

**THE AVAYA INC.**

**RETIREE DENTAL EXPENSE PLAN  
FOR SALARIED EMPLOYEES**

**SUMMARY PLAN DESCRIPTION**

**Effective 1/1/2005  
Last Updated 2/28/2005**

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2005, to **eligible retirees** under The Avaya Inc. Retiree Dental Expense Plan for Salaried Employees (Dental Plan). More detailed information is provided in the official legal Plan Document. In all instances, the Plan Document will control and govern the operation of the Dental Plan.

The Board of Directors of Avaya Inc. (or its delegate) reserves the right to modify, suspend, change 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. cannot be 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 nor a guarantee of continued benefits during retirement.

<b>TABLE OF CONTENTS</b>	<b>PAGE</b>
<b>INTRODUCTION.....</b>	<b>6</b>
<b>HIGHLIGHTS .....</b>	<b>7</b>
<b>TERMS YOU SHOULD KNOW .....</b>	<b>9</b>
<b>PARTICIPATING IN THE PLAN .....</b>	<b>14</b>
WHO IS ELIGIBLE .....	14
ELIGIBLE DEPENDENTS.....	14
ENROLLMENT.....	14
<i>Annual Enrollment</i> .....	14
<i>Confirmation Statements</i> .....	14
<i>Changing Your Coverage During the Year</i> .....	14
<i>Deferring and Electing Dental and Medical Plan Coverage</i> .....	15
WHEN COVERAGE BEGINS.....	15
<b>HOW THE PLAN WORKS .....</b>	<b>16</b>
UNDERSTANDING YOUR OPTIONS UNDER THE PLAN .....	16
<b>HOW BENEFITS ARE PAID .....</b>	<b>17</b>
MAXIMUM BENEFITS.....	17
COMPARING BENEFITS.....	17
<b>GETTING THE MOST FROM YOUR COVERAGE.....</b>	<b>18</b>
ALTERNATE PROCEDURES .....	18
PREDETERMINATION OF BENEFITS.....	18
<b>COVERAGE UNDER THE PLAN.....</b>	<b>20</b>
<b>THE PREFERRED PROVIDER ORGANIZATION (PPO).....</b>	<b>21</b>
TAKING ADVANTAGE OF THE PPO .....	21
PPO BENEFITS .....	21
<b>YOUR CONTRIBUTION .....</b>	<b>22</b>
YOUR MONTHLY CONTRIBUTION .....	22
MAXIMUM COMPANY CONTRIBUTION .....	22
AVAYA INC. CONTRIBUTION .....	22
RETIREE CONTRIBUTION.....	22
<b>MISCELLANEOUS COVERAGE INFORMATION.....</b>	<b>23</b>
CLAIMING BENEFITS.....	23
<i>Filing Deadlines</i> .....	23
COORDINATION OF BENEFITS.....	23
<i>When the COB Provision Applies</i> .....	23
<i>When the COB Provision Does Not Apply</i> .....	24
<i>The Primary Plan Determines Benefits First</i> .....	24
<i>How the Claims Administrator Determines Which Plan Is Primary</i> .....	25
RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION .....	26
OBLIGATION TO REFUND AND RIGHT OF RECOVERY AND SUBROGATION .....	26
WHEN COVERAGE ENDS.....	28
WHEN DEPENDENT COVERAGE ENDS.....	28
<i>Extension of Coverage Under the Plan</i> .....	29

CONTINUING YOUR DENTAL COVERAGE THROUGH COBRA .....	29
COBRA Coverage .....	29
Retiree Loses Coverage.....	30
Dependent Continuation Coverage.....	30
When Coverage Ends .....	31
COBRA Coverage Cost.....	31
If You Have Questions .....	31
Keep Your Plan Informed of Address Changes.....	32
<b>PERSONAL EVENTS AFFECTING COVERAGE .....</b>	<b>33</b>
IF YOU GAIN A NEW DEPENDENT .....	33
IF A DEPENDENT LOSES ELIGIBILITY .....	33
If Your Physically or Mentally Handicapped Child Reaches Age 23.....	33
IF YOU DIE WHILE COVERED UNDER THE RETIREE DENTAL EXPENSE PLAN FOR SALARIED EMPLOYEES.....	33
IF YOU MOVE .....	33
QUALIFIED STATUS CHANGES .....	34
IF YOU HAVE A CHANGE IN DEPENDENT STATUS .....	34
IF YOU ARE REHIRED .....	34
QUALIFIED MEDICAL CHILD SUPPORT ORDERS .....	35
<b>AVAYA INC. FAMILIES.....</b>	<b>36</b>
ENROLLMENT RULES.....	36
<b>IMPORTANT CONTACTS.....</b>	<b>37</b>
AVAYA HEALTH AND BENEFITS DECISION CENTER .....	37
ONLINE WITH AVAYA HEALTHY DECISIONS.....	37
AETNA .....	37
By Phone.....	37
By Mail.....	38
Online .....	38
OTHER CONTACTS .....	39
<b>OTHER IMPORTANT INFORMATION .....</b>	<b>40</b>
CLAIM PROCEDURES.....	40
Initial Claim Decision .....	40
Failure to Follow Urgent Care or Pre-Service Claims Procedure: .....	41
Notice of Incomplete Urgent Care Claim.....	41
Concurrent Care Claim.....	41
Appeal Procedures.....	42
Claims Decision Notices.....	43
YOUR RIGHTS UNDER ERISA .....	44
Right to Receive Information About the Plan and Its Benefits .....	44
Prudent Action by Plan Fiduciaries .....	44
Enforce Your Rights .....	45
If You Have Questions .....	45
PLAN FUNDING AND PAYMENT OF BENEFITS .....	46
PLAN DOCUMENT GOVERNS.....	46
BENEFITS CANNOT BE ASSIGNED .....	46
PLAN MAY BE AMENDED OR TERMINATED .....	46
PLAN ADMINISTRATOR AND CLAIMS ADMINISTRATOR.....	46
PLAN SPONSOR .....	47
<b>ADMINISTRATIVE INFORMATION .....</b>	<b>48</b>
<b>APPENDIX A: HOW THE PLAN COVERS ELIGIBLE EXPENSES .....</b>	<b>49</b>

