

THE AVAYA INC.

**RETIREE DENTAL EXPENSE PLAN
FOR SALARIED EMPLOYEES**

SUMMARY PLAN DESCRIPTION

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

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2008, to **eligible retirees** under The Avaya Inc. Retiree Dental Expense Plan for Salaried Employees (Dental Plan).

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

Please note that participation in the Dental Plan is neither an offer nor a guarantee of continued benefits during retirement.

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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 is a **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 eligible retiree and you elect coverage under The Avaya Inc. Retiree Medical Expense Plan for Salaried Employees (Medical Plan). You may also enroll your eligible dependents .
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 is a Preferred Provider Organization (PPO), which offers dental services through a network of participating dentists and specialists. Dental PPO providers charge negotiated fees for services that will generally be less than those charged by non-participating providers.</p> <p>If you use a PPO dentist, the provider's charge is guaranteed to be within the reasonable and customary charges, so you are protected from paying charges above the allowable amount.</p>
Information About the Dental Plan	Use this document as a reference and call the Claims Administrator (see "Important Contacts") for specific benefit coverage information. For questions about eligibility, your benefit options or to enroll, call the Avaya Health and Benefits Decision Center (see "Important Contacts").
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.

Aetna: the company that administers the Dental Plan.

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

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

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

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

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

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

To be eligible, a child must be:

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

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

- Incapable of self-support,

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

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

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

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

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

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

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

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

Deductible: the amount of eligible expenses you may be required to pay under the Dental Plan each year before benefits for **covered** expenses can begin. The amount of the deductible depends upon the type of service or supply you receive. Some expenses do not count toward the deductible. (See "Expenses You Pay That Do Not Count Toward the Deductible.")

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

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

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

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

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

Domestic partner(ship) benefits: retired employees are *not* permitted to enroll a new **domestic partner** and/or **domestic partnership dependent** under the Dental Plan. If, however, an active employee had a **domestic partner** and/or **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 partner** and/or **domestic partnership dependents**. If coverage for a **domestic partner** and/or **domestic partnership dependent** under the Dental Plan is terminated, the retired employee shall *not* thereafter be entitled to enroll a new **domestic partner** and/or **domestic partnership dependent**.

Eligible dependents: your eligible **Class I dependents**, **domestic partner** and **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** equals 60 or more and you have a minimum of 5 years of **net credited service** at termination.

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

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

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

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

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

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

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

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

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

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

Preferred Provider Organization (PPO): Aetna's Preferred Provider Organization (PPO). The PPO is a network of credentialed participating dentists who have agreed to accept negotiated fees for their services. You can choose any **provider** at the time of treatment, but when visiting a participating PPO dentist, you have the opportunity to lower your out-of-pocket expenses.

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

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

Qualified Medical Child Support Order (QMCSO): a judgment, decree, or order issued by a court or a certain administrative process that requires dental coverage for 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 partner** and/or **domestic partnership dependents** as a qualified status change.

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

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

- The fees a dentist usually charges most patients for a similar service, and

- The range of fees charged by dentists with similar training and experience for the same or similar services within the geographic region.

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

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

PARTICIPATING IN THE PLAN

Who Is Eligible

You are eligible to participate in the Dental Plan if you are 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 can *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 (see “Deferring and Reinstating Dental and Medical Plan Coverage”).

Once you are covered by the Dental and Medical Plans, you can waive your coverage, and re-enroll in the Dental and Medical Plans within 31 days of when previous coverage ends. However, you are required to show evidence of continuous health coverage for the period in which you were not enrolled in the Dental and Medical Plans (but no more than the most recent 12 months) in order to re-enroll (see “Waiving 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. You have 31 days after the event to make a change. If you miss the 31-day deadline, you must wait until the next **annual enrollment** period to make applicable changes to your retiree health care coverage, unless you experience another applicable **qualified status change**.

Deferring and Electing Dental and Medical Plan Coverage

You can defer retiree Dental and Medical Plan coverage with the option to elect coverage as of the first of any month. Once you enroll for coverage, you will remain continuously enrolled until you elect to waive coverage or fail to pay the required premium. If your coverage is terminated due to non-payment, you will not be able to reinstate coverage ever again.

Waiving Dental and Medical Plan Coverage

You can waive Dental and Medical Plan coverage and re-enroll in the Dental and Medical Plan within 31 days of when the previous coverage ends. You are required to show evidence of continuous health coverage for the period in which you were not enrolled in the Dental and Medical Plan (but no more than the most recent 12 months) in order to re-enroll.

