the Parent), except an interest is an excluded service. It also covers mailing these letters to the addressee and forwarding and explaining any response to you (or the Parent). *This service does not include negotiations and representation in litigation.*	
Document Review This service covers the review of any personal legal document of yours (or the Parent), such as letters, leases or purchase agreements.	
Elder Law Matters This service covers counselling you over the phone or in the office on any personal issues relating to your parents as they affect you, review of your parents' documents to advise you on their effect on you (documents include Medicare or Medicaid materials, prescription plans, leases nursing agreements, powers of attorney, living wills, and wills), preparation of deeds involving your parents when you are either the grantor or grantee, and preparation of promissory notes involving your parents when you are the payor or payee.	

Type of Legal Service	Legal Plan Benefit
Document Preparation	
Mortgages This service covers the preparation of a mortgage or deed of trust for which you (or the Parent) are the mortgagor.	
Promissory Notes This service covers the preparation of any promissory note for which you (or the Parent) are the payor or payee.	
Family Law (not included in Plus Parents)	
Divorce, Dissolution and Annulment (Contested and Uncontested) This service covers preparation and filing of all necessary pleadings, motions and affidavits, drafting settlement agreements, and representation at the hearing or trial, whether you are a plaintiff or a defendant	
Adoption and Legitimization (Contested and Uncontested) This service covers all legal services and court work in a state or federal court for an adoption for you and your spouse, and the legitimization of a child for you and your spouse, including reformation of a birth certificate, is also covered.	

Type of Legal Service	Legal Plan Benefit
Real Estate Matters (not included in Plus Parents)	
Home Equity Loans (Primary Residence) This service covers the review or preparation of a home equity loan on your primary residence. *This service does not include services provided by any attorney representing a lending institution or title company.*	
Refinancing of Home (Primary Residence) This service covers the review or preparation, by an attorney representing you, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on your primary residence, attendance of an attorney at closing, and obtaining a permanent mortgage on a newly constructed home. *This service does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose.*	
Sale or Purchase of Home (Primary Residence) This service covers the review or preparation, by an attorney representing you, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), that are involved in the purchase or sale of your primary residence or of a vacant property to be used for building a primary residence, and attendance of an attorney at closing. *This service does not include services provided by any attorney representing a lending institution or title company, or sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.*	
Traffic and Criminal Matters (not included in Plus Parents)	
Juvenile Court Defense This service covers defense of you and your dependent child in any juvenile court matter, provided there is no conflict of interest between you and your dependent child. *When a conflict exists, or where the court requires separate counsel for the child, this service provides an attorney for the employee only, including services for Parental Responsibility.*	

Type of Legal Service	Legal Plan Benefit
Wills and Estate Planning	
Trusts (Revocable and Irrevocable Living Trusts) This service covers the preparation of revocable and irrevocable living trusts for you. *This service does not include tax planning or services associated with funding the trust after it is created.*	
Living Wills (also included in Plus Parents) This service covers the preparation of a living will for you.	
Powers of Attorney (also included in Plus Parents) This service includes the preparation of any power of attorney when the Covered Person is granting the power.	
Wills and Codicils (also included in Plus Parents) This service covers the preparation of a simple or complex will for you, creation of any testamentary trust, and preparation of codicils and will amendments. *This service does not include tax planning.*	

What the Legal Plan Does Not Cover

The Legal Plan does not cover services for the following:

- Legal representation provided by another organization such as an insurance company or a government agency or if you are entitled to legal services under any other legal plan. However, if you are eligible for legal aid or public defender services, you will still be eligible for benefits under this Legal Plan so long as you meet the eligibility requirements.
- Employment-related matters, including company or statutory benefits
- Matters involving Avaya Inc., MetLife Legal Plan or their affiliates, or Plan Attorneys
- Matters in which there is a conflict of interest between you and your spouse or dependents, in which case services are excluded for your spouse and dependents
- Matters in which there is a conflict of interest between you and you parent or parent-in-law, if you have Plus Parents coverage
- Matters in which you or your dependents are involved in a dispute with another eligible employee or that employee's dependents. MetLife Legal Plans will arrange for legal representation with independent and separate counsel for both parties.
- Costs or fines
- If you are awarded attorneys' fees as a part of a court settlement, the Legal Plan must be repaid from this award to the extent that it paid the fee for your attorney.
- Matters for which an attorney-client relationship exists prior to your becoming eligible for Legal

Plan benefits.

Filing a Legal Plan Claim

Refer to *Claims and Appeals Procedures* in this SPD for information on claims and appealing a denied claim.

For More Information

- Visit info.legalplans.com (to login enter the last of digits of your Social Security Number and your zip code) to view detailed information on Legal Plan benefits, how to use the Legal Plan, finding an attorney, obtaining a case number and more, or
- Talk to a Client Service Representative at the MetLife Legal Plan Client Service Center toll-free at (800) 821-6400 between 8 a.m. and 8 p.m., ET, Monday through Friday.

CLAIMS AND APPEALS PROCEDURES

Responding to Your Claim

If you make a claim for benefits under the plan, the insurer will notify you of the benefit determination within 90 days after the Plan receives your claim. If special circumstances require additional time before processing the claim, the Plan will advise you or your beneficiary in writing or electronically before the end of the initial 90-day period. The notice of the extension will indicate the special circumstances requiring the additional time, and the date by which the plan expects to make a determination. The extension will not exceed 90 days from the end of the initial 90-day period.

If all or part of your claim is denied, you will receive a notice that:

- States the specific reason for the denial;
- Refers to the Plan provision on which the decision was based;
- Describes any additional material or information you may need to furnish to complete the claim and the reason why this material or information is needed; and,
- Describes the plan's review procedures including the applicable deadlines and a statement of your right to bring a civil action in court if the appeal of your denied claim is also denied after it has been reviewed.

If the plan does not pay benefits that you believe it should, you/your beneficiary can file an appeal as described in this section.

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. You or your authorized representative has 60 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as "relevant" to your claim if it:
    - Was relied upon in making the benefit determination
    - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
    - Is new or additional evidence or rationale the plan wishes to rely on in making a benefit determination (the plan must send such information to the participant as soon as it becomes available to the plan)
    - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination

- Request a review that takes into account all comments, documents, records and other information submitted by you relating to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.

The insurer will notify you of the Plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review by the Plan. This 60-day period may be extended for up to an additional 60 days, if the insurer both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 60-day period expires, of the special circumstances requiring the extension of time and the date by which the Plan expects to render a determination on review.

In the event an extension is necessary due to your failure to submit necessary information, the Plan's time frame for making a benefit determination on review is stopped from the date the insurer sends you the extension notification until the date you respond to the request for additional information.

The insurer's notice of an adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.

You/your beneficiary must use and exhaust this Plan's administrative claims and appeals procedure before bringing a suit in either state or federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner will also cause you/your beneficiary to lose your right to sue regarding an adverse benefit determination. Once you have exhausted all of your administrative appeals rights, if you decide to file a court action on your claim, the court action must be filed based on county/state law requirements following the date the cause of action arose.