

THE AVAYA INC.

**DENTAL EXPENSE PLAN
FOR SALARIED EMPLOYEES**

SUMMARY PLAN DESCRIPTION

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

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2008, to **eligible employees** under The Avaya Inc. Dental Expense Plan for Salaried Employees (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. 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. Avaya Inc. employees are employees at will, which means that they can terminate their employment at any time and for any reason. Likewise, Avaya Inc. may terminate an employee's employment at any time and for any reason.

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The Avaya Inc. Dental Expense Plan for Salaried Employees

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INTRODUCTION

The Avaya Inc. Dental Expense Plan for Salaried Employees (Dental Plan) is designed to promote good dental health through regular exams and preventative dentistry for you and your **eligible dependents**. You can enroll in the Dental Plan, which includes a **Preferred Provider Organization (PPO)** or **Dental Maintenance Organization (DMO[®])**, or elect No Coverage for yourself and your **eligible dependents**.

If you are a full-time **eligible employee**, Avaya Inc. automatically covers you in the **PPO** from your first day on the job. You must enroll to cover eligible family members or to select a dental option other than the **assigned option**.

The Dental Plan offers three types of coverage options:

- **Preferred Provider Organization (PPO)**
- **Dental Maintenance Organization (DMO)**
- International Dental

In addition, you may decline Avaya Inc.'s coverage to be a dependent of another **eligible employee** which may allow you to receive cash back in your paycheck.

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 **PPO** 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, salaried 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>
Enrollment	<p>If there is an assigned Dental Plan option for your job classification, you are automatically enrolled for <i>individual</i> Dental Plan coverage. See “Assigned Option.” Coverage starts on your first day of work as an eligible employee.</p> <p>You must enroll by the date specified in your enrollment letter:</p> <ul style="list-style-type: none"> • To select an option other than your assigned option, including declining coverage, • To add any eligible dependents, or • To elect Dental Plan coverage for yourself or your dependents if you have no assigned option. <p>In addition, you may decline Avaya Inc.’s coverage to be a dependent of another eligible employee. If you are a full-time employee and are not covered under any Avaya Inc. dental plan, you may be eligible to receive cash back in your paycheck.</p>
Coverage Options and Coverage Amounts	<p>The PPO option offers dental services through a network of participating dentists and specialists. Dental PPO providers charge negotiated fees for services that will generally be less than those charged by non-participating providers.</p> <p>If you use a PPO dentist, the provider’s charge is guaranteed to be within the reasonable and customary charges, so you are protected from paying charges above the allowable amount.</p> <p>A DMO is a type of dental plan that offers dental treatment through participating DMO providers. 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%. The DMO covers 50% of eligible charges for orthodontic treatment.</p>

Plan Feature	Summary
When Coverage Begins	<p>You are automatically enrolled for individual coverage under the PPO if you are a full-time employee, and may elect to participate in the DMO option or decline coverage within 31 days of your hire date. Part-time employees must enroll in coverage for themselves and any eligible dependents. Coverage starts on your first day of work as an eligible employee. You must enroll your eligible dependents if you would like them to be covered under the Dental Plan. Provided you make any changes by the date specified in your enrollment letter, coverage for you and your enrolled dependents is retroactive to your first day of work.</p>
Changing Your Coverage	<p>After you enroll for coverage, you can only make changes during the annual enrollment period, except for certain qualified status changes, such as marriage.</p> <p>If you elect No Coverage, you will <u>not</u> have dental coverage for two Plan Years. If you have a qualified status change during the Plan Year, you can elect dental coverage within 31 days after the date of the qualified status change.</p>
Information About the Dental Plan	<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>
Cost	<p>The cost of coverage varies by option and level of coverage. Your contributions are generally deducted on a pre-tax basis.</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 D. 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.

Aetna Global Benefits: the company that administers the Dental Plan option for International Assignees, the International dental option. Please refer to the detailed benefit information provided by Aetna Global Benefits for more information.

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.

Assigned option: the dental option to which you will be automatically assigned if you are eligible and do not enroll in one of the available options. Part-time employees do not have an assigned option and *must* enroll to be **covered** by the Dental Plan.

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

Basic Restorative Services: services such as fillings and root canal therapy.

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 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 own 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 must be certified for coverage by the Claims Administrator under The Avaya Inc. Medical Expense Plan for Salaried Employees. 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.

Coinsurance: the cost-sharing method by which the Dental Plan pays a percentage of the **provider’s covered** charge (for example, 80%) and you pay the remaining percentage (for example, 20%). Your coinsurance is your share of the cost.

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.

Deductible: the amount of eligible expenses you may be required to pay under the Dental Plan each year before benefits for **covered** expenses can begin. Whether a deductible applies, and the amount of the deductible depends upon the Dental Plan option you choose, the type of service or supply you receive. There is no deductible under the **DMO** option. Some expenses do not count toward the deductible. (See “Expenses You Pay That Do Not Count Toward the Deductible.”)

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 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, salaried employee who works for a **Participating Company**. Temporary employees or student interns are not considered regular employees.

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. International Assignees who are paid from the U.S. payroll of a **Participating Company** will be eligible for coverage through **Aetna Global Benefits**, and are subject to modified plan benefits.

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

In-network: the benefit choice in which you access the services of contracted **network providers** according to the rules of the option or program under which you are enrolled.

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.

Major Restorative Services: services such as inlays, onlays, crowns and prosthodontics.

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 for Salaried Employees and The Avaya Inc. Pension Plan.

