THE AVAYA INC. RETIREE DENTAL EXPENSE PLAN, A COMPONENT OF THE AVAYA INC. HEALTH AND WELFARE BENEFITS PLAN FOR RETIREES

Plan Number 553

SUMMARY PLAN DESCRIPTION

Aetna Freedom of Choice – Dental Maintenance Organization (DMO) for all states except Arizona, California, New Jersey & Texas

EFFECTIVE AS OF JANUARY 1, 2018

IF THIS SUMMARY PLAN DESCRIPTION HAS BEEN DELIVERED TO YOU BY ELECTRONIC MEANS, YOU HAVE THE RIGHT TO RECEIVE A WRITTEN DOCUMENT AND MAY REQUEST A COPY OF THIS DOCUMENT ON A WRITTEN PAPER DOCUMENT AT NO CHARGE BY CONTACTING THE PLAN ADMINISTRATOR.
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INTRODUCTION

This Summary Plan Description ("Summary") highlights the key features of the group dental benefits under the Aetna Freedom of Choice – Dental Maintenance Organization (DMO) for all states except Arizona, California, New Jersey & Texas ("DMO"), under The Avaya Inc. Retiree Dental Expense Plan, a component of The Avaya Inc. Health and Welfare Benefits Plan for Retirees ("Plan"), as in effect on January 1, 2018 (unless otherwise noted). If you terminated your employment with, or retired from, Avaya Inc. (the “Company”) prior to January 1, 2018, different provisions may apply to you – in this case, you should contact the Plan Administrator for more information. We urge you to take the time to review this Summary carefully. You have many choices under the Plan which are important to you and your family. You will obtain the greatest value from the Plan if you understand the benefits available, and the choices you can make, under the Plan. This Summary replaces and supersedes any other summary plan description previously issued to you for the group dental benefits under the Plan.

The document for the DMO benefit program under the Plan is attached to this Summary ("Program Document") in Appendix I. The Program Document provides information regarding the eligibility, participation, benefit levels and claim procedures for the benefit program. This document, together with the Program Document is the “Summary Plan Description” for the DMO benefit program under the Plan.

Please remember that this Summary only summarizes the key provisions of the DMO benefit program under the Plan. Other benefits may be described in separate booklets. Also, this Summary is not the official Plan document itself. As a summary, this document cannot explain how every Plan provision might apply in your particular situation. If you have any questions about the Plan or how it applies to you, or if you would like to review or order your own copy of the Plan document, please contact the Plan Administrator – the Plan Administrator’s contact information may be found in the “General Plan Information” section of this Summary. The Plan Administrator may charge you a reasonable fee for a copy of the Plan document. Unless contrary to applicable law, the Program Document will control in the event of any irreconcilable conflict between or among the plan documents.

Your receipt of this Summary does not necessarily mean that you are eligible for the Plan. You must satisfy the specific eligibility enrollment and participation requirements provided in the Program Document.
GENERAL PLAN INFORMATION

This section contains general information that you may need to know about the Plan.

Name of Plan


Effective Date

This Summary reflects the Plan as in effect on January 1, 2018 (unless otherwise noted). The Plan was originally effective as of January 1, 2009.

Plan Identification Number

553

Plan Sponsor

Avaya Inc.
4655 Great America Parkway
Santa Clara, CA  95054
E-mail: hwplanadmin@avaya.com
Employer Identification Number: 22-3713430

Plan Administrator

Avaya Inc.
Health & Welfare Plan Administrator
4655 Great America Parkway
Santa Clara, CA  95054
E-mail: hwplanadmin@avaya.com

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator may delegate any or all of its responsibilities to any person, committee or entity from time to time, including to a “Claims Administrator.”
Claims Administrator

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Agent for Legal Service

Any legal actions regarding a claim should be sent to the Claims Administrator. All other legal actions should be sent to:

Avaya Inc.
Attn: General Counsel
4655 Great America Parkway
Santa Clara, CA 95054

Plan Year

The 12-month period beginning on each January 1 and ending on the following December 31.

Type of Plan

The Plan is intended to be an “employee welfare benefit plan”, within the meaning of Section 3(a) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), which provides group dental benefits.

Funding Medium

With certain limited exceptions, the Company pays a majority of the costs associated with providing group dental benefits under the Plan through the Avaya Inc. Health Plans Benefit Trust, which is a trust set up under Section 501(c)(9) of the Internal Revenue Code. Bank of New York Mellon is the trustee of this Trust. Although an insurance company has been appointed as the Claims Administrator, it is only responsible for administering the claims under the Plan and does not insure any benefits under the Plan. Some or all of the benefit programs provided under the Plan may require contributions from you. If contributions are required, such amounts will be determined in accordance with the enrollment materials provided to you.

Type of Administration

Contract Administration. The Plan Administrator has contracted with Aetna Life Insurance Company to provide claims administration services for the Plan as the Claims Administrator for the group dental benefits. The Claims Administrator’s decisions are final and binding and the Company does not have the authority to change the Claims Administrator’s decision.
Amendment and Termination

Subject to the terms of any collective bargaining agreement between the Company and your union, the Company reserves the right to amend any one or more of the component benefit programs of the Plan at any time without the consent of any employee, retiree or participant. This includes, but is not limited to, reducing or eliminating benefits for any group of employees or retirees (and the dependents of each) and adjusting any required contributions. Although the Company currently expects to continue the DMO benefit program indefinitely, it is not legally bound to do so, and it reserves the right to terminate the DMO benefit program or any feature at any time and for any reason, subject to the terms of any collective bargaining agreement between the Company and your union. In addition, the Avaya Participating Company does not guarantee the continuation of any dental benefits during employment or during retirement; nor does it guarantee any specific level of benefits or contributions. Upon termination of the Plan (or feature), all elections and reductions in compensation relating to the Plan (or feature) shall terminate.

Union Agreement

The benefits described in this SPD reflect the provisions of the Plan for represented employees or retirees as referred to in applicable collective bargaining agreements between Avaya Inc. and the unions representing employees and retirees of the Avaya Participating Company. Copies of these agreements are distributed or made available to those employees or retirees covered by the agreements and to any other employee or retiree who submits a written request for a copy to the Plan Administrator. A reasonable duplication charge may be made for copies furnished in response to such written request.
ELIGIBILITY AND PARTICIPATION REQUIREMENTS

You are eligible to participate in the DMO benefit program if you are an “eligible retiree” and satisfy the eligibility provisions described in the Program Document. You are an “eligible retiree” if you were a former eligible employee of Avaya Inc. or such other affiliates that have elected to participate in the Plan with the prior approval of Avaya Inc. (an “Avaya Participating Company”) and who:

- Was covered by a collective bargaining agreement that provides for the benefits provided under the Plan,
- Was either a represented employee when you terminated from an Avaya Participating Company or transferred to a management position less than 12 months before you terminated from an Avaya Participating Company, and
- Is receiving a service or disability pension under the Avaya Inc. Pension Plan.

You are not an “eligible retiree” if:

- Prior to retiring, you were not paid from the U.S. payroll of an Avaya Participating Company, you were employed by an independent company (such as an employment agency), or your services were rendered as part of an agreement excluding participation in benefits.

Enrollment

The timeline for enrollment in Avaya’s group dental benefit plans varies by your employment status. Here are some key dates to keep in mind:

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<th>Status</th>
<th>Timeline to Enroll</th>
<th>Eligibility Coverage Date</th>
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<td>Newly-retired</td>
<td>You have 31 days from the date on your retirement eligibility letter from ADP, Avaya’s benefit administrator, to enroll in or waive coverage for yourself and/or your dependents</td>
<td>The day after your active dental coverage (as an Avaya Represented employee) ended, provided you make a timely election</td>
</tr>
<tr>
<td>Current active eligible retirees</td>
<td>Annual enrollment period</td>
<td>January 1st of the following calendar year</td>
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<td></td>
<td>Within 31 days of a qualified status change (e.g. birth, adoption, marriage, death of dependent, divorce,</td>
<td>Your coverage eligibility date depends on your qualified status change. Coverage typically begins on the date of the event or</td>
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Summary Plan Description
Aetna Freedom of Choice – Dental Maintenance Organization (DMO) for all states except Arizona, California, New Jersey & Texas
For anticipated enrollment periods, such as newly-retired or annual enrollment, information will be mailed to you from ADP, Avaya’s benefit administrator, instructing you to enroll. The correspondence will include information about how to enroll yourself and your eligible dependents in the benefits enrollment portal at https://my.adp.com and the date by which you must make your elections. If you have not received correspondence from ADP within three (3) weeks of your retirement date, contact the Avaya Health & Benefits Decision Center for assistance (via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.).

For qualified status changes, you are responsible for initiating the change within 31 days of the qualifying event (e.g. adding a newborn or dropping a divorced spouse) online by logging in to the benefits enrollment portal at https://my.adp.com or by contacting the Avaya Health & Benefits Decision Center (via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.).

If you miss your enrollment deadline(s) you may be negatively impacted for the remainder of the Plan Year. See “If You Do Not Enroll (on time)” and “Qualified Status Changes” for more detail.

Your elections are in effect as follows:

- The elections or waivers you make as a new retiree are effective for the duration of the Plan Year in which you enroll.
- The elections or waivers you make during annual enrollment are in effect for the next full Plan Year.
- The elections or waivers you make for a qualified status change are effective for the duration of the Plan Year in which you make an enrollment change.

How to Enroll or Make Changes to Your Benefits

For most benefits you can make benefit elections for you and your eligible dependents online by logging in to the benefits enrollment portal at https://my.adp.com or by contacting the Avaya Health & Benefits Decision Center (via e-mail at avayaservicecenter@adp.com or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET.).

The benefits enrollment portal is available year-round. You will use the portal as a new retiree to initially enroll in your benefits, during annual enrollment to update your elections, and/or to make qualified status changes during the year. The benefits enrollment portal contains everything you need to make an informed decision, and your
personalized enrollment webpage walks you through each of your election choices, benefit by benefit.

For example, when you enroll, you may:

- Enroll yourself and/or your eligible dependents in coverage *(Note: after your election is approved you will be required to submit proof of dependency (i.e. marriage license, Government Registration for Domestic Partners, birth certificate, etc.) for each dependent newly added to coverage before their coverage will take effect)*,
- Enroll in or waive each Avaya Inc. benefit separately. For example, you may waive medical coverage (if eligible) and still enroll in dental coverage for yourself and your dependents.

**Default Coverage Waiver (Dental Only)**

Dental coverage is automatically waived for newly-eligible represented retirees and their dependents. **Your dental election and covered dependents do NOT carryover from the benefits you had as an active represented employee.** Coverage is also waived when you move outside of the service area of the dental plan you used to be covered under. It is your responsibility to keep or amend the dental plan Default Coverage Waiver, and review all other benefits you are eligible for, within your 31-day election window. If you do not change the election, the dental plan Default Coverage Waiver will be in force for the remainder of the Plan Year. Your next opportunity to make changes to your benefits will be during the next annual enrollment period or within 31 days of a qualified status change.

**If You Do Not Enroll (on time)**

If you miss your enrollment deadline, your coverage will remain as is for the remainder of the Plan Year. You will have to wait until the next annual enrollment period to enroll in or change your election, unless you have a mid-year qualified status change. For existing retirees, this means you will retain your existing election. For new retirees or retirees that move outside of the service area of the dental plan you used to be covered under, this means you will have the Default Coverage Waiver automatically assigned to you (see “Default Coverage Waiver (Dental Only)”.

Similarly, if you do not enroll your eligible dependent(s) within 31 days of your eligibility date or within 31 days of a qualified status change, or if you do not submit proper proof of your dependents’ eligibility for benefits by the deadline on the dependent verification letter, your dependent(s) will not be covered for the remainder of the Plan Year. You will have to wait until the next annual enrollment period to enroll your eligible dependents and provide proof of dependency, unless you have a mid-year qualified status change.

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Summary Plan Description
Aetna Freedom of Choice – Dental Maintenance Organization (DMO) for all states except Arizona, California, New Jersey & Texas
Your Costs

You can find the cost for each benefit online at [https://my.adp.com](https://my.adp.com).

Contributions for Insurance Premiums

- Contributions for insurance premiums, if applicable, are clearly indicated on your annual Confirmation Statement sent to you by ADP shortly after Annual Enrollment each year. If contributions are due from you, PayFlex, our Direct Bill vendor, will contact you for payment. Payment is due by the deadline provided on the correspondence from PayFlex.

Coverage for Dependents

Your eligible dependents can also participate in the DMO benefit program if you elect coverage for them. You must enroll your dependents in the same benefit program in which you are enrolled. Eligible dependents are defined by Avaya Inc.

Eligible Dependents Include:

- **Your Lawful Spouse or Domestic Partner** (either same-sex or opposite-sex; both parties must complete and file a notarized Domestic Partner Affidavit or government registration).

- **Children** To be eligible for coverage, a dependent child must be under 23 years of age. Each child is eligible for coverage through December 31st of the year in which the child reaches age 23. An eligible dependent child includes:
  - Your biological and/or legally adopted child, including any child in the formal legal process of adoption, regardless of residence;
  - A stepchild living with you; and
  - A child living with you for whom you or your lawful spouse or your domestic partner is the legal guardian (this does not include "wards of the state" or "foster children").

  A child, for this purpose, does not include the spouse, domestic partner, or child(ren) of a child.

  Coverage for a fully handicapped child may be continued past the age limits shown above. Your child is fully handicapped if:

  - He or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your Plan; and
  - He or she depends chiefly on you for support and maintenance.
Proof that your child is fully handicapped must be submitted to the Claims Administrator no later than 90 days after the date your child reaches the maximum age under your Plan. You must complete an application form available 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.

Ineligible dependents include a legally separated spouse, a divorced spouse, and a domestic partner where the domestic partnership has terminated.

Coverage for a Domestic Partner

To be eligible for coverage, a domestic partner must meet the following criteria:

A domestic partner is an individual (same-gender or opposite-gender) who certifies, by affidavit or government registration, the following as of the date of enrollment:

- He or she is your sole domestic partner and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership.
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
- He or she resides with you in the same residence.
- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she has mental sufficiency to enter into a valid contract.

Coverage for a Domestic Partner’s Child(ren)

A domestic partner’s child is defined as:

- 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.

If You and Your Spouse or Domestic Partner Both Work (or Worked) for an Avaya Participating Company

Avaya Participating Companies have many families -- employees (or retired Avaya Participating Company employees) whose lawful spouse or domestic partner,
children (including those of your eligible Domestic Partner, if applicable), or parents are also employed by (or retired from) an Avaya Participating Company. This may affect your coverage under the DMO benefit program.

