

THE AVAYA INC.

DENTAL EXPENSE PLAN

SUMMARY PLAN DESCRIPTION

**Effective 1/1/2007
Last Updated 3/31/2008**

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2007 to **eligible employees** under The Avaya Inc. Dental Expense Plan (Dental Plan).

The Board of Directors of Avaya Inc. (or its delegate) reserves the right to modify, suspend or terminate the Dental Plan at any time, subject to the terms of applicable collective bargaining agreements. Questions regarding your benefits should be addressed to the Plan Administrator (see "Important Contacts"). Because of the many detailed provisions of the Dental Plan, no one else is authorized to advise you as to your benefits. For this reason, Avaya Inc. is not bound by statements made by anyone or any entity other than the Plan Administrator or its authorized delegates.

Please note that participation in the Dental Plan is neither an offer of employment nor a guarantee of employment for any period of time at Avaya Inc.

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INTRODUCTION

The Avaya Inc. Dental Expense Plan (Dental Plan) is designed to promote good dental health through regular exams and preventative dentistry for you and your **eligible dependents**.

If you are an **eligible employee**, Avaya Inc. automatically covers you and your **eligible dependents** in the **Traditional option** starting on the first day of the month in which you complete six months of **net credited service**. You must enroll to cover eligible family members or to select the **Dental Maintenance Organization (DMO[®])**. If you wish, you may enroll for coverage earlier by paying the full coverage cost during the six-month waiting period. This cost is waived if you meet the eligibility requirements to be **covered** as a dependent of another Avaya Inc. employee or retiree.

The Dental Plan offers two types of coverage options:

- **Traditional option**
- **Dental Maintenance Organization (DMO)**

This summary can help you compare the options and choose which one best meets your needs. While the options cover many of the same services and supplies, you will see differences in how you obtain care and how you pay for that care.

Note: (1) **DMO[®]** is a service mark of Aetna, Inc., registered in the U.S. Patent and Trademark Office.
(2) The **Traditional option** is administered by Aetna Life Insurance Company. The **DMO** is underwritten by Aetna Life Insurance Company, Aetna Dental of California Inc. (California), Aetna Dental Inc. (Texas), Aetna Dental Inc. (New Jersey), Aetna Dental Inc. (North Carolina) and/or Aetna Health Inc. (Arizona) (collectively, "Aetna").

HIGHLIGHTS

Here is a summary of some features of the Dental Plan.

Plan Feature	Summary
Eligibility	<p>If you are an eligible employee (a regular, active, full-time or part-time, represented employee who works for a Participating Company), you are eligible for coverage. You may also enroll your eligible dependents under the same coverage option you choose for yourself.</p>
When Coverage Begins	<p>If you are a <i>full-time</i> eligible employee, you and your eligible dependents are automatically covered under the Traditional option on the first day of the month in which you attain six months of net credited service with a Participating Company provided you enroll your dependents within 31 days of eligibility.</p> <p>If you are a newly hired, regular, active, full-time or part-time, represented employee, and you were covered as an eligible dependent of another Avaya Inc. employee on the day immediately before your date of hire, you are eligible for Dental Plan coverage as an employee on your first day of active service with a Participating Company.</p> <p>If you wish, you may enroll for coverage earlier by paying the full coverage cost during the waiting period (see “Enrolling Early”). This cost is waived if you meet the eligibility requirements to be covered as a dependent of another Avaya Inc. employee or retiree.</p> <p>You must enroll:</p> <ul style="list-style-type: none"> • To begin coverage before you complete six months of net credited service, • To select the Dental Maintenance Organization (DMO), or • To add your eligible dependents.

Plan Feature	Summary
<p>Coverage Options and Coverage Amounts</p>	<p>The coverage options available are the:</p> <ul style="list-style-type: none"> • Traditional option, and • DMO. <p>The Traditional option pays 100% of reasonable and customary charges for covered “Type A” diagnostic and preventative care expenses, such as routine oral exams. Benefits for other covered services (“Type B” expenses), such as crowns, are based on regional schedules after you meet a \$50 lifetime deductible.</p> <p>The DMO option covers 100% of certain basic and specialty services such as routine oral exams and selected periodontal procedures. All other eligible services under the DMO are covered at 75%.</p> <p>Both the Traditional option and DMO cover orthodontic treatment. Under the Traditional option, there is a \$1,500 lifetime maximum per person. The DMO covers 50% of eligible charges per person with a maximum benefit of \$1,000 for non-network orthodontic procedures.</p> <p>If you go to a non-participating dentist under the DMO, your benefit will be lower. In addition, an annual deductible will apply to you and each of your covered dependents. Non-participating benefits are not available in all states.</p>
<p>Changing Your Coverage</p>	<p>You may switch between the Traditional option and DMO by calling the Claims Administrator (see “Important Contacts”) at any time, but no more than once a month.</p> <p>If you have a qualified status change during the Plan Year, you can change your dental coverage within 31 days after the date of the qualifying event.</p>
<p>Information About the Dental Plan</p>	<p>Use this document as a reference and call the Claims Administrator (see “Important Contacts”) for specific benefit coverage information. For questions about eligibility, your benefit options or to enroll, call the Avaya Health and Benefits Decision Center (see “Important Contacts”).</p>

The Avaya Inc. Dental Expense Plan

Plan Feature	Summary
Cost	<p>If you are a <i>full-time eligible employee</i> with at least six months of net credited service, the Company pays 100% of the coverage cost for you and your eligible dependents. You may begin coverage before you complete six months of net credited service by enrolling and paying the full coverage cost.</p> <p>If you are a <i>part-time eligible employee</i>, see “The Cost of Coverage.”</p>

TERMS YOU SHOULD KNOW

There are several words and phrases that have a specific meaning under the Dental Plan. This section explains those terms so you can better understand your benefits. These terms are printed in **boldface** when they appear to let you know they are defined here. For a “Glossary of Dental Terms,” see Appendix E. Some definitions may differ under the **DMO**, so if you are **covered** under the **DMO**, please call the **Claims Administrator** (see “Important Contacts”) and request the **DMO** detailed documentation.

Aetna: the company that administers the Dental Plan.

Annual enrollment: the period of time each year designated by the Company in which you can generally make changes in your benefits for reasons other than a **qualified status change**. Elections made during annual enrollment are effective on the first day of the following calendar year.

Avaya Health and Benefits Decision Center: the resource to call to enroll, make changes in your coverage or ask questions about the Dental Plan options. See “Important Contacts.”

Children: include your biological children and/or legally adopted children (including those who are in the formal legal adoption process), stepchildren living with you, and children living with you for whom you, your **lawful spouse** or your **domestic partner** is the legal guardian (excluding “wards of the state” or “foster children”). See **Class I dependents** and **domestic partnership dependents**.

Claims Administrator: the health care company authorized by Avaya Inc. to administer the Dental Plan.

Class I dependents: include your **lawful spouse** and each unmarried child through December 31st of the year in which the child reaches age 23.

To be eligible, a child must be:

- Your biological child and/or your legally adopted child, including any child in the formal legal process of adoption, regardless of residence,
- A stepchild living with you, or
- A child living with you for whom you or your **lawful spouse** is the legal guardian. This does not include “wards of the state” or “foster children.”

Class I dependents also include each unmarried child of any age who is determined to be eligible by the applicable medical Claims Administrator through meeting all of the following:

- Incapable of self-support,
- Physically or mentally handicapped, and
- Fully dependent on you for support.

To be **covered** as Class I dependents, **children** beyond age 23 year must be certified for coverage by the Claims Administrator under The Avaya Inc. Medical Expense Plan. You must complete an application form available from the medical Claims Administrator and submit it for approval to the address listed on the form.

No coverage is available for a child over age 23 who is incapacitated for a short time due to illness or accident (e.g., a broken leg).

COBRA: an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. This refers to federal legislation that governs the offer of temporary continued dental coverage to participants who otherwise would lose coverage due to certain reasons, such as a loss of employment.

Coordination of benefits (COB): a feature of the Dental Plan designed to prevent duplicate benefit payments when you or your **eligible dependents** participate in more than one group plan.

Covered: eligible under the terms of the Dental Plan. “Covered” is often used to modify other terms. A covered expense is a dental cost that satisfies all of the rules to be considered for payment under the Dental Plan. A covered person is one who is enrolled and eligible for benefits under the Dental Plan. A covered provider is one who is (or which is) eligible to provide services and receive payment under the Dental Plan.

Covered dependent: a **Class I dependent, domestic partner or domestic partnership dependent** who is **covered** as the dependent of an employee.

Dental Maintenance Organization (DMO): a Dental Plan option that provides coverage through participating personal and specialty dentists with no deductible and lower out-of-pocket expenses for most services.

Domestic Partner: an individual (same-gender or opposite-gender) is your domestic partner if you both complete and file with the **Avaya Health and Benefits Decision Center** a notarized Domestic Partner Affidavit in which you both attest that you met all of the following requirements:

- Reside in the same household,

- Are age 18 or older,
- Have mental sufficiency to enter into a valid contract,
- Are not related to each other by blood,
- Are not legally married to any other person,
- Have a close and committed personal relationship with each other; intend to continue such relationship indefinitely; and have no such relationship with anyone else, and
- Have joint responsibility for each other's welfare and financial obligations.

In addition to the aforementioned requirements, the following criteria must be satisfied if applicable:

- Have complied with any state or local registration process for domestic partners; are the same-gender, reside in a state that recognizes same-gender marriages and are legally married under the laws of that state; or resides in a state that recognizes same-sex civil unions and have legally entered into such a civil union.

Domestic partnership dependent: is the natural or adopted child of a **domestic partner**, a child whom the **domestic partner** is in the formal, legal process of adopting, or a child living with you for whom the **domestic partner** is the legal guardian. The child must otherwise meet the definition of an eligible child as a **Class I dependent**.

Eligible dependents: your eligible **Class I dependents**, **domestic partner** and **domestic partnership dependents**.

Eligible employee: a regular, active, full-time or part-time, represented employee who works for a **Participating Company**.

Individuals who are not paid from the U.S. payroll of a **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 Dental Plan.

FMLA: the Family and Medical Leave Act of 1993, as amended.

Lawful spouse: a person who is the lawful husband or lawful wife for federal income tax purposes. An **eligible employee** residing in a state that recognizes common law marriage must satisfy the specific minimum state requirements to be married under common law.

Net credited service: your current continuous service plus all service credited under the service bridging rules (including mandatory portability, if applicable) of The Avaya Inc. Pension Plan and The Avaya Inc. Pension Plan for Salaried Employees.

Participating Company: Avaya and such other companies that have elected to participate in the Dental Plan, with the prior approval of Avaya.

Post-Service Claim: a dental benefit claim other than a **pre-service claim** or **urgent care claim**.

Pre-Service Claim: a dental benefit claim that requires approval before you can receive the dental care.

Qualified Medical Child Support Order (QMCSO): a judgment, decree, or order issued by a court or a certain administrative process that requires Dental Plan coverage for a participant’s child and that has been determined to be qualified under the Internal Revenue Code of 1986, as amended. It is the policy of Avaya Inc. to comply with the requirements of a QMCSO (see “Important Contacts”).

Qualified status change: as permitted under federal regulations, qualified changes in status include the following:

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

Avaya Inc. also considers corresponding changes in **domestic partner** and/or **domestic partnership dependents** as a qualified status change.

The Internal Revenue Service (IRS) states that you can change your level of coverage during the year if you have a qualified change in status. Qualified status changes must be reported to the **Avaya Health and Benefits Decision Center** (see "Important Contacts") *within* 31 days of the event.

Reasonable and customary charge: the fee determined by the **Claims Administrator** on the basis of:

- The fees a dentist usually charges most patients for a similar service, and
- The range of fees charged by dentists with similar training and experience for the same or similar services within the geographic region.

The **Claims Administrator** may also take into account the patient's condition and any additional time or special skills needed by his or her dentist for treatment. Such determinations are conclusive and binding.

Traditional option: a Dental Plan option that pays 100% of **reasonable and customary charges** for **covered** preventative care services, and provides benefits for other **covered** expenses according to geographic schedules and subject to an annual maximum after a lifetime deductible has been met.

Urgent Care Claim: a dental benefit claim where applying the non-urgent care time frames (i) could seriously jeopardize your health or ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of your dental condition, would subject you to severe pain without the care or the treatment that is the subject of the claim.

PARTICIPATING IN THE PLAN

Who Is Eligible

If you are an **eligible employee** (a regular, active, full-time or part-time, represented employee who works for a **Participating Company**), you are eligible to participate in the Dental Plan. There is a six-month waiting period. If you wish, you may enroll for coverage earlier by paying the full coverage cost during the waiting period (see “Enrolling Early”). This cost is waived if you meet the eligibility requirements to be **covered** as a dependent of another Avaya Inc. employee or retiree.

Individuals who are not paid from the U.S. payroll of a **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 Dental Plan.

Eligible Dependents

As a participant in the Dental Plan, you also may enroll your **eligible dependents** for coverage.

If you elect to enroll your **domestic partner** and/or **domestic partnership dependents**, you and your **domestic partner** must complete an Affidavit of Domestic Partnership. This affidavit is available on the Avaya Healthy Decisions Web site (www.AvayaHealthyDecisions.com) under the “Reference Materials & Forms” section. Have the agreement notarized and return the affidavit to the **Avaya Health and Benefits Decision Center**.

The **Avaya Health and Benefits Decision Center** can tell you the tax impact of enrolling a **domestic partner** and/or **domestic partnership dependents**. Under IRS regulations, you contribute toward the cost of Dental Plan coverage on a pre-tax basis for yourself and for your family members *other than* your **domestic partner** and/or **domestic partnership dependent**. The same tax advantages do not apply when you cover your **domestic partner** and/or **domestic partnership dependent**. Under IRS regulations, you cover them with after-tax contributions and the amount of the Company’s cost to cover them is reported as taxable income to you each month. This taxable income is subject to both income tax and FICA withholding. The amount of taxable income depends on whom you elect to cover.

You may enroll another **eligible employee** or Avaya Inc. retiree who participates in The Avaya Inc. Pension Plan as your dependent, as long as the eligibility requirements are satisfied. If you enroll another **eligible employee** as your **eligible dependent**, he or

she will have to waive coverage to be your dependent, since he or she cannot be **covered** as both an **eligible employee** and an **eligible dependent**.

Enrollment

What you need to do to enroll for dental coverage depends on whether you are:

- A newly **eligible employee**,
- An employee changing your existing coverage during an **annual enrollment** period, or
- An employee changing your existing coverage level during the year due to a **qualified status change** (see “Changing Your Coverage During the Year”).

Newly Hired Employees

If you are an **eligible employee**, you may enroll in the Dental Plan immediately. However, there is a six-month waiting period before the Company contributes towards the cost of your coverage. If you wish, you may enroll for coverage earlier by paying the full coverage cost during the waiting period. This cost is waived if you meet the eligibility requirements to be **covered** as a dependent of another Avaya Inc. employee or retiree. For information, see “Enrolling Early.”

After you start working for a **Participating Company**, an enrollment letter will be sent to your home. The letter will include information about how to enroll yourself and your **eligible dependents** and the date by which you must make your elections. You can make your enrollment elections online by logging onto the Avaya Healthy Decisions Web site at www.AvayaHealthyDecisions.com or by calling the **Avaya Health and Benefits Decision Center** (see “Important Contacts”).

You may enroll your **eligible dependents** by the date specified in the online enrollment letter. If you do not make any elections by the enrollment deadline, your **eligible dependents** will *not* be covered under the Dental Plan for the current year.

If you are a full-time **eligible employee**, you are automatically **covered** under the **Traditional option** on the first day of the month in which you attain six months of **net credited service** with a **Participating Company** (see “Who Is Eligible” and “Eligible Dependents”). If you wish to cover your **eligible dependents**, you must enroll your dependents within 31 days of eligibility. Generally, you must enroll your dependents in both The Avaya Inc. Medical Expense Plan and the Dental Plan unless you waive your medical coverage. Although you do not need to enroll for this option, you must register your **eligible dependents** by calling the **Avaya Health and Benefits Decision Center** (see “Important Contacts”). You may switch to the **DMO** at any time, but not more than once a month, after your coverage begins (see “Switching Between the Options”).

Automatic coverage also applies for (1) part-time **eligible employees** who are scheduled to work 25 or more hours per week and (2) any part-time **eligible employees** hired before January 1, 1981. If you are a part-time **eligible employee** hired on or after January 1, 1981 scheduled to work less than 25 hours per week, you will need to enroll for coverage. Contact the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) to enroll your **eligible dependents**. If you enroll within 31 days of becoming eligible, your coverage will be effective as of the date you became eligible. If you do not enroll within 31 days, you will have to wait for the next **annual enrollment** period.

If you are a newly hired, regular, active, full-time or part-time, represented employee *and* you were **covered** as an **eligible dependent** of another Avaya Inc. employee on the day immediately before your date of hire, you are eligible for Dental Plan coverage as an employee on your first day of active service with a **Participating Company**.

Enrolling Early

You may begin coverage before you complete six months of **net credited service** by enrolling and paying the full coverage cost. If you enroll, you also may enroll your **eligible dependents**.

Coverage begins as follows:

- If you enroll *within 31 days* of your eligibility date, coverage is effective as of your first day of work as an **eligible employee**.
- If you enroll *after* the first 31 days, coverage begins based on when you enroll, but not later than the first of the month following the month in which you enroll.

An **Avaya Health and Benefits Decision Center** representative (see “Important Contacts”) can assist you with your particular situation.

Toward the end of your six-month waiting period, you will have an opportunity to select, confirm or change your coverage elections.

As with any benefit election, you will want to carefully consider the benefits and costs for all the options available to you and to select the coverage that makes the most sense for you.

Annual Enrollment

During **annual enrollment** each year, you will have an opportunity to select the benefits that best meets your needs for the coming year. You may change the **eligible dependents** you cover and/or change Dental Plan options. **Annual enrollment** is held once a year, usually in the fall.