The effective date will be the first of the month following the month in which your previous coverage ends. It is unnecessary to show a **qualified status change** to waive coverage and there's no limit to the number of times you may waive coverage and re-enroll as long as you can prove you have continuous health coverage.

If you have continuous medical coverage but do not have continuous dental coverage, you will not have dental coverage for two Plan Years. The required contributions will not be reduced if you do not have dental coverage.

If you do not have continuous medical coverage for the period of coverage you were not enrolled in the Dental and Medical Plan, you will not be able to re-enroll 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 the required premium payments are made. If you were previously enrolled, then

waived your dental and medical coverage, and wish to re-enroll, coverage will begin the first of the month following your election, so long as you provide evidence of continuous health coverage for the period in which you were not enrolled in the Dental and Medical Plan (but no more than the most recent 12 months) and the required premium payments are made.

HOW THE PLAN WORKS

Understanding Your Options Under the Plan

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

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

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

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

You may make an 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 due to non-payment, you *cannot* re-enroll ever again.

In addition, you may waive dental and medical coverage, meaning you have been enrolled, and later opt-out of coverage. You can re-enroll in the Dental and Medical Plan within 31 days of when previous coverage ends. You must show evidence of continuous health coverage for the period in which you were not enrolled in the Dental and Medical Plan (but no more than the most recent 12 months) in order to re-enroll. There is no limit to the number of times you may waive coverage and re-enroll as long as you can prove you have continuous health coverage. If you do not have continuous medical coverage for the period of coverage you were not enrolled in the Medical Plan, you will not be able to re-enroll ever again. If you have continuous medical coverage but do not have continuous dental coverage, you will not have dental coverage for two Plan Years. The required contributions will not be reduced if you do not have dental coverage.

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

Benefits

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

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

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 separate lifetime maximum of \$1,750 per **covered** person.

Comparing Benefits

The following example will give you an idea of how benefits are paid if you elect coverage under the Dental Plan.

Example:

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

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

Taking Advantage of the PPO

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

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

Getting the Most From Your Coverage

To ensure you receive the maximum benefit under the 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 costing over \$200, you should determine before treatment begins what is **covered** and how much the Dental Plan will pay. This procedure is called “predetermination of benefits.” Here is how predetermination works:

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

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

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

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

YOUR CONTRIBUTION

Your Monthly Contribution

There is one combined rate for both your medical and dental coverage. You will be billed monthly for the required premium payments. You may also arrange to have the **Avaya Health and Benefits Decision Center** automatically deduct the 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 retiree health (medical and dental) options through the Avaya Healthy Decisions Web site (www.AvayaHealthyDecisions.com).

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

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

- If the Dental Plan through Avaya Inc. is the primary plan, it pays its benefits without regard to the secondary plan.
- If the Dental Plan is secondary, the Dental Plan coordinates benefits with the primary plan(s). Here is how this works. The **Claims Administrator** first calculates what the Dental Plan would have paid if it were the primary plan. Second, the **Claims Administrator** reviews the EOB statement you received from the primary plan to determine what the primary plan paid. The Dental Plan then pays the difference between what the Plan would have paid if there was no other coverage and the primary plan’s payment. Therefore, among the primary and secondary plans, you can receive up to the highest payment of benefits allowed by either plan.

How the Claims Administrator Determines Which Plan Is Primary

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

- If the other plan(s) does not have a **COB** feature, that plan(s) is considered primary and the Dental Plan is considered secondary.
- If both plans have a **COB** provision, the plan covering a person as a retiree is primary, and the plan covering the person as a dependent is secondary.
- For dependent **children**, determination of the primary and secondary plan(s) follows these rules in this sequence:
 - The “birthday” rule. The plan covering the parent whose birthday (month and day) comes first in the year is the primary plan for the **children**, and the plan covering the other parent is the secondary plan for the **children**. If both parents have the same birthday, the benefits of the plan that **covered** the parents longer are determined before those of the plan that **covered** the other parent for a shorter period of time. The Dental Plan uses this rule.
 - The “male-female” rule. For plans that do not use the birthday rule, the father’s group insurance is the primary plan for the **children** and the mother’s group insurance is the secondary plan for the **children**.