- No one person can receive benefits as a dependent of more than one employee or retiree, or as both a dependent and an employee or retiree. For example, you may not be covered as an active Avaya Participating Company employee or retiree and a dependent of another Avaya Participating Company employee or retiree. Either parent may cover dependent children; however, both parents cannot cover the same child at the same time.
- An eligible employee or retiree may cover another represented Avaya Participating Company employee or retiree. Therefore, if your lawful spouse or domestic partner is an active represented employee or retiree, you may enroll as his or her dependent under the DMO benefit program, or he or she may enroll as your dependent, but not both.
- A represented active Avaya Participating Company employee or retiree cannot enroll a salaried Avaya Participating Company employee or retiree as an eligible dependent.
- Only one Avaya Participating Company employee or retiree may enroll any given eligible dependent. Either you or your Avaya Participating Company 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.
CHANGING YOUR COVERAGE DURING THE YEAR

Outside of annual enrollment, if you want to make changes to your benefits during the year, you have to meet certain criteria to do so. This section discusses those criteria.

Qualified Status Changes

The Internal Revenue Service (IRS) states that you may change coverage during the year if you have a qualified change in status. As permitted under federal regulations, qualified changes in status include the following:

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<tr>
<th>Qualified Status Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
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<td>Marital Status</td>
<td>A change in your legal marital status, including marriage, death of your spouse, divorce, legal separation, or annulment.</td>
</tr>
<tr>
<td>Number of Family Members</td>
<td>Events that change the number of eligible family members, including birth, adoption, placement for adoption, or death.</td>
</tr>
<tr>
<td>Employment Status</td>
<td>A termination or commencement of employment by your spouse or child that affects benefit eligibility.</td>
</tr>
<tr>
<td>Work Schedule</td>
<td>A reduction or increase in hours of employment by your spouse or a child, including a switch between part-time and full-time, or the start of or return from an unpaid leave of absence.</td>
</tr>
<tr>
<td>Family Member Meets or No Longer Meets the Eligibility Requirements</td>
<td>An event that causes a member of your family to meet or to no longer meet a Plan’s eligibility requirements for coverage. This may include a child reaching the maximum age for coverage.</td>
</tr>
<tr>
<td>Residence or Worksite</td>
<td>A change in the place of residence or worksite of you, your spouse or a child that changes your eligibility for the Plan.</td>
</tr>
</tbody>
</table>

The changes you make must be “due to and consistent with” your qualified change in status. For example, adding your new spouse to your dental plan would be “due to and consistent with” getting married.

To be eligible to make a change, qualified status changes must be reported to the Avaya Health & Benefits Decision Center (online by logging in to the benefits enrollment portal at https://my.adp.com, via e-mail at avayaservicecenter@adp.com, or by phone at 1-800-526-8056 (option 1), Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 5 p.m., ET) within 31 days of the event. You will be asked to provide documentation of the qualified status change to add or remove your dependents from the Plan. This documentation should be in writing and should include
proof of the event (e.g. a copy of the divorce decree, documentation of domestic partnership, marriage license, birth certificate, adoption agreement or any other legal documentation to support the qualified status change).

Avaya Participating Companies consider corresponding changes in domestic partner and/or domestic partner child(ren) status as a qualified status change.

Note: You may change from the DPPO to the DMO dental plan, or vice versa, on a monthly basis by contacting Aetna Member Services at 1-877-508-6927. Certain restrictions may apply.

**Enrolling Newborns Mid-Year**

If you wish to enroll your newborn in the DMO plan, you must do so within 31 days from the date of birth. If you miss the 31-day window, the newborn will be without coverage. You will have to wait until the next annual enrollment period to enroll your newborn and provide proof of dependency, unless you have a mid-year qualified status change.
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 within 31 days of the date he or she became your dependent by notifying the Avaya Health & Benefits Decision Center (see “Qualified Status Changes”).

If a Dependent Loses Eligibility for Avaya’s Plans

If your covered dependent is no longer eligible for coverage under the DMO benefit program, (e.g. your dependent child ages-out of the Plan, you and your spouse divorce, your dependent dies, etc.), you may remove your dependent(s) within 31 days of the date he or she lost eligibility by notifying the Avaya Health & Benefits Decision Center (see “Qualified Status Changes”).

You must provide notification within 31 days when your dependent no longer qualifies as an eligible dependent to make any corresponding changes to your coverage level and ensure that your dependent is sent timely information regarding COBRA continuation coverage, if applicable. If you do not provide notification within 31 days of when the dependent loses eligibility, your coverage 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, if applicable.

If a Dependent Loses Eligibility for non-Avaya Coverage

If your eligible dependent loses non-Avaya coverage (e.g. due to an involuntary termination of employment and benefits) you may enroll them in Avaya’s plans within 31 days of the date he or she lost their coverage by notifying the Avaya Health & Benefits Decision Center (see “Qualified Status Changes”).

If You Die While Covered Under an Avaya Inc. Plan

Coverage for your enrolled dependents continues under COBRA for six months after your date of death as long as your surviving dependents make an election under COBRA. If you paid for your coverage prior to your death, your surviving dependents must pay the same amount to continue coverage under COBRA. After six months, your covered 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 “Continuing Coverage through COBRA”.

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Summary Plan Description
Aetna Freedom of Choice – Dental Maintenance Organization (DMO) for all states except Arizona, California, New Jersey & Texas
If You Move

A move may require a change in your dental plan. This is considered a qualified status change. **It is up to you to notify the Avaya Health & Benefits Decision Center of your home residence change within your 31-day window** (see “Qualified Status Changes”).

If your move requires that you change your enrollment option and you fail to make a selection within the 31-day window, you and your dependents, as applicable, will be enrolled in the Default Coverage Waiver (see “Default Coverage Waiver (Dental Only)” for details. Your next opportunity to make changes to your benefits will be during the next annual enrollment period or within 31 days of a qualified status change.
CONTINUING 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.

COBRA enables your dependents to continue group dental benefit coverage.

COBRA may extend health plan coverage for up to 18 months, 29 months or 36 months, depending on the qualifying event. The following chart summarizes who is eligible for COBRA continuation coverage, under what circumstances, and how long COBRA continuation coverage continues:

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<td>36 months</td>
</tr>
<tr>
<td>You Become divorced, legally separated, or there is a dissolution of your domestic partnership</td>
<td>Your covered dependents</td>
<td>36 months</td>
<td></td>
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<tr>
<td>Your covered dependents</td>
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<td>Your covered dependents</td>
<td>36 months</td>
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<td>Your covered dependents</td>
<td>Is no longer an eligible dependent because of your death</td>
<td>Your covered dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>Your covered dependents</td>
<td>Becomes disabled within the first 60 days of COBRA continuation coverage</td>
<td>Your covered dependents</td>
<td>Up to 29 months*</td>
</tr>
</tbody>
</table>

*Includes months of COBRA coverage already used

COBRA applies to the active health plan options your dependents are covered under at the time of their loss of coverage for one of the reasons listed above. Although not required under COBRA, the Plan provides continuation coverage to Domestic Partner and/or Domestic Partner Child(ren).

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 lawful spouse get divorced or legally separated, or there is a dissolution of your domestic partnership, or
• He or she is no longer eligible for coverage under the Plan (e.g., due to reaching the age limit)

If your covered dependents lose coverage because of your death, WageWorks will notify them of their right to continue coverage within 44 days. Your covered dependent must notify WageWorks by phone at 1-800-526-2720 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, your covered dependent must notify WageWorks by phone at 1-800-526-2720 within 60 days of the event. Notice should also be provided to WageWorks in writing and should include proof of the qualifying event (for example, a copy of the divorce decree). If WageWorks is not notified within 60 days of the qualifying event, your covered dependent will lose the right to elect COBRA continuation coverage. After your notice is received, 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 WageWorks of his or her decision to continue coverage. If WageWorks 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 your covered dependent(s) elect COBRA continuation coverage, it takes effect on the date of the qualifying event and continues until the earliest of the following:

• The end of the 18-month, 29-month or 36-month continuation period
• The date the Avaya Participating Company no longer provides dental coverage to any of its employees and/or retirees
• 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 your covered dependents become covered under another group dental plan
• The date your covered dependents become eligible for Medicare, if after the date their COBRA coverage begins. Note that coverage will still be available for family members who are not Medicare-eligible.
• With respect to the 11-month extension for disability, the date the person is no longer disabled your covered must notify WageWorks that they are no longer disabled
If WageWorks determines that your dependent’s coverage is terminating before the end of the 18-month, 29-month or 36-month period (e.g., when premiums are not being paid within the required time), they will be notified that their coverage is terminating and they will be provided with the reason why and the date their coverage is terminating.

**COBRA Coverage Cost**

Your covered dependent(s) pay the full cost for COBRA continuation coverage, plus a 2% administrative fee. If the COBRA period is extended to 29 months because your covered dependent is disabled under the Social Security Act, a 2% administrative fee applies for the first 18 months and a 50% administrative fee applies for your covered dependents for the next 11 months (from the 19th month through the 29th month).

The initial COBRA payment (which includes payment for coverage back to the date regular coverage ended) is due when your covered dependent(s) elect COBRA. However, WageWorks is legally required to provide 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. WageWorks is legally required to provide your covered dependent(s) with a 30-day grace period for these payments. No further extension is permitted. Payments received after the 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.

**COBRA Questions?**

Questions concerning COBRA continuation coverage rights should be addressed to WageWorks by phone at 1-800-526-2720. For more information about your rights under ERISA, COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 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 Employee Benefits Security Administration. You may also visit their website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**Keep the COBRA Administrator Informed of Address Changes**

In order to protect your family’s rights, keep WageWorks informed of any changes in the addresses of family members. Contact WageWorks by phone at 1-800-526-2720 and keep a copy, for your records, of any notices sent to WageWorks.
SUMMARY OF PLAN BENEFITS

Benefits

Group dental benefits are provided under the Plan. With certain limited exceptions, the Company pays a majority of the costs associated with providing group dental benefits under the Plan through the Avaya Inc. Health Plans Benefit Trust, which is a trust set up under Section 501(c)(9) of the Internal Revenue Code. Bank of New York Mellon is the trustee of this Trust. You should read the Program Documents for each benefit program to understand your benefits. In addition, please see the Benefit Plan booklet and Schedule of Benefits included in the Summary for the DMO benefit program in Appendix I.

Loss of Benefits

Coverage for retirees ends on the last day of the month in which any of the following events occur:

- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You fail to make any required contributions;
- You become covered under another plan offered by your former employer;
- You have exhausted your overall maximum lifetime benefit under your health Plan, if your Plan contains such a maximum benefit; or
- The company you retired from ceases to be an Avaya Participating Company.

Generally, your dependent’s coverage will end on the:

- Date your coverage ends;
- Last day of the month in which your covered dependent is no longer an eligible dependent; or
- Last day of the year in which your dependent turns age 23.

If your covered dependent is no longer eligible for coverage under the DMO benefit program, (e.g. your dependent child ages-out of the Plan, you and your spouse divorce, your dependent dies, etc.), you must remove your dependent(s) within 31 days of the date he or she lost eligibility by notifying the Avaya Health & Benefits Decision Center (see “Qualified Status Changes” and “If a Dependent Loses Eligibility for Avaya's Plans”).

Your coverage ends on your date of death. Coverage for your enrolled dependents continues under COBRA for six months after your date of death as long as your surviving dependents make an election under COBRA (see “If You Die While Covered Under an Avaya Inc. Plan” and “Continuing Coverage through COBRA”).
If the DMO benefit program is discontinued or the Plan is terminated, coverage for you and your eligible dependents will end on the termination date, not the last day of the month.

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 with respect to the DMO benefit program, or because you (or one of your eligible/covered dependents) knowingly gave the Plan Administrator, Claims Administrator or Avaya Health & Benefits Decision Center false, material misinformation. Examples include false information relating to a person’s eligibility or status as an eligible/covered dependent.
- You (or one of your eligible/covered dependents) permitted an unauthorized person to use one of your ID cards, or you (or one of your eligible/covered dependents) improperly use another person’s ID card.
- You (or one of your eligible/covered dependents) commit acts of physical or verbal abuse that pose a threat to the staff of the Plan Administrator, Claims Administrator, Insurer or Avaya Health & Benefits Decision Center.
- You (or one of your eligible/covered dependents) in any other way materially violates the terms of the Plan.
PLAN ADMINISTRATION

The Plan is administered by the Company as the “Plan Administrator.” Aetna Life Insurance Company, the Claims Administrator, is the contact for all claims questions.

Plan Administrator

The Plan Administrator has the power and authority in its sole and absolute discretion to control and manage the operation and administration of the Plan and shall have all powers necessary to accomplish these purposes. The Plan Administrator will administer the Plan in accordance with established policies, interpretations, practices, and procedures and in accordance with the requirements of ERISA, the Plan and applicable laws. The Plan Administrator will have absolute discretion with respect to the Plan, including the power to:

1. Interpret the terms of the Plan, including eligibility determinations;
2. Determine factual questions that arise in the course of administering the Plan;
3. Adopt and enforce rules and regulations regarding the administration of the Plan;
4. Determine the conditions under which benefits become payable under the Plan and to determine the person or persons to whom such benefits will be paid; and
5. Make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan.

Any determination made by the Plan Administrator will be final, conclusive and binding on all parties.

The Plan Administrator may delegate all or any portion of its authority to any person or entity.

Duties of the Plan Administrator

The Plan Administrator will (i) administer the Plan in accordance with its terms, (ii) decide disputes which may arise relative to a Plan participant’s rights, (iii) keep and maintain the Plan documents and all relevant records pertaining to the Plan, (iv) pay or arrange for the payment of claims, (v) establish and communicate procedures to determine whether a medical child support order is qualified under Section 609 of ERISA, and (vi) perform all necessary reporting as required by ERISA.

Claims Administrator

The Plan Administrator has contracted with Aetna Life Insurance Company to provide claims administration services for the Plan as its Claims Administrator for the group dental benefits. The Claims Administrator’s decisions are final and binding and
the Company does not have the authority to change the Claims Administrator’s decision. Although Aetna Life Insurance Company is an insurance company, Aetna Life Insurance Company only provides claims administration services to the Plan. Aetna Life Insurance Company is not an insurer under the Plan.

**Plan Administrator Compensation**

The Plan Administrator serves without additional compensation; however, all expenses for administration, including compensation for hired services, will be paid by the Plan to the extent not paid by the Company in its sole and absolute discretion.

**Fiduciary Duties**

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the employees/retirees and their dependents and defraying reasonable expenses of plan administration. These duties must be carried out with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation and in accordance with Plan documents to the extent that they are consistent with ERISA.

**The Named Fiduciary**

The Plan Administrator is the “named fiduciary” with respect to the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will not be liable for any act or omission of such person unless either (i) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures, or (ii) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

**HIPAA Notice of Privacy Practices**

The Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan’s Notice of Privacy Practices, please contact the Plan Administrator.

