THE AVAYA INC. DENTAL EXPENSE PLAN FOR SALARIED EMPLOYEES, A COMPONENT OF THE AVAYA INC. HEALTH & WELFARE BENEFITS PLAN FOR SALARIED EMPLOYEES

Plan Number 550

SUMMARY PLAN DESCRIPTION

Aetna PPO Dental Plan

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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Aetna PPO Dental Plan
Summary Plan Description

INTRODUCTION

This Summary Plan Description ("Summary") highlights the key features of the group dental benefits under the Aetna PPO Dental Plan ("DPPO"), under The Avaya Inc. Dental Expense Plan for Salaried Employees, a component of The Avaya Inc. Health & Welfare Benefits Plan for Salaried Employees ("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 DPPO 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 DPPO benefit program under the Plan.

Please remember that this Summary only summarizes the key provisions of the DPPO 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

Aetna PPO Dental Plan ("DPPO") (under The Avaya Inc. Dental Expense Plan for Salaried Employees, a component of The Avaya Inc. Health & Welfare Benefits Plan for Salaried Employees)

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

550

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

The group dental benefits under the Plan are paid from the general assets of the Company, which may include employee payroll contributions. 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. There is no special fund, trust or insurance from which benefits are paid.

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

The Board of Directors of Avaya Inc. (or its delegate) reserves the right to modify, suspend or terminate the benefits at any time without the consent of any employee or participant. This includes, but is not limited to, reducing or eliminating benefits for any group of employees (and the dependents of each) and adjusting any required contributions. Although the Company currently expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any feature at any time and for any reason. Upon termination of the Plan (or feature), all elections and reductions in compensation relating to the Plan (or feature) shall terminate. Questions regarding your benefits should be addressed to the Plan Administrator. Because of the many detailed provisions of the Plan, no one else is authorized to advise you as to your benefits. For this reason, Avaya Participating Companies are not bound by statements made by anyone or any entity other than the Plan Administrator or its authorized delegates. The Plan Administrator, or its designee, has sole discretionary authority to interpret and construe the provisions of the Plan, to determine eligibility for benefits under the Plan, and to resolve any disputes that arise under the Plan. Benefits under the DPPO benefit program will be paid only if the Plan Administrator decides, in its discretion, that the applicant is entitled to them.

ELIGIBILITY AND PARTICIPATION REQUIREMENTS[1]

You are eligible to participate in the DPPO benefit program if you are an "eligible employee" and satisfy the eligibility provisions described in the Program Document. You are an "eligible employee" if you are a regular full-time or part-time, salaried employee who works for Avaya Inc. and such other affiliates that have elected to participate in the Plan with the prior approval of Avaya Inc. (an "Avaya Participating Company").

You are not an "eligible employee" if:

- You are a Student Intern.
- You are enrolled in an International Assignee plan and paid from the U.S. payroll of an Avaya Participating Company, or you are covered through Aetna Global Benefits under the International Indemnity plan. Instead, you will receive group dental benefits through Aetna Global Benefits. Contact Aetna Global Benefits at the number on your ID card for specific information about group dental benefits.
- You are not paid from the U.S. payroll of an Avaya Participating Company, you are employed by an independent company (such as an employment agency), or your services are 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:

Employment Status	Timeline to Enroll	Eligibility Coverage Date
Newly-hired/rehired or newly-eligible active full-time or part-time employees	You have 31 days from your eligibility coverage date to enroll in or waive coverage for yourself and/or your dependents	Date of hire, rehire, or date you enter the eligible class
Current active eligible employees	Annual enrollment period	January 1st of the following calendar year
	Within 31 days of a qualified status change (e.g. birth, adoption, marriage, death of dependent, divorce, involuntary loss of other group health coverage, etc.)	Your coverage eligibility date depends on your qualified status change. Coverage typically begins on the date of the event or the first of the month following the event.

For anticipated enrollment periods, such as new hire eligibility and annual enrollment, information will be e-mailed to you from *Avaya Health & Benefits* instructing you to enroll. The e-mail 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 an e-mail and your enrollment deadline is nearing, 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 newly-hired, rehired, or newly-eligible employee 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 hire 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:

- Elect a dental plan,
- Enroll 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 and still enroll in dental coverage for yourself and your dependents.