- If one parent's plan includes the male-female rule and one parent's plan includes the birthday rule, the male-female rule applies to the extent permitted by law.
- If the parents of dependent **children** are divorced or legally separated, the Plan Administrator will determine if there is a court decree or a **Qualified Medical Child Support Order (QMCSO)** establishing financial responsibility for dental care. If an order meets the requirements of a **QMCSO**, Avaya Inc. will comply with the terms of that order. See "Important Contacts" for where to submit **QMCSOs**.
 - If there is such a decree or **QMCSO**, the plan covering the parent who has that responsibility will be the primary plan.
 - If there is no such decree or **QMCSO**, the plan that covers the parent with custody will be the primary plan; the other parent's plan will be secondary.
 - If there is no such decree or **QMCSO** and the parent with custody remarries, that parent's plan remains primary, the stepparent's plan pays secondary, and the non-custodial parent's plan pays third.
 - If payment responsibilities are still unresolved, the plan that has **covered** the patient for the longest time is the primary plan.

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

Right to Receive and Release Needed Information

Certain facts are needed to apply these **COB** rules. The **Claims Administrator** (see "Important Contacts") has the right to determine what information is needed. The **Claims Administrator** may get facts from or give them to any other organization or person, without telling, nor obtaining the consent of, any person or organization to do this. To obtain all benefits available, a claim should be filed under each plan covering the person for whom allowable expenses were incurred. Each person claiming benefits under this plan must give the **Claims Administrator** any facts needed to pay the claim.

Obligation to Refund and Right of Recovery and Subrogation

If all or some of the expenses under the Dental Plan were not paid in accordance with the terms of the Dental Plan (improper payments), or if all or some of the payments

made exceed the benefits payable under the Dental Plan (excess payments), then those improper or excess payments must be refunded to the Dental Plan.

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

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

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

- The Dental Plan shall be entitled to all of your and your **covered dependents'** rights of recovery against such third party to the extent of the reasonable value of the benefits provided under the Dental Plan.
- You and your **covered dependents** agree to reimburse the Dental Plan for the reasonable value of all benefits received under the Dental Plan out of any actual recoveries you or your **covered dependents** received from any third party (other than the participant's family members).
- The Dental Plan's subrogation and reimbursement rights apply to any recoveries that may be received or actually are received by you or your **covered dependents**, including, but not limited to, the following:
 - Any payments as a result of a settlement, judgment, or otherwise, made by or on behalf of a third party or his or her insurance company or made under an uninsured or underinsured motorist coverage,
 - Any payments under Workers' Compensation, no-fault or other state mandated motor vehicle insurance, or
 - Any payments made as a result of coverage under any automobile, school or homeowners' or other general liability insurance policy.

You and your **covered dependents** are required to fully cooperate and perform all actions necessary to secure the Dental Plan's right of recovery and subrogation, including granting a lien on any monies recovered from a third party, refraining from taking any action or negotiating any agreement with any third party that may prejudice

the Dental Plan's rights, and from assigning any rights to recover dental care expenses from any negligent party or other person or entity to any other party. You or your **covered dependents** shall not incur any expenses on behalf of the Dental Plan in pursuit of the Dental Plan's rights. No court costs or attorney's fees may be deducted from the Dental Plan's recovery without the advance express written consent of the Dental Plan.

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

When 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.

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

notification within 60 days, your dependent will lose all rights to **COBRA** continuation coverage.

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

Other Reasons Your Coverage Will End

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

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

Extension of Coverage Under the Plan

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** and/or **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 covered dependents	36 months
	Become divorced or legally separated	Your covered dependents	36 months
Your covered dependent	Is no longer an eligible dependent (due to age limit, divorce, or legal separation)	Your covered dependent	36 months
	Is no longer an eligible dependent because of your death	Your covered dependent	36 months

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. The **Avaya Health and Benefits Decision Center** will send you election information, including the cost of the coverage.

If the **Avaya Health and Benefits Decision Center** determines that you and/or your **covered dependents** are not eligible for **COBRA** continuation coverage, you will be notified in writing explaining why continuation coverage is not available.

Dependent Continuation Coverage

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

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

If your **covered dependents** lose coverage because of your death, the **Avaya Health and Benefits Decision Center** will notify them of their right to continue coverage within 44 days. Your **covered dependent** must notify the **Avaya Health and Benefits Decision Center** of their decision to continue coverage within 60 days of the later of this notification or the date benefits terminate.

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

When COBRA 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 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 partner** and/or **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 the 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 new 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 the medical health care company at the telephone number printed on your medical ID card prior to the child's 23rd birthday.

If You Die While Covered Under the Dental Plan

Coverage for your enrolled **Class I dependents**, **domestic partner** 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.”

At the end of the **COBRA** continuation period, your surviving **lawful spouse or domestic partner** and any eligible **Class I dependents** may be able to choose to continue coverage by participating in the Family Security Program through The Avaya Inc. Retiree Medical Expense Plan for Salaried Employees (**Medical Plan**). The Family Security Program is not available if you have waived Medical Plan coverage. Please see the Summary Plan Description for the Medical Plan to learn more.