**Limitations Period for Filing Suit**

Unless specifically provided otherwise under a Program Document or pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures. Claims and appeals procedures are provided in the Program Document.
IMPORTANT NOTICES

Genetic Information Non-Discrimination Act of 2008 ("GINA")

The Plan will not set contributions on the basis of genetic information. The Plan may not require a retiree (or dependent) to undergo a genetic test except in very limited circumstances. The Plan is generally prohibited from collecting genetic information regarding its participants. The Plan intends to comply with GINA.

Statement of ERISA Rights

Your Rights Under ERISA:

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants are entitled to –

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts (if any), and a copy of the latest annual report (Form 5500 series as required) and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information including insurance contracts (if any), and copies of the latest annual report (Form 5500 series as required) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies; and
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights:

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary and the documents governing the Plan, particularly the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so
prudently and in the best interest of you and other Plan participants. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

**Enforce Your Rights:**

If your claim for a benefit is denied or ignored, 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 the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a 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 from the 31st day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. No action at law or in equity may be brought to recover under the Plan until the appeal rights herein provided have been fully exercised and the Plan benefits requested in such appeal have been denied in whole or in part. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in State or Federal court.

If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the Court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 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 Employee Benefits Security Administration. You may also visit their website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).
APPENDIX I

Aetna Freedom of Choice – Dental Maintenance Organization (DMO) for all states except Arizona, California, New Jersey & Texas
Summary Plan Description
BENEFIT PLAN

Prepared Exclusively For
Avaya Inc

Freedom of Choice - Dental Maintenance
Organization (DMO)

Aetna Life Insurance Company
Booklet-Certificate

What Your Plan Covers and How Benefits are Paid

This Booklet-Certificate is part of the Group Insurance Policy
between Aetna Life Insurance Company and the Policyholder
ID Cards
If you are an enrollee with Aetna Dental coverage, you don't need an ID card. When visiting a dentist, simply provide your name, date of birth and Member ID# (or social security number). The dental office can use that information to verify your eligibility and benefits. If you still would like an ID card for you and your dependents, you can print a customized ID card by going to the secure member website at www.aetna.com. You can also access your benefits information when you’re on the go. To learn more, visit us at www.aetna.com/mobile or call us at 1-877-238-6200.

Remember, DMO®/DNO members need to choose a primary care dentist in Aetna’s network. Otherwise, you could end up paying more. You can use our provider search tool online or call us at 1-877-238-6200 to make your selection.

CA /AZ DMO® participants, if you have not selected a PCD, one may have been selected for you. View your digital ID card to determine if one was selected on your behalf.
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Aetna Life Insurance Company (ALIC) is pleased to provide you with this Booklet-Certificate. Read this Booklet-Certificate carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as Aetna).

This Booklet-Certificate is part of the Group Insurance Policy between Aetna Life Insurance Company and the Policyholder. The Group Insurance Policy determines the terms and conditions of coverage. Aetna agrees with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this Booklet-Certificate. The Policyholder selects the products and benefit levels under the plan. A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the Group Insurance Policy.

The Booklet-Certificate describes the rights and obligations of you and Aetna, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this Booklet-Certificate. Your Booklet-Certificate includes the Schedule of Benefits and any amendments or riders.

If you become insured, this Booklet-Certificate becomes your Certificate of Coverage under the Group Insurance Policy, and it replaces and supersedes all certificates describing similar coverage that Aetna previously issued to you.

Group Policyholder: Avaya Inc
Group Policy Number: GP-100462
Effective Date: January 1, 2018
Issue Date: May 31, 2018
Booklet-Certificate Number: 31

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)
Important Information Regarding Availability of Coverage (GR-9N-02-020-02 CO)

You do not receive benefits under this Booklet-Certificate if current premiums are not paid. This is subject to the Grace Period and the Premium section of the Group Insurance Policy.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this Booklet-Certificate or under the terms of the Group Insurance Policy, the plan does not pay benefits for a loss or claim for a health care, medical or dental care expense incurred before coverage starts under this plan.

This plan will not pay any benefits for any claims, or expenses incurred after the date this plan ends.

This provision applies even if the loss, or expense, was incurred because of an accident, injury or illness that occurred, began or existed while coverage was in effect.

Please refer to the sections, “Termination of Coverage (Extension of Benefits)” and “Continuation of Coverage” for more details about these provisions.

Benefits may be modified during the term of this plan as specifically provided under the terms of the Group Insurance Policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the Group Insurance Policy or in this Booklet-Certificate beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.

Coverage for You and Your Dependents (GR-9N-02-020-01 CO)

Health Expense Coverage (GR-9N-02-020-02 CO)

Benefits will be paid for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is “incurred” on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only non-occupational injuries and non-occupational illnesses are covered.

Please read the What the Plan Covers section of the Booklet-Certificate for more information about your coverage.

Treatment Outcomes of Covered Services (GR-9N-02-020-02 CO)

Aetna is not a provider of health care services. It is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors. They are neither agents nor employees of Aetna or its affiliates.
When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, “you” means the employee.

Who Can Be Covered

Employees
To be covered by this plan, the following requirements must be met:

- You will need to be in an “eligible class”, as defined below; and
- You will need to meet the “eligibility date criteria” described below.

Determining if You Are in an Eligible Class
You are in an eligible class if:

- You are a retired employee of an employer participating in this plan, and you:
  - Retired before the effective date of this plan and were covered under the prior plan for health care coverage on the day before you retired; or
  - Were covered under this plan or another plan sponsored by your employer on the day before you retired; and
  - Retire under your employer’s IRS-qualified retirement plan.
- You are a regular full-time employee, as defined by your employer.

With Respect to Retirees:

Determining When You Become Eligible (GR.9N.29.005-02)
You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan
If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan
If you are hired after the effective date of this plan, your coverage eligibility date is the date you are hired or rehired, or the date you retire, if applicable.

If you enter an eligible class after the effective date of this plan or after the retirement, your coverage eligibility date is the date you enter the eligible class.

With Respect to Active Employees:

Probationary Period
Once you enter an eligible class, you will need to complete the probationary period before your coverage under this plan begins.

Determining When You Become Eligible
You become eligible for the plan on your eligibility date, which is determined as follows.
On the Effective Date of the Plan
If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan
If you are hired or enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you complete 6 months* of continuous service with your employer. This is defined as the probationary period. If you had already satisfied the plan’s probationary period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.

*This waiting period is waived if the member contributes 100% of the cost.

Obtaining Coverage for Dependents (GR.9N 29 010 13 CO)
Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse or partner in a civil union; or
- Your domestic partner who meets the rules set by your employer; and
- Your dependent children; and
- Dependent children of your domestic partner.

“Civil union” means a relationship established by two eligible persons that entitles them to receive the benefits and protections and be subject to the responsibilities of spouses.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Domestic Partner (GR.9N 29 010 01)
A domestic partner is a person who certifies the following as of the date of enrollment:

- He or she is your sole domestic partner and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership within the past six months.
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
- He or she has cohabitated and resided with you in the same residence for the past six months and intends to cohabitate and reside with you indefinitely.
- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
  - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
  - Common ownership of a motor vehicle;
  - Driver’s license listing a common address;
  - Proof of joint bank accounts or credit accounts;
  - Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under your will; or
  - Assignment of a durable property power of attorney or health care power of attorney.
Coverage for Dependent Children  (GR-9N-29-010-08 CO)
To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

**Important Reminder**
Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

**How and When to Enroll**  (GR-9N 29-015-02)

**Initial Enrollment in the Plan**
You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by Actna and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

**Annual Enrollment**
During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period.
When Your Coverage Begins (GR-9N-29-025-01 CO)

Your Effective Date of Coverage
Your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date you return your completed enrollment information.

If you do not return your completed enrollment information within 31 days of your eligibility date, the rules under Rules and Limits That Apply to the Dental Plan section will apply.

Your Dependent’s Effective Date of Coverage
Your dependent’s coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan by then.

Note: New dependents need to be reported to Aetna within 31 days because they may affect your contributions.

Retired Employees (GR-9N-29-025-01 CO)
In lieu of corresponding rules which apply to employees:

- If any health expense benefits are payable based on a "period of disability", the rule which applies to determine when a dependent's period of disability ends will also apply to you.
- The rule which applies to a dependent to determine if total disability exists when health expense insurance ends will also apply to you.
Requirements For Coverage (GR-9N-09-005-01 CO)

To be covered by the plan, services and supplies must meet all of the conditions below:

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:
   - be a covered expense in this Booklet-Certificate;
   - Not be an excluded expense under this Booklet-Certificate. See the Exclusions sections of this Booklet-Certificate for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet-Certificate. See the What the Plan Covers section and the Schedule of Benefits for information about certain expense limits; and
   - get it in keeping with all the terms, policies and procedures outlined in this Booklet-Certificate.

2. You must get the service or supply while coverage is in effect. See the Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends and Continuation of Coverage sections for details on when coverage begins and ends.

   (GR-9N-09-005-01 CO)

1. The service or supply must be medically necessary. To meet this condition, the dental service or supply must be provided by a physician, or other health care provider or dental provider, using prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. The provision of the service or supply must be:
   (a) In line with generally accepted standards of dental practice;
   (b) Clinically appropriate, in terms of type, frequency, extent, site and duration. It must be considered effective for the patient’s illness, injury or disease;
   (c) Not primarily for the convenience of the patient, physician or dental provider or other health care provider; and
   (d) No more costly than an alternative service or sequence of services at least as likely to have the same therapeutic or diagnostic results for the diagnosis or treatment of that patient’s illness, injury, or disease.

For these purposes “generally accepted standards of dental practice” means standards that are:

- based on credible scientific proof published in peer-reviewed dental literature;
- generally known by the relevant dental community;
- consistent with physician or dental specialty society recommendations and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

(Important Note)

Some services or supplies that fit the definition for medical necessity are not covered by the plan. Exclusions and limitations apply to certain dental services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the What the Plan Covers section and the Schedule of Benefits for the plan limits and maximums.
Understanding Your Aetna Dental Plan

It is important that you have the information and useful resources to help you get the most out of your Aetna dental plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What services and supplies are covered and what limits may apply;
- What services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage and general administration of the plan.

This Booklet-Certificate describes a dental program with two options:

- The first option is a managed dental plan. You must live or work inside the service area to be eligible for this option.
- The second option is an alternate dental plan.

You may choose either plan, but you cannot be covered for both at the same time.

The choice you make for your coverage also applies to your covered dependents. You may request a switch from one plan to the other. Just call the telephone number on your ID Card. The change will be effective as follows:

- If Aetna receives a request on or before the 15th day of the month; the change will be effective on the first day of the next month.
- If Aetna receives a request after the 15th day of the month; the change will be effective on the first day of the month following the next month.
- Once the change is effective, your benefits are subject to all the terms and conditions of the plan under which you are covered. The terms and conditions of the plan under which you were covered immediately before the change in coverage no longer apply. However, dollar maximums or frequency limitations for services or supplies obtained under the prior plan will also be applied to coverage under the current plan.

Important Notes:

Unless otherwise indicated, "you" refers to you and your covered dependents.

This Booklet-Certificate applies to coverage only and does not restrict your ability to receive covered expenses that are not or might not be covered expenses under this dental plan.

Store this Booklet-Certificate in a safe place for future reference.
Getting Started: Common Terms

Many terms throughout this Booklet-Certificate are defined in the Glossary Section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About the Managed Dental Plan

Under the Managed Dental Plan, you access care through the primary care dentists (PCD) you select when you enroll. Each covered family member may select a different PCD. Your PCD provides basic and routine dental services and supplies, and will refer you to other dental providers in the network.

You may select a PCD from the Aetna network provider directory or by logging on to Aetna’s website at www.Aetna.com. You can search Aetna’s online directory, DocFind, for names and locations of network providers.

You may also seek care from an out-of-network provider for covered expenses. You will receive a lower level of benefits for covered out-of-network services and supplies.

Important Reminder
You must have a referral from your PCD in order to receive coverage for any services a specialist dentist provides. Please refer to the Referral Process section.

The Choice Is Yours
Each time you need non-emergency care, you have a choice:

Accessing Network Providers

- The plan pays a higher level of benefits when your PCD provides your care or refers you to a specialist dentist.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your coinsurance).
- The coinsurance for primary dental services is a percent of the PCD’s usual fee* for that service, reviewed by Aetna for reasonableness.
- The coinsurance for specialty dental services is a percent of the specialist dentist’s fee for that service or supply. The “fee” may be a fee negotiated with the specialist dentist and approved by Aetna. In that case, the coinsurance will be based on the actual, negotiated fee. If Aetna compensates a specialist dentist on another basis, the “fee” will be the specialist dentist’s usual fee*, reviewed by Aetna for reasonableness.

*“Usual fee” means the fee the PCD or specialist dentist charges patients in general. Your PCD will give you a copy of the usual fee schedule, upon request. You will be informed of the fee when you visit a specialist dentist. It is not part of this booklet-certificate and may be changed from time to time. It is used only for the purpose of calculating your coinsurance and is not the basis of compensation to the network provider. Aetna compensates network providers based on separate, negotiated agreements that may be less than or unrelated to the network provider’s usual and customary charges. These agreements may vary among dentists.

If you need a service that is not available from a network provider, your PCD may refer you to an out-of-network provider. You will receive the network level of coverage if your PCD gets approval from Aetna for this referral.

Changing Your PCD
You may change your PCD at any time on Aetna’s website, www.Aetna.com, or by writing to Aetna or calling the Member Services toll-free number on your identification card. The change will be effective as follows:

- If Aetna receives a request on or before the 15th day of the month, the change will be effective on the first day of the next month.
- If Aetna receives a request after the 15th day of the month, the change will be effective on the first day of the month following the next month.
Availability of Providers
Aetna cannot guarantee the availability or continued participation of a particular provider. Either Aetna or any network provider may terminate the provider contract or limit the number of patients accepted in a practice. If the PCD initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection. If the agreement between Aetna and your selected PCD is terminated, Aetna will notify you of the termination and request you to select another PCD.

Accessing Out-of-Network Providers
You can directly access dentists of your choice without a referral from your PCD. Your covered expenses will be covered as out-of-network expenses if you do not obtain services and supplies from your PCD or with a referral from your PCD, even if you choose a provider in the network. The plan covers out-of-network services and supplies, but your out-of-pocket expenses may be higher.

You must satisfy a deductible before the plan begins to pay benefits.

You share the cost of covered services and supplies by paying a portion of certain expenses. You are responsible for the portion of the dentist’s charge that is above the scheduled limit shown for a service in the dental care schedule.

If the dentist you select charges more than the recognized charge, you must also pay any expenses above the recognized charge. That excess amount does not apply toward your coinsurance limit.

You must file a claim to receive reimbursement from the plan.