Network: the **providers** in a given area who participate with the **Claims Administrator**. Network **providers** offer services to members enrolled with the **Claims Administrator** at a **prenegotiated rate**. A network **provider** means a **provider** who participates in the network.

Non-network: refers to a **provider** that has not signed a **network provider** agreement with the **Claims Administrator**.

Out-of-network: the benefit choice in which you access services without following the rules of the program for accessing contracted **network providers**.

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**.

Preferred Provider Organization (PPO): Aetna's Preferred Provider Organization (PPO). The PPO is a network of credentialed participating dentists who have agreed to

accept negotiated fees for their services. You can choose any **provider** at the time of treatment, but when visiting a participating PPO dentist, you have the opportunity to lower your out-of-pocket expenses.

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

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

Provider: a **dentist** who has entered into a written agreement with the **Claims Administrator** to provide dental care described under the Dental Plan to **covered** persons.

Qualified Medical Child Support Order (QMCSO): a judgment, decree, or order issued by a court or a certain administrative process that requires dental coverage for an **eligible employee'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 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.
Residence or Worksite	A change in the place of residence or worksite of you, your spouse, or a child.

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.

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

You are eligible to participate in the Dental Plan if you are a regular, active, full-time or part-time, salaried 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. International Assignees who are paid from the U.S. payroll of a **Participating Company** will be eligible for coverage through **Aetna Global Benefits** under the International dental option, and subject to modified plan benefits.

Eligible Dependents

As a participant in the Dental Plan, you may also 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 the Dental Plan option you elect, and on whom you elect to cover.

You may enroll another **eligible employee** or Avaya Inc. salaried retiree (who participates in The Avaya Inc. Pension Plan for Salaried Employees) as your dependent, as long as the eligibility requirements are satisfied. If you enroll another **eligible employee** or Avaya Inc. salaried retiree 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**. However, he or she would

not be eligible to receive cash back. A salaried active or retired Avaya Inc. employee cannot enroll a represented active or retired Avaya Inc. employee as 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 a full-time employee when you start working for Avaya Inc., you are automatically enrolled in your **assigned option** for individual Dental Plan coverage. The **assigned option** is the **PPO** option. Coverage begins on your first day of work as an **eligible employee**. Part-time employees must enroll to be covered under the Dental Plan.

An enrollment letter will be sent to your home address. 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”).

After you receive the letter, by the specified date in the enrollment letter, you may:

- Change from the **assigned option** to another available option,
- Choose a coverage option, if one was not assigned, or
- Enroll your **eligible dependents**.

In addition, you may elect to:

- Decline Avaya Inc.'s dental coverage. In this case, if you are a full-time employee you may be able to receive cash back in your paycheck.
- Decline your own coverage under the Dental Plan in order to be covered as a dependent of another **eligible employee**.

If you do not make any elections by the specified date indicated in your enrollment letter, here is what will happen:

- If you are a regular full-time employee, you will continue to be **covered** under your **assigned option**. Your dependents *will not* be covered. You may change your coverage level due to a **qualified status change**. Otherwise, you will *not* be permitted to make any changes until the next **annual enrollment**.
- If you are a part-time employee, *no coverage* will be assigned. This means you and your dependents *will not* be **covered** under the Dental Plan for the current year. See “Declining Avaya Inc. Dental Coverage” below.

Generally, you do not need to re-enroll each year, unless you wish to change your coverage category. However, if you choose No Coverage, you cannot change your coverage for two enrollment periods, unless you have a **qualified status change**.

Assigned Option

The **assigned option** is automatically assigned if you do not enroll. Not all employees have an **assigned option**. Your eligibility for an **assigned option** depends on your job classification. The option that is assigned is the **PPO**.

Generally, coverage *automatically* begins under your **assigned option** on your first day of work as an **eligible employee**. If you do not meet the requirements for an **assigned option**, you must enroll by the specified date in your enrollment letter to have dental coverage.

If you enroll your **eligible dependents** at the same time you enroll yourself, coverage for those dependents begins the same day as your coverage begins.

Declining Avaya Inc. Dental Coverage

You may elect to decline Avaya Inc.'s Dental Plan coverage. In this event, if you are a full-time employee, you will be reimbursed a portion of your cost for coverage as taxable income in your paycheck. This reimbursement is not available to part-time employees.

The cash back option is not available if you are **covered** as a dependent of another Avaya Inc. employee/retiree.

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.

If you decline coverage, you cannot change your coverage for two enrollment periods, unless you have a **qualified status change**.

Annual Enrollment

During **annual enrollment** each year, you will have an opportunity to select the benefits that best meet your needs for the coming year. You may change the **eligible dependents** you cover and/or change Dental Plan options. Keep in mind that if you elect No Coverage, you will not be able to elect coverage for two enrollment periods, unless you have a **qualified status change**. **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. If it is discontinued, you will be enrolled in your **assigned option**. However, if you are not eligible for an **assigned option**, you will not be enrolled in any option unless you actively enroll. For more information, see “Assigned Option.”

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 Participating Company

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

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). You *must* contact 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**.

Special Note for Part-Time Employees

Part-time employees and their dependents are eligible for dental coverage. The amount the Company pays for coverage for you and your **eligible dependents** under the Dental Plan depends upon the number of hours you work each week as outlined in the following chart:

Scheduled Work Hours	The Company Pays This Percentage of the Cost	You Pay This Percentage of the Cost
At least 25 hours per week	50%	50%
Fewer than 25 hours per week	0%	100%

If you need to enroll yourself or your **eligible dependents** for coverage in the Dental Plan, you must do so *within* 31 days of your eligibility date (see “Who Is Eligible” and “Eligible Dependents”). If you do not enroll within 31 days, you will have to wait for the next **annual enrollment** period.