You will receive enrollment information, including the coverage options available to you for the following year. If you do not elect to make any changes, your current coverage option will continue unless it is being discontinued or replaced by another option for your area and/or job classification.

Elections made during **annual enrollment** are effective on the first day of the following calendar year.

Confirmation Statements

A confirmation statement will be generated after you enroll or change benefits during **annual enrollment** or at any other time during the year. Be sure to review the information carefully and report any discrepancies immediately to the **Avaya Health and Benefits Decision Center** (see “Important Contacts”).

If You and Your Spouse or Domestic Partner Work for a Participant Company

Only one employee of Avaya Inc. may enroll any given **eligible dependent**. Either you or your **lawful spouse** (or **domestic partner**) may cover your dependent **children**. A child may not be **covered** under the Dental Plan by both parents at the same time.

Switching Between the Options

Once you are **covered** under the Dental Plan, you may switch back and forth between the **Traditional option** and the **DMO** at any time, but not more than once a month. You must call the **Claims Administrator** (see “Important Contacts”) to make the change. If you call by the 15th of the month, your change will become effective on the first day of the following month.

Changing Your Coverage During the Year

If you have a **qualified status change**, you may make a related change in your Dental Plan coverage level, that is, in the **eligible dependents** you cover and your tier of coverage (individual, two-person, family, or no coverage). The change to the Dental Plan must be consistent with the change to coverage under the Medical Plan.

You must call the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) any time you have a **qualified status change** and wish to make a corresponding change in coverage. You have 31 days after the event to make a change. If you miss the 31-day deadline, you must wait until the next **annual enrollment** period to make applicable changes to your Dental Plan coverage, unless you experience another applicable **qualified status change**..

The Cost of Coverage

Generally, you only pay for coverage under the Dental Plan if:

- You enroll for coverage before you complete six months of **net credited service** (see “Enrolling Early”), or
- You are a part-time employee scheduled to work less than 25 hours a week and you were hired on or after January 1, 1981.

If you are a part-time **eligible employee** hired on or after January 1, 1981 and you are scheduled to work *less than* 25 hours per week, you can pay for coverage on a pre-tax basis. The following chart shows the percentage of any coverage cost for you and your **eligible dependents**:

Scheduled Work Hours (for part-time employees hired after 1/1/1981)	The Company Pays This Percentage of the Cost	You Pay This Percentage of the Cost
At least 25 hours per week	100%	0%
Between 17 and 24 hours per week	50%	50%
Fewer than 17 hours per week	0%	100%

Your payroll deduction amount for benefit coverage will appear on your pay statement. Any contributions toward the cost of Dental Plan coverage are on a pre-tax basis for yourself and your **covered dependents**, other than your **domestic partner** and/or **domestic partnership dependents**.

Cost information will be provided through the Avaya Healthy Decisions Web site at www.AvayaHealthyDecisions.com.

HOW THE PLAN WORKS

Understanding Your Options Under the Plan

There are two coverage options available under the Dental Plan:

Traditional option – This option pays 100% of **reasonable and customary charges** for **covered** diagnostic and preventative services under Type A, such as routine oral exams and cleaning and scaling of teeth. Benefits for other **covered** expenses as listed under Type B, such as fillings, crowns and orthodontia, are paid according to geographic schedules and are subject to an annual maximum after a lifetime deductible has been met. See Appendix A for more information about Type A and Type B services.

DMO – This option provides coverage through participating personal and specialty dentists with no deductible and lower out-of-pocket expenses for most services. This option covers 100% of certain basic and specialty services and 75% of others as detailed in the Plan Document and summarized in “Appendix B.” The **DMO** covers 50% of eligible charges for orthodontic treatment. See “Appendix B” for benefit limits on services provided by non-participating dentists.

Changing to or From the DMO

You can change from the **Traditional option** to the **DMO** (or from the **DMO** back to the **Traditional option**) at any time, but not more than once a month. You must call the **Claims Administrator** (see “Important Contacts”) to make the change. If you call by the 15th of the month, the change will take effect on the first day of the following month.

HOW BENEFITS ARE PAID

The **Traditional option** covers 100% of **reasonable and customary charges** for Type A **covered** diagnostic and preventative services (see Appendix A for a list of the more common **covered** services). Benefits for Type B other **covered** services (see Appendix A) are paid according to geographic schedules and are subject to an annual maximum after the \$50 individual lifetime deductible is met under any Avaya Inc. dental plan.

The **DMO** covers 100% of certain basic and specialty services provided by participating personal and specialty dentists with no deductible, and covers a percentage of other **covered** services including orthodontic treatment (see **DMO** Benefits in Appendix B). Under the **DMO**, there is no annual or lifetime benefit maximum except for services by a non-participating dentist. See Appendix B for benefit limits on services provided by non-participating dentists. When you use a **DMO** participating personal or specialty dentist, depending on the treatment or service you need, you may receive a higher level of benefits than under the **Traditional option**.

Non-participating benefits are not available in all states (see Appendix B for this specific limitation).

Maximum Benefits

The following chart highlights the annual and lifetime maximum benefits for each coverage option.

Dental Plan Option	Annual Maximum Benefit	Lifetime Maximum for Orthodontia Services
Traditional option	\$1,500 per person (Type A and Type B services)	\$1,500 per person
DMO	No annual benefit maximum	Generally, no lifetime benefit maximum for a participating dentist

THE TRADITIONAL OPTION

Getting the Most From Your Coverage

To ensure you receive the maximum benefit under the **Traditional option**, it is important to keep the following in mind when arranging dental care.

Alternate Procedures

Often, there are several ways to treat a particular dental problem. For example, suppose that in repairing your tooth, the dentist has the option of using a filling or crown, and that either treatment meets the professionally accepted dental standards. In such instances, the **Traditional option** will cover only the less expensive treatment – in this case, the filling. So it is important to discuss the choices for treating your problem with your dentist before work begins. If your dentist used a crown instead, you would be responsible for the charges above what the **Traditional option** would pay for the less expensive treatment – namely, the filling.

You can avoid such unnecessary charges by discussing treatment choices with your dentist prior to beginning work or by having your dentist file a predetermination of benefits, as described below.

Predetermination of Benefits

If you need dental work costing over \$200, you should determine before treatment begins what is **covered** and how much the **Traditional option** will pay. This procedure is called “predetermination of benefits.” Here is how predetermination works:

- If you do not have a claim form, get one from the **Claims Administrator** (see “Important Contacts”) or through the “Reference Materials & Forms” section of the Avaya Healthy Decisions Web site (www.AvayaHealthyDecisions.com) and give it to your dentist.
- Your dentist outlines the treatment plan and fees on the claim form, and sends it to the **Claims Administrator**.
- The **Claims Administrator** determines the amount the **Traditional option** will pay, and informs you and your dentist.

If, after reviewing the predetermination, you and your dentist decide to change the treatment plan, the **Claims Administrator** will adjust its payment accordingly. If there is any change in the treatment plan, your dentist should submit a revised plan.

If you do not request predetermination of benefits for claims over \$200, the **Claims Administrator** will pay the claim based on the information it has about your case. If it is determined a less expensive treatment was possible, you may receive a lower benefit than you expected. Predetermination of benefits could help you avoid expensive surprises.

If you have a treatment plan approved and then your coverage ends before the start of treatment or services being rendered, subsequent benefits are generally not payable.

Traditional Option Coverage for Orthodontia

The **Traditional option** covers approved orthodontia according to the schedule shown in Appendix A. Orthodontic treatment under the **Traditional option** has a \$1,500 lifetime maximum.

Coverage is limited to one complete course of treatment in a lifetime for procedures that are required to correct:

- Faulty position of teeth (malposition), or
- Abnormal bite (malocclusion).

Services Covered Under the Traditional Option

See Appendix A for a list of Type A and Type B eligible expenses **covered** under the **Traditional option**.

Services Not Covered Under the Plan

See Appendix C for a list of expenses not **covered** under the Dental Plan.

THE DMO

The **DMO** offers dental services through participating personal and specialty dentists. The **DMO** covers almost all the same services as the **Traditional option**, with these added features when you use a **DMO** participating personal or specialty dentist:

- There is no annual benefit maximum or deductible.
- You generally pay less for Type B and Type C other **covered** services than you would under the **Traditional option**.
- You do not need to file claim forms.

Employees enrolled in the **DMO** should refer to their certificate for further details.

Electing DMO Coverage

To participate in the **DMO**, you must enroll by contacting the **Claims Administrator** (see "Important Contacts"). You will be sent a directory listing of **DMO** participating personal and specialty dentists for your area.

You and your **covered dependents** can select the same or different providers, but to receive maximum benefits, each person should go to their personal **DMO** dentist.

If you go to a non-participating dentist after you enroll in the **DMO**, your benefit generally will be lower since it will be limited to a specific dollar amount (see Appendix B). In addition, you will have to pay an annual deductible (which applies to each person **covered** under the **DMO** who uses a non-participating dentist). The deductible is \$100 in most states (although a \$0 deductible applies for Pennsylvania residents and a \$500 deductible applies for Massachusetts residents).

Non-participating benefits are not available in California, New Jersey and Texas, except in certain emergency situations. Massachusetts' benefits vary from the schedule (see Appendix B).

Planning Your Care

Your participating personal dentist will provide all basic dental services and, if you need specialty services, must arrange for a specialist. You may self-refer to a participating **DMO** orthodontist without an initial consultation with your primary care dentist or a referral to obtain services.

Changing Your Personal DMO Participating Dentist

You may change your personal **DMO** dentist at any time by contacting the **Claims Administrator** (see “Important Contacts”). If you call by the 15th of the month, the change will take effect on the first day of the following month.

Services Covered Under the DMO

See Appendix B for a list of eligible expenses **covered** under the **DMO** and the corresponding benefits.

Services Not Covered Under the Dental Plan

See Appendix C for a list of expenses not **covered** under the Dental Plan.

Emergency DMO Care

Emergency care consists of dental services provided by any licensed dentist, other than your personal dentist, more than a 50 mile distance from where you live. To qualify for payment under the **DMO** when you see a dentist other than your participating personal or specialty dentist, the services must be necessary to relieve pain or to prevent the worsening of the condition. The 50 mile distance rule does not apply to residents of Texas.

DMO Coverage for Orthodontia

When you use a **DMO** participating specialist for orthodontic treatment, the **DMO** covers 50% of eligible charges with no maximum. Orthodontic treatment from a non-participating specialist has a \$1,000 lifetime maximum.

There is an exception for Massachusetts residents, for whom the **DMO** covers 30% of eligible charges after a \$1,000 deductible with no maximum.

Coverage is limited to one complete course of treatment in a lifetime for procedures that are required to correct:

- Faulty position of teeth (malposition), or
- Abnormal bite (malocclusion).

The orthodontist is paid directly. You are responsible for the copayment.

Orthodontic Treatment Plan

Orthodontia services must be approved prior to beginning treatment. Your dentist should submit a treatment plan including:

- A description of the recommended treatment,
- An estimate of how long the care will last,
- The cost, and
- Supporting X-rays, study models and other evidence.

The treatment plan will be reviewed and your dentist will be notified as to what benefits will be paid.

DMO Benefits

The **DMO** provides coverage for services of participating personal and specialty dentists with no deductible, as follows:

Categories of Services	Percent of Eligible Charges Covered by the DMO	Amount You Pay (Your DMO Copayment)
Basic Services – Type A and Type B	100%	0%
Basic Services – Type C	75%	25%
Specialty Services – Type A	100%	0%
Specialty Services – Type B and Type C	75%	25%
Orthodontia Services	50%	50%

Your Share of Eligible Expenses

The **DMO** makes payments directly to personal and specialty dentists according to pre-negotiated fee schedules. You are responsible for any copayments required by the **DMO**. The copayment is determined by applying the copayment percentage to the personal or specialty dentist's usual fee, as approved by the **Claims Administrator** (see "Important Contacts"). (If the dentist is paid on a discounted fee-for-service basis, then that discounted fee is also used to determine your copayment.)

See Appendix B for a list of the services **covered** under the **DMO**. If a service is not listed in the Appendix, but the Dental Plan does cover a service that is equally suitable for the condition being treated, then the Dental Plan will provide an alternate benefit for that service. If you wish to have the non-covered service provided instead of the alternate service, you will be responsible for any charges in excess of the charge that would have applied for the alternate service. If there is no alternate service, you will be responsible for the full cost of treatment for any non-covered service.

See Appendix C for a list of the services not **covered** under the **DMO**.

MISCELLANEOUS COVERAGE INFORMATION

Claiming Benefits

Under the Traditional Option

Use the claim form provided by the **Claims Administrator** (see “Important Contacts”) to request benefit payments.

Under the DMO

When you use your personal or specialty **DMO** dentist, you do not have to submit claims. Your provider will bill you for any services not **covered** in full by the Dental Plan.

When you use non-participating dentists, you are responsible for submitting claim forms. The same claim procedures described for the **Traditional option** apply.

Filing Deadlines

Generally, you should submit completed claim forms to the **Claims Administrator** (see “Important Contacts”) within 90 days of the date the service is provided. If it is not reasonably possible to submit claims within this time frame, an extension of up to 15 months from the date of service will be allowed. *No benefits will be paid for claims submitted more than 15 months after the date of service.*

Coordination of Benefits

The Dental Plan has a **coordination of benefits (COB)** provision. This feature is designed to prevent duplicate benefit payments when you or your **eligible dependents** participate in more than one group plan.

When the COB Provision Applies

The **COB** provision applies when you or your **eligible dependents** have dental coverage other than that provided under the Dental Plan (i.e., from another source), such as:

- Another employer’s plan,
- A group-sponsored insurance or prepayment plan, or
- A government-sponsored plan.

Under the **COB** provision, the term “plan” means a plan that provides benefits or services for dental care and that is:

- A group insurance plan,
- A group blanket plan, not including school accident-type coverage covering students in:
 - A grammar school,
 - A high school, or
 - A college

for accident only (including athletic injuries) either on a 24-hour basis or on a “to and from school” basis,

- A group practice plan,
- A group service plan,
- A group prepayment plan,
- Any other plan that covers people as a group, or
- A governmental program or coverage required or provided by law, except Medicaid, but including any motor vehicle no-fault coverage required by law.

Each such policy, contract or other arrangement will be treated as a separate plan. No benefits will be paid for any charges reduced under a primary plan because a **covered** person does not comply with the plan provisions or for any charges otherwise excluded under the Dental Plan.

When the COB Provision Does Not Apply

The **COB** provision described in this section does not apply:

- To benefits under any personal policy (except no-fault or other state-mandated automobile insurance), and
- To two related people, both of whom are employees or retirees of a **Participating Company**, due to the following two rules:

- One person cannot receive Dental Plan benefits as both an employee or retiree of a **Participating Company**, and as an **eligible dependent** of an employee or retiree.
- One person cannot receive Dental Plan benefits as an **eligible dependent** of more than one employee or retiree of a **Participating Company**.

The Primary Plan Determines Benefits First

Under the **COB** feature, the **Claims Administrator** (see “Important Contacts”) determines that one plan is primary and determines its benefits first. Any other plan is secondary.

To claim benefits, submit your claim to the primary plan first. After that plan determines its benefits, submit a claim to the secondary plan(s) along with a copy of the explanation of benefits (EOB) statement you received from the primary plan. The secondary plan(s) will then determine if any additional benefits are payable.

- If the Dental Plan through Avaya Inc. is the primary plan, it pays its benefits without regard to the secondary plan.
- If the Dental Plan is secondary, the Dental Plan coordinates benefits with the primary plan(s). Here is how this works. The **Claims Administrator** first calculates what the Dental Plan would have paid if it were the primary plan. Second, the **Claims Administrator** reviews the EOB statement you received from the primary plan to determine what the primary plan paid. The Dental Plan then pays the difference between the allowable amount and the primary plan’s payment, not more than the amount the Dental Plan would have paid if it were the primary plan. Therefore, among the primary and secondary plans, you can receive up to 100% (but not more than 100%) of the allowable amount.

How the Claims Administrator Determines Which Plan Is Primary

The **Claims Administrator** (see “Important Contacts”) determines which plan is primary and which plan(s) is secondary under the following rules:

- If the other plan(s) does not have a **COB** feature, that plan(s) is considered primary and the Dental Plan is considered secondary.
- If both plans have a **COB** provision, the plan covering a person as an employee is primary, and the plan covering the person as a dependent is secondary.
- For dependent **children**, determination of the primary and secondary plan(s) follows these rules in this sequence:

- The “birthday” rule. The plan covering the parent whose birthday (month and day) comes first in the year is the primary plan for the **children**, and the plan covering the other parent is the secondary plan for the **children**. If both parents have the same birthday, the benefits of the plan that **covered** the parents longer are determined before those of the plan that **covered** the other parent for a shorter period of time. The Dental Plan uses this rule.
 - The “male-female” rule. For plans that do not use the birthday rule, the father’s group insurance is the primary plan for the **children** and the mother’s group insurance is the secondary plan for the **children**.
 - If one parent’s plan includes the male-female rule and one parent’s plan includes the birthday rule, the male-female rule applies to the extent permitted by law.
- If the parents of dependent **children** are divorced or legally separated, the Plan Administrator will determine if there is a court decree or a **Qualified Medical Child Support Order (QMCSO)** establishing financial responsibility for dental care. If an order meets the requirements of a **QMCSO**, Avaya Inc. will comply with the terms of that order. See “Important Contacts” for where to submit **QMCSOs**.
 - If there is such a decree or **QMCSO**, the plan covering the parent who has that responsibility will be the primary plan.
 - If there is no such decree or **QMCSO**, the plan that covers the parent with custody will be the primary plan; the other parent’s plan will be secondary.
 - If there is no such decree or **QMCSO** and the parent with custody remarries, that parent’s plan remains primary, the stepparent’s plan pays secondary, and the non-custodial parent’s plan pays third.
 - If payment responsibilities are still unresolved, the plan that has **covered** the patient for the longest time is the primary plan.