**APPENDIX B: SERVICES AND/OR CHARGES NOT COVERED UNDER THE PLAN .....53**  
    GENERAL EXCLUSIONS .....53  
**APPENDIX C: GLOSSARY OF DENTAL TERMS .....55**

## **INTRODUCTION**

The Avaya Inc. Retiree 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 an optional **Preferred Provider Organization (PPO)** network.

If you are an **eligible retiree**, Avaya Inc. provides you with retiree dental coverage automatically when you elect retiree medical benefits.

## HIGHLIGHTS

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

Plan Feature	Summary
Eligibility	You are eligible to participate in the Dental Plan if you are an <b>eligible retiree</b> and you elect coverage under The Avaya Inc. Retiree Medical Expense Plan for Salaried Employees (Medical Plan). You may also enroll your <b>eligible dependents</b> .
Enrollment	<p>When you retire, enrollment materials and information about your coverage options will be sent to you at your home address.</p> <p>You must enroll by the date specified in your enrollment package. If you do not enroll by the specified enrollment deadline, you will be defaulted to deferred coverage. You may enroll for coverage at a later date, but you will not have coverage retroactively.</p>
Coverage Amounts	<p>The Dental Plan includes the <b>Preferred Provider Organization (PPO)</b>, a feature that can help reduce your out-of-pocket costs when you receive services from a participating <b>PPO</b> dentist. This is because participating <b>PPO</b> dentists agree to accept fees for services that are typically 10% to 30% lower than <b>reasonable and customary charges</b> within that geographic region.</p> <p>The Dental Plan usually pays:</p> <ul style="list-style-type: none"> <li>• 100% of <b>reasonable and customary charges</b> for <b>covered</b> diagnostic and preventative expenses, such as routine oral exams</li> <li>• 80% of <b>reasonable and customary charges</b> for basic restorative expenses</li> <li>• 50% of <b>reasonable and customary charges</b> for major restorative expenses</li> <li>• 50% of <b>reasonable and customary charges</b> for orthodontia</li> </ul> <p>If you use a <b>PPO</b> dentist, the provider's charge is guaranteed to be within the <b>reasonable and customary charges</b>, so you are protected from paying charges above the allowable amount.</p>
Information About the Dental Plan	Use this document as a reference and call the <b>Claims Administrator</b> (see "Important Contacts") for specific benefit coverage information. For questions about eligibility, your benefit options, or to enroll, call the <b>Avaya Health and Benefits Decision Center</b> (see "Important Contacts").

<b>Plan Feature</b>	<b>Summary</b>
Cost	The cost of coverage varies by your medical option, level of coverage, years of service at retirement, age at retirement, hire date and retirement date.

## **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 C.

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

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

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

**Children:** include your own 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 partnership dependent** is the legal guardian (excluding “wards of the state” or “foster children”). See **Class I dependents** and **domestic partnership dependents**.

**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 applicable Claims Administrator under The Avaya Inc. Retiree Medical Expense Plan for Salaried Employees. You must complete an application form available from your applicable medical Claims Administrator and submit it for approval to the address listed on the form.

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

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

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

**Covered:** eligible under the terms of the Dental Plan. "Covered" is often used to modify other terms. A covered expense is a dental cost that satisfies all of the rules to be considered for payment under the Dental Plan. A covered person is one who is 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** or **domestic partnership dependent** who is **covered** as the dependent of an **eligible retiree**.