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 new hires and rehires, this means you will have no dental coverage for yourself or your eligible dependents. For existing employees, this means you will retain your existing election. All applicable payroll contributions will apply.

Similarly, if you do not enroll your eligible dependent(s) within 31 days of your hire/rehire/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.

Your Costs

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

Payroll Deductions for Insurance Premiums

Your payroll deductions for benefits are clearly indicated on your pay statement (paystub).

- For new hires/rehires and for benefit changes made during the year (for qualified status changes), your deductions/contributions generally begin within 1-2 pay periods (prospectively, as soon as administratively feasible) after your enrollment is received and processed.
- For elections made during annual enrollment your deductions/contributions begin on your first paycheck in January.

Coverage for Dependents

Your eligible dependents can also participate in the DPPO 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 26 years of age. Each child is eligible for coverage through December 31st of the year in which the child reaches age 26. 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 26 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 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 DPPO 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 salaried Avaya Participating Company employee or retiree. Therefore, if your lawful spouse or domestic partner is an active salaried employee or retiree, you may enroll as his or her dependent under the DPPO benefit program, or he or she may enroll as your dependent, but not both.
- A salaried active Avaya Participating Company employee or retiree cannot enroll a represented 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:

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

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: A qualified status change does not permit you to change your dental plan option (e.g. DPPO to DMO). You may only make a change to your dental plan option during annual enrollment or if you move out of a DMO service area (if enrolled in the DMO at the time of the event).

Enrolling Newborns Mid-Year

If you wish to enroll your newborn in the DPPO 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 DPPO 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

Your covered dependents have the option of continuing coverage under COBRA for up to 36 months if they make the required contributions.

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 dental plan and you fail to make a selection within the 31-day window, your and your eligible dependents', as applicable, dental coverage will be waived 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.

EMPLOYMENT-RELATED EVENTS AFFECTING COVERAGE

If Your Employment Status Changes

Since your options are based, in part, on your employment status, it is possible that a change in your employment status may affect your coverage. If a change in your employment status requires that you change your dental plan and you fail to make a selection within the 31-day window, your and your eligible dependents', as applicable, dental coverage will be waived 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 change from Part-Time to Full-Time

Dental benefit coverage is NOT impacted by a change from part-time to full-time status.

If you change from Full-Time to Part-Time

Dental benefit coverage is NOT impacted by a change from full-time to part-time status.

If you change from Salaried to Represented

Your group dental benefit coverage will end on the last day of the month in which your status changes and you will become eligible to participate in the dental plan(s) offered to represented employees.

If Your Employment Terminates

Refer to the "Loss of Benefits" section of this booklet.

If You Are Laid Off

For group dental benefit coverage, depending upon your years of Net Credited Service and/or your job title and the type of layoff, part of your cost for COBRA coverage may be paid by the Avaya Participating Company. Your Force Management Program package will provide the details.

If You Retire

Refer to the "Loss of Benefits" section of this booklet.

When you retire, you will receive information at your home address about your rights to continue coverage (as applicable) under COBRA (see "Continuing Coverage through COBRA").

If You Transfer

If you transfer to another Avaya Participating Company, it will not affect your participation in the Plans. If you transfer to a non-Avaya Participating Company, refer to the "Loss of Benefits" section of this booklet.

If You Are Rehired

Refer to the "Enrollment" section of this booklet.

If you Become Disabled

Your participation may be affected if you become disabled. Your length of service and the duration of your disability determine what happens to your coverage during a disability. Refer to the "If you Become Disabled" section of the *Avaya Inc. Summary Wrap Description for Salaried Employees* located at https://www.avaya.com/benefitanswers.

CONTINUING COVERAGE THROUGH COBRA

A federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended) requires employers to offer eligible employees and their covered dependents the opportunity to continue their group health coverage *at their own expense* for a limited period of time if they lose coverage due to a qualifying event.