When both parents have coverage through a **Participating Company**, either parent (but not both) may choose to cover the **children**. Claims for the **children** are submitted to the **Claims Administrator** (see “Important Contacts”) of the parent covering the **children**. The other parent’s dental coverage is not secondary because it does not cover the **children**. So expenses that are not paid by the primary plan cannot be submitted to the Dental Plan by the second parent.

Right to Receive and Release Needed Information

Certain facts are needed to apply these **COB** rules. The **Claims Administrator** (see “Important Contacts”) has the right to determine what information is needed. The

Claims Administrator may get facts from or give them to any other organization or person, without telling, nor obtaining the consent of, any person or organization to do this. To obtain all benefits available, a claim should be filed under each plan covering the person for whom allowable expenses were incurred. Each person claiming benefits under this plan must give the **Claims Administrator** any facts needed to pay the claim.

Obligation to Refund and Right of Recovery and Subrogation

If all or some of the expenses under the Dental Plan were not paid in accordance with the terms of the Dental Plan (improper payments), or if all or some of the payments made exceed the benefits payable under the Dental Plan (excess payments), then those improper or excess payments must be refunded to the Dental Plan.

If the refund is due from another person or organization, you or your **covered dependents** must assist the Dental Plan in getting the refund when requested. You or your **covered dependents** are still responsible for any improper or excess payments made to you or your **covered dependents** or to providers under the Dental Plan.

Failure by you or your **covered dependents**, or any other person or organization that was improperly or excessively paid, to promptly refund the full amount may reduce the amount of any future benefits that are payable to or on behalf of you or your **covered dependents** under the Dental Plan.

The Dental Plan provides certain benefits to you and your **covered dependents** that are not provided by any third party. So, benefits provided under the Dental Plan as a result of any illness or injury that gives rise to a claim by you or your **covered dependents** against a third party (as the result of or attributable to the negligent or wrongful acts or omission of such third party) are excluded and are not **covered** under the Plan. If such benefits *have* been paid by the Dental Plan:

- The Dental Plan shall be entitled to all of your and your **covered dependents'** rights of recovery against such third party to the extent of the reasonable value of the benefits provided under the Dental Plan.
- You and your **covered dependents** agree to reimburse the Dental Plan for the reasonable value of all benefits received under the Dental Plan out of any actual recoveries you or your **covered dependents** received from any third party (other than the participant's family members).
- The Dental Plan's subrogation and reimbursement rights apply to any recoveries that may be received or actually are received by you or your **covered dependents**, including, but not limited to, the following:

- Any payments as a result of a settlement, judgment, or otherwise, made by or on behalf of a third party or his or her insurance company or made under an uninsured or underinsured motorist coverage,
- Any payments under Workers' Compensation, no-fault or other state mandated motor vehicle insurance, or
- Any payments made as a result of coverage under any automobile, school or homeowners' or other general liability insurance policy.

You and your **covered dependents** are required to fully cooperate and perform all actions necessary to secure the Dental Plan's right of recovery and subrogation, including granting a lien on any monies recovered from a third party, refraining from taking any action or negotiating any agreement with any third party that may prejudice the Dental Plan's rights, and from assigning any rights to recover dental care expenses from any negligent party or other person or entity to any other party. You or your **covered dependents** shall not incur any expenses on behalf of the Dental Plan in pursuit of the Dental Plan's rights. No court costs or attorney's fees may be deducted from the Dental Plan's recovery without the advance express written consent of the Dental Plan.

In the event you or your **covered dependents** fail or refuse to honor these terms, the Dental Plan will be entitled to recover any cost incurred in enforcing these terms and conditions, including reasonable attorneys' fees.

When Employee Coverage Ends

Your coverage under the Dental Plan ends on the last day of the month in which any of the following events occur:

- You terminate your employment with a **Participating Company** or otherwise cease to be an **eligible employee**,
- The company you work for ceases to be a **Participating Company**,
- You request cancellation of coverage and have experienced a **qualified status change** to permit the cancellation of coverage,
- You fail to make any required contributions, or
- The Dental Plan is terminated.

When your coverage ends, you may be able to continue coverage. For more information, see "Continuing Your Dental Coverage Through COBRA."

When Dependent Coverage Ends

Generally, dependent coverage under the Dental Plan ends on the:

- Date your coverage ends, or
- Last day of the month in which your **covered dependent** is no longer an **eligible dependent**.

You *must* notify the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) within 31 days when your dependent no longer qualifies as an **eligible dependent**, to make any corresponding changes to your coverage level (individual, two-person, family) and ensure that your dependent is sent timely information regarding **COBRA** continuation coverage. If you do not provide notification within 31 days of when the dependent loses eligibility, your level and rates will not be retroactively adjusted, but the dependent will be ineligible to claim benefits. If you do not provide notification within 60 days, your dependent will lose all rights to **COBRA** continuation coverage.

For information about what happens to dependent coverage following your death, see “If You Die While Covered Under the Dental Plan.”

Other Reasons Your Coverage Will End

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

- Fraud or misrepresentation, or because you (or one of your **covered dependents**) knowingly gave the Plan Administrator, **Claims Administrator** or **Avaya Health and Benefits Decision Center** false, material information. Examples include false information relating to a person’s eligibility or status as a **covered dependent**.
- You (or one of your **covered dependents**) permitted an unauthorized person to use one of your ID cards, or you (or one of your **dependents**) improperly use another person’s ID card.
- You (or one of your **covered dependents**) in any other way materially violates the terms of the Dental Plan.

Extension of Coverage Under the Traditional Option

No benefits are paid under the **Traditional option** for **covered** dental services or supplies received after coverage ends, except for:

- *Dentures or bridgework*, if the impressions were taken and the abutment teeth were prepared before coverage stopped and the device is delivered and installed within the next two calendar months,
- *A crown*, if the dentist prepared the tooth before coverage stopped and installs the crown within the next two calendar months, or
- *Root canal therapy*, if the tooth was opened before coverage stopped and the treatment is completed within the next two calendar months.

Extension of Coverage Under the DMO

Under the **DMO**, coverage is extended for charges incurred within 30 days after coverage stops for the following services only:

- *An appliance or an alteration of one*, for which an impression was made while the person was **covered** under the **DMO**,
- *A crown, bridge or cast restoration*, for which the tooth was prepared while the person was **covered** under the **DMO**, or
- *Root canal therapy*, for which the pulp chamber was opened while the person was **covered** under the **DMO**.

Continuing Your Dental Coverage Through COBRA

A federal law known as **COBRA** (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended) requires employers to offer **eligible employees** and their **covered dependents** the opportunity to continue their group health coverage at their own expense for a limited period of time if they lose coverage due to a qualifying event. Although not required under **COBRA**, the Dental Plan provides continuation coverage to your **domestic partner** and/or **domestic partner dependents**.

COBRA Coverage

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

If:	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
You	Become laid off	You and your covered dependents	18 months

If:	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
	Have a reduction in hours	You and your covered dependents	18 months
	Terminate employment (for reasons other than gross misconduct)	You and your covered dependents	18 months
	Do not return from an FMLA leave of absence	You and your covered dependents	18 months
	Become disabled within the first 60 days of COBRA continuation coverage	You and your covered dependents	Up to 29 months*
	Die	Your covered dependents	36 months
	Become divorced or legally separated	Your covered dependents	36 months
Your covered dependent	Is no longer an eligible dependent (due to age limit, divorce, or legal separation)	Your covered dependent	36 months
	Is no longer an eligible dependent because of your death	Your covered dependent	36 months
	Becomes disabled within the first 60 days of COBRA continuation coverage	You and your covered dependent	Up to 29 months*
*Includes months of COBRA coverage already used.			

Employee Loses Coverage

If you lose coverage because of a layoff, termination of employment (for reasons other than gross misconduct), or if you do not return to work after an **FMLA** leave of absence, **COBRA** continuation coverage is available to you and your **covered dependents** for up to 18 months from the date of the qualifying event. If you elect **COBRA** coverage and you acquire a new child (birth, adoption or placement of adoption) during your **COBRA** continuation period, you may enroll that new child in **COBRA** continuation coverage.

You and your **covered dependents** will be notified by the **Avaya Health and Benefits Decision Center** when an event makes continuation of coverages available and sends you election information, including the cost of the coverage. You and each of your **covered dependents** have an independent right to elect **COBRA** continuation coverage. You (or a **covered dependent**) must notify the **Avaya Health and Benefits Decision Center** (within 60 days of the date the notice is sent or coverage is lost, whichever is later) of your decision to continue coverage. If you do not elect continuation coverage during the first 60-day election period and you become eligible for trade adjustment assistance, you may elect continuation coverage during a second

60-day period that begins on the first day of the month in which you are determined to be eligible for such assistance. In this situation, your election must be made within 6 months of your first **COBRA** qualifying event.

If you or your **covered dependent** becomes disabled within the meaning of the Social Security Act during the first 60 days of **COBRA** continuation coverage, you and your **covered dependents** may extend the 18-month continuation period to 29 months. For the 29-month continuation coverage period to apply, you must notify the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) within 60 days of the determination of your disability by the Social Security Administration and within the initial 18-month continuation coverage period. This notice should be in writing and should include a copy of the Social Security Administration’s disability determination. If the **Avaya Health and Benefits Decision Center** determines that you or your **covered dependents** are not eligible for an extension of the **COBRA** continuation period, you will be provided a written explanation of why extended **COBRA** continuation coverage is not available.

If one of your **covered dependents** experiences another qualifying event (for example, your child loses eligibility due to age, or you die during the **COBRA** continuation period), the **COBRA** continuation period can be extended for that dependent. You or your **covered dependent** must notify the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) within 60 days of the second event. (Note that a second qualifying event is not triggered when you become entitled to Medicare.) This notice should be in writing and should include proof of the second qualifying event. If the **Avaya Health and Benefits Decision Center** determines that you or your **covered dependents** are not eligible for an extension of the **COBRA** continuation period, you will be provided a written explanation of why extended **COBRA** continuation coverage is not available.

Dependent Continuation Coverage

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

- You die,
- You and your spouse get divorced or legally separated, or
- He or she is no longer eligible for coverage under the Dental Plan (e.g., due to the age limit)

If your **covered dependents** lose coverage because of your death, the **Avaya Health and Benefits Decision Center** will notify them of their right to continue coverage within 44 days. Your **covered dependent** must notify the **Avaya Health and Benefits**

Decision Center of their decision to continue coverage within 60 days of the later of this notification or the date benefits terminate.

If you get divorced or legally separated, or if your child no longer meets the eligibility requirements, you or your **covered dependent** must notify the **Avaya Health and Benefits Decision Center** within 60 days of the event. This notice should be in writing and should include proof of the qualifying event (for example, a copy of the divorce decree). If the **Avaya Health and Benefits Decision Center** is not notified within 60 days of the qualifying event, your **covered dependent** will lose the right to elect **COBRA** continuation coverage. After the **Avaya Health and Benefits Decision Center** is notified, your **covered dependent** will be notified of his or her right to continue coverage within 14 days. Within 60 days of the later of this notification or the date benefits terminate, your **covered dependent** must notify the **Avaya Health and Benefits Decision Center** of his or her decision to continue coverage. If the **Avaya Health and Benefits Decision Center** determines that your **covered dependent** is not eligible for **COBRA** continuation coverage, your **covered dependent** will be notified in writing explaining why continuation coverage is not available.

When Coverage Ends

If you and/or your **covered dependent** elect **COBRA** continuation coverage, it takes effect on the date of your qualifying event and continues until the earliest of the following:

- The end of the 18-month, 29-month or 36-month continuation period
- The date Avaya Inc. no longer provides health care coverage to any of its employees
- When there is a significant underpayment of a premium or when premiums for **COBRA** continuation coverage are not paid within the required time
- The date you or your **covered dependents** become **covered** under another group health care plan other than TRICARE (provided pre-existing condition exclusions or limitations under the new group health care plan do not apply)
- With respect to the 11-month extension for disability, the date the person is no longer disabled (you must notify the **Avaya Health and Benefits Decision Center** within 30 days of a determination by the Social Security Administration that you or the **covered dependent** is no longer disabled)

If the **Avaya Health and Benefits Decision Center** determines that your coverage is terminating before the end of the 18-month, 29-month or 36-month period (e.g., when premiums are not being paid within the required time), you will be notified that your

coverage is terminating and you will be provided with the reason why and the date your coverage is terminating.

COBRA Coverage Cost

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

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

Military Leave of Absence

If you lose coverage because you enter into active military duty covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you and your **covered dependents** are eligible for **COBRA** continuation coverage. Under USERRA, however, you and your **covered dependents** are only required to pay the regular employee contribution for the first 30 days of coverage, and the duration of the continuation coverage is 24 months instead of 18 months.

Special rules apply if your active military duty is in connection with “Operation Enduring Freedom”. In that case, Avaya provides you and your **covered dependents** with continued coverage under the Dental Plan for the first 60 months of your military leave of absence. To receive this continued coverage, you must pay the regular employee contribution. This coverage satisfies the Dental Plan’s obligation to provide you with **COBRA** continuation coverage. As a result, if you lose coverage at the end of your military leave of absence because you do not return to Avaya, then you (and your **covered dependents**) will have no right to **COBRA** continuation coverage.

If You Have Questions

Questions concerning your **COBRA** continuation coverage rights should be addressed to the **Avaya Health and Benefits Decision Center** (see “Important Contacts”). For more information about your rights under ERISA, including **COBRA**, the Health Insurance Portability and Accountability Act, and other laws affecting group health

plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA Web site.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the **Avaya Health and Benefits Decision Center** (see "Important Contacts") informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the **Avaya Health and Benefits Decision Center**.

EMPLOYMENT-RELATED EVENTS AFFECTING COVERAGE

Your coverage under the Dental Plan will end if certain events occur.

If You Change Your Employment Status

Changes in your employment status, such as going from full-time to part-time, generally do not affect your participation in the Dental Plan. The cost to you may change.

If your employment status changes from represented to salaried due to a promotion, you will become eligible to participate in the dental plan offered to salaried employees. Shortly after being promoted, you will receive an information package explaining your new coverage options and the associated costs. You will then have a limited time in which to change your coverage option and enroll your **eligible dependents**.

If You Terminate Your Employment

Your coverage under the Dental Plan ends on the last day of the month in which your employment ends. Different rules apply if you retire (see "If You Retire").

When coverage ends, you may be eligible to continue coverage for yourself and your eligible **covered dependents** under **COBRA**. For more information, see "Continuing Your Dental Coverage Through COBRA."

If You Are Laid Off

If you are laid off, you will be able to continue coverage for yourself and your **eligible covered dependents** through **COBRA**. See "Continuing Your Dental Coverage Through COBRA." Your coverage under the Dental Plan will end as of the last day of the month in which your layoff occurs. Generally, if you are laid off, you can continue coverage for up to 3 months by paying the full cost of your coverage at the group rate (in lieu of the **COBRA** rate).

If You Retire

Retiree dental coverage is bundled with medical coverage. This means that you cannot elect dental coverage independently from your medical coverage except if you have waived medical coverage.

If you retire with a service or disability pension, enrollment material and information about your coverage options under The Avaya Inc. Retiree Dental Expense Plan will be sent to you at your home address. If you enroll by the date specified in your enrollment

material, coverage will become effective on the first day of the month following the month in which you retire.

If you retire with a service or disability pension, but you do not enroll by the enrollment deadline, you will *not* have retiree health coverage until you enroll.

To provide coverage for your **domestic partner** and/or **domestic partnership dependents**, they must be enrolled as your dependents in the Dental Plan when you retire. You cannot add a **domestic partner** and/or **domestic partnership dependents** after you retire.

More information may be found in the SPD for The Avaya Inc. Retiree Dental Expense Plan.

When you retire, you will also have the option to continue coverage under **COBRA**. A **COBRA** enrollment package will also be sent automatically to your home address.

If You Transfer

If you transfer to another **Participating Company**, it will not affect your participation in the Dental Plan. If you transfer to a non-Participating Company, your coverage under the Dental Plan ends on the last day of the month in which you are no longer an **eligible employee**.

If You Are Rehired

If you leave the Company and then return after a break in service, your coverage resumes based on the Dental Plan's eligibility rules and the service bridging rules of The Avaya Inc. Pension Plan or The Avaya Inc. Pension Plan for Salaried Employees (see "Who Is Eligible" and "When Coverage Begins").

If You Become Disabled

Your participation in the Dental Plan may be affected if you become disabled.

If you are absent due to a temporary disability and are collecting sickness or accident disability benefits under The Avaya Inc. Sickness and Accident Disability Benefit Plan, then you are eligible to continue coverage under the Dental Plan. You will be subject to the same costs as an active employee during that time. This coverage will continue for as long as you continue to receive benefits under The Avaya Inc. Sickness and Accident Disability Benefit Plan.

If you are collecting benefits under The Avaya Inc. Long-Term Disability Plan, you are no longer eligible for coverage under the Dental Plan. However, you may be eligible to continue coverage for yourself and your **eligible covered dependents** through **COBRA**. See “Continuing Your Dental Coverage Through COBRA.”

Your coverage under the Dental Plan will automatically resume on your first day of work upon your return.

If You Take an Approved Leave of Absence

If you take an approved leave of absence, you can continue dental coverage for yourself and your **covered dependents**. In some instances, you will have to pay the full cost. A leave of absence to enter active military service is not considered a leave under the Dental Plan. If you enter the military, except for reserve training, coverage for you and your **covered dependent** under this Dental Plan ends. You and your **covered dependents** will be notified of any continuation rights available under **COBRA**.