Important Reminder
Refer to the Schedule of Benefits for details about any applicable deductibles, copayments, coinsurance and maximum benefit limits. There is separate deductible and maximum that applies to orthodontic treatment.

Using Your Dental Plan (GR-9N 16-020-01)

The Referral Process
There may be times when you need services and supplies that only a dental specialist can provide. In these cases, your PCD will make a referral to a specialist dentist. A PCD referral is not required for any orthodontic services.

Having a referral from your PCD keeps your out-of-pocket expenses lower for services of a specialist dentist and any necessary follow-up treatment. The referral is important because it is how your PCD arranges for you to receive care and follow-up treatment.

Important Reminder
You must have a referral from your PCD in order to receive the network level of coverage for any services received from a specialist dentist.

How Referrals Work
Here are some important points to remember:

When your PCD determines that your treatment should be provided by a specialist dentist, you'll receive a written or electronic referral. The referral will be good for 90 days, as long as you remain covered under the plan.

Go over the referral with your PCD. Make sure you understand what types of services have been recommended and why.

When you visit the specialist dentist, bring the referral (or check in advance to verify that they have received the electronic referral). Without it, you'll receive out-of-network benefits – even if you receive your treatment from a network provider.
You can not request a referral from your PCD after you have received services from a specialist dentist.

If a service you need isn't available from a network provider, your PCD may refer you to an out-of-network provider. Your PCD must get precertification from Aetna and issue a special out-of-network referral for services from out-of-network providers to be covered at the network level of coverage.

When You Do Not Need a PCD Referral
You do not need a PCD referral for:

- Emergency care. Please refer to the "In the case of a Dental Emergency" section.
- Out-of-network Benefits. The plan gives you the option to visit any dental provider without a referral from your PCD and receive coverage at the out-of-network benefit level. Remember that you will receive this lower benefit level even if the provider is a network provider. You may save money by visiting network providers because they have agreed to negotiated charges for their services, and these fees may be lower than those charged by out-of-network providers.
- Direct Access Services. Orthodontic services and supplies do not require a referral.

In Case of a Dental Emergency (GR-9N-16-040-01)
If you need dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week.

A dental emergency is any dental condition which:

- Occurs unexpectedly;
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.

Follow the guidelines below when you believe you have a dental emergency.

If you have a dental emergency, call your PCD. If you cannot reach your PCD or are away from home, you may get treatment from any dentist. You may also call Member Services for help in finding a dentist. The care must be for the temporary relief of the dental emergency until you can be seen by your PCD. The care provided must be a covered service or supply. You must submit a claim to Aetna describing the care given.

The plan pays a benefit up to the dental emergency maximum.

All follow-up care should be provided by your PCD.

If you seek care from an out-of-network provider for a non-emergency dental condition (that is, one that does not meet the definition above), benefits will be paid at the lower out-of-network level.

What The Plan Covers (GR-9N-19-005-01)
Managed Dental Plan
Managed Dental Plan is merely a name of the benefits in this section. The plan does not pay a benefit for all dental expenses you incur.

Important Reminder
Your dental services and supplies must meet the following rules to be covered by the plan:

- The services and supplies must be medically necessary.
- The service and supplies must be in the listed in the dental care schedule.
- You must be covered by the plan when you incur the expense.
Covered expenses include charges made by a dental provider only for the services and supplies that are listed in the dental care schedule that applies.

The next sentence applies if:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition.

In that case, the charge will be considered to have been made for a service in the list that Aetna determines would have produced a professionally acceptable result.

Dental Care Schedule for the Managed Dental Plan
The Dental Care Schedule is a list of dental expenses that are covered by the plan. There are several categories of covered expenses that are focused on keeping your teeth healthy: diagnostic, preventive and restorative services and supplies.

Coverage is also provided for a dental emergency. For additional information, please refer to In Case of a Dental Emergency.

Important Reminder
The copays, deductible, and coinsurance that apply to each type of dental care are shown in the Schedule of Benefits.

You may receive care from network and out-of-network providers. Services and supplies given by a network provider are covered at the network level of benefits shown in the Schedule of Benefits. Services and supplies given by an out-of-network provider are covered at the out-of-network level of benefits shown in the Schedule of Benefits.

Managed Dental Expense Coverage Plan (GR-9N-19-006-01 CO)

The following additional dental expenses will be considered covered expenses for you and your covered dependent if you have medical coverage insured or administered by Aetna and have at least one of the following conditions:

- Pregnancy;
- Coronary artery disease/cardiovascular disease;
- Cerebrovascular disease; or
- Diabetes

Additional Covered Dental Expenses

- One additional prophylaxis (cleaning) per year.
- Scaling and root planing, (4 or more teeth); per quadrant;
- Scaling and root planing (limited to 1-3 teeth); per quadrant;
- Full mouth debridement;
- Periodontal maintenance (one additional treatment per year).

The plan coinsurance applied to the other covered dental expenses above will be 100%. These added benefits will not be subject to any frequency limits except as shown above.

Network Benefits (GR-9N-19-010-01)
This Dental Care Schedule applies to covered services and supplies provided by Primary Care Dentists and other network providers upon referral from your PCD. The plan covers only the services and supplies in the list below.
Primary Dental Services
Type A Expenses
Visits and Exams

- Office visit for oral exam (limited to 4 visits per year)
- Emergency palliative treatment
- Prophylaxis (cleaning) (limited to 6 treatments per year)
  - Adult
  - Child
- Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 18)
- Oral hygiene instruction
- Sealants, per tooth (limited to 1 application every 3 years for permanent molars only)
- Diagnostic casts

X-Rays and Pathology

- Bitewing X-rays (limited to 2 sets per year)
- Entire series, including bitewings, or panoramic films (limited to 1 set every 3 years)
- Vertical bitewing X-rays (limited to 1 set every 3 years)
- Periapical X-rays
- Intra-oral, occlusal view, maxillary, or mandibular
- Extra-oral upper or lower jaw
- Biopsy and histopathologic examination of oral tissue

Type B Expenses
Endodontics

- Pulp capping
- Pulpotomy
- Surgical exposure for rubber dam isolation
- Root canal therapy, including necessary X-rays
  - Anterior
  - Bicuspid

Restoration and Repair

- Amalgam restoration
  - 1 surface
  - 2 surfaces
  - 3 or more surfaces
- Resin restoration (other than for molars)
  - 1 surface
  - 2 surfaces
  - 3 or more surfaces or incisal angle
- Retention pins
- Sedative fillings
- Stainless steel crowns
- Prefabricated resin crowns (excluding temporary crowns)
- Recementing inlays, crowns, bridges, space maintainers
- Tissue conditioning for dentures
Periodontics

- Scaling and root planning - per quadrant (limited to 4 separate quadrants, every year)
- Scaling and root planning - 1 to 3 teeth, per quadrant (limited to once per site, every year)
- Periodontal maintenance procedures following surgical therapy (limited to 2 per year)

Oral Surgery (Includes local anesthetics and routine post-operative care)

- Extractions, erupted tooth or exposed root
- Extractions, coronal remnants
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth (soft tissues)
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva
- Incision and drainage of abscess
- Crown exposure to aid eruption
- Removal of foreign body from soft issue
- Suture of soft tissue injury

Type C Expenses

Restorations

- Inlays
  - 1 surface
  - 2 surfaces
  - 3 or more surfaces
- Onlays
  - 2 surfaces
  - 3 surfaces
  - 4 or more surfaces
- Crowns (including build-ups when necessary)
  - Post and core
- Pontics

Dentures and Partial (includes relines, rebases, and adjustments within 6 months after installation.)

- Full (upper and lower)
- Partial
- Stress breakers (per unit)
- Interim partial denture (stayplate), anterior only
- Crown and bridge repairs
- Adding teeth to an existing denture
- Full and partial denture repairs
- Relining/rebasing dentures (including adjustments within six months after installation)
- Occlusal guard (for bruxism only)

Oral Surgery

- Cleft Lip or cleft palate surgery for a child under age 18

Periodontics

- Full mouth debridement
Orthodontics

- Limited to treatment of cleft lip or cleft palate for a child under age 18

**Space Maintainers** Only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation.)

- Fixed, band type
- Removable acrylic with round wire clasp
- Removable appliance to correct habits
- Fixed or cemented appliance to correct habits

**Specialty Dental Services**

**Type B Expenses**

**Endodontics** (Includes local anesthetics where necessary)

- Apexification/recalification
- Apicoectomy (per tooth) - first root
- Apicoectomy (per tooth) - each additional root
- Retrograde Filling
- Root Amputation
- Hemisection

**Oral Surgery** (Includes local anesthetics where necessary and post-operative care)

- Removal of residual root
- Removal of odontogenic cyst
- Closure of oral fistula
- Removal of foreign body from bone
- Sequestrectomy
- Frenectomy
- Transplantation of tooth or tooth bud
- Alveoplasty in conjunction with extractions - per quadrant
- Alveoplasty not in conjunction with extractions - per quadrant
- Removal of exostosis
- Sialolithotomy; removal of salivary calculus
- Closure of salivary fistula

**Periodontics**

- Gingivectomy or gingivoplasty - per quadrant
- Gingivectomy or gingivoplasty - 1 to 3 teeth
- Gingival flap procedure - per quadrant
- Soft tissue procedures
- Occlusal adjustment (other than with an appliance or by restoration)

**Type C Expenses**

**Endodontics** (Includes local anesthetics where necessary)

- Molar root canal therapy, including necessary X-rays
Intravenous Sedations and General Anesthesia

Oral Surgery (Includes local anesthetics where necessary and post-operative care)

- Surgical removal of impacted teeth
  - Partially bony
  - Completely bony
  - Completely bony with unusual surgical implications

Periodontics

- Osseous surgery (including flap entry and closure), per quadrant
- Osseous surgery (including flap entry and closure), 1 to 3 teeth per quadrant
- Clinical crown lengthening - hard tissue

Orthodontics

- Interceptive orthodontic treatment
- Limited orthodontic treatment
- Comprehensive orthodontic treatment of adult or adolescent dentition
- Post treatment stabilization

Rules and Limits That Apply to the Dental Plan (GR-9N 20-005-01)

Several rules apply to the dental plan. Following these rules will help you use the plan to your advantage by avoiding expenses that are not covered by the plan.

Orthodontic Treatment Rule

The plan does not cover the following orthodontic services and supplies:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macrognathia;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners").

The plan will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the plan.

Orthodontic Limitation for Late Enrollees

The plan will not cover the charges for an orthodontic procedure for which an active appliance for that procedure has been installed within the two year-period starting with the date you became covered by the plan. This limit applies only if you do not become enrolled in the plan within 31 days after you first become eligible.
Replacement Rule \( (\text{GR-9N 20-010-01}) \)
Crows, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures or bridges are covered only when you give proof to Aetna that:

- While you were covered by the plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
- You had a tooth (or teeth) extracted while you were covered by the plan. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Tooth Missing but Not Replaced Rule
The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while you were covered by the plan; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Alternate Treatment Rule \( (\text{GR-9N-20-015-01}) \)
Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

Coverage for Dental Work Begun Before You Are Covered by the Plan \( (\text{GR-9N-20-020-01}) \)
The plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan;
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan; or
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan.
Coverage for Dental Work Completed After Termination of Coverage

Your dental coverage may end while you or your covered dependent is in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan, and installed within 30 days after your coverage ends.

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

"Ordered" means:

- For a denture: the impressions from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.
- For any other item: the teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item; and
  - Impressions have been taken from which the item will be prepared.

Late Entrant Rule (GR-9N 20-025-01)

The plan does not cover services and supplies given to a person age 5 or more if that person did not enroll in the plan:

- During the first 31 days the person is eligible for this coverage, or
- During any period of open enrollment agreed to by the Policyholder and Aetna.

This exclusion does not apply to charges incurred:

- After the person has been covered by the plan for 12 months, or
- As a result of injuries sustained while covered by the plan, or
- For services listed as Visits and X-rays, Visits and Exams, and X-ray and Pathology in the Dental Care Schedule.

What The Managed Dental Plan Does Not Cover (GR-9N-28-025-01 CO)

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What the Plan Covers section or by amendment attached to this Booklet-Certificate. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These dental exclusions are in addition to the exclusions that apply to health coverage.

Any instruction for diet, plaque control and oral hygiene.

Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the What the Plan Covers section.
Crown, inlays and onlays, and veneers unless:

- It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
- The tooth is an abutment to a covered partial denture or fixed bridge.

Dental implants, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

Dental services and supplies that are covered in whole or in part:

- Under any other part of this plan; or
- Under any other plan of group benefits provided by the policyholder.

Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.

Except as covered in the What the Plan Covers section, treatment of any jaw joint disorder other than temporomandibular joint disorder (TMJ) treatment and treatments to alter bite or the alignment or operation of the jaw, other than temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.

General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.

**Orthodontic treatment** except as covered in the What the Plan Covers section.

Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).

Prescribed drugs; pre-medication; or analgesia.

Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

Surgical removal of impacted wisdom teeth only for orthodontic reasons.

Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:

- Scaling of teeth; and
- Cleaning of teeth.
Additional Items Not Covered By A Health Plan

Not every health service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What The Plan Covers section or by amendment attached to this Booklet-Certificate.

Acupuncture, acupressure and acupuncture therapy, except as provided in the What the Plan Covers section.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet-Certificate.

Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider’s license.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Court ordered services, including those required as a condition of parole or release.

Examinations:

- Any dental examinations:
  - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
  - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
  - any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the What the Plan Covers section.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service; or
  - Care while in the custody of a governmental authority.

Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Routine dental exams and other preventive services and supplies, except as specifically provided in the What the Plan Covers section.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the Continuation of Coverage section of this Booklet-Certificate.
Work related: Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers’ compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers’ compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered “non-occupational” regardless of cause.

When Coverage Ends (GR.9N:30-015-04)

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or
- Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, Aetna may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not actively at work due to illness or injury, your coverage may continue, until stopped by your employer, but not beyond 30 months from the start of your absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day you are actively at work before the start of the lay-off or leave of absence.

It is your employer’s responsibility to let Aetna know when your employment ends. The limits above may be extended only if Aetna and your employer agree, in writing, to extend them.

When Coverage Ends for Dependents (GR.9N:30-015-06.CO)

Coverage for your dependents will end if:

- You are no longer eligible for dependents’ coverage;
- You do not make your contribution for the cost of dependents’ coverage;
- Your own coverage ends for any of the reasons listed under When Coverage Ends for Employees (This does not apply if you use up your overall lifetime maximum);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar year when your dependent does not meet the plan’s definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer.
In addition, a "domestic partner" will no longer be a defined dependent on the earlier to occur of:

- The date this plan no longer allows coverage for domestic partners.
- The date the domestic partnership ends.

