

## 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.

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

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