If you are eligible for a leave under the Family and Medical Leave Act of 1993, as amended (FMLA), Avaya Inc. will comply with this legislation.

PERSONAL EVENTS AFFECTING COVERAGE

If You Gain a New Dependent

If you gain a new dependent (through marriage, birth or adoption), you may enroll your new dependent if you do so within *31 days of the date he or she became your dependent*. Contact the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) for additional information. If you enroll your dependent *within* the specified 31-day time frame, he or she is **covered** from the date he or she became your dependent. *If you do not enroll your new dependent within 31 days, you will not be permitted to elect coverage for your dependent until the next **annual enrollment** period, unless you experience another applicable **qualified status change**.*

If a Dependent Loses Eligibility

Contact the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) within 31 days of the date your **covered dependent** is no longer eligible. Also, see “Continuing Your Dental Coverage Through COBRA”.

If Your Physically or Mentally Handicapped Child Reaches Age 23

If your physically or mentally handicapped child is incapable of self-support when he or she reaches age 23, coverage may be continued beyond that age, if the child is fully dependent on you for support at that time. You must apply for this coverage. It is not automatic. To apply for coverage, contact the medical health care company at the telephone number printed on your medical ID card prior to the child's 23rd birthday.

If You Die While Covered Under the Dental Plan

If you die while **covered** under the Plan, your **covered dependents** have the option of continuing coverage under **COBRA** for up to 36 months if they make the required contributions. For more information about continuing coverage under **COBRA**, see “Continuing Your Dental Coverage Through COBRA.”

Qualified Status Changes

Between **annual enrollment** periods, coverage type changes are allowed for certain **qualified status changes**. The type of change you can make (e.g., a change in coverage option or coverage category) depends on the event. You may only make a change in coverage that is consistent with your **qualified status change**. For example,

if you marry, you may elect to change your coverage from “individual” coverage to “family” coverage.

To be eligible to make a change, you must report your **qualified status change** to the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) *within* 31 days of the qualifying event or you will have to wait until the next **annual enrollment period** to make the change, unless you experience another applicable **qualified status change**. Contact the **Avaya Health and Benefits Decision Center** for additional information.

If You Move

If you move out of the area and have selected the **DMO**, it is a good idea to select a new **DMO** participating provider or change from the **DMO** to the **Traditional option** before your move. This will save you time when you need care, and could save you money as well.

If You Have a Change in Dependent Status

You must update your dependent information whenever you have a change in dependent status, for example, if your dependent no longer meets the eligibility requirements (see “Participating in the Plan”). To update dependent information, contact the **Avaya Health and Benefits Decision Center** (see “Important Contacts”).

Qualified Medical Child Support Orders

Payments under the Dental Plan will be made according to the terms of a **Qualified Medical Child Support Order (QMCSO)**. If the Plan Administrator determines that a medical child support order qualifies, benefit payments from the Dental Plan may be made according to the qualified order to the child or **children** named in the order, or to the custodial parent or legal guardian, where appropriate, or to health care **providers** (if benefits have been properly assigned by the child or **children** or by the custodial parent or legal guardian). See “Important Contacts” for the address to submit correspondence concerning a **QMCSO**.

AVAYA INC. FAMILIES

Avaya Inc. has many families -- employees (or retired Avaya Inc. employees) whose **lawful spouse, domestic partner, children, or domestic partnership dependents** also are employed by (or retired from) Avaya Inc. This may affect your coverage under the Dental Plan.

Enrollment Rules

You may only elect to be **covered** as a dependent under another Avaya Inc. family member's coverage if you are a part-time employee regularly scheduled to work fewer than 25 hours per week.

During your initial six-month period of employment or if you are a part-time employee regularly scheduled to work fewer than 25 hours per week, your cost of employee coverage under the Dental Plan is waived if you meet the eligibility requirements to be **covered** as a dependent of another Avaya Inc. (represented or salaried) employee or retiree.

An **eligible employee** may cover another represented Avaya Inc. employee or retiree. Therefore, if your **lawful spouse** or **domestic partner** is an active represented employee, you may enroll as his or her dependent under the Medical Plan, or he or she may enroll as your dependent, but not both. If your spouse is a retired represented employee, you may enroll as his or her dependent under The Avaya Inc. Retiree Dental Expense Plan.

A represented active or retired Avaya Inc. employee cannot enroll a salaried active or retired Avaya Inc. employee as an **eligible dependent**.

Each Avaya Inc. employee may choose any of the options available to him or her, regardless of the option the other family member selects.

Only one Avaya Inc. employee or retiree may enroll any given **eligible dependent**. Either you or your Avaya Inc. **lawful spouse** or **domestic partner**, as an employee or retiree, may cover your dependent **children**. A child may not be **covered** by both parents or by both a parent and a **domestic partner** at the same time.

IMPORTANT CONTACTS

Here is a list of resources for the Dental Plan.

Aside from this summary, your other primary sources of Dental Plan information are the member services representatives at the **Claims Administrator** and **Avaya Health and Benefits Decision Center**. Additional resources include the Avaya Healthy Decisions Web site at www.AvayaHealthyDecisions.com.

Avaya Health and Benefits Decision Center

The **Avaya Health and Benefits Decision Center** is the enrollment administrator. You can reach the **Avaya Health and Benefits Decision Center** by phone on business days, Monday through Friday, from 8 a.m. to 8 p.m., Eastern time, at 1-800-526-8056 (option 1). You can call 1-800-952-0450 to reach a telecommunications device for the deaf.

Online With Avaya Healthy Decisions

You can access the Avaya Healthy Decisions Web site at www.AvayaHealthyDecisions.com.

Through the Web site, you can:

- Obtain claim forms,
- Browse through health and insurance information, or
- Make your benefit elections (during designated enrollment periods).

Aetna

Your primary source for Dental Plan information is **Aetna**, the **Claims Administrator** of the Dental Plan.

By Phone

Call **Aetna** Dental Customer Service at 1-877-508-6927. Representatives are available on business days, Monday through Friday from 8:00 am to 6:00 pm, Eastern time. Call this customer service number to:

- Obtain claim forms,

- Check the status of a claim,
- Register a complaint,
- Review a treatment plan,
- Get information regarding a predetermination of benefits,
- Enroll in the **DMO**, change your **DMO** dentist, or request a list of **DMO** dentists, or
- Switch between the **Traditional option** and the **DMO**.

For the hearing impaired, you may call 1-800-346-3344 to reach a telecommunications device for the deaf (TDD).

By Mail

Following is the address for all correspondence (including claim forms and legal actions regarding a claim for benefits), for the **Traditional option** and **DMO**.

Aetna Dental
P.O. Box 14066
Lexington, KY 40512-4066

When corresponding with Aetna, please indicate the coverage option you have selected.

Online

You can access the self-service Navigator Web site at www.aetnanavigator.com.

Through the Web site, you can:

- View and/or print current eligibility information,
- Locate a dentist,
- Check claim status and details,
- Request ID cards (**DMO** only), or
- Contact **Aetna** Member Services.

Other Contacts

Here is a list of other resources to contact about your coverage under the Dental Plan:

Contact / Service Provided	Address / Telephone Number
Domestic Relations Matters Group: Contact for matters relating to a Qualified Medical Child Support Order (QMCSO) .	Domestic Relations Matters Group Aon Consulting of New Jersey, Inc. 270 Davidson Avenue, 7th Floor Somerset, NJ 08873
Plan Administrator: Contact for all legal actions, except for legal actions regarding a claim for benefits. Legal actions regarding a claim for benefits should be directed to Aetna (the Claims Administrator) at the above address.	Avaya Inc. Dental Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920 E-mail: hwplanadmin@avaya.com

OTHER IMPORTANT INFORMATION

This section contains administrative information about the Dental Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Claim Procedures

Participants, their beneficiaries (if applicable) or any individual duly authorized by them, have the right under ERISA and the Dental Plan to file a written claim for benefits with the **Claims Administrator** or Plan Administrator (see “Important Contacts”), as the case may be.

Claims concerning whether you or your dependent is eligible to participate in the Dental Plan are decided by the Plan Administrator (see “Important Contacts”). Claims concerning the amount and extent of benefits are decided by the **Claims Administrator**.

You (or another person) cannot challenge a claim decision in court until the following claim and appeal procedures have been complied with and exhausted.

Initial Claim Decision

When a claim is received, the **Claims Administrator** must decide whether (and/or at what level) the benefit is covered under the Dental Plan, as the case may be. When the dental benefit is provided or denied, you will receive a notice explaining how the coverage level was calculated or why benefits have been denied. How fast this notice must be given to you depends on whether the claim is an **urgent care claim**, a **pre-service claim** or a **post-service claim**. The deadline for this notice is no later than:

- For an **urgent care claim**, 72 hours after the claim is received.
- For a **pre-service claim**, 15 days after the claim is received.
- For a **post-service claim**, 30 days after the claim is received.

The notice will contain the information outlined under the section “Claims Decision Notices”.

If your claim is an **urgent care claim** or a **pre-service claim**, you can be notified of an initial denial decision orally, and a written or electronic notice will be provided no more than 3 days after the oral notice.

Failure to Follow Urgent Care or Pre-Service Claims Procedure

If you fail to follow the procedures for filing an **urgent care claim** or a **pre-service claim**, you will be notified by the **Claims Administrator** of the failure and the proper procedure that you must follow. This notice must be provided no later than 24 hours after the failure for **urgent care claims** or 5 days after the failure for **pre-service claims**. This notice may be oral unless you (or your authorized representative) request a written notice. This notice is triggered when:

- You (or your authorized representative) make a communication that is received by a person or organization unit customarily responsible for handling benefit matters; and
- The communication names a specific participant or covered dependent, a specific medical condition and a specific treatment, service or product for which approval is requested.

Notice of Incomplete Urgent Care Claim

If you (or your authorized representative) submit an **urgent care claim** that is missing necessary information, you will receive a notice from the **Claims Administrator**. This notice will tell you the specific information needed to complete the claim. The notice will be given no later than 24 hours after receiving the claim. You must be given a reasonable time to provide the information but not less than 48 hours. You will be notified of the decision concerning your **urgent care claim** as soon as possible but no later than 48 hours after the earlier of:

- When the Dental Plan receives the requested information, or
- The end of the period you were given to provide the information.

Concurrent Care Claim

At times the **Claims Administrator** may approve a course of treatment that is provided over time or for a specific number of treatments. If the **Claims Administrator** later terminates or reduces the previously-approved course of treatment, the **Claims Administrator** will notify you of this decision so you (or your authorized representative) will have sufficient time to appeal that decision before the course of treatment is deemed not covered or coverage is provided at a reduced rate.

If you need to extend a course of treatment and the original request for the treatment was an **urgent care claim**, you should contact the **Claims Administrator** at least 24 hours before the approved course of treatment will expire. If you do so, the **Claims Administrator** will provide you with a notice of its decision concerning the requested extension within 24 hours of your request. If you (or your authorized representative) request an extension later, you will receive a notice of the **Claims Administrator's** decision based on whether that request is an **urgent care claim** or **pre-service claim**.

Appeal Procedures

After the **Claims Administrator** (for benefits) or Plan Administrator (see “Important Contacts”) (for eligibility to participate) denies your claim, you (or your authorized representative) may request a full review if you disagree with the denial. You (or your authorized representative) must submit your written request for review to the **Claims Administrator** (for benefits claims) or the Plan Administrator (for eligibility to participate claims) within 180 days after you receive the denial notice. In connection with your appeal, you (or your authorized representative) may review relevant documents and submit issues and comments in writing.

The relevant documents that must be made available to you upon request include documents, records and other information that:

- Were relied on in deciding your benefit claim;
- Were submitted, considered or generated in the course of deciding your benefit claim;
- Demonstrate that the decision complied with the Dental Plan’s administrative procedures or safeguards; or
- State the Dental Plan’s policy or guidelines regarding the benefits for your diagnosis, whether or not it was relied upon.

Your appeal will be reviewed. Someone other than the person who made the first decision on your claim must make this review. Upon written request, the **Claims Administrator** must disclose the identity of any dental or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a dental judgment, the **Claims Administrator** must consult with a health care professional who has the appropriate training and experience in the field of dentistry involved.

After a decision by the **Claims Administrator** or Plan Administrator, as the case may be, is made concerning your appeal, you will be notified of the findings and decision in writing. This notice will be provided no later than:

- For an **urgent care claim**, 36 hours after receiving the appeal.
- For a **pre-service claim**, 15 days after receiving the appeal.
- For a **post-service claim**, 30 days after receiving the appeal.

If you disagree with the first appeal decision, you (or your authorized representative) may request a second appeal in writing no later than 60 days after you receive the first appeal decision. In connection with your second appeal, you (or your authorized

representative) may review relevant documents and submit issues and comments in writing. After a decision by the **Claims Administrator** is made concerning your second appeal, you will be notified of the findings and decision in writing. This notice will be provided no later than:

- For an **urgent care claim**, 36 hours after receiving the appeal.
- For a **pre-service claim**, 15 days after receiving the appeal.
- For a **post-service claim**, 30 days after receiving the appeal.

This decision is final and is not subject to further internal review.

Claims Decision Notices

The notice given to you concerning the decision on either your initial claim or your appeal will include:

- The specific reason or reasons for the decision;
- The specific Dental Plan provisions upon which the benefit decision is based;
- A statement that you are entitled to receive upon request (and free of charge) reasonable access to, and copies of, all document, records and other information relevant to your claim;
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary;
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request;
- If the decision is based on a dental limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the Dental Plan's terms to your dental circumstances), or a statement that such an explanation will be provided free of charge upon request;
- For an initial claim, a description of the appeal procedures; and
- A statement that the claimant has the right to bring a civil action under ERISA Section 502(a) following a denial upon appeal.

Your Rights Under ERISA

It is Avaya Inc.'s policy to provide meaningful benefits – above and beyond your paycheck. Part of this additional protection is provided through the Dental Plan. You are entitled to certain rights and protection under ERISA. These rights are described in this section.

Right to Receive Information About the Plan and Its Benefits

It is your right to know about your benefits. Therefore, in addition to this SPD of your benefits under the Dental Plan, you will have the opportunity to obtain a summary of the Dental Plan's annual financial report. You also may examine all Dental Plan documents governing the Dental Plan and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor. These documents are available for you to examine without charge in the Plan Administrator's office.

You can receive a copy of any of these documents, for a reasonable charge, by making a written request to the Plan Administrator (see "Important Contacts").

You also have the right to:

- Continue dental coverage for yourself, spouse, or dependents if there is a loss of coverage under the Dental Plan as a result of a qualifying event under **COBRA**. You or your dependents will have to pay for such coverage. Review this summary plan description and the documents governing the Dental Plan for the rules governing your **COBRA** continuation rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under that plan, when you become entitled to elect **COBRA** continuation coverage, when your **COBRA** continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action by Plan Fiduciaries

You also have the right to expect the fiduciaries – the people responsible for the operation of the Dental Plan – to act prudently and in the best interest of those who participate as a whole. The Dental Plan's fiduciaries must act in the best interest of all Dental Plan participants.

No one, including the Company may dismiss you or discriminate against you to prevent you from obtaining benefits or exercising any of your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of plan documents or the latest annual report (Form 5500 Series) from the Plan Administrator and do not receive them within 30 days, you may file suit in 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 for 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 – after going through the appeals procedures, you may file suit in a state or federal court.
- If you disagree with the Plan's decision or lack of response to your request concerning the qualified status of a **qualified medical child support order (QMCSO)**, you may file suit in federal court.
- If it should happen that the Dental Plan fiduciaries misuse the Dental Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court.
- If you file suit against the Dental Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees – if, for example, it finds your claim is frivolous.

If You Have Questions

For answers to questions about the Dental Plan, contact the **Claims Administrator** or Plan Administrator (see "Important Contacts"). If you have any questions about this statement of your rights or about your rights under ERISA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA), listed in your telephone directory; or contact the Division of Technical Assistance and Inquiries, U.S. Department of Labor, EBSA, 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 EBSA or visit the EBSA Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA Web site.)

Plan Funding and Payment of Benefits

With certain limited exceptions, the Company pays the costs associated with providing benefits under The Avaya Inc. Dental Expense Plan through the Avaya Inc. Health Plans Benefit Trust, which is a trust set up under Section 501(c)(9) of the Internal Revenue Code. State Street Bank and Trust Company is the trustee of this Trust.

Benefits Cannot Be Assigned

Assignment or alienation of any benefits provided by the Dental Plan will not be permitted or recognized, except as otherwise required by applicable law. This means that benefits provided under the Dental Plan are not subject to sale, assignment, anticipation, alienation, attachment, garnishment, levy, execution or any other form of transfer. Generally, state and local laws will not be recognized unless permitted by or under applicable federal law, such as ERISA.

Union Agreement

The benefits described in this SPD reflect the provisions of the Dental Plan as referred to in applicable collective bargaining agreements between the Company and the unions representing employees of the 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.

Plan May Be Amended or Terminated

The Company expects to continue the Dental Plan, but reserves the right to amend or terminate the Dental Plan at any time by the resolution of the Board of Directors or its properly authorized designee, subject to the terms of applicable collective bargaining agreements. In addition, the Company does not guarantee the continuation of any dental benefits during employment or during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administrator and Claims Administrator

The Plan Administrator and **Claims Administrator** have the full discretionary authority and power to control and manage all aspects of the Dental Plan, to determine eligibility for Dental Plan benefits, to interpret and construe the terms and provisions of the Dental Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Dental Plan as they may deem appropriate in accordance with the terms of the Dental Plan, applicable collective bargaining agreements and all applicable laws.

Plan Sponsor

The Plan Sponsor may allocate or delegate its responsibilities for the administration of the Dental Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Dental Plan, including discretionary authority to interpret and construe the terms of the Dental Plan, to direct disbursements, and to determine eligibility for Dental Plan benefits.