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, unless you experience another applicable **qualified status change**. Contact the **Avaya Health and Benefits Decision Center** for additional information.

If You Have a Change in Dependent Status

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

If You Are Rehired

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

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

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

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

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, domestic partner, 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 **lawful spouse** or **domestic partner** is an active salaried employee, you may enroll as his or her dependent under the Dental Plan, or he or she may enroll as your dependent, but not both. If your **lawful spouse** is a retired salaried employee, you may enroll as his or her dependent under The Avaya Inc. Retiree Dental Expense Plan for Salaried Employees.

A salaried retired or active Avaya Inc. employee cannot enroll a represented Avaya Inc. retired or active 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 partner**, as an employee or retiree, may cover your dependent **children**. A child may not be **covered** by both parents or by both a parent and a **domestic partner** at the same time.

IMPORTANT CONTACTS

Here is a list of resources for the Dental Plan.

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

Avaya Health and Benefits Decision Center

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

Online With Avaya Healthy Decisions

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

Through the Web site, you can:

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

Aetna

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

By Phone

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

- Obtain claim forms,

- Check the status of a claim,
- Register a complaint,
- Review a treatment plan,
- Get information regarding a predetermination of benefits, or
- Request a list of **PPO** dentists.

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

By Mail

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

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

Online

You can access the self-service **Aetna** Navigator Web site at www.aetn navigator.com.

Through the Web site, you can:

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

Other Contacts

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

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

OTHER IMPORTANT INFORMATION

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

Claim Procedures

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

Claims concerning whether you or your dependents are 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 a written request for review to the **Claims Administrator** (for benefits claims) or the Plan Administrator (for eligibility to participate claims) within 180 days after you receive the denial notice. In connection with your appeal, you (or your authorized representative) may review relevant documents and submit issues and comments in writing.

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

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

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

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

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

If you disagree with the first appeal decision, you (or your authorized representative) may request a second appeal in writing no later than 60 days after you receive the first appeal decision. In connection with your second appeal, you (or your authorized representative) may review relevant documents and submit issues and comments in writing. After a decision is made by the **Claims Administrator** concerning your second

appeal, you will be notified of the findings and decision in writing. This notice will be provided no later than:

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

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

Claims Decision Notices

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

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

Your Rights Under ERISA

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

Right to Receive Information About the Plan and Its Benefits

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

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

You also have the right to:

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

Prudent Action by Plan Fiduciaries

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

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

Enforce Your Rights

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

- If you request a copy of plan documents or the latest annual report (Form 5500 Series) from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials – unless the materials were not sent for reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits that is denied or ignored – in whole or in part – after going through the appeals procedures, you may file suit in a state or federal court.
- If you disagree with the Plan’s decision or lack of response to your request concerning the qualified status of a **qualified medical child support order (QMCSO)**, you may file suit in federal court.
- If it should happen that the Dental Plan fiduciaries misuse the Dental Plan’s money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court.
- If you file suit against the Dental Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees – if, for example, it finds your claim is frivolous.

If You Have Questions

For answers to questions about the Dental Plan, contact the **Claims Administrator** or the Plan Administrator (see “Important Contacts”). If you have any questions about this statement of your rights or about your rights under ERISA, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) listed in your telephone directory; or contact the Division of Technical Assistance and Inquiries, U.S. Department of Labor, EBSA, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA or visit the EBSA Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA Web site.)

Plan Funding and Payment of Benefits

With certain limited exceptions, the Company pays the costs associated with providing benefits under The Avaya Inc. 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.

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 benefits during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administrator and Claims Administrator

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

Plan Sponsor

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

ADMINISTRATIVE INFORMATION

Plan Name	The official Plan Name is The Avaya Inc. Retiree Dental Expense Plan for Salaried Employees which is part of The Avaya Inc. Health & Welfare Benefits Plan for Salaried Retirees.
Plan Sponsor	The Plan Sponsor is Avaya Inc.
Plan Administrator	The Plan Administrator is: Avaya Inc. Dental Plan Administrator 211 Mount Airy Road Basking Ridge, NJ 07920 E-mail: hwplanadmin@avaya.com
Type of Administration	The Dental Plan is administered on Avaya Inc.'s behalf by: Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156
Claims Administrator	The Claims Administrator is Aetna . Claims should be submitted to: Aetna Dental P.O. Box 14066 Lexington, KY 40512-4066
Agent for Service of Legal Process	Legal actions regarding a claim for benefits should be sent to the Claims Administrator . All other legal actions should be sent to the Plan Administrator.
Plan Records and Plan Year	The Dental Plan and all its records are maintained on a calendar year basis, beginning on January 1st and ending on December 31st of each year.
Type of Plan	The Dental Plan is considered a "health & welfare plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Trustee	State Street Bank and Trust Company is the trustee of the Avaya Inc. Health Plans Benefit Trust. State Street Bank and Trust Company is located at 1 Enterprise Drive, North Quincy, MA 02171.
Plan Number	The Plan Number is 552.
Employer Identification Number	The Employer Identification Number is 22-3713430.