**Domestic partnership benefits:** retired employees are *not* permitted to enroll a new **domestic partnership dependent** under the Dental Plan. If, however, an active employee had a **domestic partnership dependent covered** under the Dental Plan on the date of his or her retirement from the Company, he or she shall be permitted to continue the coverage for the enrolled **domestic partnership dependents**. If coverage for a **domestic partnership dependent** under the Dental Plan is terminated, the retired employee shall *not* thereafter be entitled to enroll a new **domestic partnership dependent**.

**Domestic partnership dependent:** an individual who:

- Is a member of the same sex as the employee,
- Complies with any state or local registration process for domestic partners, if applicable, or resides in a state that recognizes same-sex marriages and are legally married under the laws of that state, and
- Satisfies each of the specific criteria identified below and completes a Notarized Affidavit attesting that the employee and the domestic partner:

- Reside in the same household as a member of the household,
  - Are each 18 years of age or older,
  - Have mental capacity sufficient to enter into a valid contract,
  - Are unrelated to each other by blood,
  - Not legally married to any other person,
  - Consider themselves to have a close and committed personal relationship, intend to continue such relationship indefinitely and have no other such relationship with any other person, and
  - Are responsible for each other's welfare and financial obligations, or
- Is the natural or adopted child of a domestic partner meeting all of the criteria described above, 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.

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

**Eligible retiree:** a former eligible employee of Avaya Inc. and participant in The Avaya Inc. Dental Expense Plan for Salaried Employees who terminated from a **Participating Company** and who:

- Retired with a service or disability pension under The Avaya Inc. Pension Plan for Salaried Employees, or
- Is eligible for Access to Retiree Health Care. You are eligible for Access to Retiree Health Care if you were a salaried employee and your age plus **net credited service** equal 60 or more and you have a minimum of 5 years of **net credited service** at termination.

**Lawful spouse:** a person who is recognized as the lawful husband or lawful wife of a retired employee under the laws of the state or jurisdiction of the **eligible retiree's** domicile as limited by the Federal Defense of Marriage Act. An **eligible retiree** residing in a state that recognizes common law marriage must satisfy the specific minimum state requirements to be married under common law.

**Medical Plan:** the Avaya Inc. Retiree Medical Expense Plan for Salaried Employees.

**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.

**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.

**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 a participant's child and that has been determined to be qualified under the Internal Revenue Code of 1986, as amended. It is the policy of Avaya Inc. to comply with the requirements of a QMCSO (see "Important Contacts").

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

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

Avaya Inc. also considers corresponding changes in **domestic 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 an **eligible retiree** and have elected to participate in The Avaya Inc. Retiree Medical Expense Plan for Salaried Employees (Medical Plan).

Upon your termination of service and eligibility for the Dental Plan, you have a one-time option to defer your retiree medical and dental coverage until a later date. At your election, you can choose to be covered by the Dental and Medical Plans upon termination or any time in the future without providing proof of insurability. However, once you are covered by the Dental and Medical Plans and subsequently drop your coverage, you cannot be covered again, regardless of your health condition (see “Deferring and Reinstating Dental and Medical Plan Coverage”).

### ***Eligible Dependents***

As a participant in the Dental Plan, you may enroll your **eligible dependents** for coverage. Your **eligible dependents** are generally the same as those enrolled under Medical Plan.

### ***Enrollment***

See “Enrollment” in The Avaya Inc. Retiree Medical Expense Plan for Salaried Employees SPD.

### ***Annual Enrollment***

See “Enrollment” in The Avaya Inc. Retiree Medical Expense Plan for Salaried Employees SPD.

### ***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”).

### ***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 or family). The change to the Dental Plan must be consistent with the change to coverage under the Medical Plan.

You must call the **Avaya Health and Benefits Decision Center** any time you have a **qualified status change** and wish to make a corresponding change in coverage. If you miss the 31-day deadline, you must wait until the next **annual enrollment** period to make applicable changes to your retiree health care coverage.

### **Deferring and Electing Dental and Medical Plan Coverage**

You can also defer retiree Dental and Medical Plan coverage with the option to elect coverage at a later date. However, once you enroll for coverage (coverage to be effective first of the following month), you must remain continuously enrolled. If you subsequently drop coverage or coverage is terminated due to non-payment, you will not be able to reinstate coverage ever again.

### ***When Coverage Begins***

Coverage under the retiree medical and dental plans begins the first of the month following retirement, unless you deferred coverage. If coverage is deferred and you wish to enroll, coverage will begin the first of the month following your election, so long as any required premium payments are made.

## HOW THE PLAN WORKS

### *Understanding Your Options Under the Plan*

If you elect coverage, the Dental Plan covers 100% of **reasonable and customary charges** for **covered** diagnostic and preventative services, such as routine oral exams and cleaning and scaling of teeth. Benefits for **covered** basic restorative services, such as fillings and root canal therapy, are **covered** at 80% of **reasonable and customary charges**. **Covered** major restorative services, such as inlays, onlays and crowns, and orthodontia services are **covered** at 50% of **reasonable and customary charges**.