Coverage for dependents may extend for a period after your death. Coverage for handicapped dependents may extend after they reach any limiting age. See Continuation of Coverage for more information.

**Continuation of Coverage** (GR-9N-31-015-05 CO)

**Continuing Health Care Benefits** (GR-9N-31-015-06)

**Continuing Coverage for Dependent Students on Medical Leave of Absence** (GR-9N-31-015-06 CO)

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious illness or injury, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. Aetna may require a written certification from the treating physician which states that the child is suffering from a serious illness or injury and that the resulting leave of absence (or change in full-time student status) is medically necessary.

**Important Note**

If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, Handicapped Dependent Children, for more information.

**Handicapped Dependent Children** (GR-9N-31-015-01 CO)

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.
Proof that your child is fully handicapped must be submitted to **Aetna** no later than 90 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

**Aetna** will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

**Extension of Benefits** *(GR-9N 31-020 01)*

**Coverage for Health Benefits**
If your health benefits end while you are totally disabled, your health expenses will be extended as described below. To find out why and when your coverage may end, please refer to *When Coverage Ends*.

“Totally disabled” means that because of an **injury** or **illness**:

- You are not able to work at your own occupation and you cannot work at any occupation for pay or profit.
- Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

**Extended Health Coverage** *(GR-9N 31-020 01)*

**(GR-9N 31-020 01)**

**Dental Benefits (other than Basic Dental benefits):** Coverage will be available while you are totally disabled, for up to 12 months. Coverage will be available only if covered services and supplies have been rendered and received, including delivered and installed, prior to the end of that 12 month period.

**When Extended Health Coverage Ends**
Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

**COBRA Continuation of Coverage** *(GR-9N:31-02501 CO)*

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a “qualifying event” that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.
Continuing Coverage through COBRA
When you or your covered dependents become eligible, your employer will provide you with detailed information. This information will tell you how to continue your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage. This application states your intent to continue coverage.
- Send your application within:
  - 60 days of the qualifying event; or
  - 60 days of your employer’s notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

Who Qualifies for COBRA
You have 60 days from the qualifying event to elect COBRA. If you do not apply within 60 days, you will give up your COBRA continuation rights.

Below is a list of the qualifying events and a summary of the maximum coverage periods based on COBRA requirements.

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<th>Qualifying Event Causing Loss of Health Coverage</th>
<th>Covered Persons Eligible to Elect Continuation</th>
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<td>You and your dependents</td>
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<td>Your working hours are reduced</td>
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<td>You divorce or legally separate and are no longer responsible for dependent coverage</td>
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<td>You are a retiree eligible for health coverage and your former employer files for bankruptcy</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
</tbody>
</table>

Disability May Increase Maximum Continuation to 29 Months
If You or Your Covered Dependents Are Disabled.

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage past the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period. This is subject to the overall COBRA conditions.
- Must tell your employer within 60 days of the disability determination status.
- Must tell your employer before the 18 month continuation period ends.
- Must tell the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Must pay the premiums after the 18th month, through the 29th month.
If There Are Multiple Qualifying Events.

A covered dependent could qualify for an extension of the 18 or 29 month continuation period. This happens if they meet the requirements of another qualifying event, such as divorce or death. The total continuation period is 36 months.

Determining Your Premium Payments for Continuation Coverage
Your premium payments are regulated by law, based on the following:

- For the 18 or 36 month periods, premiums may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 percent of the plan costs.

When You Acquire a Dependent During a Continuation Period
If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent;
- Your employer is notified about your dependent within 31 days of eligibility; and
- Additional premiums for continuation are paid on a timely basis.

Important Note
For more information about dependent eligibility, see the Eligibility, Enrollment and Effective Date section.

When Your COBRA Continuation Coverage Ends
Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.
Coordination of Benefits - What Happens When There is More Than One Health Plan

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to this plan when you or your covered dependent has health coverage under more than one plan. “Plan” and “This plan” are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including, deductibles, coinsurance and copayments, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the Plans routinely provides coverage for hospital private rooms) is not an allowable expense.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced by the primary plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan’s payment arrangements shall be the allowable expense for all the Plans.

Claim Determination Period. Usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person is covered by a plan during a portion of a claim determination period of that person's coverage starts or ends during the claim determination period. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.
Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded sole custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any Plan providing benefits or services by reason of health care or treatment. However, if separate contracts are used to provide coordinated coverage for members of the group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes:
- Group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured);
- Hospital indemnity benefits in excess of $200 per days;
- Medical care components of group long-term care contracts, such as skilled nursing care;
- Medical benefits under group, or individual automobile contracts and;
- Medicare or other governmental benefits as permitted by law.

(2) Plan does not include:
- Individual or family insurance;
- Closed panel or other individual coverage (except for group-type coverage);
- Amounts of hospital indemnity insurance of $200 or less per day;
- School accident-type coverage;
- Benefits for non-medical components of group, long-term care policies;
- Medicare supplement policies;
- Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan when compared to another Plan covering the person.

- When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits.
- When This Plan is a Secondary Plan, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan’s benefits.

Which Plan Pays First (GR-9N 33 01002 CO)

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      i. The parents are married;
      ii. The parents are not separated whether or not they have been married or;
      iii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   B. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
   C. If the parents are separated (whether or not they have ever been married) or are divorced the order of benefits is:
      - The plan of the custodial parent;
      - The plan of the spouse of the custodial parent;
      - The plan of the noncustodial parent; and then
      - The plan of the spouse of the noncustodial parent.

3. Active Employee or inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired, is the primary plan. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled "Non-Dependent or Dependent".

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, or subscriber longer is primary.

6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, This Plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Works

When this plan is secondary, it may reduce its benefits so that total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

(1) Determine its obligation to pay or provide benefits under its contract;
(2) Determine whether a benefit reserve has been recorded for the covered person; and
(3) Determine whether there are any unpaid allowable expenses during that claim determination period.
If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100% of total allowable expenses incurred during the claim determination period. At the end of the claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

If a covered person is enrolled in two or more closed panel plans the following coordination of benefit rules will apply:

1. COB does not occur if the enrollee did not go to either plan's closed panel, unless there is covered benefit (i.e. medical emergency, etc.)
2. The two plans will coordinate benefits for covered services for both plans (i.e. emergency services, services from providers that are participating in both plans, etc.)
3. If the covered person goes to the primary plan's closed panel providers for covered services, the secondary carrier shall coordinate benefits only to the extent that there are benefits or reserves available.
4. If the primary closed panel has no liability because the covered person did not use the closed panel providers, but the covered person used the secondary closed panel providers, the secondary plan will pay benefits as though they are primary.

Right To Receive And Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. Aetna may get the facts it needs from or give them to other organization or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefit. Aetna need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give this plan any facts it needs to apply those rules and determine benefits payable.

Facility of Payment
Any payment made under another plan may include an amount, which should have been paid under this plan. If so, Aetna may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Aetna will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.
When You Have Medicare Coverage

This section explains how the benefits under This Plan interact with benefits available under Medicare.

Medicare, when used in this Booklet-Certificate, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare

You are eligible for Medicare if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease; or
- Not covered under it because you:
  1. Refused it;
  2. Dropped it; or
  3. Failed to make a proper request for it.

If you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays or would have paid in the event you did not enroll for Medicare Part B. Sometimes, the plan is the primary payor, which means that the plan pays benefits before Medicare pays benefits. Under other circumstances, the plan is the secondary payor, and pays benefits after Medicare.

Which Plan Pays First

The plan is the primary payor when your coverage for the plan’s benefits is based on current employment with your employer. The plan will act as the primary payor for the Medicare beneficiary who is eligible for Medicare:

- Solely due to age if the plan is subject to the Social Security Act requirements for Medicare with respect to working aged (i.e., generally a plan of an employer with 20 or more employees);
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for Medicare benefits. This provision does not apply if, at the start of eligibility, you were already eligible for Medicare benefits, and the plan’s benefits were payable on a secondary basis;
- Solely due to any disability other than end stage renal disease; but only if the plan meets the definition of a large group health plan as outlined in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more employees).

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary

The plan pays benefits first when it is the primary payor. You may then submit your claim to Medicare for consideration.
When Medicare is Primary
Your health care expense must be considered for payment by Medicare first. You may then submit the expense to Aetna for consideration. Medicare Part B benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is enrolled in Medicare Part B.

Aetna will calculate the benefits the plan would pay in the absence of Medicare:

The amount will be reduced so that when combined with the amount paid by Medicare, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under Medicare will be applied under the plan in the order received by Aetna. Aetna will apply the largest charge first when two or more charges are received at the same time.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.
General Provisions (GR-9N-32-005-02-CO)

Type of Coverage

Coverage under this plan is non-occupational. Only non-occupational accidental injuries and non-occupational illnesses are covered. This plan covers charges made for services and supplies only while the person is covered under this plan.

Physical Examinations (GR-9N-32-005-03-CO)

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person who is requesting certification or benefits for new and ongoing claims. Multiple exams, evaluations, and functional capacity exams may be required during your disability for an ongoing claim. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

No legal action can be brought to recover payment under any benefit before the end of 60 days after written proof of loss has been furnished. Also, no action can be brought after 3 years from the time written proof of loss is required.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before your coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Confidentiality (GR-9N 32-005 01 CO)

Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by Aetna when necessary for your care or treatment, the operation of this plan and administration of this Booklet-Certificate, or other activities, as permitted by applicable law. You can obtain a copy of Aetna’s Notice of Information Practices by calling Member Services at the number on the back of the ID card.

Additional Provisions (GR-9N 32-005 01 CO)

The following additional provisions apply to your coverage.

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under this plan because you are connected with more than one Policyholder.
- In the event of a misstatement of any fact affecting your coverage under this plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of this plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this plan or about the proper payment of benefits, contact your Policyholder or Aetna.
- Your Policyholder hopes to continue this plan indefinitely but, as with all group plans, this plan may be changed or discontinued with respect to your coverage.
Assignments (GR-9N-32-005-03-CO)

An assignment is the transfer of your rights under the group policy to a person you name.

All coverage may be assigned only with the written consent of Aetna. To the extent allowed by law, Aetna will not accept an assignment to an out-of-network provider, including but not limited to, an assignment of:

- The benefits due under this group insurance policy;
- The right to receive payments due under this group insurance policy; or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this group insurance policy.

Misstatements (GR-9N-32-005-03-CO)

If any fact as to the Policyholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by Aetna in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

Aetna’s failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of Aetna’s right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability (GR-9N-32-005-03-CO)

As to Accident and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the Policyholder shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by you or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Recovery of Overpayments (GR-9N-32-015-01 CO)

Health Coverage

If a benefit payment is made by Aetna, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, Aetna has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery Aetna may have with respect to such overpayment.
**Reporting of Claims**

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. Your employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

**Notice of Claim - Claim Forms (GR-9N-32.020-01 CO)**

Written notice of claim must be furnished to Aetna. This must be done within 20 days after any loss covered by the group contract occurs, or as soon after that as is possible. Notice given, at Aetna’s Home Office or to one of its agents, by or for a person making claim shall be deemed to be notice of claim, as long as the facts are clear enough to identify you.

Aetna will furnish the person making claim with claim forms within 15 days of the notice of claim. If forms are not furnished, written proof of loss must still be furnished as set forth in the next section.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

**Payment of Benefits (GR-9N-32.025-02.CO)**

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, Aetna has the right to pay any health benefits to the service provider. This will be done unless you have told Aetna otherwise by the time you file the claim.

Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

Any unpaid balance will be paid within 30 days of receipt by Aetna of the due written proof.

Aetna may pay up to $1,000 of any other benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

**Records of Expenses (GR-9N-32.030-02)**

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of dentists who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.
Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to Aetna, you may contact Aetna’s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use Aetna’s toll free Member Services phone number on your ID card or visit Aetna’s web site at www.aetna.com.

Effect of Benefits Under Other Plans *(GR-9N 32.035.01)*

Effect of An Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen dental coverage under an HMO Plan offered by your employer, you will be excluded from dental expense coverage on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan providing dental coverage, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change dental coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change dental coverage when there is not an open enrollment period, coverage will take effect only if and when Aetna gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change dental coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when Aetna gives its written consent.

Any extension of dental benefits under this plan will not apply on or after the date of a change to an HMO Plan.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Prior Coverage - Transferred Business *(GR-9N 32.040.05 CO)*

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by your employer (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

If:

- A dependent child's eligibility under the prior coverage is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;
coverage under this plan will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided under the section, *Continuing Coverage for Dependent Students on Medical Leave of Absence*.

If part or all of your **deductible** under the prior coverage was applied against covered medical expenses incurred by you, your **deductible** under this plan will be reduced by the amount which was applied. This will be done if:

- Your coverage under this Major or Comprehensive Medical Expense plan replaces medical coverage you had with another carrier within 31 days of the termination of that coverage
- The coverage under this plan is through the same employer
- The medical expenses which were applied to the deductible were incurred during the 90 days prior to the effective date of this coverage.

This will only apply for the calendar year in which you became covered under this plan.

**Discount Programs** *(GR-9N 32-045-07)*

**Discount Arrangements**

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called "third party service **providers**". These third party service **providers** may pay us so that they can offer you their services.

The third party service **providers** are independent contractors. The third party service provider is responsible for the goods or services they deliver.

We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third party service **providers** for the services they offer. You are responsible for paying for the discounted goods or services.

**Wellness and Other Incentives** *(GR-9N 32-045-07)*

**Aetna** may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services, and continue participation as an **Aetna** member through incentives. You and your **physician** can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, **Aetna** may provide incentives based on your participation and your results. Incentives may include but are not limited to:

- Modifications to **copayment**, **deductible**, or **coinsurance** amounts
- **Premium** discounts or rebates
- Contributions to a health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards, or
- Any combination of the above.
 Appeals Procedure (GR.9N-32.050-002)

Definitions

**Adverse Benefit Determination (Decision):** A determination by Aetna or its designee that a request for a pre-service or post-service claim has been reviewed and, based upon the information provided:

- does not meet the plan's requirement for medical necessity;
- the benefit is not appropriate, effective, or efficient;
- is not provided in or at the appropriate health care setting or level of care; or
- is determined to be experimental investigational,

and is therefore denied, reduced, or terminated.

An adverse benefit determination also includes a denial for a benefit that is excluded by this plan for which the claimant is able to present evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit.

An adverse benefit determination also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

**Appeal:** An oral or written request to Aetna to reconsider an adverse benefit determination.

**Complaint:** Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

**Concurrent Care Claim Extension:** A request to extend a course of treatment that was previously approved.

**Concurrent Care Claim Reduction or Termination:** A decision to reduce or terminate a course of treatment that was previously approved.

**Date of Receipt of Notice:** The date that shall be calculated to be no less than 3 calendar days after the date the notice is postmarked by Aetna.