Your Monthly Contribution

Your payroll deduction amount for benefit coverage appears on your pay statement. Remember, you contribute toward the cost of Dental Plan coverage 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. Remember, if you elect to decline coverage under the Dental Plan, and if you are a full-time employee, you may be eligible to receive a credit in each paycheck. This amount is considered taxable income.

HOW THE PLAN WORKS

Understanding Your Options Under the Plan

There are two coverage options available under the Dental Plan:

PPO - This option provides a preferred level of benefits and reduced paperwork when you choose **in-network providers** for your dental care, yet gives you the flexibility to go **out-of-network** when you choose. You choose between **in-network** or **out-of-network providers** each time you need dental care, but using **in-network providers** can help reduce your costs.

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 summarized in “Appendix B.” The **DMO** covers 50% of eligible charges for orthodontic treatment.

If you are an International Assignee, you will be eligible for the International Dental option offered through **Aetna Global Benefits**. Your coverage will be similar to the **in-network** benefits shown for the **PPO option**. Please refer to the Certificate of Coverage through **Aetna Global Benefits**, or contact **Aetna Global Benefits** customer service for more information (see “Important Contacts”).

Not everyone needs dental coverage. You can decide not to receive dental coverage, by electing No Coverage. However, if you choose No Coverage, you cannot elect coverage for two Plan Years, unless you experience a **qualified status change**.

If you elect to participate in the Dental Plan, you have a choice of three coverage categories:

- *Individual* – for yourself only
- *Two-Person* – for you and one **eligible dependent**
- *Family* – for you and two or more **eligible dependents**

Your share of the cost for dental coverage depends on the option and coverage category you select.

PPO OPTION

The **PPO** option has **in-network** and **out-of-network** coverage. **In-network** dental **providers** generally agree to accept fees at or lower than **reasonable and customary charges**. If you use an **out-of-network provider**, the reimbursement rates will generally be lower. If you live out-of-area, you will receive the **in-network** level of benefits. By visiting **in-network dental providers**, you will also benefit from **Aetna's** negotiated rates. See Appendix A for a list of **covered** services. See Appendix C for a list of the services not **covered** under the **PPO**.

Benefits

The **PPO** provides coverage for services, as follows:

	In-Network or Out-of-Area*	Out-of-Network**
Annual Deductible (for preventative care services)	\$25/individual \$50/two-person or family	\$25/individual \$50/two-person or family
Type A Services - Diagnostic and Preventative	100% of PPO fee***	90% of reasonable and customary charges
Type B Services - Basic Restorative	80% of PPO fee***	70% of reasonable and customary charges
Type C Services - Major Restorative	50% of PPO fee***	50% of reasonable and customary charges
Orthodontia	50% of PPO fee***	50% of reasonable and customary charges
* If you are Out-of-Area, benefits are paid as a percentage of reasonable and customary charges . ** In-network refers to benefits for services that are rendered by a participating PPO dentist. Out-of-network refers to benefits for services that are rendered by a dentist who does not participate in the PPO . *** PPO fee refers to the typically lower "negotiated fees" that participating PPO network dentists accept as "payment in full" from eligible participants.		

Maximum Benefits

The **PPO** option pays benefits for diagnostic, preventative, and restorative services up to an annual maximum of \$2,250 for both **in-network** and **out-of-network** services (combined) per **covered** person. This limit does not apply to orthodontia, which has a separate lifetime maximum of \$1,750 per **covered** person.

Comparing Benefits

The following example will give you an idea of how benefits are paid if you elect coverage under the **PPO** option.

Example:

Suppose you need a crown. Here is how the **PPO** option pays benefits:

	If you use a PPO provider	If you use a non-PPO provider
Dentist's usual fee	\$825	\$825
PPO negotiated fee	\$586	Not applicable
Reasonable and customary charge	Not applicable	\$750
Amount PPO option pays	\$293 (50% of PPO negotiated fee)	\$375 (50% of reasonable and customary charge)
Amount you pay	\$293 (\$586 minus \$293)	\$450 (\$825 minus \$375)
Amount you save by using a PPO provider	\$157 (\$450 minus \$293)	N/A
Note: The chart is for illustrative purposes only. Charges and PPO discounts will vary.		

Taking Advantage of the PPO

You can access a directory of participating **PPO** dentists online at www.AetnaNavigator.com, or contact the **Claims Administrator** (see "Important Contacts") to request a directory of participating **PPO** dentists for your area. You and your **covered dependents** can select the same or different dentists. You do not have to select a primary dentist in the **PPO** to take advantage of the feature; simply go to a participating dentist.

Participating **PPO** dentists have agreed to provide services at a negotiated rate for non-covered services such as cosmetic tooth whitening or inlays, so you generally pay less out of pocket. The reduced fees range from 10 to 40 percent off their average fee for service.

Getting the Most From Your Coverage

To ensure you receive the maximum benefit under the **PPO** 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 a crown, and that either treatment meets the professionally accepted dental standards. In such instances, the Dental Plan 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 Dental Plan 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 Dental Plan 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 Dental Plan 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, 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.

DMO OPTION

The **DMO** option offers dental services through participating **providers**. The **DMO** covers almost all the same services as the **PPO** option, with these added features:

- There is no annual benefit maximum or deductible.
- You generally pay less for basic restorative and major restorative **covered** services than you would under the **PPO option**.
- You do not need to file claim forms.