There is also a **PPO** network available, which helps reduce your costs when you go to a participating **PPO** dentist. See “The Preferred Provider Organization (PPO)” for more information.

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 ore more **eligible dependents**

Generally, you must elect the same category (individual, two-person or family) for the Dental and Medical Plan.

You may make a one-time election to defer enrolling in retiree health (medical and dental) benefits. There is no limit on how long you may defer. If you elect to defer coverage, you may enroll at a future date. If you later terminate coverage, you *cannot* re-enroll ever again.

You must make an election within 31 days of receipt of your retirement kit in order to be covered. If you do not make an election, the default coverage is deferred coverage.

## HOW BENEFITS ARE PAID

The Dental Plan covers 100% of **reasonable and customary charges** for **covered** diagnostic and preventative services. **Covered** expenses for basic restorative services are paid at 80% of **reasonable and customary charges**. **Covered** expenses for major restorative services and orthodontia are **covered** at 50% of **reasonable and customary charges**. See “Appendix A” for a complete list of **covered** services.

You can also select coverage through the **PPO** network. See “The Preferred Provider Organization (PPO)” for more information.

### **Maximum Benefits**

The Dental Plan 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 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 Dental Plan.

*Example:*

Suppose you need a crown. Here is how the Dental Plan pays benefits:

	<b>If you use a PPO provider</b>	<b>If you use a non-PPO provider</b>
Dentist’s usual fee	\$600	\$600
<b>PPO</b> negotiated fee	\$420	Not applicable
<b>Reasonable and customary charge</b>	Not applicable	\$500
Amount Dental Plan pays	\$210 (50% of <b>PPO</b> negotiated fee)	\$250 (50% of <b>reasonable and customary charge</b> )
Amount you pay	\$210 (\$420 minus \$210)	\$350 (\$600 minus \$250)
Amount you save by using a <b>PPO</b> provider	<b>\$140</b> (\$350 minus \$210)	<b>N/A</b>

Note: The chart is for illustrative purposes only. Charges and **PPO** discounts will vary.

## **GETTING THE MOST FROM YOUR COVERAGE**

To ensure you receive the maximum benefit under the Dental Plan, 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 that will cost 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 Reference Materials and Forms section of the Avaya Healthy Decisions Web site (<http://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** (see “Important Contacts”).
- 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 for claims over \$200, the **Claims Administrator** will pay the claim based on the information it has about your case. If it is determined a less expensive treatment was possible, you may receive a lower benefit

than you expected. Predetermination of benefits could help you avoid expensive surprises.

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

## **COVERAGE UNDER THE PLAN**

See “Appendix A” for a list of diagnostic, preventative, basic restorative, major restorative and orthodontic services **covered** under the Dental Plan.

## THE PREFERRED PROVIDER ORGANIZATION (PPO)

The **PPO** network offers dental services through participating dentists, including specialists.

By going to a dentist who participates in the **PPO** network, you and your **covered dependents** will receive dental care at charges lower than the average cost for care in your area. You receive the same reimbursement percentage of **covered** charges whether or not you visit a dentist in the program. However, since a dentist who participates may charge less for the services than those charged by non-participating dentists, the remaining cost will be lower, reducing your out-of-pocket expense.

### **Taking Advantage of the PPO**

To take advantage of the **PPO** network, you must first enroll in the Dental Plan. Once you are enrolled, you can access a directory or participating PPO dentists online at <http://www.aetnavigators.com>, or contact the **Claims Administrator** (see “Important Contacts”) to request a directory of participating **PPO** dentists for your area. Once you are enrolled, you may also contact the **Claims Administrator** (see “Important Contacts”) and 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.

### **PPO Benefits**

The **PPO** provides coverage for services with no deductible, as follows:

	<b>In-Network*</b>	<b>Out-of-Network*</b>
Diagnostic and Preventative	100% of <b>PPO fee**</b>	100% of <b>reasonable and customary charges</b>
Basic Restorative	80% of <b>PPO fee**</b>	80% of <b>reasonable and customary charges</b>
Major Restorative	50% of <b>PPO fee**</b>	50% of <b>reasonable and customary charges</b>
Orthodontia	50% of <b>PPO fee**</b>	50% of <b>reasonable and customary charges</b>
<p>* In-network refers to benefits for services that are rendered by a participating <b>PPO</b> dentist. Out-of-network refers to benefits for services that are rendered by a dentist who does not participate in the <b>PPO</b>.</p> <p>** <b>PPO</b> fee refers to the typically lower “negotiated fees” that participating <b>PPO</b> network dentists accept as “payment in full” from eligible Plan participants.</p>		

## **YOUR CONTRIBUTION**

### ***Your Monthly Contribution***

There is one combined rate for both your medical and dental coverage. You have the option to elect monthly billing for the required premium payments. You may also arrange to have the **Avaya Health and Benefits Decision Center** automatically deduct your payment from your bank account. When you first become eligible, and during **annual enrollment**, you will have access to cost information for all the available options.