**Designated Representative:**

- A person, including the treating provider or an authorized person, to whom you have given express written consent to represent him or her in an **External Review;** or
- A person authorized by law to provide substituted consent for you, including but not limited to a guardian, agent under power of attorney, or proxy.

**External Review:** A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner and made up of physicians or other appropriate health care providers. The ERO must have expertise in the problem or question involved.

**Final Adverse Benefit Determination:** An adverse benefit determination that has been upheld by Aetna at the exhaustion of the appeals process.

**Pre-service Claim:** Any claim for medical care or treatment that requires approval before the medical care or treatment is received.
Post-Service Claim: Any claim that is not a “Pre-Service Claim.”

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- seriously jeopardize your life or health;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals
As to medical and prescription drug claims and appeals only, Aetna will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the final adverse benefit determination is required to be provided so that you may respond prior to that date.

Prior to issuing a final adverse benefit determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of final adverse determination is required.

Claim Determinations – Group Health Coverage
Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and prescription drug claims only, if Aetna makes an adverse benefit determination, written notice will be provided to you, or in the case of a concurrent care claim, to your provider.

For Utilization Review

Expedited Appeal Review
In an Expedited Appeal review, Aetna will make a decision and notify you or your designee (or the provider acting on his or her behalf) as expeditiously as the medical condition requires, but in no event more than 72 hours after the review is started. If the review is a concurrent review determination, the service shall be continued without liability to you until you have been notified of the determination.

Aetna will provide written confirmation of our decision concerning an Expedited Appeal review within 2 working days of providing notification of that decision. In the case of an adverse benefit determination, the written decision shall include the same information specified under the Standard First Level Appeal Review section.

If the expedited review process does not resolve a difference of opinion between Aetna and you (or the provider acting on your behalf), you or your attending provider may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. The written grievance in this case shall be handled as a Standard Second Level Appeal Review.

For other Than Utilization Review

Urgent Care Claims
Aetna will notify you of an urgent care claim decision as soon as possible, but not later than 72 hours after the claim is made.

If more information is needed to make an urgent claim decision, Aetna will notify the claimant within 72 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier to occur:

- The receipt of the additional information; or
- The end of the 48 hour period given the physician to provide Aetna with the information.
The requirements apply to all written request received by Aetna that are submitted by you, your designated representative or provider requesting a determination of coverage for a specific health care service or treatment for you.

**Pre-Service Claims**
Aetna will notify you of a pre-service claim decision as soon as possible, but not later than 15 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, if not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 15 calendar day period. If this extension is needed because Aetna needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide Aetna with the required information. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline will be extended to the next business day.

The requirements apply to all written request received by Aetna that are submitted by you, your designated representative or provider requesting a determination of coverage for a specific health care service or treatment for you.

**Post-Service Claims**
Aetna will notify you of a post-service claim decision as soon as possible, but not later than 30 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, if not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 30 calendar days, from the date of the notice, to provide Aetna with the required information. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline will be extended to the next business day.

**Concurrent Care Claim Extension**
Following a request for a concurrent care claim extension, Aetna will notify you of a claim decision for urgent care as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a concurrent care claim extension.

**Concurrent Care Claim Reduction or Termination**
Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an appeal.

If you file an appeal, coverage under the plan will continue for the previously approved course of treatment until a final appeal decision is rendered. During this continuation period, you are responsible for any copayments; coinsurance; and deductibles; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under appeal. If Aetna’s initial claim decision is upheld in the final appeal decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

**Complaints**
If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must call or write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.
Appeals of Adverse Benefit Determinations
You may submit an appeal if Aetna gives notice of an adverse benefit determination. This Plan provides for two levels of appeal depending upon the type of coverage provided under the Plan. A final adverse benefit determination notice will also provide an option to request an External Review (if available).

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an adverse benefit determination to request your Level One Appeal. If the deadline for filing a request ends on a weekend or holiday, the deadline will be extended to the next business day. Your appeal may be submitted orally or in writing and must include:

- Your name.
- The Policyholder's name.
- A copy of Aetna's notice of an adverse benefit determination.
- Your reasons for making the appeal.
- Any other information you would like to have considered.

Send your written appeal to Member Services at the address shown on your ID Card, or call in your appeal to Member Services using the telephone number shown on your ID Card.

You may also choose to have another person (an authorized representative) make the appeal on your behalf. You must provide written consent to Aetna.

You may be allowed to provide evidence or testimony during the appeal process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Level One Appeal – Group Health Claims

For Utilization Review
Your Appeal may be submitted orally or in writing to Aetna within 180 days with respect to Group Health and Group Disability and 60 calendar days with respect to all Other Group Claims of the date that Aetna provides notice of denial including a benefit denied due to a contractual exclusion. Aetna's address is on your ID card.

A response will be sent to you and your attending physician or other health care provider within 15 calendar days following receipt of the request for a Standard First Level Appeal Review. The response will be based on the information provided with, or after, receipt of the request for the Appeal. Such response shall include the following:

- The name, title and qualifying credentials of the physician evaluating the appeal and the qualifying credentials of the clinical peers with whom the physician consults (together referred to as the “reviewers”). The reviewers will not have been involved in the initial adverse benefit determination but a person that was previously involved with the denial may answer questions. In the case of dental care, the Level One Appeal may be evaluated by a dentist, who shall consult with an appropriate clinical peer, unless the reviewing dentist is a clinical peer. A licensed dentist familiar with standards of care in Colorado may sign the written denial.
- A statement of the reviewer's understanding of the reason for the appeal.
- The reviewer's decision in clear terms. This will include the medical rationale that applies in sufficient detail for you to respond further to Aetna's position.
- A reference to the evidence or documentation used as the basis for the decisions, including the clinical review criteria used to make the determination, and instructions for requesting such criteria.
- A description of the procedures for obtaining an independent external review of the adverse benefit determination.
- A description of the process for submitting a Level Two Appeal Review.

For Other Than Utilization Review
A review of a Level One Appeal of an adverse benefit determination shall be provided by Aetna personnel. They shall not have been involved in making the adverse benefit determination.
Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 36 hours of receipt of the request for an appeal.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for an appeal.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

You or your authorized representative does not have the right to attend the first level review. You are entitled to:

a. Submit written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review.

For review of a benefit denial due to a contractual exclusion, you will provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply; and

b. Receive from Aetna, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to your request for benefits. A document, record or other information shall be considered "relevant" to your request for benefits if the document, record or other information:

   (1) Was relied upon in making the benefit determination;

   (2) Was submitted, considered or generated in the course of making the adverse benefit determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;

   (3) Demonstrates that, in making the benefit determination, Aetna consistently applied required administrative procedures and safeguards with respect to you as other similarly situated covered persons; or

   (4) Constitutes a statement of policy or guidance with respect to the health coverage plan concerning the denied health care service or treatment for your diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

Level Two Appeal - Group Health Claims

For Utilization Review - Applies Only to Group Health Claims
If you are not satisfied with the Level One Appeal Review decision, you shall have the option of choosing whether to utilize the voluntary Level Two Appeal Review or the External Review.

With respect to a voluntary Level Two Appeal Review of a first level review decision, the denial shall be reviewed by a review panel comprised of health care professionals with appropriate expertise who:

- were not previously involved in the appeal; and
- do not have a direct financial interest in the case or the outcome of the review.
You have the right to:

- attend the Level Two Appeal Review;
- present your case to the review panel in person or in writing;
- submit supporting material both before, and at, the review meeting;
- request a copy of the materials that Aetna intends to present at the review at least 5 days prior to the review meeting. Any new material developed after the 5 day deadline should be provided as soon as possible.
- present written comments, documents, records and other materials relating to the request for benefits for the review to consider when conducting the review both before and, if applicable at the review meeting. A copy of the materials you plan to present or have presented on your behalf should be provided to Aetna at least 5 days prior to the date of the review meeting. Any new materials developed after the 5 day deadline should be provided as soon as possible.
- within seven (7) calendar days in advance of the review, inform Aetna if you intend to have an attorney present to represent such person’s interests. If you decide to have an attorney present after the seven-day deadline, notice will be provided to Aetna when practicable.
- ask questions of any Aetna representatives prior to the hearing and question any panelist at the hearing; and
- be assisted or represented by a person of your choice, including counsel, advocates and health care professionals.

Upon request, Aetna will provide to you all relevant information that is not confidential or privileged under state or federal law.

The review panel will schedule and hold a review meeting within 60 calendar days of Aetna’s receipt of a your request for a Level Two Appeal Review. If you request the opportunity to appear in person before the panel, the review meeting will be held during regular business hours at a location reasonably accessible to you, including accommodations for disabilities. Aetna will not discourage you from requesting a face-to-face meeting. However, in cases where a face-to-face meeting is not practical for geographic reasons, Aetna will offer you the opportunity to communicate with the review panel (at Aetna’s expense) by conference call, video conferencing, or other appropriate technology. You will be notified in writing at least 20 calendar days in advance of the review date.

After private deliberation, the review panel shall issue a written decision to you within 7 calendar days of the conclusion of the review meeting. The decision shall contain the following:

- The names, titles, and qualifying credentials of the members of the review panel.
- A statement of the review panel’s understanding of the nature of the appeal and the material facts related thereto, including issues that you raised and all pertinent facts.
- The rationale for the review panel's decision.
- Reference to evidence or documentation considered by the review panel in making that decision.
- In the case of adverse benefit determinations, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.
- An explanation of any further rights available under the medical plan that you have regarding the appeal.
- Instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination, and additional appeal, review, arbitration or other options available to you, if any.
- Notice of your right to request an independent External Review.

**Expedited Appeals**

The following procedures for the review of an adverse benefit determination apply to situations where the timeframe of a Standard Appeal would seriously jeopardize your life, health, or your ability to regain maximum function, or, if you are disabled, create an imminent and substantial limitation in your existing ability to live independently.

An Expedited Appeal shall be available to, and may be initiated by, you or the provider acting on your behalf. Expedited Appeals shall be evaluated by an appropriate clinical peer(s) in the same or similar specialty as would typically manage the case under review. The clinical peer(s) shall not have been involved in the initial adverse benefit determination. Aetna shall give reasonable access, not to exceed 1 business day after receiving a request for an Expedited Appeal review, to a clinical peer who can perform the review.
**Aetna** shall provide an Expedited Appeal review to all requests concerning an admission; availability of care; continued stay; or health care service if you have received emergency services but have not been discharged from a facility. **Adverse benefit determinations** made on a retrospective basis may only be appealed through the Standard Appeal review process. All necessary information, including **Aetna's** decision, shall be transmitted between **Aetna** and you (or the provider acting on your behalf) either electronically, by telephone, or facsimile.

**For Other Than Utilization Review**
If **Aetna** upholds an adverse benefit determination at the first level of appeal, and the reason for the decision was based on medical necessity or experimental or investigational reasons, you or your authorized representative have the right to file a Level Two Appeal. The appeal must be submitted within 60 calendar days following the receipt of a decision of a Level One Appeal. If the deadline for filing a request ends on a weekend or holiday, the deadline will be extended to the next business day.

Review of a Level Two Appeal of an adverse benefit determination of an urgent care claim, a Pre-Service Claim, or a Post-Service Claim shall be provided by **Aetna** personnel. They shall not have been involved in making the adverse benefit determination.

**Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)**
**Aetna** shall issue a decision within 36 hours of receipt of the request for a Level Two Appeal.

**Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)**
**Aetna** shall issue a decision within 15 calendar days of receipt of the request for a Level Two Appeal.

**Post-Service Claims**
**Aetna** shall issue a decision within 30 calendar days of receipt of the request for a Level Two Appeal.

**Exhaustion of Process**
You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- Contact the Colorado Department of Insurance to request an investigation of a complaint or appeal; or
- File a complaint or appeal with the Colorado Department of Insurance; or
- Establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by **Aetna** or any matter within the scope of the Appeals Procedure.

Under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include Urgent Care Claims and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

**Important Note:**
If **Aetna** does not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the appeal requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or an appeal straight to an External Review. Your claim or internal appeal, will not go straight to **External Review** if:

- A rule violation was minor and isn’t likely to influence a decision or harm you;
- It was for a good cause or was beyond **Aetna**’s control; and
- It was part of an ongoing, good faith exchange between you and **Aetna**.
External Review

For Utilization Review (GR-9N:32.053)

Within 4 months after the date of Receipt of a Notice of Aetna’s adverse determination following the completion or exhaustion of the internal appeals process following the completion of a voluntary second level appeal, you may file a request for an External Review with Aetna. The date of receipt shall be calculated to be no less than 3 calendar days after the date the notice is postmarked by Aetna. If the deadline for filing a request ends on a weekend or holiday, the deadline will be extended to the next business day.

You may request an external review if an adverse benefit determination has been made involving a recommended or requested medical service that is experimental or investigational if the treating physician certifies that the recommended or requested health care service or treatment will be less effective if not begun immediately, and:

1. The treating physician certifies that standard health care services or treatments have not improved the condition of the covered person or are not medically appropriate for the covered person; or
2. The treating physician certifies that there is no standard health care service or treatment available that is covered by Aetna that is more beneficial to the covered person than the recommended or requested health care service or treatment, and that the physician is a board-certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition.

The physician must also certify that scientifically valid studies support the health care service or treatment subject to denial is likely to be more beneficial to the covered person than any available standard health care services or treatments.

Your request for an External Review must be made in writing and include a completed External Review Request Form and a signed consent form authorizing Aetna to disclose protected health information, including medical records concerning you, that are pertinent to the External Review. A request for an Expedited External Review must also include a physician's certification that the medical condition meets the necessary criteria. At this time, you may include new or additional information, if it is significantly different from information previously provided, for consideration by Aetna or the Independent External Review Entity. Aetna's consideration of such new information will not stop or delay the External Review.

Aetna’s denial of a request for a standard External Review will be made in writing and include the specific reasons for the denial and will provide information appealing the denial of the request with the Division of Insurance at the same time it is sent to you or, if applicable, your designated representative.

Aetna’s denial of a request for an expedited External Review will be made in writing and transmitted electronically or by facsimile or any other available expeditious method. It shall include the specific reasons for the denial and shall provide information about appealing the denial of the request with the Division of Insurance. A copy of the denial shall be sent to the Division of Insurance at the same time it is sent to you or, if applicable, your designated representative.

The External Review may only be stopped if Aetna decides to reverse their final adverse benefit determination and provide coverage or payment for the health care service that is the subject of the review. If Aetna decides to reverse their adverse benefit determination, Aetna will notify you, the assigned Independent External Review Entity, and the Commissioner of such decision. The Independent External Review Entity will stop the External Review upon receipt of such notice.
Unless otherwise noted, all notices and exchange of documents, information and materials between parties shall be made electronically, by facsimile, or by telephone, followed by a written confirmation.