The **DMO** is available to participants who live in eligible zip codes. See Appendix B for a list of **covered** services.

The following chart summarizes how the **DMO** option covers expenses.

	Percent of Eligible Charges Covered by the DMO	Amount You Pay (Your DMO Copayment)
Annual Deductible	N/A	None
Type A Services - Diagnostic and Preventative	100%	0%
Type B Services - Basic Restorative	100%	0%
Type C Services - Major Restorative	75%	25%
Orthodontia	50%	50%

Electing a Personal DMO Participating Dentist

You and your **covered dependents** each need to designate and use a **Primary Care Dentist (PCD)**. You may designate your **PCD** through **Aetna Navigator** (www.AetnaNavigator.com) or by calling the **Claims Administrator** (see “Important Contacts”).

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 Primary Care Dentist

You may change your **primary care 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.

Emergency DMO Care

Emergency care consists of dental services provided by any licensed dentist, other than your **primary care 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 **primary care 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.

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.

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 PPO Option

If you use a **PPO** dentist, he or she will submit a claim form for you.

If you use a non-PPO dentist, use the claim form provided by the **Claims Administrator** (see “Important Contacts”) to request benefit payments.

Under the DMO

You do not have to submit claims. Your provider will bill you for any services not **covered** in full by the Dental Plan.

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 amount the Plan would have paid if there was no other coverage and the primary plan’s payment. Therefore, among the primary and secondary plans, you can receive up to the highest payment of benefits allowed by either plan.

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**,
- You fail to make any required contributions,
- You request cancellation of coverage and have experienced a **qualified status change** to permit the cancellation of coverage,
- The company you work for ceases to be a **Participating Company**, 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**) commit acts of physical or verbal abuse that pose a threat to the staff of the Plan Administrator, **Claims Administrator** or **Avaya Health and Benefits Decision Center**.
- You (or one of your **covered dependents**) in any other way materially violates the terms of the Dental Plan.

Extension of Coverage Under the Plan under the PPO

In general, no benefits will be paid under the Dental Plan 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 ends 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**, or
- *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
	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

If:	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
	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	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 becomes ineligible 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.

If the **Avaya Health and Benefits Decision Center** determines that you and/or your **covered dependents** are not eligible for **COBRA** continuation coverage, you will be notified in writing explaining why 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 timely 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. However, you may need to re-enroll due to the change in your cost of coverage. You will receive an enrollment package from the **Avaya Health and Benefits Decision Center** and must make your election within 31 days of the qualified event.

If your employment status changes from salaried to represented, it will affect your eligibility for dental benefits as follows:

- Coverage under the Dental Plan will end on the last day of the month in which your status changes.
- Your status change to a represented position will make you eligible to participate in the dental plan offered to represented employees.

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 or terminate and your age plus **net credited service** equal at least 60, and you have a minimum of 5 years of **net credited service** (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 Retire

Retiree dental coverage is bundled with medical coverage. This means that you cannot elect dental coverage independently from your medical coverage. The **DMO** option is not offered to retirees.

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 for Salaried Employees 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. You may elect coverage at a later date if you wish.

If you terminate employment and are eligible for access to retiree health care because your age plus your **net credited service** equals at least 60, and you have at least 5 years of **net credited service**, you will have access to retiree health care and will receive enrollment material and information about your coverage options 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 terminate employment.

If you have access to retiree health care, but you do not enroll by the enrollment deadline, you will *not* have retiree health coverage. You may elect coverage at a later date if you wish.

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 for Salaried Employees. Business Assistants hired before January 1, 1999 who participate in The Avaya Inc. Pension Plan (as offered to represented employees), should reference the SPD for The Avaya Inc. Retiree Dental Expense Plan, as certain provisions differ.

When you retire, you 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 Laid Off

If you are laid off, you will be able to continue Dental Plan coverage 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.

If You Are Rehired

If you are returning to Avaya Inc. within six months of your date of separation, your prior **net credited service** will be immediately bridged, minus the period of time that you were not employed by Avaya Inc. If you are returning to Avaya Inc. and it has been longer than six months since your date of separation, your **net credited service** will not be immediately bridged. Upon completion of two years of continuous Avaya employment after re-employment, your prior Avaya Inc. service will be bridged for certain Avaya Inc. benefits purposes.

Should you terminate employment before your **net credited service** is bridged, your new **net credited service** date will be based on your rehire date and any previous service will not have an impact in the calculation of this new **net credited service**.

If you were previously service pension-eligible on your first termination date and you are rehired, you will continue to be eligible for subsidized coverage under the Medical Plan at your next termination. The amount the Company will contribute will be based on the rules in effect at the time of your next termination. Currently, the Company will contribute 3% of the Maximum Company Contribution for every year of **net credited service** up to service accrued as of 2003 with a Maximum Company Contribution percentage set at 75%.

If you were not previously service pension-eligible or a participant of the account balance plan on your first termination date and you are rehired, your age plus **net credited service** must equal at least 60 with at least 5 years of **net credited service** at the next termination to be eligible for continued coverage (other than COBRA). You will have access to purchase group retiree health insurance through Avaya at 100% of the cost.

If You Become Disabled

Your participation in the Dental Plan may be affected if you become disabled. Your length of service and the duration of your disability determine what happens to your coverage during a disability.

If you become partially or totally disabled as determined under The Avaya Inc. Short-Term Disability Plan for Salaried Employees, you will continue to be eligible for 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. Short-Term Disability Plan for Salaried Employees.