COBRA enables you or 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:

If	Qualifying Event	Who is eligible for COBRA Coverage	Duration of COBRA Coverage
You	Become laid off	You and your covered dependents	18 months
You	Have a reduction in hours	You and your covered dependents	18 months
You	Are terminated from employment (for reasons other than gross misconduct)	You and your covered dependents	18 months
You	Do not return from an FMLA leave of absence (or state equivalent)	You and your covered dependents	18 months
You	Become disabled within the first 60 days of COBRA continuation coverage	You and your covered dependents	Up to 29 months*
You	Die	Your covered dependents	36 months
You	Become divorced, legally separated, or there is a dissolution of your domestic partnership	Your covered dependents	36 months
Your covered dependents	Is no longer an eligible dependent (due to age limit, divorce, or legal separation or this is a dissolution of your domestic partnership)	Your covered dependents	36 months
Your covered dependents	Is no longer an eligible dependent because of your death	Your covered dependents	36 months

Your covered dependents	Becomes disabled within the first 60 days of COBRA continuation coverage	Your covered dependents	Up to 29 months*

*Includes months of COBRA coverage already used

COBRA applies to the health plan options you and your dependents are covered under at the time of your loss of active coverage. The group dental benefit plan you have at the time of your loss of coverage as an active employee is your option as a COBRA Qualified Beneficiary. Although not required under COBRA, the plans provide continuation coverage to Domestic Partner and/or Domestic Partner Child(ren).

Loss of Coverage

You and your covered dependents will be notified when an event makes continuation of coverage available. Avaya's COBRA vendor, WageWorks, will send election information, including the cost of the coverage. You and each of your covered dependents have an independent right to elect COBRA continuation coverage. You (or a covered dependent) must notify WageWorks (within 60 days of the date the notice is sent or coverage is lost, whichever is later) of the decision to continue coverage.

If you do not elect continuation coverage during the first 60-day election period and you become eligible for trade adjustment assistance, you may elect continuation coverage during a second 60-day period that begins on the first day of the month in which you are determined to be eligible for such assistance. In this situation, your election must be made within six months of your first COBRA qualifying event.

If you elect COBRA coverage and you acquire a new dependent (e.g. through marriage, birth, adoption, etc.) during your COBRA continuation period, you may enroll that new dependent in COBRA continuation coverage with required documentation (i.e. marriage, birth or adoption certificate).

COBRA May Be Extended

If you or your covered dependent becomes disabled within the meaning of the Social Security Act during the first 60 days of COBRA continuation coverage, you and your covered dependents may extend the 18-month continuation period to 29 months. For the 29-month continuation coverage period to apply, you must notify WageWorks by phone at 1-800-526-2720 within 60 days of the determination of your disability by the Social Security Administration and within the initial 18-month continuation coverage period. This notice should be in writing and should include a copy of the Social Security Administration's disability determination. If WageWorks determines that you or your covered dependents are not eligible for an extension of the COBRA continuation period, you will be provided a written explanation of why extended COBRA continuation coverage is not available.

If one of your covered dependents experiences another qualifying event (for example, your child is no longer eligible for coverage due to age, you die during the COBRA continuation period, etc.), the COBRA continuation period can be extended for that dependent. You or your covered dependent must notify WageWorks by phone at 1-800-526-2720 within 60 days of the second event. (Note that a second qualifying event is not triggered when you become entitled to Medicare.) This notice should be in writing and should include proof of the second qualifying event. If WageWorks determines that your covered dependent is not eligible for an extension of the COBRA continuation period, the dependent will be provided a written explanation of why extended COBRA continuation coverage is not available.

Dependent Continuation Coverage

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

- You die,
- You and your 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, you or 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 you and/or 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 health care coverage to any of its employees
- When there is a significant underpayment of a premium or when premiums for COBRA continuation coverage are not paid within the required time
- The date you or your covered dependents become covered under another group health care plan other than TRICARE (The civilian health care component of the Military Health System) (provided pre-existing condition exclusions or limitations under the new group health care plan do not apply)
- The date you or your covered dependents become eligible for Medicare, if after the date your 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 you must notify WageWorks that you or the covered dependent is no longer disabled

If WageWorks determines that your coverage is terminating before the end of the 18-month, 29-month or 36-month period (e.g., when premiums are not being paid within the required time), you will be notified that your coverage is terminating and you will be provided with the reason why and the date your coverage is terminating.

COBRA Coverage Cost

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

The initial COBRA payment (which includes payment for coverage back to the date regular coverage ended) is due when you elect COBRA. However, 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 you 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 for a Military Leave of Absence

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. The terms “Uniformed Services” or “Military Service” mean the Armed Forces (i.e., Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

If you lose coverage because you enter into active military duty covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you and your covered dependents are eligible for COBRA continuation coverage. Under USERRA, however, you and your covered dependents are only required to pay the regular employee contribution for the first 30 days of coverage, and the duration of the continuation coverage is 24 months instead of 18 months.