**Standard External Review**

Upon receipt of the request for an **External Review**, **Aetna** will deliver a copy of the request to the Commissioner within 2 business days.

Whenever Aetna receives an incomplete standard request for external review that fails to meet Aetna’s filing procedures, Aetna will notify the covered person of this failure as soon as possible, but in no event later than five (5) days following the date the incomplete request was received.

Whenever Aetna receives an incomplete expedited request for external review that fails to meet Aetna’s filing procedures, Aetna shall notify the covered person of this failure as soon as possible, but in no event later than twenty-four (24) hours after the incomplete request was received.

If, prior to sending such notification to the Commissioner, **Aetna** reverses their final **adverse benefit determination** based on new information you or your designated representative submitted, **Aetna** will notify you or your designated representative within 1 business day of its reversal.

Within 2 business days after a request for **External Review** is received from **Aetna**, the Commissioner will randomly assign an Independent **External Review** Entity to conduct the review. Upon assignment, the Commissioner will notify **Aetna** of the name and address of the Independent **External Review** Entity to which the appeal should be sent.

Within 1 business day of this notice, **Aetna** will provide you or your designated representative with:

- a description of the Independent **External Review** Entity; and
- instructions on how to file any documentation concerning a potential conflict of interest of the Independent **External Review** Entity with the Commissioner.

Within 2 business days of receipt of **Aetna**’s notice regarding the Independent **External Review** Entity, you or your designated representative may provide the Commissioner with documentation relating to a potential conflict of interest on the part of the Independent **External Review** Entity.

If the Commissioner determines that a conflict of interest exists, a new Independent **External Review** Entity will be assigned within 1 business day of such determination. The Commissioner will notify you or your designated representative of the determination regarding the potential conflict of interest and the identity of the new Independent **External Review** Entity, if applicable. The Commissioner will notify **Aetna** of the name and address of the new Independent **External Review** Entity to which the appeal should be sent.

Within 5 business days of receipt of the notice from **Aetna**, you may provide additional information to the independent **External Review** entity that shall be considered during the review. The independent **External Review** organization is not required to, but may, accept and consider additional information submitted after 5 business days. The independent **External Review** organization shall forward this information to **Aetna** within 1 business day of receipt.

Within 5 business days from the date **Aetna** receives notice as to the identity of the Independent **External Review** Entity, **Aetna** will deliver to such entity the documents and information considered in making their final **adverse benefit determination**, including an index of all submitted documents. If **Aetna** fails to provide the required documents and information within the time specified, the Independent **External Review** Entity may terminate the **External Review** and make a decision to reverse **Aetna**’s final **adverse benefit determination**.
Within 2 business days of receipt, the Independent External Review Entity will deliver to you or your designated representative, the index of all materials submitted to them by Aetna. Upon request, Aetna will provide you or your designated representative with all relevant information supplied to the Independent External Review Entity that is not confidential or privileged under state or federal law concerning the case under review.

After receipt of the required documentation, the Independent External Review Entity will notify you, your attending provider, and Aetna of any additional medical information required to conduct the review. Within 5 business days of such a request, you or your designated representative or the attending provider must submit the additional information, or an explanation of why the additional information is not being submitted to the Independent External Review Entity and Aetna. If you or your designated representative or the attending provider fails to provide the additional information within the time specified, the Independent External Review Entity will make its decision based on the information provided by Aetna.

The Independent External Review Entity will base its determination on an objective review of relevant medical and scientific evidence. In reaching a decision, the Independent External Review Entity is not bound by any decisions or conclusions reached during Aetna's utilization review process or internal Appeals Procedure.

Within 45 calendar days after the date of receipt of the request for External Review by the independent External Review entity, it will:

- Make a decision to uphold or reverse Aetna's final adverse benefit determination in whole or in part; and
- Provide a written notification of its decision to the following:
  - You;
  - If applicable, your designated representative;
  - Aetna;
  - The physician or other health care professional; and
  - The Commissioner.

Upon receipt of the Independent External Review Entity’s decision to reverse Aetna’s final adverse benefit determination, Aetna will approve the coverage that was the subject of the review. For concurrent and prospective reviews, this will happen within 1 business day. For retrospective reviews, this will happen within 5 business days. Aetna will provide written notice of the approval to you within 1 business day of Aetna's approval of coverage.

**Expedited External Review**

You may request an Expedited External Review if you have a medical condition where the timeframe for completion of a Standard External Review would seriously jeopardize your life, health, or ability to regain maximum function or, if you are disabled, create an imminent and substantial limitation in your ability to live independently.

You may request a concurrent expedited External Review when a request for an Expedited internal review has been made.

Upon receipt of your request for an Expedited External Review and the physician’s certification, Aetna will notify and send a copy to the Commissioner within 1 business day either electronically, by telephone, or facsimile.

Within 1 business day from the time the Commissioner receives a request for an Expedited External Review, the Commissioner will assign an Independent External Review Entity to conduct the review. The commissioner will select an Independent External Review Entity that does not have a conflict of interest with the case. Upon assignment, the Commissioner will inform Aetna of the name and address of the Independent External Review Entity to which the appeal should be sent. Within 1 business day of this notice, Aetna will provide information to you or your designated representative describing the Independent External Review Entity selected.

Immediately upon receipt of the notification, Aetna will deliver the documents and information considered in making its final determination, including an index of all submitted documents, to the Independent External Review Entity.
The Independent **External Review** Entity will base its determination on an objective review of relevant medical and scientific evidence. In reaching a decision, the Independent **External Review** Entity is not bound by any decisions or conclusions reached during **Aetna** utilization review process or internal **Appeals** Procedure.

Within 72 hours after the receipt of the assignment of the request for **External Review**, the Independent **External Review** Entity will:

- Make a decision to uphold or reverse **Aetna**’s final adverse benefit determination in whole or in part; and
- Provide a notification of the decision to the following:
  - You;
  - Your designated representative, if applicable;
  - **Aetna**;
  - Your physician; and
  - The Commissioner.

If the first notification you receive from the Independent **External Review** Entity is not in writing, the Independent **External Review** Entity will provide written confirmation within 48 hours of the initial notification.

Immediately upon receipt of the Independent **External Review** Entity’s notice of a decision to reverse **Aetna**’s final adverse benefit determination, **Aetna** will approve the coverage that was the subject of the review. **Aetna** will provide written notice of the approval to you or your designated representative.

The **External Review** decision is binding on **Aetna** and you. You may not request a second **External Review** of an adverse benefit determination.

**For Other Than Utilization Review**

You may receive an adverse benefit determination or final adverse benefit determination.

In these situations, you may request an **External Review** if you or your provider disagrees with **Aetna**’s decision.

To request an **External Review**, any of the following requirements must be met:

- You have received an adverse benefit determination notice by **Aetna**, and **Aetna** did not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services.
- You have received a final adverse benefit determination notice of the denial of the claim by **Aetna**.
- Your claim was denied because **Aetna** determined that the care was not necessary or was experimental or investigational.
- You qualify for a faster review as explained below.

There is no minimum dollar amount for a claim to be eligible for **External Review**.

The notice of adverse benefit determination or final adverse benefit determination that you receive from **Aetna** will describe the process to follow if you wish to pursue an **External Review**, and will include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to the U.S. Office of Personnel Management within 123 calendar days of the date you received the adverse benefit determination or final adverse benefit determination notice. You also must include a copy of the notice and all other pertinent information that supports your request.

The U.S. Office of Personnel Management will contact the ERO that will conduct the review of your claim. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow **Aetna**’s contractual documents and plan criteria governing the benefits. You will be notified of the decision of the ERO usually within 45 calendar days of **Aetna**’s receipt of your request form and all the necessary information.
A faster review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would:

- seriously jeopardize your life or health; or
- jeopardize your ability to regain maximum function; or
- if the adverse benefit determination relates to experimental or investigational treatment, if the physician certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

You may also receive a faster review if the final adverse benefit determination relates to an admission; availability of care; continued stay; or health service for which you received emergency care, but have not been discharged from a facility.

Faster reviews are decided within 72 hours after Aetna receives the request.

Aetna will abide by the decision of the ERO, except where Aetna can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to Aetna. Aetna is responsible for the cost of sending this information to the ERO and for the cost of the external review except for dental, vision and hearing claims.

For more information about the Appeals Procedure or External Review processes, call the Member Services telephone number shown on your ID card.
Glossary

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

A (GR-9N 34-005 05)

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.

C (GR-9N 34-015 02)

Coinsurance
Coinsurance is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as “plan coinurance” and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinurance amounts.

Copay or Copayment
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various copayments, and these copayment amounts or percentages are specified in the Schedule of Benefits.

Cosmetic
Services or supplies that alter, improve or enhance appearance.

Covered Expenses
Medical, dental, vision or hearing services and supplies shown as covered under this Booklet-Certificate.

D (GR-9N 34-020 06)

Deductible
The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding deductibles and deductible amounts can be found in the Schedule of Benefits.

Dental Provider
This is:

- Any dentist;
- Group;
- Organization;
- Dental facility; or
- Other institution or person.

legally qualified to furnish dental services or supplies.

Dental Emergency
Any dental condition that:

- Occurs unexpectedly;
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.
**Dentist**
A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

**Directory**
A listing of all **network providers** serving the class of employees to which you belong. The policyholder will give you a copy of this directory. **Network provider** information is available through **Aetna’s online provider directory**, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this directory.

**Experimental or Investigational**
Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the U.S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

It also includes the written informed consent used by the treating facility or by:

- the treating facility; or
- by another facility studying the same:
  - drug;
  - device;
  - procedure; or
  - treatment
    - that states that it is **experimental or investigational**, or for research purposes.

**Hospital**
An institution that:

- is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- is supervised by a staff of **physicians**;
- provides twenty-four (24) hour-a-day **R.N.** service,
- charges patients for its services;
- is operating in accordance with the laws of the jurisdiction in which it is located; and
• Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations; and
• Is currently licensed or certified by the Colorado Department of Health and Environment.

**In no event** does hospital include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative hospital or facility primarily for rehabilitative or custodial services.

(I (GR-9N 34-045-02))

**Illness** (GR-9N-34-045-02 CO)
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings. The findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

**Injury** (GR-9N-34-045-02 CO)
An accidental bodily injury that is the sole and direct result of:

• An unexpected or reasonably unforeseen occurrence or event; or
• The reasonable unforeseeable consequences of a voluntary act by the person.

The act or event must be definite as to time and place.

(J (GR-9N-34-050-01-CO))

**Jaw Joint Disorder** (GR-9N-34-050-01 CO)
This is:

• A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
• A Myofacial Pain Dysfunction (MPD); or
• Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

(M (GR-9N-34-065-03 CO))

**Medically Necessary or Medical Necessity** (GR-9N-34-065-04 CO)
These are health care or dental services, and supplies or **prescription drugs** that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

• preventing;
• evaluating;
• diagnosing; or
• treating:
  − an illness;
  − an injury;
  − a disease; or
  − its symptoms.
The provision of the service, supply or prescription drug must be:

a) In accordance with generally accepted standards of medical or dental practice;

b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

c) Not mostly for the convenience of the patient, physician, other health care or dental provider; and

d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with physician or dental specialty society recommendations. They must be consistent with the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

N (GR.9N 34.070.02)

Negotiated Charge (GR.9N-34.070.11 CO)
As to health expense coverage, other than Prescription Drug Expense Coverage, this is either:

- The amount a network provider has agreed to accept
- The amount Aetna agrees to pay directly to a network provider or third party vendor (including any administrative fee in the amount paid)

for providing services, prescription drugs or supplies to plan members. This does not include prescription drug services from a network pharmacy.

Network Provider
A dental provider who has contracted to furnish services or supplies for this plan; but only if the provider is, with Aetna's consent, included in the directory as a network provider for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)
Health care service or supply that is:

- Furnished by a network provider; or
- Furnished or arranged by your PCD.

Non-Occupational Illness
A non-occupational illness is an illness that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an illness that does.

An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that illness under such law.
Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury which does.

Occupational Injury or Occupational Illness
An injury or illness that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an injury or illness that does.

Occurrence
This means a period of disease or injury. An occurrence ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or injury; and
- Neither takes any medication, nor has any medication prescribed, for a disease or injury.

Orthodontic Treatment
This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Out-of-Network Service(s) and Supply(ies)
Health care service or supply that is:

- Furnished by an out-of-network provider; or
- Not furnished or arranged by your PCD.

Out-of-Network Provider
A dental provider who has not contracted with Aetna, an affiliate, or a third party vendor, to furnish services or supplies for this plan.
Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your illness or injury is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Precertification or Precertify
A process where Aetna is contacted before certain services are provided, such as hospitalization or outpatient surgery, or prescription drugs are prescribed to determine whether the services being recommended or the drugs prescribed are considered covered expenses under the plan. It is not a guarantee that benefits will be payable.

Prescriber
Any physician or dentist, acting within the scope of his or her license, who has the legal authority to write an order for a prescription drug.

Prescription
An order for the dispensing of a prescription drug by a prescriber. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug
A drug, biological, or compounded prescription which, by State and Federal Law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription."

This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Dentist (PCD)
This is the network provider who:

- Is selected by a person from the list of Primary Care Dentists in the directory;
- Supervises, coordinates and provides dental services to a person;
- Initiates referrals for specialist dentist care and maintains continuity of patient care; and
- Is shown on Aetna’s records as the person's primary care dentist.

If you do not choose a PCD, Aetna will have the right to make a selection for you. You will be notified of the selection.
Recognized Charge (GR-9N 34-090 16)
The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider’s full charge.

In all cases, the recognized charge is determined based on the Geographic Area where you receive the service or supply.

Except as otherwise specified below, the recognized charge for each service or supply is the lesser of what the provider bills and:

- For dental expenses:
  - 80% of the prevailing charge rate

We have the right to apply Aetna reimbursement policies. Those policies may further reduce the recognized charge. These policies take into account factors such as:

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow up care is included;
- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the provider.

Aetna reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice and
- The views of physicians and dentists practicing in the relevant clinical areas.

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms used
Geographic Area and Prevailing Charge Rates are defined as follows:

Geographic Area
The Geographic Area is made up of the first three digits of the U.S. Postal Service zip code. If we determine we need more data for a particular service or supply, we may base rates on a wider Geographic Area such as an entire state.

Prevailing Charge Rates
The percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, Aetna has the right to substitute an alternative database that Aetna believes is comparable.

Additional Information:
Get the most value out of your benefits. Use the “Estimate the Cost of Care” tool on Aetna Navigator to help decide whether to get care in network or out-of-network. Aetna's secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Member Payment Estimator” tools.
Referral
This is a written or electronic authorization made by your primary care physician (PCP) or primary care dentist (PCD) to direct you to a network provider, for medically necessary services or supplies covered under the plan.