If you are eligible for a service pension under the Service Based Program of The Avaya Inc. Pension Plan for Salaried Employees or The Avaya Inc. Pension Plan, and you elect to retire and waive your right to future disability benefits, your benefits would be provided under The Avaya Inc. Retiree Dental Expense Plan for Salaried Employees

and your coverage under The Avaya Inc. Dental Expense Plan for Salaried Employees would end.

If you continue to be disabled after you have received the maximum number of weeks of short-term disability benefits, you may be eligible for benefits under The Avaya Inc. Long-Term Disability Plan for Salaried Employees. If you are covered by the Service Based Program of The Avaya Inc. Pension Plan for Salaried Employees or The Avaya Inc. Pension Plan and you are eligible for a disability or service pension, you will be covered by The Avaya Inc. Retiree Dental Expense Plan for Salaried Employees and your coverage under The Avaya Inc. Dental Expense Plan for Salaried Employees will end. If you are not eligible for a disability or service pension, but you are eligible for benefits under The Avaya Inc. Long-Term Disability Plan for Salaried Employees, your Dental Plan coverage would continue as indicated below.

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

Long-Term Disability

Dental Plan coverage under The Avaya Inc. Dental Expense Plan for Salaried Employees is available under **COBRA** to employees eligible for The Avaya Inc. Long-Term Disability Plan for Salaried Employees who are not eligible for coverage under The Avaya Inc. Retiree Dental Expense Plan for Salaried Employees, as described above.

If You Take an Approved Leave of Absence

If you take an approved leave of absence under the Family and Medical Leave Act (FMLA), your coverage under the Dental Plan may continue for up to 12 work weeks. The Company continues its share of the cost of this coverage. You must pay your share of any cost of coverage to continue coverage during your FMLA leave. If you choose not to continue such coverage, you remain eligible for reinstatement upon your return to work.

If you are eligible for an FMLA leave under The Family and Medical Leave Act of 1993, as amended, 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

Call 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

Because you pay for your dental coverage on a pre-tax basis, federal rules limit your ability to make changes to your dental coverage during a calendar year. Generally, you may not elect a change unless you have a **qualified status change**.

Under Internal Revenue Service (IRS) regulations, if you have a **qualified status change**, you may *only* change your *coverage level* (individual, two-person, family or no

coverage), and only to the extent that the change in coverage is consistent with your **qualified status change**. You may not make changes in your coverage option, unless you move in or out of the area covered by the **DMO**, or are changing from no coverage to coverage or vice versa. For example, if you marry, you may elect to change your coverage from “individual” coverage to “two-person” coverage, or drop coverage to be covered under your new spouse’s plan. Or, if you declined dental coverage and your spouse loses coverage under his or her employer’s dental plan, you may elect coverage under the Dental Plan.

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 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

An **eligible employee** may cover another salaried Avaya Inc. employee or retiree. Therefore, if your **lawful spouse** or **domestic partner** is an active salaried employee, you may enroll as his or her dependent under the Dental Plan, or he or she may enroll as your dependent, but not both. If your spouse is a retired salaried employee, you may enroll as his or her dependent under The Avaya Inc. Retiree Dental Expense Plan for salaried employees. If you elect to be **covered** as a dependent under another salaried Avaya Inc. employee or retiree, you would not be eligible for cash back in your paycheck.

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

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.

Domestic Employees	International Employees	Hearing Impaired Employees
Call 1-800-526-8056 (option 1).	Outside the U.S., dial your country's AT&T Access Number; then enter 800-526-8056. To obtain the AT&T Access Number, log on to www.att.com/traveler or call 1-800-331-1140.	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, or
- Request a list of **PPO** or **DMO** dentists.

For the hearing impaired, you may call 1-800-346-3323 to reach a telecommunications device for the deaf.

By Mail

Following is the address for all correspondence (including claim forms and legal actions regarding a claim for benefits).

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

Online

You can access the self-service **Aetna** Navigator Web site at www.aetn navigator.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, or
- Contact **Aetna** Member Services.

Other Contacts

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

Contact / Service Provided	Address / Telephone Number
<p>Aetna Global Benefits International Dental Option</p>	<p>In the U.S.: 1-800-231-7729 Outside U.S./Canada (call collect): 1-813-775-0190 24 hours a day/seven days a week Web site: www.aetnaglobalbenefits.com</p>
<p>Domestic Relations Matters Group: Contact for matters relating to a Qualified Medical Child Support Order (QMCSO).</p>	<p>Domestic Relations Matters Group Aon Consulting of New Jersey, Inc. 270 Davidson Avenue, 7th Floor Somerset, NJ 08873</p>
<p>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.</p>	<p>Avaya Inc. Dental Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920 E-mail: hwplanadmin@avaya.com</p>

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 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 the 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 for Salaried Employees 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.

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. 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 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 for Salaried Employees which is a part of The Avaya Inc. Health & Welfare Benefits Plan for Salaried Employees.
Plan Sponsor	The Plan Sponsor is Avaya Inc.
Plan Administrator	The Plan Administrator is: Avaya Inc. Dental Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920 E-mail: hwplanadmin@avaya.com
Type of Administration	The Dental Plan is administered on Avaya Inc.'s behalf 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 Dental 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 Dental 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 550.
Employer Identification Number	The Employer Identification Number is 22-3713430.

APPENDIX A: ELIGIBLE EXPENSES UNDER THE PPO OPTION

Following is a comparison schedule of benefits (**in-network**, **out-of-network** and out-of-area) under the Dental Plan's **PPO** option. For a complete description of terms described in this section, see "Appendix D."