Special rules apply if your active military duty is in connection with “Operation Enduring Freedom”. In that case, the Avaya Participating Company provides you and your covered dependents with continued coverage under the dental benefit plan, as applicable, for the first 60 months of your military leave of absence. To receive this continued coverage, you must pay the regular employee contribution. This coverage satisfies the Plan obligation to provide you with COBRA continuation coverage. As a result, if you lose coverage at the end of your military leave of absence because you do not return to the Avaya Participating Company, then you (and your covered dependents) will have no right to COBRA continuation coverage, so long as you were on military leave for at least 18 months.

If You Have 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.

Keep the COBRA Administrator Informed of Address Changes

In order to protect your family's rights, you should keep WageWorks informed of any changes in the addresses of family members. You may contact WageWorks by phone at 1-800-526-2720. You should also keep a copy, for your records, of any notices you send to WageWorks.

SUMMARY OF PLAN BENEFITS

Benefits

Group dental benefits are provided under the Plan. These benefits are paid from the general assets of the Company, which may include employee payroll contributions. There is no special trust, fund or insurance for the payment of benefits. 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 DPPO benefit program in Appendix I.

Loss of Benefits

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

- You retire or die;
- You voluntarily stop your coverage;
- 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 employer notifies Aetna that your employment is ended.

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

- Date your coverage ends;
- Last day of the month in your which your covered dependent is no longer an eligible dependent; or
- Last day of the year in which your dependent turns age 26.

If your covered dependent is no longer eligible for coverage under the DPPO 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").

If the DPPO 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.

When your coverage ends, you and your eligible dependents may be eligible for COBRA continuation coverage (see "Continuing Coverage through COBRA").

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 DPPO 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 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

Uniformed Services Reemployment Rights

If you take leave to perform qualifying military service, you may qualify to elect continuation coverage for yourself and any covered eligible dependents pursuant to a Federal law called the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Continuation coverage rights under USERRA are similar to COBRA continuation coverage rights, but not identical.

In order to qualify for USERRA continuation coverage, you must be performing duty on a voluntary or involuntary basis in qualifying military service. Qualifying military service includes active duty, active and inactive duty for training, National Guard duty under Federal law and a period for which you are absent for an examination to determine your fitness to perform those duties. Qualifying military service also includes a period for which you are absent to perform funeral honors duty as authorized by law and services as an intermittent disaster-response appointee of the National Disaster Medical System. Qualifying military service (also referred to as "uniformed services") means the following: Armed Forces; Army National Guard; Air National Guard when engaged in active duty for training, inactive duty training, or fulltime National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President in time of war or national emergency.

If you qualify for USERRA continuation coverage, you may continue coverage for yourself and any covered eligible dependents for whom you elect coverage for up to 24 months from the date your coverage would end because of your leave. Your USERRA coverage will end earlier than the end of the 24 month period if:

1. You fail to pay the required premiums on a timely basis as described in the enclosed brochure;
2. You fail to return to work within the time required under USERRA; or
3. You lose your USERRA rights because you are dishonorably discharged or because of other conduct specified in USERRA.

COBRA coverage and USERRA coverage begin at the same time and run concurrently – in other words, the coverage periods run at the same time. COBRA coverage can continue for up to 18 months and is subject to extension and early termination in certain circumstances that do not apply under USERRA.

The rules and procedures regarding COBRA coverage generally apply to USERRA coverage (i.e., election procedures, premium payment procedures, etc.), except to the extent inconsistent with USERRA requirements.

If you would like to receive additional information about USERRA, contact the Plan Administrator.

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

The Plan will not set employee contributions on the basis of genetic information. The Plan may not require an employee (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.

Leave Under Family Medical Leave Act ("FMLA")

If you take a leave of absence for your own serious health condition or to care for family members with a serious health condition or to care for newborn or adopted child, you may be able to continue your health coverage under the Plan. During FMLA leave, you will continue to have group dental benefit coverage: (a) if you had such coverage before taking the leave, and (b) your coverage will be under the same terms as if you had continued to work. You will need to pay your share of the group health plan contributions while on leave. If you choose not to continue your group dental benefits coverage while on leave, your coverage will be reinstated when you return to work, subject to Plan provisions.