### ***Maximum Company Contribution***

The Maximum Company Contribution is the amount the company determines that it will pay towards the cost of retiree health (medical and dental) coverage. Please see “Maximum Company Contribution” in The Avaya Inc. Retiree Medical Expense Plan for Salaried Employees SPD for more details.

### ***Avaya Inc. Contribution***

The Avaya Inc. Contribution is for retiree health (medical and dental) coverage. Please see “Avaya Inc. Contribution” in The Avaya Inc. Retiree Medical Expense Plan for Salaried Employees SPD for more details.

### ***Retiree Contribution***

Your retiree contribution is the difference between the actual total cost of coverage (which changes annually to reflect the actual claims experience of the Plan, health care cost inflation, and any Plan design changes) and Avaya Inc.’s contribution. You are responsible for the increase in the cost of coverage from one year to the next. Conversely, if the cost of coverage decreases from year to year, the savings are passed on to you in the form of lower costs.

## MISCELLANEOUS COVERAGE INFORMATION

### ***Claiming Benefits***

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.

### **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, one plan is primary and determines its benefits first. Any other plan is secondary.

To claim benefits, submit your claim to the primary plan first. After that plan determines its benefits, submit a claim to the secondary plan(s) along with a copy of the explanation

of benefits (EOB) statement you received from the primary plan. The secondary plan(s) will then determine if any additional benefits are payable.

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

### **How the Claims Administrator Determines Which Plan Is Primary**

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

- If the other plan(s) does not have a **COB** feature, that plan(s) is considered primary and the Dental Plan is considered secondary.
- If both plans have a **COB** provision, the plan covering a person as an employee is primary, and the plan covering the person as a dependent is secondary.
- For dependent **children**, determination of the primary and secondary plan(s) follows these rules in this sequence:
  - The "birthday" rule. The plan covering the parent whose birthday (month and day) comes first in the year is the primary plan for the **children**, and the plan covering the other parent is the secondary plan for the **children**. If both parents have the same birthday, the benefits of the plan that **covered** the parents longer are determined before those of the plan that **covered** the other parent for a shorter period of time. The Dental Plan uses this rule.
  - The "male-female" rule. For plans that do not use the birthday rule, the father's group insurance is the primary plan for the **children** and the mother's group insurance is the secondary plan for the **children**.
  - If one parent's plan includes the male-female rule and one parent's plan includes the birthday rule, the male-female rule applies to the extent permitted by law.
- If the parents of dependent **children** are divorced or legally separated, the Plan Administrator will determine if there is a court decree or a **Qualified Medical Child**

**Support Order (QMCSO)** establishing financial responsibility for dental care. If an order meets the requirements of a **QMCSO**, Avaya Inc. will comply with the terms of that order. See “Important Contacts” for where to submit **QMCSOs**.

- If there is such a decree or **QMCSO**, the plan covering the parent who has that responsibility will be the primary plan.
- If there is no such decree or **QMCSO**, the plan that covers the parent with custody will be the primary plan; the other parent’s plan will be secondary.
- If there is no such decree or **QMCSO** and the parent with custody remarries, that parent’s plan remains primary, the stepparent’s plan pays secondary, and the noncustodial 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, your **lawful spouse** or your **eligible dependents**, including **domestic partnership 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 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 fail to make any required contributions,
- You request cancellation of coverage,
- The company you retired from 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,
- Last day of the month in which your **covered dependent** is no longer an **eligible dependent**, or,
- The last day of the sixth month following the date of death of the retired employee.

For information about what happens to dependent coverage following your death, see "If You Die While Covered Under the Retiree Dental Expense Plan for Salaried Employees."

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**. Information about continuing coverage will be sent to your dependent.

## Extension of Coverage Under the Plan

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.

## 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 retirees** 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 dependents**.

## COBRA Coverage

**COBRA** may extend your coverage under the Dental Plan for up to 36 months. If you or your **covered dependents** are eligible for any other continuing health care coverage, that coverage also counts toward your **COBRA** continuation period. 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	Die	Your <b>covered dependents</b>	36 months
	Become divorced or legally separated	Your <b>covered dependents</b>	36 months
Your <b>covered dependent</b>	Is no longer an <b>eligible dependent</b> (due to age limit, divorce, or legal separation)	Your <b>covered dependent</b>	36 months
	Is no longer an <b>eligible dependent</b> because of your death	Your <b>covered dependent</b>	36 months

## **Retiree Loses Coverage**

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 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 the **Avaya Health and Benefits Decision Center** determines that you and 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 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 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)

If the **Avaya Health and Benefits Decision Center** determines that your coverage is terminating before the end of the 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.

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.

### **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 <http://www.dol.gov/ebsa>. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA Web site.)