	Amount Plan Pays	
	<u>In-Network or Out-of-Area*</u>	<u>Out-of-Network</u>
<u>Diagnostic and Preventative Services</u>		
<u>Type A Services</u>		
Twice in a calendar year:	100% of PPO fee	90% of reasonable and customary charges
<ul style="list-style-type: none"> Routine Periodic Oral Examination Regular cleaning of teeth when performed by a dentist or dental hygienist 		
In a calendar year:	100% of PPO fee	90% of reasonable and customary charges
<ul style="list-style-type: none"> One fluoride treatment, when performed by a dentist or dental hygienist: 		
As specified:	100% of PPO fee	90% of reasonable and customary charges
<ul style="list-style-type: none"> Space maintainers for Dependents and Employees under the age of 23. <ul style="list-style-type: none"> ⇒ Installation of fixed or removable appliances to maintain existing space by preventing movement of adjacent or opposing teeth (but only as a replacement of prematurely lost or extracted teeth) Dental X-rays and radiographs: <ul style="list-style-type: none"> ⇒ Full-mouth or panoramic X-rays (not more than once in three rolling years**) ⇒ Vertical bitewings (not more than one set in three rolling years**) ⇒ Supplementary bitewing X-rays, 1-4 films, one set (not more than twice in a calendar year) ⇒ Diagnostic dental X-rays required for a specific condition, except X-rays in conjunction with orthodontics Diagnostic Testing <ul style="list-style-type: none"> ⇒ Bacteriologic studies for determination of Pathological Agents ⇒ Caries Susceptibility Testing ⇒ Pulp Vitality Tests ⇒ Study Models – Diagnostic Casts Sealants for dependent children 13 years old and younger (once per permanent molar every 3 rolling years) Emergency Palliative Treatment 		

X-rays within three years of the last treatment will be **covered if the expense is incurred within the last 30 days of such three-year period.

	Amount Plan Pays	
	<u>In-Network or Out-of-Area*</u>	<u>Out-of-Network</u>
<u>Basic Restorative Services</u>		
<u>Type B Services</u>		
Restorations:	80% of PPO fee	70% of reasonable and customary charges
<ul style="list-style-type: none"> • Fillings <ul style="list-style-type: none"> ⇒ Amalgam 1-3 surfaces ⇒ Composite Resin – 1-4 anterior surfaces ⇒ Filling (sedative) • Stainless Steel Crown – Child • Resin Crown • Pin Retention 		
Root Canal Therapy:	80% of PPO fee	70% of reasonable and customary charges
<i>Procedures used to prevent and treat diseases of the dental pulp</i>		
<ul style="list-style-type: none"> • 1-3 canals (traditional) • Pulp cap – direct/indirect • Pulp Treatment: 		
Periodontics:	80% of PPO fee	70% of reasonable and customary charges
<i>Surgical and nonsurgical procedures to treat the supporting area around the teeth, except periodontal splinting</i>		
<ul style="list-style-type: none"> • Periodontic Maintenance after surgery therapy (2 per calendar year) • Gingivectomy (1 per quad/tooth every 3 rolling years) • Gingival Flap • Surgical Tooth Revision • Scaling and Root Planing (4 separate quads per 2 rolling years) 		
Oral Surgery:	80% of PPO fee	70% of reasonable and customary charges
<ul style="list-style-type: none"> • Simple Extractions • Surgical removal of residual roots (cutting procedure) • Biopsy Of Oral Tissue • Transseptal Fiberotomy • Alveoplasty • Remove Odontogenic Tumor • I&D Of Abscess • Frenulectomy 		
Other Type B Services:	80% of PPO fee	70% of reasonable and customary charges
<ul style="list-style-type: none"> • Therapeutic Drug Injection • Desensitizing Medication/Resin • Adjust Occlusion • Oral Pathology 		

	Amount Plan Pays	
	<u>In-Network or Out-of-Area*</u>	<u>Out-of-Network</u>
Major Restorative Services		
<u>Type C Services</u>		
Inlays, onlays and crowns:	50% of PPO fee	50% of reasonable and customary charges
<ul style="list-style-type: none"> • Onlays to restore tooth structure • Crowns to restore tooth structure <ul style="list-style-type: none"> ⇒ Resin crown with noble metal ⇒ Porcelain crown ⇒ Porcelain with semiprecious metal crown ⇒ Gold or full cast crown ⇒ Crown Build-up ⇒ Labial Veneer ⇒ Crown Repair 		
Periodontics:		
<i>Surgical procedures to treat the supporting area around the teeth, except periodontal splinting</i>	50% of PPO fee	50% of reasonable and customary charges
<ul style="list-style-type: none"> • Osseous surgery – including flap entry and closure (1-3 teeth, per quadrant) (1 per quad every 3 rolling years) 		
Prostodontics:		
<i>To replace teeth (except wisdom teeth) extracted while covered by the Plan.</i>	50% of PPO fee	50% of reasonable and customary charges
<ul style="list-style-type: none"> • Complete dentures (including six months post-delivery care): <ul style="list-style-type: none"> ⇒ Complete upper ⇒ Complete lower ⇒ Immediate upper ⇒ Immediate lower • Partial dentures (including six months post-delivery care): <ul style="list-style-type: none"> ⇒ Lower with metal frame, resin base (including clasps, rests, teeth) ⇒ Upper with metal frame, resin base (including clasps, rests, teeth) ⇒ Full cast partial with two chrome clasps (upper) • Bridge Pontics: <ul style="list-style-type: none"> ⇒ Cast gold ⇒ Porcelain fused to semiprecious metal ⇒ Resin with noble metal 		
<i>Prostodontic services include:</i>		
Initial installation of fixed bridgework, including inlays and crowns to form abutments.		
Initial installation of partial or full removable dentures, including adjustments during the six-month period after they are installed.		
The addition of teeth to an existing partial removable denture or to bridgework.		
Installation of a permanent full denture that replaces and is installed within 12 months of a temporary denture.		
Replacement of an existing partial denture, full removable denture or fixed bridgework, provided the existing denture or bridge is at least five years old and cannot be made serviceable. (The five-year limitation is waived if additional extractions require the replacement.)		
Repairing or re-cementing inlays, crowns, bridgework, or dentures, or relining of dentures.		

