

## **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.