ADMINISTRATIVE INFORMATION

Plan Name	The official Plan Name is The Avaya Inc. Dental Expense Plan, which is a part of The Avaya Health & Welfare Benefits Plan.
Plan Sponsor	The Plan Sponsor is Avaya Inc.
Plan Administrator	The Plan Administrator is: Avaya Inc. Dental Plan Administrator 211 Mt. Airy Road Basking Ridge, NJ 07920 E-mail: hwplanadmin@avaya.com
Type of Administration	The Dental Plan is administered on behalf of Avaya Inc. by: Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156
Claims Administrator	The Claims Administrator is Aetna . Claims should be submitted to: Aetna Dental P.O. Box 14066 Lexington, KY 40512-4066
Agent for Service of Legal Process	Legal actions regarding a claim for benefits should be sent to the Claims Administrator . All other legal actions should be sent to the Plan Administrator.
Plan Records and Plan Year	The Plan and all its records are maintained on a calendar year basis, beginning on January 1st and ending on December 31st of each year.
Type of Plan	The Plan is considered a “health & welfare plan” under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Trustee	State Street Bank and Trust Company is the trustee of the Avaya Inc. Health Plans Benefit Trust. State Street Bank and Trust Company is located at 1 Enterprise Drive, North Quincy, MA 02171.
Plan Number	The Plan Number is 551.
Employer Identification Number	The Employer Identification Number is 22-3713430.

APPENDIX A: ELIGIBLE EXPENSES UNDER THE TRADITIONAL OPTION

Following is a schedule of eligible expenses under the **Traditional option**. For a complete description of terms described in this section, see Appendix E.

ADA Codes	Type A Expense	Traditional Option			
		#1	#2	#3	#4
D0100	Clinical Oral Examination				
D0120	Periodic Oral Examinations	100% of R&C			
D0140	Limited Oral Examination – problem focused	100% of R&C			
D0145	Oral Evaluation- Child under 3	100% of R&C			
D0150	Comprehensive Oral Examination, problem focused, by report	100% of R&C			
D0160	Detailed and extensive	100% of R&C			
D0170	Re-evaluation Limited	100% of R&C			
D0180	Comprehensive periodontal evaluation - new or established patient	100% of R&C			
D0200	Radiograph				
D0210	Intraoral – complete series (including Bitewings)	100% of R&C			
D0220	Intraoral – single, first film	100% of R&C			
D0230	Intraoral – each additional film	100% of R&C			
D0240	Intraoral – occlusal, single first film	100% of R&C			
D0250	Extraoral – single, first film	100% of R&C			
D0260	Extraoral – each additional film	100% of R&C			
D0270	Bitewing – single film	100% of R&C			
D0272	Bitewings – two films	100% of R&C			
D0273	Bitewings – three films	100% of R&C			
D0274	Bitewings – four films	100% of R&C			
D0277	Vertical Bitewing – 7 to 8 films	100% of R&C			
D0290	Posteroanterior and lateral skull and facial bone survey film	100% of R&C			
D0310	Sialography	100% of R&C			
D0320	TMJ Arthrogram, including injection	100% of R&C			
D0321	Temporomandibular joint, single film	100% of R&C			
D0322	Tomographic Survey	100% of R&C			
D0330	Panoramic – maxilla and mandible, single film	100% of R&C			
D0340	Cephalometric film non-ortho	100% of R&C			
D0350	Oral Facial Images	Not Covered			
D0360	Cone Beam CT	Not Covered			
D0362	Cone Beam - 2 Dimensional	Not Covered			
D0363	Cone Beam – 3 Dimensional	Not Covered			
D0400	Tests and Laboratory Examinations				
D0415	Bacteriologic cultures for determination of pathologic agents	100% of R&C			
D0416	Viral Culture	100% of R&C			
D0421	Genetic test- susceptibility to oral disease	100% of R&C			
D0425	Caries susceptibility tests	Not covered			
D0431	Adjunctive pre-diagnostic test, not to include cytology or biopsy procedures	100% of R&C			
D0460	Pulp vitality tests	100% of R&C			
D0470	Diagnostic casts	100% of R&C			
D0472	Accession of Tissue	100% of R&C			
D0473	Accession of Tissue /Micro Exam	100% of R&C			
D0474	Accession of Tissue/Surgical	100% of R&C			
D0475	Decalcification procedure	100% of R&C			
D0476	Special Stains for microorganisms	100% of R&C			
D0477	Special Stains, not for microorganisms	100% of R&C			
D0478	Immunohistochemical Stains	100% of R&C			
D0479	Tissue in-site hybridization, including interpretation	100% of R&C			
D0480	Precession of Cystologic Smears	100% of R&C			
D0481	Electron microscopy	100% of R&C			
D0482	Direct microscopy	100% of R&C			
D0483	Indirect immunofluorescence	100% of R&C			

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ADA Codes	Type A Expense	Traditional Option			
		#1	#2	#3	#4
D0484	Consultation on slides	100% of R&C			
D0485	Consultation including the preparation of slides	100% of R&C			
D0486	Accession of brush sample- report	Not covered			
D0502	Pathology procedure	100% of R&C			
D1100	Dental Prophylaxis				
D1110	Prophylaxis – adult	100% of R&C			
D1120	Prophylaxis – child	100% of R&C			
D1200	Topical Fluoride Treatments (Office Procedures)				
D1203	Topical application of Fluoride, one treatment (excluding Prophylaxis, child)	100% of R&C			
D1204	Topical application of Fluoride, one treatment (excluding prophylaxis, adult)	100% of R&C			
D1206	Topical Fluoride Varnish	100% of R&C			
D1300	Other Preventive Services				
D1310	Dietary planning for the control of dental caries	Not covered			
D1320	Tobacco counseling for control and prevention of oral disease	Not covered			
D1330	Oral hygiene instruction	Not covered			
D1351	Topical application of Sealants – per tooth	Not covered			
D1500	Space Maintainers				
D1510	Fixed-unilateral type	100% of R&C			
D1515	Fixed-bilateral type	100% of R&C			
D1520	Removable unilateral type	100% of R&C			
D1525	Removable bilateral type	100% of R&C			
D1550	Recementation of space maintainer	100% of R&C			
D1555	Removal of Fixed space maintainer	100% of R&C			

ADA Codes	Type B Expense	Traditional Option			
		#1	#2	#3	#4
D2100	Amalgam Restorations (including polishing)				
D2140	Amalgam - one surface, primary or permanent	\$22	\$28	\$30	\$33
D2150	Amalgam - two surfaces, primary or permanent	\$35	\$42	\$48	\$52
D2160	Amalgam – three surfaces, primary or permanent	\$52	\$59	\$65	\$72
D2161	Amalgam - four surfaces, primary or permanent	\$54	\$64	\$72	\$80
D2300	Resin Restorations				
D2330	Resin – one surface (anterior)	\$32	\$35	\$42	\$44
D2331	Resin – two surfaces (anterior)	\$52	\$59	\$65	\$72
D2332	Resin – three surfaces	\$66	\$79	\$88	\$97
D2335	Resin - (Involving incisal angle)	\$63	\$71	\$83	\$91
D2390	Resin based composite crown, anterior	\$59	\$69	\$77	\$86
D2391	Resin based composite – one surface posterior	\$32	\$35	\$42	\$44
D2392	Resin based composite two surfaces, posterior	\$52	\$59	\$65	\$72
D2393	Resin based composite , three surfaces, posterior	\$66	\$79	\$88	\$97
D2394	Resin based composite, four or more surfaces, posterior	\$89	\$102	\$118	\$128
D2400	Gold Foil Restorations				
D2410	Gold foil - one surface	\$66	\$76	\$86	\$95
D2420	Gold foil - two surfaces	\$166	\$192	\$218	\$244
D2430	Gold foil - three surfaces	\$249	\$288	\$327	\$364
D2500	Metallic Restorations				
D2510	Inlay, metallic – one surface	\$132	\$152	\$171	\$191
D2520	Inlay, metallic – two surfaces	\$196	\$225	\$255	\$284
D2530	Inlay, metallic - three surfaces	\$218	\$251	\$282	\$316
D2542	Metallic Onlay – 2 surfaces	\$221	\$257	\$288	\$322
D2543	Onlay, metallic – three surfaces	\$243	\$281	\$316	\$354
D2544	Onlay, metallic – four or more surfaces	\$243	\$281	\$316	\$354
D2600	Porcelain Restorations				
D2610	Inlay, Porcelain/Ceramic – one surface	\$132	\$152	\$171	\$191
D2620	Inlay, Porcelain/Ceramic – two surfaces	\$196	\$225	\$255	\$284
D2630	Inlay, Porcelain/Ceramic – three surfaces	\$218	\$251	\$282	\$316
D2642	Onlay, Porcelain/Ceramic – two surfaces	\$221	\$257	\$288	\$322
D2643	Onlay, Porcelain/Ceramic – three surfaces	\$243	\$281	\$316	\$354
D2644	Onlay, Porcelain/Ceramic – four or more surfaces	\$243	\$281	\$316	\$354
D2650	Inlay-Composite/Resin-one surface (lab processed)	\$51	\$56	\$68	\$72
D2651	Inlay-Composite/Resin-two surface (lab processed)	\$83	\$95	\$106	\$117

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ADA Codes	Type B Expense	Traditional Option			
		#1	#2	#3	#4
D2652	Inlay-Composite/Resin-three surfaces (lab processed)	\$108	\$128	\$144	\$159
D2662	Onlay-Composite/Resin two surface (lab processed)	\$108	\$125	\$140	\$155
D2663	Onlay-Composite/Resin three surface (lab processed)	\$134	\$158	\$178	\$197
D2664	Onlay-Composite/Resin four or more surfaces (lab processed)	\$134	\$158	\$178	\$197
D2700	Crowns – single Restorations Only				
D2710	Crown Resin Based Composite (Indirect)	\$146	\$170	\$191	\$214
D2712	Crown ¾ Resin Based Composite (Indirect)	\$197	\$228	\$258	\$288
D2720	Plastic with high noble	\$293	\$338	\$383	\$426
D2721	Plastic with predom. base metal	\$227	\$262	\$297	\$330
D2722	Plastic with noble metal	\$245	\$282	\$320	\$357
D2740	Porcelain/Ceramic	\$284	\$327	\$370	\$412
D2750	Porcelain with high noble	\$311	\$358	\$405	\$454
D2751	Porcelain with predom. base metal	\$239	\$275	\$311	\$347
D2752	Porcelain with noble metal	\$257	\$298	\$335	\$374
D2780	¾ Cast High Noble Metal	\$246	\$285	\$322	\$359
D2781	¾ Cast Predom Base Metal	\$246	\$285	\$322	\$359
D2782	¾ Cast Noble	\$246	\$285	\$322	\$359
D2783	¾ Cast Porcelain/Ceramic	\$246	\$285	\$322	\$359
D2790	Gold (full cast) high noble	\$252	\$290	\$328	\$365
D2791	Metal (full cast) predom. base metal	\$192	\$224	\$252	\$281
D2792	Noble metal (full cast)	\$210	\$242	\$273	\$304
D2794	Crown Titanium	\$252	\$290	\$328	\$365
D2799	Crown Provisional	\$50	\$56	\$64	\$71
D2900	Other Restorative Services				
D2910	Recement Inlays	\$22	\$24	\$27	\$30
D2915	Recement cast of prefabricated post and core	\$11	\$12	\$14	\$15
D2920	Recement Crowns	\$22	\$24	\$27	\$30
D2930	Stainless Steel "primary"	\$59	\$69	\$77	\$86
D2931	Stainless Steel "permanent"	\$59	\$69	\$77	\$86
D2932	Prefabricated Resin Crown	\$71	\$82	\$94	\$104
D2933	Prefabricated stainless steel Crown with window	\$59	\$69	\$77	\$86
D2934	Prefabricated esthetic coated stainless steel crown- primary tooth	\$59	\$69	\$77	\$86
D2940	Fillings (sedative)	\$22	\$24	\$27	\$30
D2950	Crown buildups-pin-retained	\$59	\$69	\$77	\$86
D2951	Pin retention – per tooth, in addition to Restoration	\$17	\$21	\$22	\$24
D2952	Cast post and core (in addition to Crown)	\$113	\$131	\$149	\$165
D2953	Cast post core each additional tooth	\$57	\$66	\$75	\$83
D2954	Prefabricated post and core (in addition to Crown)	\$64	\$72	\$82	\$92
D2955	Post removal (not in conjunction with Endodontic Therapy)	Not covered			
D2957	Prefabricated post/core each additional	\$32	\$36	\$41	\$46
D2960	Labial veneer (lamine)-chairside	\$146	\$170	\$191	\$214
D2961	Labial veneer (resin laminate)-laboratory	\$51	\$56	\$68	\$72
D2962	Labial veneer (porcelain laminate)-laboratory	\$196	\$225	\$255	\$284
D2970	Temporary (fractured tooth)	\$50	\$56	\$64	\$71
D2971	Additional procedures to construct new crown under existing partial denture framework	\$12	\$14	\$16	\$17
D2975	Coping	Not covered			
D2980	Crown repair, by report	\$25	\$28	\$32	\$36
D3100	Pulp Capping				
D3110	Pulp cap – direct - (excluding final Restorations)	\$18	\$22	\$24	\$27
D3120	Pulp cap - indirect - (excluding final Restorations)	\$15	\$16	\$18	\$21
D3200	Pulpotomy (excluding final Restoration)				
D3220	Therapeutic Pulpotomy	\$40	\$45	\$51	\$56
D3221	Gross pulpal debridement	\$45	\$45	\$51	\$56
D3230	Pulpal Therapy (resorbable filing) anterior, Primary	\$40	\$45	\$51	\$56
D3240	Pulpal Therapy (resorbable filing) posterior, Primary	\$40	\$45	\$51	\$56
D3300	Root Canal therapy (includes treatment plan, Clinical Procedures, and follow-up care)				
D3310	Anterior (excludes final Restoration)	\$186	\$212	\$243	\$270
D3320	Bicuspid (excludes final Restoration)	\$227	\$262	\$297	\$330
D3330	Molar (excludes final Restoration)	\$285	\$329	\$372	\$414
D3331	Treatment of root canal construction	Not Covered			

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ADA Codes	Type B Expense	Traditional Option			
		#1	#2	#3	#4
D3332	Incomplete root canal therapy	Not Covered			
D3333	Internal root repair	Not Covered			
D3346	Retreatment of previous Root Canal Therapy- anterior	\$186	\$212	\$243	\$270
D3347	Retreatment of previous Root Canal Therapy- bicuspid	\$227	\$262	\$297	\$330
D3348	Retreatment of previous Root Canal Therapy- molar	\$285	\$329	\$372	\$414
D3351	Apexification/Recalcification – initial visit	\$66	\$76	\$86	\$95
D3352	Apexification/Recalcification – Interim medication placem	\$66	\$76	\$86	\$95
D3353	Apexification/Recalcification – final visit	\$66	\$76	\$86	\$95
D3400	Periapical Services				
D3410	Apicoectomy, Periradicular Surgery - anterior	\$135	\$156	\$178	\$197
D3421	Apicoectomy, Periradicular Surgery - bicuspid (first root)	\$135	\$156	\$178	\$197
D3425	Apicoectomy/Periradicular Surgery - molar (first root)	\$135	\$156	\$178	\$197
D3426	Apicoectomy/Periradicular Surgery (each additional root)	\$101	\$118	\$134	\$149
D3430	Retrograde filling (per tooth)	\$161	\$188	\$212	\$238
D3450	Root resection (per tooth)	\$111	\$128	\$144	\$162
D3460	Endodontic implants	Not covered			
D3470	Intentional reimplantation- including splinting	Not covered			
D3900	Other Endodontic Procedures				
D3910	Gingival curettage -necessary for isolation of tooth with rubber dam	\$59	\$69	\$77	\$86
D3920	Hemisection	\$78	\$90	\$101	\$114
D3950	Canal preparation and fitting of preformed dowel or post	Not covered			
D4200	Surgical Services				
D4210	Gingivectomy or gingivoplasty - per quadrant	\$132	\$152	\$171	\$191
D4211	Gingivectomy or gingivoplasty less than a quadrant per tooth	\$33	\$41	\$43	\$49
D4230	Anatomical crown exposure- 4 or more contiguous teeth per quadrant	Not covered			
D4231	Anatomical crown exposure- one to three teeth per quadrant	Not covered			
D4240	Gingival flap procedure per quadrant	\$119	\$137	\$155	\$173
D4241	Gingival flap procedure per quadrant	\$72	\$83	\$93	\$104
D4245	Apically positioned Flap	\$119	\$137	\$155	\$173
D4249	Crown lengthening-hard and soft tissue, by report	\$72	\$82	\$94	\$105
D4260	Osseous surgery (including flap entry and closure) per quadrant	\$284	\$327	\$370	\$412
D4261	Osseous surgery 1-3TTH Quad	\$171	\$197	\$222	\$248
D4263	Bone replacement graft – first site in quadrant	\$132	\$152	\$171	\$191
D4264	Bone replacement graft – each additional site in quadrant	\$66	\$76	\$86	\$96
D4265	Biologic Materials	Not Covered			
D4266	Guided tissue regeneration – resorbable barrier, per site, per tooth	Not covered			
D4267	Guided tissue regeneration – nonresorbable barrier, per site, per tooth	Not covered			
D4268	Surgical revision of tooth	\$72	\$82	\$94	\$105
D4270	Pedicle soft tissue grafts	\$154	\$178	\$200	\$224
D4271	Free soft tissue grafts	\$174	\$201	\$228	\$255
D4273	Subepithelial connective tissue graft procedure (including donor site surgery)	\$218	\$251	\$286	\$318
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$88	\$101	\$114	\$128
D4275	Soft tissue allograft	\$218	\$251	\$286	\$318
D4276	Connective tissue & pedicle graft	\$240	\$277	\$286	\$350
D4300	Adjunctive Periodontal Services				
D4320	Provisional splinting – intracoronal	Not covered			
D4321	Provisional splinting - extracoronal	Not covered			
D4341	Periodontal scaling and root planing per quadrant	\$55	\$64	\$72	\$81
D4342	Periodontal scaling and planning 1-3TTH	\$30	\$35	\$39	\$44
D4355	Full mouth Debridement to enable comprehensive periodontal evaluation and diagnosis	Not covered			
D4381	Localized delivery of chemotherapeutic agents, per tooth, by report	Not covered			
D4900	Other Periodontic Services				
D4910	Preventive periodontal procedures (periodontal Prophylaxis)	\$39	\$44	\$48	\$53
D4920	Unscheduled dressing change (by other than treating Dentist)	\$27	\$33	\$36	\$40
D5100	Complete Dentures – Including six months' post-delivery care				
D5110	Complete upper	\$447	\$515	\$584	\$651
D5120	Complete lower	\$432	\$500	\$566	\$630
D5130	Immediate upper	\$470	\$540	\$612	\$683
D5140	Immediate lower	\$432	\$500	\$566	\$630