### **Keep Your Plan Informed of Address Changes**

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

## 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 (other than a **domestic partnership 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 day he or she became your dependent. *If you do not enroll the dependent within 31 days, you will not be permitted to elect coverage for the dependent until the next **annual enrollment** period, unless you experience another applicable **qualified status change**.*

### ***If a Dependent Loses Eligibility***

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 your 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 Retiree Dental Expense Plan for Salaried Employees***

Coverage for your enrolled **Class I dependents** and **domestic partnership dependents** may continue for six months after you die. Your dependents must pay the same amount to continue coverage. After six months, your dependents have the option of continuing coverage under **COBRA** for up to another 30 months (for a total of 36 months) if they make the required contributions. For more information about continuing coverage under **COBRA**, see “COBRA Continuation Coverage.”

### ***If You Move***

Any time your home address changes, it is important to provide the **Avaya Health and Benefits Decision Center** (see “Important Contacts”) with your new address. You should notify the **Avaya Health and Benefits Decision Center** before, or as soon as possible after, your move. This ensures that your benefits will continue uninterrupted.

### **Qualified Status Changes**

If you have a **qualified status change**, you may *only* change your *coverage level* (individual, two-person or family), and only to the extent that the change in coverage is consistent with your **qualified status change**. 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.

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. 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”).

### **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 your previous employment was before 2004, for retirement benefit plan purposes, you will resume coverage under the plans that you participated in when you left Avaya Inc., subject to the plan provisions in effect at the time you are rehired.

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. If your previous employment was before 2004, for retirement benefit plan purposes, your eligibility and coverage will vary based upon which plans you participated in prior to separation of service. 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 service date will be based on your rehire date and any previous service will not have an impact in the calculation of your **net credited service** date.

### **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 – retired employees whose **lawful spouse, children, or domestic partnership dependents** also may have retired from or be employed by Avaya Inc. This may affect your coverage under the Dental Plan.

### ***Enrollment Rules***

An **eligible retiree** may cover another salaried Avaya Inc. employee or retiree. Therefore, if your spouse 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 Medical Expense Plan for Salaried Employees.

A salaried retired or active Avaya Inc. employee cannot enroll a represented retired or active Avaya Inc. employee 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 partnership dependent**, 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 <http://www.avayahealthydecisions.com>.

### ***Avaya Health and Benefits Decision Center***

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

### ***Online With Avaya Healthy Decisions***

You can access the Avaya Healthy Decisions Web site online at <http://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** dentists.

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

### **By Mail**

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

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

### **Online**

You can access the self-service Navigator Web site online at <http://www.aetnavigators.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
<b>Domestic Relations Matters Group:</b> Contact for matters relating to a <b>Qualified Medical Child Support Order (QMCSO)</b> .	Domestic Relations Matters Group Aon Consulting of New Jersey, Inc. 270 Davidson Avenue, 7th Floor Somerset, NJ 08873
<b>Plan Administrator:</b> 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 <b>Claims Administrator</b> ) at the above address.	Avaya Inc. Dental Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920  E-mail: <a href="mailto:hwplanadmin@avaya.com">hwplanadmin@avaya.com</a>

## **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 relative documents that must be made available to you 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 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 automatically receive 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.

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 <http://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. Retiree 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.

### ***Plan Document Governs***

This SPD is designed to describe The Avaya Inc. Retiree Dental Expense Plan for Salaried Employees in easy-to-understand terms. It is less technical than the official legal Plan Document. However, the Plan Document and contracts determine your rights and the rights of your **eligible dependents** under the Plan. In all instances, the Dental Plan Document will govern.

### ***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 the **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

<b>Plan Name</b>	The official Plan Name is The Avaya Inc. Retiree Dental Expense Plan for Salaried Employees.
<b>Plan Sponsor</b>	The Plan Sponsor is Avaya Inc.
<b>Plan Administrator</b>	The Plan Administrator is:  Avaya Inc. Dental Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920  E-mail: <a href="mailto:hwplanadmin@avaya.com">hwplanadmin@avaya.com</a>
<b>Type of Administration</b>	The Dental Plan is administered on Avaya Inc.'s behalf by:  Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156
<b>Claims Administrator</b>	The <b>Claims Administrator</b> is Aetna. Claims should be submitted to:  Aetna Dental P.O. Box 14066 Lexington, KY 40512-4066
<b>Agent for Service of Legal Process</b>	Legal actions regarding a claim for benefits should be sent to the <b>Claims Administrator</b> . All other legal actions should be sent to the Plan Administrator.
<b>Plan Records and Plan Year</b>	The Plan and all its records are maintained on a calendar year basis, beginning on January 1st and ending on December 31st of each year.
<b>Type of Plan</b>	The Plan is considered a "health & welfare plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
<b>Trustee</b>	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.
<b>Plan Number</b>	The Plan Number is 508.
<b>Employer Identification Number</b>	The Employer Identification Number is 22-3713430.