	Amount Plan Pays	
	<u>In-Network or Out-of-Area*</u>	<u>Out-of-Network</u>
Oral Surgery:	50% of PPO fee	50% of reasonable and customary charges
<ul style="list-style-type: none"> • Surgical extractions: • Single teeth, surgical extractions (includes partial or complete bony impaction) • Anesthesia 		
Other Services	50% of PPO fee	50% of reasonable and customary charges
<ul style="list-style-type: none"> • Occlusal guard for bruxism (1 per 3 rolling years) 		
Orthodontics:		
<i>To prevent and correct malocclusion of teeth and associated facial problems</i>	50% of PPO fee	50% of reasonable and customary charges
<ul style="list-style-type: none"> • Appliances for tooth guidance or to control harmful habits, fixed or removable • Comprehensive full-banded treatment, preliminary study including X-rays and treatment plan • Active treatment, including appliances 		
*If you are Out-of-Area, benefits are paid as a percentage of reasonable and customary charges .		

Note: Dental treatment that spans two Plan Years (for example: dentures, bridgework, crown or root canal therapy) will be paid according to the **reasonable and customary** rates in effect when a service is provided. For Dental Plan purposes, a service is considered to be “provided” when treatment begins (when a tooth is prepared or a canal opened).

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.

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**.

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.

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

	DMO Participating Personal and Specialty Dentists Benefit (percent of dentist's eligible charge)
Basic Services – Type A	
• Visits and Exams:	
⇒ Office visit for oral examination (limited to four visits a year)	100%
⇒ Emergency palliative treatment	100%
⇒ Prophylaxis (cleaning) (limited to six treatments a year)	
o Adult	100%
o Child	100%
⇒ Topical application of fluoride (limited to one course of treatment a year and to children under age 18)	100%
⇒ Oral hygiene instruction	100%
⇒ Sealants (limited to once each tooth every three years, permanent molars only)	100%
⇒ Pulp vitality test	100%
⇒ Diagnostic casts	100%
• X-rays and Pathology:	
⇒ Bitewing X-rays (limited to two sets per year)	100%
⇒ Entire series; including bitewings; panoramic film (limited to one set every three years)	100%
⇒ Vertical bitewing X-ray (limited to one set every three years)	100%
⇒ Periapical X-rays	100%
⇒ Intra-oral, occlusal view, maxillary or mandibular	100%
⇒ Extra-oral upper or lower jaw	100%
⇒ Biopsy and histopathologic examination of oral tissue	100%

**DMO Participating
Personal and
Specialty Dentists
Benefit** (percent of
dentist's eligible
charge)

Basic Services – Type B

• Endodontics:	
⇒ Pulp cap	100%
⇒ Pulpotomy	100%
⇒ Surgical exposure for rubber dam isolation	100%
⇒ Root canal therapy (including necessary X-rays and cultures but excluding complex molar cases approved as specialty services):	
○ Anterior	100%
○ Bicuspid	100%
• Restoration and Repairs:	
⇒ Amalgam restoration:	
○ One surface	100%
○ Two surfaces	100%
○ Three or more surfaces	100%
⇒ Resin restoration (other than for molars):	
○ One surface	100%
○ Two surfaces	100%
○ Three or more surfaces or incisal angle	100%
⇒ Retention pins	100%
⇒ Sedative fillings	100%
⇒ Stainless steel crowns	100%
⇒ Prefabricated resin crowns (excluding temporary crowns)	100%
⇒ Recementing inlays, crowns, bridges, space maintainers	100%
⇒ Tissue conditioning for dentures	100%
• Periodontics:	
⇒ Emergency treatment (abscess, acute periodontitis, etc.)	100%
⇒ Subgingival curettage (limited to four separate quadrants a year)	100%
⇒ Scaling and root planing (limited to four separate quadrants a year)	100%
⇒ Periodontal maintenance procedures following surgical therapy (limited to two a year)	100%
• Oral Surgery: (includes local anesthetics and routine post-operative care)	
⇒ Extractions, uncomplicated	100%
⇒ Surgical removal of erupted tooth	100%
⇒ Surgical removal of impacted tooth (soft tissue)	100%
⇒ Excision of hyperplastic tissue	100%
⇒ Excision of pericoronal gingiva	100%
⇒ Incision and drainage of abscess	100%
⇒ Crown exposure to aid eruption	100%
⇒ Removal of foreign body from soft tissue	100%
⇒ Suture of soft tissue injury	100%