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ADA Codes	Type B Expense	Traditional Option			
		#1	#2	#3	#4
D5200	Partial Dentures - Including six months' post-delivery care				
D5211	Upper – resin base	\$468	\$538	\$608	\$680
D5212	Lower – resin base	\$455	\$525	\$594	\$662
D5213	Upper – metal base with resin saddles	\$432	\$500	\$566	\$630
D5214	Lower – metal base with resin saddles	\$426	\$490	\$566	\$620
D5225	Maxillary partial denture- flexible base	\$555	\$639	\$722	\$806
D5226	Mandibular partial denture- flexible base	\$555	\$639	\$722	\$806
D5281	Removable unilateral partial Denture - one place cast metal (including clasps and Pontics)	\$220	\$254	\$288	\$322
D5400	Adjustments to Dentures (by other than Dentist providing Appliances)				
D5410	Complete Denture (upper)	\$28	\$34	\$39	\$42
D5411	Complete Denture (lower)	\$28	\$34	\$39	\$42
D5421	Partial Denture (upper)	\$22	\$24	\$27	\$30
D5422	Partial Denture (lower)	\$22	\$24	\$27	\$30
D5510	Repair broken complete Denture base	\$45	\$52	\$59	\$66
D5520	Replace missing or broken teeth-complete Denture each tooth	\$35	\$41	\$46	\$51
D5600	Repairs to Dentures				
D5610	Repair broken complete or partial Denture, no teeth damaged resin saddle or base	\$45	\$52	\$59	\$66
D5620	Repair broken complete or partial Denture, and replace one broken tooth (cast framework)	\$50	\$56	\$64	\$71
D5630	Repair or replace broken clasp (each tooth)	\$27	\$33	\$35	\$40
D5640	Replace broken tooth on Denture, no other repairs, (each tooth)	\$35	\$41	\$46	\$51
D5650	Adding tooth to partial Denture to replace extracted tooth, each tooth (not involving clasp or Abutment tooth)	\$54	\$64	\$71	\$80
D5660	Add clasp to existing partial Denture	\$80	\$92	\$105	\$116
D5670	Replace all teeth – upper partial	\$119	\$137	\$155	\$173
D5671	Replace all teeth – lower partial	\$119	\$137	\$155	\$173
D5700	Denture Relining				
D5710	Rebase complete upper Denture	\$128	\$146	\$165	\$186
D5711	Rebase complete lower Denture	\$128	\$146	\$165	\$186
D5720	Rebase upper partial Denture	\$119	\$137	\$155	\$173
D5721	Rebase lower partial Denture	\$119	\$137	\$155	\$173
D5730	Relining upper complete Denture (office reline)	\$94	\$107	\$123	\$135
D5731	Relining lower complete Denture (office reline)	\$94	\$107	\$123	\$135
D5740	Relining upper partial Denture (office reline)	\$81	\$95	\$106	\$117
D5741	Relining lower partial Denture (office reline)	\$81	\$95	\$106	\$117
D5750	Relining upper complete Denture (laboratory)	\$128	\$146	\$165	\$186
D5751	Relining lower complete Denture (laboratory)	\$128	\$146	\$165	\$186
D5760	Relining upper partial Denture (laboratory)	\$119	\$137	\$155	\$173
D5761	Relining lower partial Denture (laboratory)	\$119	\$137	\$155	\$173
D5800	Other Prosthetic Services				
D5810	Denture – Interim (complete) upper	\$192	\$224	\$252	\$281
D5811	Denture – Interim (complete) lower	\$192	\$224	\$252	\$281
D5820	Denture – Interim (partial) upper	50% R&C			
D5821	Denture – Interim (partial) lower	50% R&C			
D5850	Tissue conditioning, upper Denture	\$45	\$52	\$59	\$66
D5851	Tissue conditioning, lower Denture	\$45	\$52	\$59	\$66
D5860	OverDenture complete (by report)	R&C			
D5861	OverDenture partial (by report)	R&C			
D5862	Precision attachment, by report	50% R&C			
D5867	Replace precision attachment	50% R&C			
D5875	MOD of removable prosthesis	Not covered			
D5900	Maxillofacial prosthetics				
D5911	Facial moutage (sectional)	Not covered			
D5912	Facial mouthage (complete)	Not covered			
D5913	Nasal Prosthesis	Not covered			
D5914	Auricular Prosthesis	Not covered			
D5915	Orbital Prosthesis	Not covered			
D5916	Ocular Prosthesis	Not covered			
D5919	Facial Prosthesis	Not covered			
D5922	Nasal septal Prosthesis	Not covered			

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ADA Codes	Type B Expense	Traditional Option			
		#1	#2	#3	#4
D5923	Ocular Prosthesis, interim	Not covered			
D5924	Cranial Prosthesis	Not covered			
D5925	Facial augmentation implant Prosthesis	Not covered			
D5926	Nasal Prosthesis, replacement	Not covered			
D5927	Auricular Prosthesis, replacement	Not covered			
D5928	Orbital Prosthesis, replacement	Not covered			
D5929	Facial Prosthesis, replacement	Not covered			
D5931	Surgical obturator	\$468	\$538	\$608	\$680
D5932	Post-surgical obturator	\$468	\$538	\$608	\$680
D5933	Refitting of obturator	\$468	\$538	\$608	\$680
D5934	Mandibular resection Prosthesis without guide flange	\$468	\$538	\$608	\$680
D5935	Mandibular resection Prosthesis without guide flange	\$468	\$538	\$608	\$680
D5936	Obturator Prosthesis, interim	\$468	\$538	\$608	\$680
D5937	Trismus Appliance (not for TMD treatment)	Not covered			
D5951	Feeding Aid	Not covered			
D5952	Speech aid Prosthesis, pediatric	\$468	\$538	\$608	\$680
D5953	Speech aid Prosthesis, adult	\$468	\$538	\$608	\$680
D5954	Palatal augmentation Prosthesis	\$468	\$538	\$608	\$680
D5955	Palatal lift Prosthesis, definitive	\$468	\$538	\$608	\$680
D5958	Palatal lift Prosthesis, interim	\$468	\$538	\$608	\$680
D5959	Palatal lift Prosthesis, modification	\$468	\$538	\$608	\$680
D5960	Speech aid Prosthesis, modification	Not covered			
D5982	Surgical Stent	Not covered			
D5983	Radiation carrier	Not covered			
D5984	Radiation shield	Not covered			
D5985	Radiation cone locator	Not covered			
D5986	Fluoride gel carrier	Not covered			
D5987	Commissure splint	Not covered			
D5988	Surgical splint	Not covered			
D6000	Implant Services				
D6010	Surgical placement of implant body: entosteal implant	Not covered			
D6012	Surgical placement of implant body: endosteal implant	Not covered			
D6040	Surgical placement: entosteal implant	Not covered			
D6050	Surgical placement: transosteal implant	Not covered			
D6053	Implant abut sup remov full denture	\$515	\$593	\$672	\$749
D6054	Implant abut sup remov partial denture	\$476	\$550	\$623	\$693
D6055	Dental implant supported by connecting bar	Not covered			
D6056	Prefabricated abutment	Not covered			
D6057	Custom abutment	Not covered			
D6058	Abut supp by porcelin/ceramic crown	\$311	\$358	\$405	\$454
D6059	Abut supp by processed fused metal crown	\$260	\$299	\$338	\$376
D6060	Abut supp fused cast metal high nobel	\$239	\$275	\$311	\$347
D6061	Abut supp fused metal crown nobel	\$260	\$299	\$338	\$376
D6062	Abut supp fused cast metal high nobel	\$311	\$358	\$405	\$454
D6063	Abut sup fused metal crown base nobel	\$201	\$232	\$262	\$293
D6064	Abut supp fused metal crown nobel	\$218	\$251	\$282	\$316
D6065	Implant supp by porcelin/ceramic crown	\$311	\$358	\$405	\$454
D6066	Implant supp fused metal crown high	\$311	\$358	\$405	\$454
D6067	Implant supp fused metal crown high	\$239	\$275	\$311	\$347
D6068	Abut sup by retainer porc/ceram	\$239	\$275	\$311	\$347
D6069	Abut sup ret porcelin fused high	\$239	\$275	\$311	\$347
D6070	Abut supp ret for porc fused metal base	\$239	\$275	\$311	\$347
D6071	Abut supp ret for fused metal nobel	\$239	\$275	\$311	\$347
D6072	Abut supp ret for fused cast metal high	\$239	\$275	\$311	\$347
D6073	Abut supp ret for fused metal base	\$239	\$275	\$311	\$347
D6074	Abut supp ret for fused cast metal nobel	\$239	\$275	\$311	\$347
D6075	Abut supp ret for ceramic	\$239	\$275	\$311	\$347
D6076	Abut supp for metal high	\$239	\$275	\$311	\$347
D6077	Abut supp for cast metal high sup	\$239	\$275	\$311	\$347
D6078	Implant/abut sup for fixed denture – full	R&C	\$275	\$311	\$347
D6079	Implant/abut sup for fixed denture – partial	R&C			

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ADA Codes	Type B Expense	Traditional Option			
		#1	#2	#3	#4
D6080	Implant maintenance procedures, including: removal of Prosthesis, cleansing of Prosthesis and Abutments, reinsertion of Prosthesis	Not covered			
D6090	Repair implant, by report	Not covered			
D6091	Replacement of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	Not covered			
D6092	Recement implant/abutment supported crown	Not covered			
D6093	Recement implant/abutment supported fixed partial denture	Not covered			
D6094	Abutment supported crown -titanium	\$311	\$358	\$405	\$454
D6095	Repair implant Abutment, by report	Not covered			
D6100	Implant removal, by report	Not covered			
D6190	Radiographic/surgical implant index, by report	Not covered			
D6194	Abutment supported crown for FDP (titanium)	\$239	\$275	\$311	\$347
D6199	Unspecified Implant procedure	Not covered			
D6200	Bridge Pontics				
D6210	Cast high noble metal	\$260	\$299	\$338	\$376
D6211	Cast predominately base metal	\$201	\$232	\$262	\$293
D6212	Cast noble metal	\$218	\$251	\$282	\$316
D6214	Pontic –titanium	\$260	\$299	\$338	\$376
D6240	Porcelain fused to high noble metal	\$311	\$358	\$405	\$454
D6241	Porcelain fused to predominately base metal	\$239	\$275	\$311	\$347
D6242	Porcelain fused to noble metal	\$260	\$299	\$338	\$376
D6245	Porcelain/ceramic Pontic	\$284	\$327	\$370	\$412
D6250	Resin with high noble metal	\$281	\$326	\$366	\$410
D6251	Resin with predominately base metal	\$218	\$251	\$282	\$316
D6252	Resin with noble metal	\$232	\$267	\$302	\$336
D6253	Provisional pontic	\$50	\$56	\$64	\$71
D6500	Retainers				
D6545	Cast metal retainer	\$123	\$141	\$161	\$186
D6548	Porcelain/ceramic retainer	\$146	\$170	\$191	\$214
D6600	Inlay por/ceram 2 surfaces	\$196	\$225	\$255	\$284
D6601	Inlay por/ceram 3 or more surfaces	\$218	\$251	\$282	\$316
D6602	Inlay cast high noble metal 2 surfaces	\$226	\$255	\$285	\$314
D6603	Inlay cast high noble 3 or more surfaces	\$248	\$281	\$312	\$346
D6604	Inlay cast pred base metal 2 surfaces	\$196	\$225	\$255	\$284
D6605	Inlay cast pred base metal 3 or more surfaces	\$218	\$251	\$282	\$316
D6606	Inlay cast noble metal 2 surfaces	\$216	\$245	\$275	\$304
D6607	Inlay cast noble metal 3 or more surfaces	\$238	\$271	\$302	\$336
D6608	Onlay por/ceram 2 surfaces	\$221	\$257	\$288	\$322
D6609	Onlay por/ceram 3 or more surfaces	\$243	\$281	\$316	\$354
D6610	Onlay cast high noble 2 surfaces	\$251	\$287	\$318	\$352
D6611	Onlay cast high noble 3 or more surfaces	\$273	\$311	\$346	\$384
D6612	Onlay pred base metal 2 surfaces	\$221	\$257	\$288	\$322
D6613	Onlay pred base metal 3 or more surfaces	\$243	\$281	\$316	\$354
D6614	Onlay cast noble base 2 surfaces	\$241	\$277	\$308	\$342
D6615	Onlay cast noble 3 or more surfaces	\$243	\$301	\$336	\$374
D6624	Inlay –titanium	\$226	\$255	\$285	\$314
D6634	Onlay – titanium	\$251	\$287	\$318	\$352
D6700	Crowns				
D6710	Crown- Indirect resin base composite	\$227	\$262	\$297	\$330
D6720	Resin with high noble metal	\$293	\$338	\$383	\$426
D6721	Resin with predominately base metal	\$227	\$262	\$297	\$330
D6722	Resin with noble metal	\$245	\$282	\$320	\$357
D6740	Porcelain/ceramic Abutment	\$284	\$327	\$370	\$412
D6750	Porcelain fused to high noble metal	\$311	\$358	\$405	\$454
D6751	Porcelain fused to predominately metal	\$239	\$275	\$311	\$347
D6752	Porcelain fused to noble metal	\$260	\$299	\$338	\$376
D6780	¾ Cast high noble metal	\$270	\$310	\$352	\$392
D6781	¾ Cast metal Abutment	\$270	\$310	\$352	\$392
D6782	¾ Cast noble Abutment	\$270	\$310	\$352	\$392
D6783	¾ porcelain/ceramic Abutment	\$270	\$310	\$352	\$392
D6790	Full cast high noble metal	\$275	\$317	\$359	\$400

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ADA Codes	Type B Expense	Traditional Option			
		#1	#2	#3	#4
D6791	Full cast predominately base metal	\$212	\$244	\$275	\$308
D6792	Full cast noble metal	\$228	\$264	\$299	\$334
D6793	Provisional retainer crown	\$50	\$56	\$64	\$71
D6794	Crown – titanium	\$275	\$317	\$359	\$400
D6900	Other Prosthetic Services				
D6920	Connector bar	\$77	\$88	\$100	\$111
D6930	Recement Bridge	\$35	\$41	\$46	\$51
D6940	Stress breaker	\$77	\$88	\$100	\$111
D6950	Precision or semi-precision attachment	50% of R&C			
D6970	Cast post and core in addition to fixed partial Denture retainer	\$41	\$131	\$149	\$165
D6972	Prefabricated post and core in addition to fixed partial Denture retainer	\$59	\$69	\$77	\$86
D6973	Core build up for retainer, including any pins	\$59	\$69	\$77	\$86
D6975	Coping-metal	Not covered			
D6976	Additional cast post	\$64	\$72	\$82	\$92
D6977	Additional prefabricated post	\$59	\$69	\$77	\$86
D6980	Bridge repair, by report	\$59	\$112	\$128	\$142
D6985	Pediatric partial denture	R&C			
D7100	Simple Extractions - Includes local Anesthesia and routine ostoperative care				
D7111	Coronal remnants	\$15	\$19	\$20	\$22
D7140	Extraction erupted tooth/root	\$33	\$41	\$43	\$49
D7200	Surgical Extractions - Includes local Anesthesia and routine postoperative care				
D7210	Extraction of tooth, erupted	\$54	\$61	\$69	\$77
D7220	Impaction that requires incision of overlying soft tissue and the removal of the tooth	\$81	\$93	\$105	\$116
D7230	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone and the removal of the tooth	\$115	\$130	\$150	\$164
D7240	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone and sectioning of the tooth for removal	\$150	\$168	\$193	\$216
D7241	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances	50% of R&C			
D7250	Root recovery (surgical removal of residual root)	\$48	\$54	\$62	\$69
D7260	Oral antral fistula closure (and/or antral root recovery)	\$96	\$110	\$125	\$137
D7261	Primary closure of sinus perforation	\$96	\$110	\$125	\$137
	Other Surgical Procedures Applied to Teeth				
D7270	Tooth replantation	\$132	\$152	\$171	\$191
D7272	Tooth transplantation	\$132	\$152	\$171	\$191
D7280	Surgical exposure of impacted or unerupted tooth for Orthodontic reasons- including wire attachment when indicated	\$92	\$106	\$119	\$132
D7282	Mobilization of erupted or malpos tth	\$53	\$62	\$70	\$77
D7283	Placement of device to facilitate eruption of impacted tooth	\$19	\$22	\$24	\$27
D7285	Biopsy of oral tissue (hard)	\$59	\$69	\$77	\$86
D7286	Biopsy of oral tissue (soft)	\$52	\$59	\$68	\$74
D7287	Cystolgy sample	\$26	\$30	\$34	\$37
D7288	Brush biopsy- transpithelial sample collecton	Not covered			
D7290	Surgical repositioning of teeth	50% of R&C			
D7291	Transseptal fiberotomy	Not covered			
D7292	Surgical placement temporary anchorage device requiring surgical flap	Not covered			
D7293	Surgical placement temporary anchorage device requiring surgical flap	Not covered			
D7294	Surgical placement temporary anchorage device without surgical flap	Not covered			
D7300	Alveoloplasty (surgical preparation of ridge of Dentures)				
D7310	Per quadrant, in conjunction with extractions	\$63	\$72	\$81	\$90
D7311	One to three teeth per quadrant with extractions	\$32	\$36	\$41	\$45
D7320	Per quadrant, not in conjunction without extractions	\$70	\$80	\$92	\$101
D7321	One to three teeth per quadrant without extractions	\$35	\$40	\$46	\$51
	Vestibuloplasty - including revision of soft tissue on ridges, muscle reattachment, tongue, palate, and other oral soft tissues				
D7340	Per arch, uncomplicated	\$96	\$110	\$125	\$137
D7350	Per arch, complicated - including ridge extension soft tissue grafts, and management of hypertrophied and hyperplastic tissue	50% of R&C			
D7400	Surgical excision – excision of reactive inflammatory lesion (scar tissue or localized congenital lesions)				
D7410	Radical excision lesion diameter up to 1.25 cm	Not covered (paid under medical)			
D7411	Excision benign tumor more than 1.25cm	Not covered (paid under medical)			