## APPENDIX A: HOW THE PLAN COVERS ELIGIBLE EXPENSES

Following is a comparison schedule of in-network and out-of-network benefits under the Dental Plan. For a complete description of terms described in this section, see “Appendix C.”

	Amount Plan Pays	
	In-Network	Out-of-Network
<b><u>Diagnostic and Preventative Services</u></b>		
<b><u>Type A Services</u></b>		
<b>Twice in a calendar year:</b>	100% of PPO fee	100% of reasonable and customary charges
<ul style="list-style-type: none"> <li>• Routine Periodic Oral Examination</li> <li>• Cleaning and scaling of teeth when performed by a dentist or dental hygienist</li> </ul>		
<b>In a calendar year:</b>	100% of PPO fee	100% of reasonable and customary charges
<ul style="list-style-type: none"> <li>• Fluoride treatments when performed by a dentist or dental hygienist:                             <ul style="list-style-type: none"> <li>⇒ Up to four topical applications of sodium fluoride</li> <li>⇒ One topical application of stannous fluoride</li> <li>⇒ One topical application of acid fluoride phosphate</li> </ul> </li> </ul>		
<b>As specified:</b>	100% of PPO fee	100% of reasonable and customary charges
<ul style="list-style-type: none"> <li>• Space maintainers for Dependents and Employees under the age of 23.                             <ul style="list-style-type: none"> <li>⇒ 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)</li> </ul> </li> <li>• Dental X-rays and radiographs:                             <ul style="list-style-type: none"> <li>⇒ Full-mouth X-rays (not more than once in three rolling years*)</li> <li>⇒ Supplementary bitewing X-rays (not more than twice in a calendar year)</li> <li>⇒ Diagnostic dental X-rays required for a specific condition, except X-rays in conjunction with orthodontics</li> </ul> </li> <li>• Diagnostic Testing                             <ul style="list-style-type: none"> <li>⇒ Bacteriologic Cultures</li> <li>⇒ Caries Susceptibility</li> <li>⇒ Pulp Vitality Tests</li> <li>⇒ Diagnostic Casts</li> <li>⇒ Diagnostic Photographs</li> </ul> </li> <li>• Sealants for dependent children 13 years old and younger (once per tooth every 3 rolling years); molars (one-time application)</li> <li>• Emergency Palliative Treatment</li> </ul>		

	Amount Plan Pays	
	In-Network	Out-of-Network
*Full mouth X-rays within three years of the last treatment will be <b>covered</b> if the expense is incurred within the last 30 days of such three-year period.		
<b><u>Basic Restorative Services</u></b>		
<b><u>Type B Services</u></b>		
<b>Restorations:</b>	80% of <b>PPO</b> fee	80% of <b>reasonable and customary charges</b>
<ul style="list-style-type: none"> <li>• Fillings                             <ul style="list-style-type: none"> <li>⇒ Amalgam 1-3 surfaces, deciduous</li> <li>⇒ Amalgam 1-3 surfaces, permanent</li> <li>⇒ Silicate Cement – per restoration Acrylic or Plastic</li> <li>⇒ Composite Resin – 1-4 anterior surfaces</li> <li>⇒ Filling (sedative)</li> </ul> </li> <li>• Stainless Steel Crown – Child</li> <li>• Resin Crown</li> <li>• Pin Retention</li> </ul>		
<b>Root Canal Therapy:</b>		80% of <b>reasonable and customary charges</b>
<i>Procedures used to prevent and treat diseases of the dental pulp</i>	80% of <b>PPO</b> fee	
<ul style="list-style-type: none"> <li>• 1-3 canals (traditional)</li> <li>• Pulp cap – direct/indirect</li> <li>• Pulp Treatment:</li> </ul>		
<b>Periodontics:</b>		80% of <b>reasonable and customary charges</b>
<i>Surgical and nonsurgical procedures to treat the supporting area around the teeth, except periodontal splinting</i>	80% of <b>PPO</b> fee	
<ul style="list-style-type: none"> <li>• Preventive Periodontal Procedure</li> <li>• Gingival curettage code</li> <li>• Gingivectomy</li> <li>• Gingival Flap</li> <li>• Surgical Tooth Revision</li> <li>• Scaling and Root Planing</li> </ul>		
<b>Oral Surgery:</b>	80% of <b>PPO</b> fee	80% of <b>reasonable and customary charges</b>
<ul style="list-style-type: none"> <li>• Simple Extractions</li> <li>• Root Recovery</li> <li>• Biopsy Of Oral Tissue</li> <li>• Transseptal Fiberotomy</li> <li>• Alveoplasty</li> <li>• Remove Odontogenic Tumor</li> <li>• I&amp;D Of Abscess</li> <li>• Frenulectomy</li> </ul>		
<b>Other Type B Services:</b>	80% of <b>PPO</b> fee	80% of <b>reasonable and customary charges</b>
<ul style="list-style-type: none"> <li>• Therapeutic Drug Injection</li> <li>• Desensitizing Medication/Resin</li> <li>• Adjust Occlusion</li> <li>• Oral Pathology</li> <li>• Histopathologic Exam</li> </ul>		