Referral Care
Covered services given to you by a specialist dentist who is a network provider after referral by your primary care dentist and providing that Aetna approves coverage for the treatment.

R.N.
A registered nurse.

S
(GR-9N 34-95-10)

Service Area
This is the geographic area, as determined by Aetna, in which network providers for this plan are located.

Skilled Nursing Facility
An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
  - Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or an R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a skilled nursing facility under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation hospitals (all levels of care, e.g. acute) and portions of a hospital designated for skilled or rehabilitation services.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, substance abuse or mental disorders.
Specialist
A physician who practices in any generally accepted medical or surgical sub-specialty.

Specialist Dentist
Any 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.

Specialty Care
Health care services or supplies that require the services of a specialist.
Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.
Additional Information Provided by

Avaya Inc

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Refer to your Plan Administrator for this information

Employer Identification Number:
22-3713430

Plan Number:
507

Type of Plan:
Health and welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Avaya Inc
4655 Great America Parkway
Santa Clara, CA 95054
Telephone Number: (669) 242-8054

Agent For Service of Legal Process:
Legal action regarding a claim for benefits should be sent to the Claims Administrator. All other legal action should be sent to the Plan Administrator.

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31st of each year

Source of Contributions:
If you are a full-time employee, the company pays 100% of the coverage; if you are a part-time employee see "The Cost of Coverage".
**Procedure for Amending the Plan:**
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, subject to the terms of applicable collective bargaining agreements. In addition, the Company does not guarantee the continuation of any dental benefits during employment or during retirement, nor does it guarantee any specific level of benefits or contributions.

**ERISA Rights**
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

**Receive Information about Your Plan and Benefits**
Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

**Continue Group Health Plan Coverage**
Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

**Prudent Actions by Plan Fiduciaries**
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**Enforce Your Rights**
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain 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 the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.
If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request FMLA leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.
Schedule of Benefits

Applies to the Managed Dental Coverage

Employer: Avaya Inc

Group Policy Number: GP-100462

Issue Date: May 31, 2018
Effective Date: January 1, 2018
Schedule: 31A
Cert Base: 31

For: Freedom of Choice - Dental Maintenance Organization (DMO)

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Managed Dental Plan

Schedule of Managed Dental Benefits (GR-9N 5.23-005)

Primary Care Dentists and Specialty Care Dentist (Network Dental Provider) Covered Expenses
Coverage is provided only for services shown in the Dental Care Schedule (see What the Plan Covers section). This dental expense coverage is segmented into four service types. The copayments shown below apply. The "amounts payable", shown on the List, will not apply when services are provided by network providers.

<table>
<thead>
<tr>
<th>Dental Care Schedule</th>
<th>Copayment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Type</td>
<td>Primary Care Services</td>
</tr>
<tr>
<td>Type A Expenses</td>
<td>0%</td>
</tr>
<tr>
<td>Type B Expenses</td>
<td>0%</td>
</tr>
<tr>
<td>Type C Expenses</td>
<td>25%</td>
</tr>
</tbody>
</table>

Orthodontic Expenses
Orthodontic Lifetime Maximum: 24 months of active treatment plus 24 months of retention.

Dental Emergency Maximum $100

Out-of-Network Dental Provider Covered Expenses
Coverage is provided only for services shown in the list of Covered Dental Services. The "Amount Payable" shown applies only to services and supplies provided by out-of-network providers. The amounts shown are not copayments. They are the maximum charges eligible for coverage under the plan for the service listed.

Deductible Amount: $100
The deductible does not apply to orthodontic services.

Orthodontic Lifetime Maximum Benefit: $1000
List of Covered Dental Services
If:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition, then the charge will be considered to have been made for a service that would have produced a professionally acceptable result, as determined by Aetna.

Primary Care Services

Schedule (GR-9N: 5-23-010401)

Type A Services
Visits and Exams

<table>
<thead>
<tr>
<th>Service</th>
<th>Out-of-Network maximum Amount Payable by Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit for oral examination (limited to 4 visits per year)</td>
<td>$12</td>
</tr>
<tr>
<td>Emergency palliative treatment</td>
<td>$12</td>
</tr>
<tr>
<td>Prophylaxis (cleaning) (limited to 2 treatments per year)</td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>$26</td>
</tr>
<tr>
<td>Child</td>
<td>$14</td>
</tr>
<tr>
<td>Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 18)</td>
<td>$16</td>
</tr>
<tr>
<td>Oral hygiene instruction</td>
<td>$12</td>
</tr>
<tr>
<td>Sealants; per tooth (limited to 1 application every 3 years for permanent molars)</td>
<td>$10</td>
</tr>
<tr>
<td>Pulp vitality test</td>
<td>$8</td>
</tr>
<tr>
<td>Consultation</td>
<td>$12</td>
</tr>
<tr>
<td>Diagnostic casts</td>
<td>$20</td>
</tr>
</tbody>
</table>

X-Ray and Pathology

<table>
<thead>
<tr>
<th>Service</th>
<th>Out-of-Network maximum Amount Payable by Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bitewing x-rays (limited to 2 sets per year)</td>
<td>$8</td>
</tr>
<tr>
<td>Entire series; including bitewings; or panoramic film (limited to 1 set every 3 years)</td>
<td>$14</td>
</tr>
<tr>
<td>Vertical bitewing x-rays (limited to 1 set every 3 years)</td>
<td>$12</td>
</tr>
<tr>
<td>Periapical x-rays</td>
<td>$6</td>
</tr>
<tr>
<td>Intra-oral; occlusal view; maxillary or mandibular</td>
<td>$8</td>
</tr>
<tr>
<td>Extra-oral upper or lower jaw</td>
<td>$12</td>
</tr>
<tr>
<td>Biopsy and histopathologic examination of oral tissue</td>
<td>$27</td>
</tr>
</tbody>
</table>

Type B Services

Endodontics

<table>
<thead>
<tr>
<th>Service</th>
<th>Out-of-Network maximum Amount Payable by Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulp cap</td>
<td>$3</td>
</tr>
<tr>
<td>Pulpotomy</td>
<td>$27</td>
</tr>
<tr>
<td>Root canal therapy; including necessary x-rays</td>
<td></td>
</tr>
<tr>
<td>Anterior</td>
<td>$80</td>
</tr>
<tr>
<td>Bicuspid</td>
<td>$96</td>
</tr>
</tbody>
</table>

Restorations and Repairs

Amalgam restoration

<table>
<thead>
<tr>
<th>Surfaces</th>
<th>Out-of-Network maximum Amount Payable by Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12</td>
</tr>
<tr>
<td>2</td>
<td>$16</td>
</tr>
<tr>
<td>3</td>
<td>$24</td>
</tr>
<tr>
<td>4 or more</td>
<td>$26</td>
</tr>
</tbody>
</table>

Resin restoration (other than for molars)

<table>
<thead>
<tr>
<th>Surfaces</th>
<th>Out-of-Network maximum Amount Payable by Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12</td>
</tr>
<tr>
<td>2</td>
<td>$16</td>
</tr>
</tbody>
</table>
### 3 surfaces
- 4 or more surfaces or incisal angle: $30
- Retention pins: $14
- Sedative filling: $12
- Stainless steel crowns: $26
- Prefabricated resin crowns (excluding temporary crowns): $60
- Recementing inlays or crowns: $16
- Recementing bridges and space maintainers: $16
- Tissue conditioning for dentures: $26

### Periodontics
- Emergency treatment (abscess; acute periodontitis; etc.): $26
- Scaling and root planning (limited to 4 separate quadrants every year): $40
- Periodontal maintenance procedures following surgical therapy (limited to 2 per year): $40

### Oral Surgery - Includes local anesthetics and routine post-operative care.
- Extractions; exposed root or erupted tooth: $27
- Surgical removal of erupted tooth: $32
- Surgical removal of impacted tooth (soft tissue): $40
- Excision of hyperplastic tissue: $32
- Excision of pericoronal gingival: $40
- Incision and drainage of abscess: $20
- Crown exposure to aid eruption: $26
- Removal of foreign body from soft tissue: $20
- Suture of soft tissue injury: $20

### Type C Services
#### Restorations
##### Inlays
- 1 surface: $60
- 2 or more surfaces: $80

##### Onlays
- 2 surfaces: $80
- 3 or more surfaces: $80

##### Crowns (including build-ups when necessary)
- Resin: $120
- Resin with noble metal: $120
- Resin with base metal: $120
- Porcelain: $120
- Porcelain with noble metal: $120
- Porcelain with base metal: $120
- Base metal (full cast): $120
- Noble metal (full cast): $120
- Metallic (3/4 cast): $120
- Post and core: $27

##### Pontics
- Base metal (full cast): $20
- Noble metal (full cast): $20
- Porcelain with noble metal: $20
- Porcelain with base metal: $20
- Resin with noble metal: $20
- Resin with base metal: $20
**Dentures and Partial**s - (includes relines; rebases and adjustments within six months after installation)
- Complete (Upper or Lower) $120
- Partial $120
- Stress breakers (per unit) $40
- Interim partial denture; (stayplates); anterior only $40
- Crown and bridge repairs $27
- Adding teeth to an existing denture $40
- Full and partial denture repairs $27
- Relining/rebasing dentures (includes adjustments with six months after installation) $40
- Occlusal guard (for bruxism only) $40

**Space maintainers** - Includes all adjustments within six months after installation.
- Fixed; band type $40
- Removable acrylic with round wire clasp $32
- Recement space maintainer $10
- Removal of fixed space maintainer (by dentist who did not place appliance) $10

**Specialty Care Dental Services**
**Type B Services**
**Endodontics** - Includes local anesthetics where necessary.
- Apexification/recalcification - per visit $32
- Apicoectomy
  - First root $60
  - Each additional root $40
- Retrograde Filling $14
- Root Amputation $27
- Hemisection $27

**Oral Surgery** - Includes local anesthetics where necessary and post-operative care.
- Removal of residual root $27
- Removal of odontogenic cyst $40
- Closure of oral fistula $48
- Removal of foreign body from bone $20
- Sequestrectomy $20
- Frenectomy $40
- Transplantation of tooth or tooth bud $48
- Alveoplasty in conjunction with extractions - per quadrant $27
- Alveoplasty not in conjunction with extractions - per quadrant $40
- Removal of exostosis $60
- Sialolithotomy; removal of salivary calculus $36
- Closure of salivary fistula $36

**Periodontics**
- Gingivectomy or gingivoplasty - per quadrant $40
- Gingivectomy or gingivoplasty, 1 to 3 teeth - per quadrant $20
- Gingival flap procedure - per quadrant $60
- Occlusal adjustment (other than with an appliance or by restoration)
  - Limited $20
  - Entire Mouth $40
Type C Services

Endodontics - Includes local anesthetics where necessary.
Complex Molar Root Canal Therapy $120

Intravenous Sedation and General Anesthesia
- per 15-minute segment. $20

Oral Surgery - Includes local anesthetics where necessary and post-operative care.
Surgical removal of impacted tooth
  Partially bony $53
  Completely bony $60
  Completely bony with unusual surgical complications $64

Periodontics
Osseous surgery (including flap entry and closure) - per quadrant $80
Osseous surgery (including flap entry and closure) - 1 to 3 teeth per quadrant $40
Clinical crown lengthening - hard tissue $40

Orthodontics
Comprehensive orthodontic treatment
Post Treatment Stabilization
Interceptive orthodontic treatment
Limited orthodontic treatment
Lifetime Maximum: $1000

Expense Provisions (GR-9N-S-09-005-02 CO)

This section explains your health expense insurance plan.
This section covers:
  - cost sharing features;
  - benefit maximums; and
  - other important items that apply to your Plan.

In the Schedule of Benefits are your:
  - cost sharing features;
  - dollar amounts; and
  - benefit percentages.

The insurance shown in this Schedule of Benefits is a part of Aetna Life Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

Deductible Provisions (GR-9N-S-09-005-02 CO)

Out-of-Network Calendar Year Deductible
This is an amount of out-of-network covered expenses incurred each Calendar Year for which no benefits will be paid. The out-of-network Calendar Year deductible applies separately to you and each of your covered dependents. After covered expenses reach the out-of-network Calendar Year deductible, the plan will begin to pay benefits for covered expenses for the rest of the Calendar Year.
Copayments and Benefit Deductible Provisions (GR.9N-09-015-01 CO)

Copayment, Copay
This is a specified dollar amount or percentage, shown in the Schedule of Benefits, you are required to pay for covered expenses.

Coinsurance Provisions (GR.9N-S-09-020 01)

Coinsurance
This is the percentage of your covered expenses that the plan pays and the percentage of covered expenses that you pay. The percentage that the plan pays is referred to as the “Plan Coinsurance”. Once applicable deductibles have been met, your plan will pay a percentage of the covered expenses, and you will be responsible for the rest of the costs. The coinsurance percentage may vary by the type of expense. Refer to your Schedule of Benefits for coinsurance amounts for each covered benefit.

General (GR.9N-S-28-01 01)

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.
**Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

**Smartphone or Tablet**

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

**Non-Discrimination**

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-982-3862.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).*
Language Assistance

TTY: 711

For language assistance in English call 1-888-982-3862 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862. (Spanish)

欲取得繁體中文語音協助，請撥打1-888-982-3862，無需付費。 (Chinese)

Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad. (Tagalog)

Tūá shi shizaad k’ehji bee shiká a’doowol ninizingo Diné k’ehji kojí t’áá jiik’e hółne’ 1-888-982-3862 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an. (German)

Për asistencë në gjuhën shqipe telefononi fala në 1-888-982-3862. (Albanian)

(English)

Por asistencia en árabe llame sin cargo al 1-888-982-3862 para hablar español. (Arabic)

Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa. (Bantu-Kirundi)

Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad. (Bisayan-Visayan)

বাংলায় ভাষা সহযোগিতা জন্য বিনামূল্যে 1-888-982-3862 কেল করুন। (Bengali-Bangala)
Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862bila malipo. (Swahili)

Assyrian-Syriac

(Thai)

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā tōtōngi. (Tongan)

Trukese-Chuukese

(Turkish)

(Ukrainian)

(Vietnamese)

(Yiddish)

(Yoruba)
Date May 31, 2018

We make it easy for you to make informed health care decisions

Dear Aetna Member:

You’ll find your Summary of Coverage/Schedule of Benefits and your booklet on your member website, Aetna Navigator®. These documents have the details of your health care benefits. You’ll also learn about your share of the costs and which services are covered.


We provide free aids and services to people with disabilities to help them communicate effectively with us. If you need these services, just contact the number on your ID card.

What happens if I change plans or coverage?
You can always rely on Aetna Navigator to display the most up-to-date versions of the Summary of Coverage/Schedule of Benefits and your booklet.

If you don’t have access to the Internet or would prefer a paper copy, please contact your employer’s benefits office.

Sincerely,
Aetna