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ADA Codes	Type B Expense	Traditional Option			
		#1	#2	#3	#4
D7412	Excision benign tumor – complicated	Not covered (paid under medical)			
D7413	Excision malignant tumor up to 1.25 cm	Not covered (paid under medical)			
D7414	Excision malignant tumor more than 1.25 cm	Not covered (paid under medical)			
D7415	Excision malignant tumor – complicated	Not covered (paid under medical)			
	Excision of Tumors				
D7440	Excision of malignant tumor, lesion diameter up to 1.25 cm	Not covered (paid under medical)			
D7441	Excision of malignant tumor, lesion diameter over 1.25 cm	Not covered (paid under medical)			
	Removal of cysts and neoplasms				
D7450	Removal of odontogenic cyst or tumor, up to 1.25 cm in diameter	50% of R&C			
D7451	Removal of odontogenic cyst or tumor, over 1.25 cm in diameter	50% of R&C			
D7460	Removal of nonodontogenic cyst or tumor, up to 1.25 cm in diameter	Not covered (paid under medical)			
D7461	Removal of nonodontogenic cyst or tumor, over 1.25 cm in diameter	Not covered (paid under medical)			
D7465	Destruction of lesions by physical methods: electrosurgery, chemotherapy, cryotherapy	Not covered (paid under medical)			
	Excision of Bone Tissue				
D7471	Removal of lateral exostosis	50% of R&C			
D7472	Removal of torus palatinus	R&C			
D7473	Removal of torus mandibularis	R&C			
D7490	Radical resection of mandible with bone graft	Not covered (paid under medical)			
D7500	Surgical Incision				
D7510	Incision and drainage of abscess, intraoral	\$35	\$41	\$46	\$51
D7511	Incision and drainage of abscess, intraoral- complicated	\$39	\$46	\$51	\$57
D7520	Incision and drainage of abscess, extraoral	50% of R&C			
D7521	Incision and drainage of abscess, extraoral -complicated	50% of R&C			
D7530	Removal of foreign body, skin or subcutaneous areolar tissue	Not covered (paid under medical)			
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system	Not covered (paid under medical)			
D7550	Sequestrectomy for osteomyelitis	Not covered (paid under medical)			
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	50% of R&C			
D7600	Treatment of Fractures – simple				
D7610	Maxilla, open reduction, teeth immobilized (if present)	Not covered			
D7620	Maxilla, closed reduction, teeth immobilized (if present)	Not covered			
D7630	Mandible, open reduction, teeth immobilized (if present)	Not covered			
D7640	Mandible, closed reduction, teeth immobilized (if present)	Not covered			
D7650	Malar and/or zygomatic arch, open reduction	Not covered			
D7660	Malar and/or zygomatic arch, closed reduction	Not covered			
D7670	Alveolus - stabilization of teeth, open reduction splinting	Not covered			
D7680	Facial bones, complicated reduction with fixation and multiple surgical approaches	Not covered			
D7700	Treatment of Fractures - compound				
D7710	Maxilla, open reduction	Not covered			
D7720	Maxilla, closed reduction	Not covered			
D7730	Mandible, open reduction	Not covered			
D7740	Mandible, closed reduction	Not covered			
D7750	Malar and/or zygomatic arch, open reduction	Not covered			
D7760	Malar and/or zygomatic arch, closed reduction	Not covered			
D7770	Alveolus - stabilization of teeth, open reduction splinting	Not covered			
D7780	Facial bones, complicated reduction with fixation and multiple surgical approaches	Not covered			
D7800	Surgical Management of Temporomandibular Joint Pathology				
D7810	Open reduction of dislocation	Not covered			
D7820	Closed reduction of dislocation	Not covered			
D7830	Manipulation under Anesthesia	Not covered			
D7840	Condylectomy	Not covered			
D7850	Surgical discectomy	Not covered			
D7852	Disc repair	Not covered			
D7854	Synovectomy	Not covered			
D7856	Myotomy	Not covered			
D7858	Joint reconstruction	Not covered			
D7860	Arthrotomy	Not covered			
D7865	Arthroplasty	Not covered			
D7870	Arthrocentesis	Not covered			

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ADA Codes	Type B Expense	Traditional Option			
		#1	#2	#3	#4
D7872	Arthroscopy-diagnosis, with or without biopsy	Not covered			
D7873	Arthroscopy-surgical: lavage and lysis of adhesions	Not covered			
D7874	Arthroscopy-surgical: disc repositioning and stabilization	Not covered			
D7875	Arthroscopy-surgical: synovectomy	Not covered			
D7876	Arthroscopy-surgical: discectomy	Not covered			
D7877	Arthroscopy-surgical: debridement	Not covered			
D7880	Occlusal orthotic device, by report	Not covered			
	Adjunctive General Services				
D7899	Treatment of temporomandibular joint dysfunction	See schedule for particular service, if applicable			
D7900	Other Oral Surgery				
D7910	Repair of Traumatic Wounds-simple suture of recent small wounds up to 5 cm	Not covered			
	Complicated suturing (reconstruction requiring delicate handling of tissues, wide undermining for meticulous closure)				
D7911	Diameter up to 5 cm	Not covered			
D7912	Diameter over 5 cm	Not covered			
D7920	Skin grafts (identify defect covered, location, and type of graft)	Not covered			
	Other Repair Procedures				
D7940	Osteoplasty (that is, for prognathism and micrognathism)	Not covered			
D7941	Osteotomy-ramus, closed	Not covered			
D7942	Osteotomy-ramus, open	Not covered			
D7943	Osteotomy-ramus, open with bone graft	Not covered			
D7944	Osteotomy-segmented or subapical-per sextant or quadrant	Not covered			
D7945	Osteotomy-body of mandible	Not covered			
D7946	LeFort 1 (maxilla – total)	Not covered			
D7947	LeFort 1 (maxilla – segmented)	Not covered			
D7948	LeFort 11 or 111 (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	Not covered			
D7949	LeFort 11 or 111 – with bone graft	Not covered			
D7950	Osseous, Osteoperiosteal, periosteal or cartilage graft of the mandible – autogenous or nonautogenous, by report	50% R&C			
D7951	Sinus augmentation with bone or bone substitutes	R&C			
D7953	Bone replacement graft for ridge preservation- per site	\$66	\$76	\$86	\$96
D7955	Repair of maxillofacial soft and hard tissue defects	50% R&C			
D7960	Frenulectomy - separate procedure (frenectomy or frenotomy)	\$94	\$107	\$123	\$135
D7963	Frenuloplasty	\$99	\$113	\$130	\$142
D7970	Excision of hyperplastic tissue, per arch	\$104	\$119	\$135	\$152
D7971	Excision of pericoronar gingival	\$27	\$33	\$35	\$40
D7972	Surgical reduction of fibrous tuberosity	\$52	\$60	\$68	\$76
D7980	Sialolithotomy (parotid)	Not covered			
D7981	Excision of salivary gland	Not covered			
D7982	Sialodochoplasty	Not covered			
D7983	Closure of salivary fistula	Not covered			
D7990	Emergency tracheotomy	Not covered			
D7991	Coronoidectomy	Not covered			
D7995	Synthetic graft – mandible or facial bone, by report	Not covered			
D7996	Implant – mandible for augmentation purposes	Not covered			
D7998	Intraoral placement of fixation device not in conjunction with a fracture	Not covered			
	Orthodontics - Preventive treatment procedures – only one such Appliance per individual is considered a Dental Service				
D8010	Limited Orthodontic treatment of the primary dentition	Not covered			
D8020	Limited Orthodontic treatment of the transitional dentition	Not covered			
D8030	Limited Orthodontic treatment of the adolescent dentition	Not covered			
D8040	Limited Orthodontic treatment of the adult dentition	Not covered			
D8050	Interceptive Orthodontic treatment of the primary dentition	\$164	\$189	\$214	\$238
D8060	Interceptive Orthodontic treatment of the transitional dentition	\$164	\$189	\$214	\$238
D8070	Comprehensive Orthodontic treatment of the transitional dentition	\$502	\$578	\$653	\$731
D8080	Comprehensive Orthodontic treatment of the adolescent dentition	\$502	\$578	\$653	\$731
D8090	Comprehensive Orthodontic treatment of the adult dentition	\$502	\$578	\$653	\$731
D8210	Appliance for minor treatment to control harmful habits (removable)	\$164	\$189	\$214	\$238
D8220	Appliance for minor treatment to control harmful habits (fixed or cemented)	\$164	\$189	\$214	\$238
D8660	Pre-Orthodontic treatment visit	\$100	\$114	\$129	\$143
D8670	Periodic Orthodontic treatment visit	\$64	\$72	\$82	\$92

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ADA Codes	Type B Expense	Traditional Option			
		#1	#2	#3	#4
D8680	Orthodontic retention (removal of Appliances, construction and placement of retainers)	\$110	\$126	\$142	\$160
D8690	Orthodontic treatment, alternative billing to a contract fee	\$39	\$44	\$51	\$53
D8691	Repair ortho Appliance	\$82	\$95	\$107	\$119
D8692	Replace lost or broken retainer	\$82	\$95	\$107	\$119
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	\$82	\$95	\$107	\$119
D8888	Ortho Installment	\$64	\$72	\$82	\$92
	Unclassified Treatment				
D9110	Palliative (emergency) treatment of dental pain, minor procedures	\$22	\$24	\$27	\$30
D9120	Fixed partial denture sectioning	50% R&C			
D9200	Anesthesia				
D9210	Local (not in conjunction with operative or surgical procedures) should be combined	Not covered			
D9211	Regional block Anesthesia	Not covered			
D9212	Trigeminal division block	Not covered			
D9215	Local	Not covered			
D9220	General – first 30 minutes	\$59	\$66	\$76	\$84
D9221	General – each additional 15 minutes	\$16	\$18	\$21	\$23
D9230	Analgesia	Not covered			
D9241	Intravenous sedation – first 30 minutes	\$59	\$66	\$76	\$84
D9242	Intravenous sedation – each additional 15 minutes	\$16	\$18	\$21	\$23
D9300	Professional Consultation - diagnostic service provided by physician or Dentist other than practitioner providing treatment				
D9310	Consultation, per session	\$33	\$36	\$41	\$45
D9400	Professional Visits				
D9410	House calls	\$52	\$59	\$69	\$76
D9420	Hospital calls	\$27	\$33	\$35	\$40
D9430	Office visit, during regularly scheduled office hours (no operative services performed)	Not covered			
D9440	Office visit, after regularly scheduled office hours (no operative services performed)	Not covered			
D9600	Drugs				
D9610	Therapeutic drug injection	Not covered			
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	Not covered			
D9630	Other drugs and/or medicaments	Not covered			
D9900	Miscellaneous Services				
D9910	Application of desensitizing medicaments (Fluoride past, silver nitrate and so forth)	\$16	\$18	\$21	\$23
D9920	Behavior management, by report	Not covered			
D9930	Complications (postsurgical-unusual circumstances)	\$12	\$14	\$15	\$16
D9940	Special periodontal Appliances (including occlusal guards by report)	\$164	\$189	\$214	\$238
D9941	Fabrication of athletic mouthguards	Not covered			
D9942	Repair/Relining of an occlusal guard	\$23	\$26	\$30	\$33
D9950	Occlusal analysis (mounted case)	Not covered			
D9951	Occlusal adjustment (limited)	\$39	\$44	\$50	\$54
D9952	Occlusal adjustment (complete)	\$123	\$141	\$160	\$179
D9970	Enamel microabrasion	Not covered			

NOTE: The Maximum Allowance for any eligible dental procedure not listed above or for which “individual consideration” is shown will be determined by the Claims Administrator. Such maximum allowances will be comparable to those of other listed procedures.

APPENDIX B: ELIGIBLE EXPENSES UNDER THE DMO

Under the **DMO**, benefits are paid for dental services **covered** by the **DMO**. When you receive care from your personal or specialty **DMO** participating dentist, benefits are paid directly to the provider.

When you receive care from a non-participating dentist, benefits are paid directly to you, up to the maximum shown in the Schedule of Allowances with the following exceptions.

Benefits for employees living in Massachusetts who use a non-participating dental provider or non-participating specialist dentist are paid at 20% (for Type A and Type B services) and 45% (for Type C services) less than the amount that would have been payable by using a **DMO** participating dentist (after satisfaction of a \$500 deductible per person; \$1,000 for orthodontics) and are not based on a schedule. The deductible does not apply to out-of-area emergency care. The copayment percentage for orthodontic services is 70%.

Benefits for employees living in Oklahoma who use a non-participating dental provider or non-participating specialist dentist are paid at 30% (for Type A and Type B services) and 55% (for Type C services) less than the amount that would have been payable by using a **DMO** participating dentist (after satisfaction of a \$500 deductible per person) and are not based on a schedule. The deductible does not apply to out-of-area emergency care. The copayment percentage for orthodontic services is 80%.

In California, coverage does not include non-participating dental providers except for emergency palliative treatment from a dentist more than 50 miles from your home. A \$100 benefit for emergency dental procedures is allowed.

In New Jersey, coverage does not include non-participating dental providers except for emergency palliative treatment from a dentist more than 50 miles from your home. Benefits for such emergency services are paid at 100% up to the usual and prevailing fee. A \$100 benefit for emergency dental procedures is allowed.

In Texas, coverage does not include non-participating dental providers except for emergency palliative treatment from a dentist. Benefits for such emergency services are payable up to 100%, of the **reasonable and customary charge**.

Benefits are also paid directly to you for services, such as emergency care, when such services are performed by someone other than your personal or specialty **DMO** dentist, even if the provider participates in the **DMO**.

A copayment is required for certain basic and specialty services. The copayment is a percentage of the **DMO** personal or specialty dentist's usual fee for that service, as set forth in the provider's usual fee schedule. The usual fee, which is reviewed by the **Claims Administrator** (see "Important Contacts") for reasonableness, is used only for the purposes of calculating a copayment.

Participating personal or specialty **DMO** dentists are compensated based on separate, negotiated agreements, which may be less than or unrelated to the dentist's usual fee. These agreements also may vary among participating **DMO** providers.

The percentage of the **DMO** personal or specialty dentist's eligible charges paid directly to the provider is shown in the Schedule of Allowances.

A copayment is required when the benefit provided under the **DMO** is less than 100%.

Following is a schedule of eligible expenses under the **DMO**. For a complete description of terms described in this section, see Appendix E.