	Amount Plan Pays	
	In-Network	Out-of-Network
<b>Major Restorative Services</b>		
<b><u>Type C Services</u></b>		
<b>Inlays, onlays and crowns:</b>	50% of <b>PPO</b> fee	50% of <b>reasonable and customary charges</b>
<ul style="list-style-type: none"> <li>• Inlays and onlays to restore tooth structure</li> <li>• Crowns to restore tooth structure                             <ul style="list-style-type: none"> <li>⇒ Plastic with semiprecious metal crowns</li> <li>⇒ Porcelain crown</li> <li>⇒ Porcelain with semiprecious metal crown</li> <li>⇒ Gold or full cast crown</li> <li>⇒ Crown Build-up</li> <li>⇒ Labial Veneer</li> <li>⇒ Crown Repair</li> </ul> </li> </ul>		
<b>Periodontics:</b>		
<i>Surgical procedures to treat the supporting area around the teeth, except periodontal splinting</i>	50% of <b>PPO</b> fee	50% of <b>reasonable and customary charges</b>
<ul style="list-style-type: none"> <li>• Osseous surgery – including flap entry and closure (per quadrant)</li> <li>• Osseous graft – single site</li> </ul>		
<b>Prosthetic:</b>		
<i>To replace teeth (except wisdom teeth) extracted while covered by the Plan.</i>	50% of <b>PPO</b> fee	50% of <b>reasonable and customary charges</b>
<ul style="list-style-type: none"> <li>• Complete dentures (including six months post-delivery care):                             <ul style="list-style-type: none"> <li>⇒ Complete upper</li> <li>⇒ Complete lower</li> <li>⇒ Immediate upper</li> <li>⇒ Immediate lower</li> </ul> </li> <li>• Partial dentures (including six months post-delivery care):                             <ul style="list-style-type: none"> <li>⇒ Upper with two chrome clasps with rests, acrylic base</li> <li>⇒ Lower with chrome lingual bar, two clasps, acrylic or cast base</li> <li>⇒ Upper with chrome palatal bar, two clasps, acrylic or cast base</li> <li>⇒ Full cast partial with two chrome clasps (upper)</li> </ul> </li> <li>• Bridge Pontics:                             <ul style="list-style-type: none"> <li>⇒ Cast gold</li> <li>⇒ Slotted pontic</li> <li>⇒ Porcelain fused to semiprecious metal</li> <li>⇒ Plastic processed to semiprecious metal</li> </ul> </li> </ul>		

	<b>Amount Plan Pays</b>	
	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>
<i>Prosthetic services include:</i>		
<ul style="list-style-type: none"> <li>Initial installation of fixed bridgework, including inlays and crowns to form abutments.</li> <li>Initial installation of partial or full removable dentures, including adjustments during the six-month period after they are installed.</li> <li>The addition of teeth to an existing partial removable denture or to bridgework.</li> <li>Installation of a permanent full denture that replaces and is installed within 12 months of a temporary denture.</li> <li>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.)</li> <li>Repairing or re-cementing inlays, crowns, bridgework, or dentures, or relining of dentures.</li> </ul>		
<b>Oral Surgery:</b>	50% of <b>PPO</b> fee	50% of <b>reasonable and customary charges</b>
<ul style="list-style-type: none"> <li>Surgical extractions:</li> <li>Single teeth, surgical extractions (includes partial or complete bony impaction)</li> <li>Anesthesia</li> </ul>		
<b>Other Services</b>	50% of <b>PPO</b> fee	50% of <b>reasonable and customary charges</b>
<ul style="list-style-type: none"> <li>Occlusal guard for bruxism</li> </ul>		
<b>Orthodontics:</b>		
<i>To prevent and correct malocclusion of teeth and associated facial problems</i>	50% of <b>PPO</b> fee	50% of <b>reasonable and customary charges</b>
<ul style="list-style-type: none"> <li>Appliances for tooth guidance or to control harmful habits, fixed or removable</li> <li>Comprehensive full-banded treatment, preliminary study including X-rays and treatment plan</li> <li>Active treatment, including appliances</li> </ul>		

**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 Plan purposes, a service is considered to be "provided" when treatment begins (when a tooth is prepared or a canal opened).

## **APPENDIX B: SERVICES AND/OR CHARGES NOT COVERED UNDER THE PLAN**

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

### ***General Exclusions***

All of the following services, supplies or expenses are excluded from benefits under the Dental Plan:

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

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

## APPENDIX C: 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.

**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.

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

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

**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.

**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.

**Preferred Health Care Provider:** a health care provider that has contracted to furnish services or supplies for a negotiated fee; but only if the provider is, with the Claim Administrator's consent, included in the directory as a preferred health care provider for the service or supply involved.

**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.