APPENDIX A: HOW THE PLAN COVERS ELIGIBLE EXPENSES

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

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

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

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

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

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

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

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

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

Exclusions and Limitations

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

- Work done while not **covered** under the Dental Plan (excluding orthodontic work in progress)
- Charges you have no legal obligation to pay
- Charges third parties are required to pay
- Work that is otherwise free of charge
- Charges for broken appointments
- Charges for completing or filing claim forms
- Educational training programs, dietary instructions, or plaque control programs
- Treatment resulting from or caused by the negligent or wrongful act of a third party
- Drugs or their administration
- Charges for a service or supply to the extent that it is:
 - Not reasonably necessary or customarily performed
 - More than the usual charge made when there is no insurance
 - Above the prevailing charge in the area for dental care of a comparable nature, as determined by **Aetna**
 - **Covered** under any other program paid for in full or in part, directly or indirectly, by a plan sponsored by Avaya Inc. or any **Participating Company**, including insured and uninsured programs
 - Above any limits shown in the applicable list of dental services

- Not listed in the dental care schedule, unless otherwise specified
- Provided by someone other than a dentist, except a licensed dental hygienist under the direction of a dentist
- Charges for:
 - Replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect
 - Appliances or services used to alter vertical dimension to restore occlusion, or for the purpose of splinting or correcting attrition, abrasion or erosion
 - Replacing or modifying a partial or full removable denture, bridge, or fixed bridgework, or for adding teeth to any of these, or for replacing or modifying a crown or gold restoration, within five years after that denture, bridge, bridgework, crown or gold restoration was installed
 - Extra sets of dentures or other appliances
 - Implantology
 - Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
 - A partial or full removable denture, bridge or fixed bridgework if it includes the replacement of one or more natural teeth missing before coverage under the Dental Plan was effective (unless the appliance also includes replacement of a natural tooth that is removed while the person is **covered** by the Dental Plan, *and* which was not an abutment to a partial denture, removable bridge or fixed bridge installed during the prior five years)
 - An appliance or modification of one if an impression for it was made before the person became **covered**
 - A crown, bridge or cast or processed restoration if a tooth was prepared for it before the person became **covered**
 - Root canal therapy if the pulp chamber for it was opened before the person became **covered**
 - A crown, cast or processed restoration, unless required for the treatment of decay or an injury that makes it impossible to restore the tooth with a filling material; or unless the tooth is an abutment to a **covered** partial denture or fixed bridge

- Services for the treatment of problems of the jaw joint, including temporomandibular joint disorder (TMJ), craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint
 - Pontics, crowns, cast or processed restorations made with high noble metals; except as specifically provided
 - Surgical removal of impacted wisdom teeth only for orthodontic reasons; except as specifically provided
 - Plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to repair an injury. Surgery must be performed in the calendar year of the accident, which causes the injury, or in the next calendar year. Facings on molar crowns and pontics will always be considered cosmetic
 - General anesthesia and intravenous sedation; unless done in conjunction with another necessary **covered** service
 - Services done where there is no evidence of pathology, dysfunction or disease other than **covered** preventive services
 - Injury arising out of, or in the course of, any work for wages or profit (whether or not with the employer), or diseases covered with respect to such work, by any Workers' Compensation law, occupational disease law or similar law
 - In connection with services, procedures, drugs, or other supplies that are determined by **Aetna** to be experimental, or still under clinical investigation by health professionals
- A charge for a service to the extent that it is:
 - Furnished by or on behalf of the United States Government or any other government, unless payment of the charge is required by law
 - Provided by any law or governmental plan under which the person is or could be covered. This does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program

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.

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

Crown: the portion of a tooth covered by enamel.

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

Dentist: a person duly licensed to practice dentistry by governmental authorities having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered. As used in this Dental Plan, the term dentist also includes a licensed physician authorized by his or her license to perform the particular dental service rendered.

Denture: a device replacing missing teeth.

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

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

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

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

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

Malposition: faulty position of teeth.

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

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

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

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

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

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

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

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

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

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

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

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

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.