	Non- Participating Dentists Limit	DMO Participating Personal and Specialty Dentists Benefit* (percent of dentist's eligible charge)
<u>Basic Services – Type A</u>		
• Visits and Exams:		
⇒ Office visit for oral examination (limited to four visits a year)	\$12	100%
⇒ Emergency palliative treatment	12	100%
⇒ Prophylaxis (cleaning) (limited to six treatments a year)		
o Adult	26	100%
o Child	14	100%
⇒ Topical application of fluoride (limited to one course of treatment a year and to children under age 18)	16	100%
⇒ Oral hygiene instruction	12	100%
⇒ Sealants (limited to once each tooth every three years, permanent molars only)	10	100%
⇒ Pulp vitality test	8	100%
⇒ Diagnostic casts	20	100%
• X-rays and Pathology:		
⇒ Bitewing X-rays (limited to two sets per year)	8	100%
⇒ Entire series; including bitewings; panoramic film (limited to one set every three years)	14	100%
⇒ Vertical bitewing X-ray (limited to one set every three years)	12	100%
⇒ Periapical X-rays	6	100%
⇒ Intra-oral, occlusal view, maxillary or mandibular	8	100%
⇒ Extra-oral upper or lower jaw	12	100%
⇒ Biopsy and histopathologic examination of oral tissue	27	100%
<u>Basic Services – Type B</u>		
• Endodontics:		
⇒ Pulp cap	3	100%
⇒ Pulpotomy	27	100%
⇒ Surgical exposure for rubber dam isolation	26	100%
⇒ Root canal therapy (including necessary X-rays and cultures but excluding complex molar cases approved as specialty services):		
o Anterior	80	100%
o Bicuspid	96	100%
• Restoration and Repairs:		
⇒ Amalgam restoration:		
o One surface	12	100%
o Two surfaces	16	100%
o Three or more surfaces	24	100%

	Non- Participating Dentists Limit	DMO Participating Personal and Specialty Dentists Benefit* (percent of dentist's eligible charge)
<u>Basic Services – Type B (continued)</u>		
⇒ Resin restoration (other than for molars):		
○ One surface	\$12	100%
○ Two surfaces	16	100%
○ Three or more surfaces or incisal angle	26	100%
⇒ Retention pins	14	100%
⇒ Sedative fillings	12	100%
⇒ Stainless steel crowns	26	100%
⇒ Prefabricated resin crowns (excluding temporary crowns)	60	100%
⇒ Recementing inlays, crowns, bridges, space maintainers	16	100%
⇒ Tissue conditioning for dentures	26	100%
• Periodontics:		
⇒ Emergency treatment (abscess, acute periodontitis, etc.)	26	100%
⇒ Subgingival curettage (limited to four separate quadrants a year)	40	100%
⇒ Scaling and root planing (limited to four separate quadrants a year)	40	100%
⇒ Periodontal maintenance procedures following surgical therapy (limited to two a year)	40	100%
• Oral Surgery:		
(includes local anesthetics and routine post-operative care)		
⇒ Extractions, uncomplicated	27	100%
⇒ Surgical removal of erupted tooth	32	100%
⇒ Surgical removal of impacted tooth (soft tissue)	40	100%
⇒ Excision of hyperplastic tissue	32	100%
⇒ Excision of pericoronal gingival	40	100%
⇒ Incision and drainage of abscess	20	100%
⇒ Crown exposure to aid eruption	26	100%
⇒ Removal of foreign body from soft tissue	20	100%
⇒ Suture of soft tissue injury	16	100%
<u>Basic Services – Type C</u>		
• Restorations:		
⇒ Inlays		
○ One surface	60	75%
○ Two or more surfaces	80	75%
⇒ Onlays		
○ Two surfaces	80	75%
○ Three or more surfaces	80	75%
⇒ Crowns (including build-ups when necessary)	120	75%
⇒ Posts and core	27	75%
⇒ Pontics	20	75%

	Non- Participating Dentists Limit	DMO Participating Personal and Specialty Dentists Benefit* (percent of dentist's eligible charge)
<u>Basic Services – Type C (continued)</u>		
• Dentures and Partial:		
(includes relines, rebases and adjustments within six months after installation)		
⇒ Complete (upper or lower)	\$120	75%
⇒ Partial	120	75%
⇒ Stress breakers (per unit)	40	75%
⇒ Interim partial dentures (stayplates); anterior only	40	75%
⇒ Crown and bridge repairs	27	75%
⇒ Adding teeth to an existing partial denture	40	75%
⇒ Full and partial denture repairs	27	75%
⇒ Relining/rebasing dentures (includes adjustments within six months after installation)	40	75%
⇒ Occlusal guard (for bruxism only)	40	75%
• Space Maintainers:		
(includes all adjustments within six months after installation)		
⇒ Fixed, band type	40	75%
⇒ Removable acrylic with round wire clasp	32	75%
⇒ Removable appliance to correct habits	32	75%
⇒ Fixed or cemented appliance to correct habits	40	75%
<u>Specialty Services – Type B</u>		
• Endodontics:		
(includes local anesthetics when necessary)		
⇒ Apexification/recalcification – per visit	32	100%
⇒ Apicoectomy (per tooth) – first root	60	100%
⇒ Apicoectomy (per tooth) – each additional root	40	100%
⇒ Retrograde filling	14	100%
⇒ Root amputation	27	100%
⇒ Hemisection	27	100%
• Oral Surgery:		
(includes local anesthetics when necessary and post-operative care)		
⇒ Removal of residual root	27	100%
⇒ Removal of odontogenic cyst	40	100%
⇒ Closure of oral fistula	48	100%
⇒ Removal of foreign body from bone	20	100%
⇒ Sequestrectomy	20	100%
⇒ Frenectomy	40	100%
⇒ Transplantation of tooth or tooth bud	48	100%
⇒ Alveolectomy (in conjunction with extractions) – per quadrant	27	100%
⇒ Alveolectomy (not in conjunction with extractions) – per quadrant	40	100%
⇒ Removal of exostosis	60	100%
⇒ Sialolithotomy; removal of salivary calculus	36	100%

	Non- Participating Dentists Limit	DMO Participating Personal and Specialty Dentists Benefit* (percent of dentist's eligible charge)
⇒ Closure of salivary fistula	36	100%
<u>Specialty Services – Type B (continued)</u>		
• Periodontics:		
⇒ Gingivectomy or gingivoplasty – per quadrant	\$ 40	100%
⇒ Gingivectomy or gingivoplasty – per tooth	20	100%
⇒ Gingival flap procedures – per quadrant	60	100%
⇒ Free soft tissue graft	60	100%
⇒ Occlusal adjustment (other than with an appliance or by restoration):		
o Limited	20	100%
o Entire mouth	40	100%
<u>Specialty Services – Type C</u>		
• Endodontics:		
(includes local anesthetics when necessary)		
⇒ Complex molar root canal therapy	120	75%
• Intravenous Sedation and General Anesthesia:		
⇒ Per 15-minute segment	20	75%
• Oral Surgery:		
(includes local anesthetics when necessary and post- operative care)		
⇒ Surgical removal of impacted teeth:		
o Partially bony	53	75%
o Completely bony	60	75%
o Completely bony with unusual surgical complications	64	75%
• Periodontics:		
⇒ Osseous surgery (including flap entry and closure) – per quadrant	80	75%
• Orthodontics**:		
⇒ Comprehensive orthodontic treatment		
⇒ Post treatment stabilization		
⇒ Interceptive orthodontic treatment		
⇒ Limited orthodontic treatment		

* Exceptions by state.

** Lifetime maximum of \$1,000 per **covered** person.

APPENDIX C: SERVICES AND/OR CHARGES NOT COVERED UNDER THE PLAN

Certain services, supplies or charges are excluded under the Dental Plan. No benefits will be paid for excluded expenses under any circumstances.

Traditional Option Exclusions

The following services are not **covered** under the **Traditional option**:

- Work done for appearance (cosmetic purposes)
- Fees in excess of **reasonable and customary charges**
- Replacement of lost or stolen appliances
- Work furnished or payable by the armed forces of any government or by any civil unit of any government
- Treatment resulting from declared or undeclared war, insurrection, participation in a riot, or service in the armed forces of any government
- Appliances, restorations or procedures to alter vertical dimension or restore occlusion, or for the purpose of splinting or correcting attrition or abrasion
- Services payable under Workers' Compensation or similar laws
- Services covered by any other Company-provided health plan
- Work done while not **covered** under the Dental Plan, except for certain services as explained in this SPD under "Extension of Coverage"
- Extra sets of dentures or other appliances
- Work that is otherwise free of charge
- Services or supplies not necessary for proper dental care, as determined by the **Claims Administrator** (see "Important Contacts")
- Charges for missed/broken appointments
- Charges for completing or filing claim forms
- Educational training programs, dietary instructions, or plaque control programs

- Sealants
- Implantology
- Treatment resulting from or caused by the negligent or wrongful act of a third party
- Periodontal splinting
- Anesthesia, except general anesthesia when medically necessary in connection with oral surgery
- Drugs or their administration
- Experimental and investigative procedures, as determined by the **Claims Administrator**

DMO Exclusions

The following services are not **covered** under the **DMO**:

- Charges for a service or supply to the extent that it is:
 - Not reasonably necessary or customarily performed
 - More than the usual charge made when there is no insurance
 - Above the prevailing charge in the area for dental care of a comparable nature, as determined by the **Claims Administrator**
 - **Covered** under any other program paid for in full or in part, directly or indirectly, by a plan sponsored by Avaya Inc. or any **Participating Company**, including insured and uninsured programs
 - Above any limits shown in the applicable list of dental services
 - Not listed in the dental care schedule, unless otherwise specified
 - Provided by someone other than a dentist, except a licensed dental hygienist under the direction of a dentist
- Charges for:
 - Replacement of a lost or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect

- Appliances or services used to alter vertical dimension or restore occlusion, or for the purpose of splinting or correcting attrition or abrasion or erosion
- Replacing or modifying a partial or full removable denture, bridge, or fixed bridgework, or for adding teeth to any of these, or for replacing or modifying a crown or gold restoration, within five years after that denture, bridge, bridgework, crown or gold restoration was installed
- A partial or full removable denture, bridge or fixed bridgework if it includes the replacement of one or more natural teeth missing before coverage under the Dental Plan was effective (unless the appliance also includes replacement of a natural tooth that is removed while the person is **covered** by the Dental Plan, *and* which was not an abutment to a partial denture, removable bridge or fixed bridge installed during the prior five years)
- An appliance or modification of one if an impression for it was made before the person became **covered** under the **DMO**
- A crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became **covered** under the **DMO**
- Root canal therapy if the pulp chamber for it was opened before the person became **covered** under the **DMO**
- A cast or processed restoration, or crown, unless required for the treatment of decay or an injury that makes it impossible to restore the tooth with a filling material; or unless the tooth is an abutment to a **covered** partial denture or fixed bridge
- Services for the treatment of problems of the jaw joint, including temporomandibular joint disorder (TMJ), craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint
- Services furnished for cosmetic purposes, unless the services are needed as the result of accidental injuries sustained while a person is **covered** under the **DMO** feature (facings on molar crowns or pontics – those behind the second bicuspid – will be considered cosmetic)
- Plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to repair an injury. Surgery must be performed in the calendar year of the accident, which causes the injury, or in the next calendar year. Facings on molar crowns and pontics will always be considered cosmetic

- Injury arising out of, or in the course of, any work for wages or profit (whether or not with the employer), or diseases covered with respect to such work, by any Workers' Compensation law, occupational disease law or similar law
- In connection with services, procedures, drugs, or other supplies that are determined by the **Claims Administrator** (see "Important Contacts") to be experimental, or still under clinical investigation by health professionals

Additional DMO Exclusions

A charge for a service to the extent that it is:

- Furnished by or on behalf of the United States Government or any other government, unless payment of the charge is required by law
- Provided by any law or governmental plan under which the person is or could be covered. This does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program

You may be eligible for reimbursement for expenses not **covered** by the Dental Plan through The Avaya Inc. Health Care Reimbursement Account Plan.

APPENDIX D: DENTIST LOCATION LIST

How to Use This List

The fee schedules listed below apply to Type B other **covered** services under the **Traditional option** only. The list is arranged alphabetically by state. In states with more than one fee schedule, the numbers in parentheses to the right of the location indicate the first three numbers of the zip code range for which that particular schedule applies.

Please note that the fee schedule is based on your dentist's office location and not your home location.

Dentist's Location	Schedule No.
Alabama	I
Alaska	II
Arizona	II
Arkansas	I
California	IV
Colorado	III
Connecticut	
- New London Area (063)	III
- Waterbury Area (067)	III
- Remainder of State	IV
Delaware	
- Wilmington (198)	IV
- Remainder of State	III
District of Columbia	III

Dentist's Location	Schedule No.
Florida	
- Pensacola Area (324-325)	II
- Orlando Area (327-329)	II
- Remainder of State	III
Georgia	
- Atlanta (303)	III
- Atlanta Area (300-302)	II
- Remainder of State	I
Hawaii	III
Idaho	II
Illinois	II
Indiana	
- Indianapolis Area (460-462)	II
- Gary, South Bend, Ft. Wayne and Surrounding Areas (463-469 and 473)	II
- Remainder of State	I
Iowa	I
Kansas	II
Kentucky	
- Louisville (402)	II
- Remainder of State	I
Louisiana	
- Baton Rouge (708)	II
- Remainder of State	I

Dentist's Location	Schedule No.
Maine	II
Maryland	III
Massachusetts	III
Michigan	
- Detroit Area (480-483)	III
- Remainder of State	II
Minnesota	
- Minneapolis/St. Paul (550-554)	III
- Remainder of State	I
Mississippi	
- Jackson (392)	II
- Remainder of State	I
Missouri	
- St. Louis Area (630-633)	II
- Kansas City Area (640-641)	II
- Remainder of State	I
Montana	II
Nebraska	I
Nevada	III
New Hampshire	II
New Jersey	
- Newark Area (070, 079)	IV
- Southern New Jersey (080-084)	II
- Remainder of State	III

Dentist's Location	Schedule No.
New Mexico	II
New York	
- New York City Area and Westchester and Putnam Counties (100-112)	III
- Remainder of State	II
North Carolina	II
North Dakota	I
Ohio	
- Cleveland Area (440-441)	II
- Cincinnati Area (450-452)	II
- Remainder of State	I
Oklahoma	
- Oklahoma City Area (730-731)	II
- Tulsa Area (740 and 741)	II
- Remainder of State	I
Oregon	III
Pennsylvania	
- Philadelphia (189, 190)	III
- Remainder of State	II
Rhode Island	III
South Carolina	II
South Dakota	I

Dentist's Location	Schedule No.
Tennessee	
- Nashville (372)	II
- Memphis (381)	II
- Remainder of State	I
Texas	
- Houston (770-772)	III
- Austin (787)	III
- Remainder of State	II
Utah	I
Vermont	III
Virginia	
- Washington, DC Area (201, 220-223)	III
- Remainder of State	II
Washington	
- Seattle, Tacoma Areas (980-984)	IV
- Remainder of State	III
West Virginia	
- Wheeling Area (260)	II
- Remainder of State	I
Wisconsin	II
Wyoming	II
Outside U.S.	II

APPENDIX E: GLOSSARY OF DENTAL TERMS

To help you better understand your benefits under the Dental Plan, the following is a glossary of common dental terms.

Abutment: a terminal tooth or root that retains or supports a bridge or a fixed or removed prosthesis.

Anesthesia: the condition produced by the administration of specific agents to a patient to minimize or avoid pain response. *Local* anesthesia achieves the loss of conscious pain response in a specific location or area of the body. *General* anesthesia renders the patient completely unconscious and completely without conscious pain response.

Anesthetic: a drug that produces loss of feeling of sensation either generally or locally.

Appliance: a device used to provide function or therapeutic (healing) effect. A *fixed* appliance is one that is cemented to the teeth or attached by adhesive materials. A *prosthetic* appliance is one that is used to provide replacement for a missing tooth.

Bitewing: a dental X-ray showing approximately the coronal (crown) halves of the upper and lower jaw.

Bridgework: a type of partial denture. *Fixed* bridgework is a partial denture retained with crowns or inlays cemented to natural teeth, which are used as abutments. *Fixed-removable* bridgework is one that the dentist can remove, but the patient cannot. *Removable* bridgework is a partial denture retained by attachments, which permit removal of the denture. Bridgework is normally held by clasps.

Caries: decay of a tooth.

Covered Orthodontic Expenses: an expense incurred for **covered** orthodontic services and supplies given to a **covered** person; while the person is a **covered** person. These expenses are subject to the limitations and exclusions of the Dental Plan and the terms of the fee schedule.

Crown: the portion of a tooth covered by enamel.

Dental hygienist: a person who has been trained and licensed to remove calcareous deposits and stains from the surfaces of the teeth and to provide additional services and information on the prevention of oral disease under the direction of a dentist.

Dentist: a legally qualified dentist. Also a **physician** who is licensed to do the dental work he or she performs.

Denture: a device replacing missing teeth.

Fixed bridge: a prosthesis that replaces one or several teeth and which is cemented in place in the mouth. It consists of one or more pontics held in place by one or more retainers on the abutment teeth.

Fluoride: a solution of fluorine, which is applied topically to the teeth for the purpose of preventing dental decay.

Impression: a negative reproduction of a given area. For example, in bridgework, this may be an impression of a tooth (abutment) that has been prepared for an inlay or crown.

Inlay: a restoration made to fit a prepared tooth cavity and then cemented into place.

Malocclusion: an abnormal relation to the opposing teeth when brought into habitual opposition.

Malposition: faulty position of teeth.

Necessary: a service or supply furnished by a **dentist** is necessary if the **Claims Administrator** determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

Non-participating dental provider: a **dentist** who has not entered into a written agreement with the **Claims Administrator** (see "Important Contacts") to provide Dental Plan coverage to **covered** persons.

Onlay: an occlusal restoration that is extended to cover the entire biting surface of the tooth. It often is used to restore lost tooth structure and increase height of tooth.

Orthodontics: the branch of dentistry primarily concerned with the detection, prevention and correction of abnormalities in the positioning of teeth in their relationship to the jaws. Commonly, straightening teeth.

Orthodontic treatment: any medical service or supply; or dental service or supply furnished to prevent, diagnose or correct a misalignment of the teeth, bite or jaws or jaw joint relationship whether or not for the purpose of relieving pain. The installation of a space maintainer or a surgical procedure to correct malocclusion is not orthodontic treatment.

Partial denture: a prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures and that is supported by the teeth and/or the gums; may be removable or fixed, one side or two sides.

Participating dental provider: a **dentist** who has entered into a written agreement with the **Claims Administrator** (see "Important Contacts") to provide dental care described under the Dental Plan to **covered** persons.

Participating specialist dentist: a **dentist** who, by virtue of advanced training, is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry, and who has entered into a written agreement with the **Claims Administrator** (see “Important Contacts”) to provide the dental care described under the Dental Plan to **covered** persons.

Primary Care Dentist: a **participating dental provider** currently chosen by you to provide dental care to a **covered** person.

Periapical: the enclosing or surrounding of the tissues and bony sockets of the teeth.

Pontic: the part of a fixed bridge that is suspended between the abutments and that replaces a missing tooth or teeth.

Prophylaxis: the cleaning of the teeth by a dentist or dental hygienist through the removal of tartar and stains.

Prosthesis: an artificial replacement of one or more natural teeth and/or associated structures.

Restoration: a broad term applied to any inlay, crown, bridge, partial denture or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape, form and function of part or all of a tooth or teeth.

Root canal/endodontic therapy: treatment of a tooth having a damaged pulp. This is usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with sealing material.

Scale: the removal of calculus (tartar) and stains from teeth with special instruments.

Sealants: mechanically and/or chemically prepared enamel surface sealed to prevent decay.

Topical: the painting of the surface of teeth, as in fluoride treatment, or the application of a cream-like anesthetic formula to the surface of the gum.