Basic Services – Type C

- **Restorations:**
 - ⇒ Inlays
 - One surface 75%
 - Two or more surfaces 75%
 - ⇒ Onlays
 - Two surfaces 75%
 - Three or more surfaces 75%
 - ⇒ Crowns (including build-ups when necessary) 75%
 - ⇒ Posts and core 75%
 - ⇒ Pontics 75%
- **Dentures and Partial:**
(includes relines, rebases and adjustments within six months after installation)
 - ⇒ Complete (upper or lower) 75%
 - ⇒ Partial 75%
 - ⇒ Stress breakers (per unit) 75%
 - ⇒ Interim partial dentures (stayplates); anterior only 75%
 - ⇒ Crown and bridge repairs 75%
 - ⇒ Adding teeth to an existing partial denture 75%
 - ⇒ Full and partial denture repairs 75%
 - ⇒ Relining/rebasing dentures (includes adjustments within six months after installation) 75%
 - ⇒ Occlusal guard (for bruxism only) 75%
- **Space Maintainers:**
(includes all adjustments within six months after installation)
 - ⇒ Fixed, band type 75%
 - ⇒ Removable acrylic with round wire clasp 75%
 - ⇒ Removable appliance to correct habits 75%
 - ⇒ Fixed or cemented appliance to correct habits 75%

Specialty Services – Type B

- **Endodontics:**
(includes local anesthetics when necessary)
 - ⇒ Apexification/recalcification – per visit 100%
 - ⇒ Apicoectomy (per tooth) – first root 100%
 - ⇒ Apicoectomy (per tooth) – each additional root 100%
 - ⇒ Retrograde filling 100%
 - ⇒ Root amputation 100%
 - ⇒ Hemisection 100%
- **Oral Surgery:**
(includes local anesthetics when necessary and post-operative care)
 - ⇒ Removal of residual root 100%
 - ⇒ Removal of odontogenic cyst 100%
 - ⇒ Closure of oral fistula 100%
 - ⇒ Removal of foreign body from bone 100%
 - ⇒ Sequestrectomy 100%
 - ⇒ Frenectomy 100%
 - ⇒ Transplantation of tooth or tooth bud 100%
 - ⇒ Alveolectomy (in conjunction with extractions) – per quadrant 100%

- ⇒ Alveolectomy (not in conjunction with extractions) – per quadrant 100%
- ⇒ Removal of exostosis 100%
- ⇒ Sialolithotomy; removal of salivary calculus 100%
- ⇒ Closure of salivary fistula 100%

Specialty Services – Type B (continued)

- **Periodontics:**
 - ⇒ Gingivectomy or gingivoplasty – per quadrant 100%
 - ⇒ Gingivectomy or gingivoplasty – per tooth 100%
 - ⇒ Gingival flap procedures – per quadrant 100%
 - ⇒ Free soft tissue graft 100%
 - ⇒ Occlusal adjustment (other than with an appliance or by restoration):
 - Limited 100%
 - Entire mouth 100%

Specialty Services – Type C

- **Endodontics:**
(includes local anesthetics when necessary)
 - ⇒ Complex molar root canal therapy 75%
- **Intravenous Sedation and General Anesthesia:**
 - ⇒ Per 15-minute segment 75%
- **Oral Surgery:**
(includes local anesthetics when necessary and post-operative care)
 - ⇒ Surgical removal of impacted teeth:
 - Partially bony 75%
 - Completely bony 75%
 - Completely bony with unusual surgical complications 75%
- **Periodontics:**
 - ⇒ Osseous surgery (including flap entry and closure) – per quadrant 75%
- **Orthodontics:**
 - ⇒ Comprehensive orthodontic treatment
 - ⇒ Post treatment stabilization
 - ⇒ Interceptive orthodontic treatment
 - ⇒ Limited orthodontic treatment

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

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

Exclusions and Limitations

All of the following services, supplies or expenses are excluded from benefits under the **PPO** option and **DMO**:

- Work done while not **covered** under the Dental Plan (excluding orthodontic work in progress)
- Charges you have no legal obligation to pay
- Charges third parties are required to pay
- Work that is otherwise free of charge
- Charges for broken appointments
- Charges for completing or filing claim forms
- Educational training programs, dietary instructions, or plaque control programs
- Treatment resulting from or caused by the negligent or wrongful act of a third party
- Drugs or their administration
- 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 **Aetna**
 - **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, missing 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 to restore occlusion, or for the purpose of splinting or correcting attrition, 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
 - Extra sets of dentures or other appliances
 - Implantology
 - Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
 - 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**
 - A crown, bridge or cast or processed restoration if a tooth was prepared for it before the person became **covered**
 - Root canal therapy if the pulp chamber for it was opened before the person became **covered**
 - A crown, cast or processed restoration, 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
 - Pontics, crowns, cast or processed restorations made with high noble metals; except as specifically provided
 - Surgical removal of impacted wisdom teeth only for orthodontic reasons; except as specifically provided
 - 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
 - General anesthesia and intravenous sedation; unless done in conjunction with another necessary **covered** service
 - Services done where there is no evidence of pathology, dysfunction or disease other than **covered** preventive services
 - 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 **Aetna** to be experimental, or still under clinical investigation by health professionals
- 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: 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 person duly licensed to practice dentistry by governmental authorities having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered. As used in this Dental Plan, the term dentist also includes a licensed physician authorized by his or her license to perform the particular dental service rendered.

Denture: a device replacing missing teeth.

Fixed bridge: a prosthesis that replaces one or several teeth and that 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 that 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.

Negotiated fee: the maximum fee a preferred health care provider has agreed to make as to any service or supply for the purpose of the benefits under the Dental Plan.

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.

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.

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.

Overbite: the vertical overlap of the upper teeth over the lower teeth.

Overjet: the horizontal overlap of the upper teeth over the lower teeth.

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** 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** to provide the dental care described under the Dental Plan to **covered** persons.

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.

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

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.