Plan is Not an Employment Contract

The Plan is not intended to be, and should not be construed as, a contract for or of employment between you and the Company for any specific period of time.

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.

APPENDIX I

Aetna PPO Dental Plan
Summary Plan Description

BENEFIT PLAN

Prepared Exclusively for
Avaya Inc

PPO Dental Plan

What Your Plan Covers and How Benefits are Paid

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.

Table of Contents

*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface

The dental benefits plan described in this *Booklet* is a benefit plan of the Employer. These benefits are not insured with **Aetna** but will be paid from the Employer's funds. **Aetna** will provide certain administrative services under the **Aetna** dental benefits plan.

Aetna agrees with the Employer to provide administrative services in accordance with the conditions, rights, and privileges as set forth in this *Booklet*. The Employer selects the products and benefit levels under the **Aetna** dental benefits plan.

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

This *Booklet* replaces and supercedes all **Aetna** *Booklets* describing coverage for the dental benefits plan described in this *Booklet* that you may previously have received.

Employer:	Avaya Inc.
Contract Number:	100462
Effective Date:	January 1, 2017
Issue Date:	January 1, 2017
Booklet Number:	5

Coverage for You and Your Dependents

Health Expense Coverage

Benefits are payable 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.

Refer to the *What the Plan Covers* section of the *Booklet* for more information about your coverage.

Treatment Outcomes of Covered Services

Aetna is not a provider of health care services and therefore 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 and 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 Is Eligible

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 regular full-time employee, as defined by your employer.
- 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.

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 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 date of retirement, if applicable, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents

Your dependents can be covered under this Plan, as defined by your Employer.

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 (regardless of student status, marital status and/or financial dependency on employee).

Class II Dependents (must receive less than $12,000 per year in income from all sources, other than the Avaya employee's support; must live with you or in a nearby household provided by you, and in the case of unmarried dependent stepchildren, live with you throughout the period of coverage; AND must either have been continuously re-enrolled during each Annual Enrollment since January 1, 1996 and continue to be re-enrolled each year (non-grandfathered Class II dependents), or have been enrolled before June 1, 1986 and continuously enrolled each plan year thereafter (grandfathered Class II dependents).

Class II Dependents include:
- Your unmarried dependent child(ren) not included above;
- Your unmarried dependent stepchild(ren) not included above;
- Your unmarried grandchild(ren);
- Your unmarried brothers and sisters;
- Your parents and grandparents;
- Your lawful spouse's parents and grandparents.)

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

Coverage for Domestic Partner

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.
- 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 Dependent Children

To be eligible for coverage, a dependent child must be under 26 years of age. Each child is eligible for coverage through December 31st of the year in which the child reaches age 26.

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; and
- a child living with you for whom you or your lawful spouse is the legal guardian (this does not include "wards of the state" or "foster children")

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

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

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 **Aetna** 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

Your Effective Date of Coverage

Your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date your enrollment information is received; and
- The date your required contribution is received by **Aetna**.

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

Important Notice:
You must pay the required contribution in full or coverage will not be effective.

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 your employer within 31 days because they may affect your contributions.

Requirements For Coverage

To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:

   - Be included as a covered expense in this Booklet;
   - Not be an excluded expense under this Booklet. Refer to the *Exclusions* sections of this Booklet for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.

2. The service or supply must be provided 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.

3. The service or supply must be **medically necessary**. To meet this requirement, the dental service or supply must be provided by a **physician**, or other health care provider or **dental provider**, exercising 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 accordance with generally accepted standards of 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 primarily for the convenience of the patient, **physician** or **dental provider** or other health care provider;
   (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent 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 dental practice" means standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by the relevant dental community, or otherwise 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

- Not every service or supply that fits the definition for **medical necessity** is 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.

How Your Aetna Dental Plan Works

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 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.

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

This Booklet 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 in a safe place for future reference.

Getting Started: Common Terms

Many terms throughout this Booklet 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 PPO Dental Plan

The plan is a Preferred **Provider** Organization (PPO) that covers a wide range of dental services and supplies. You can visit the **dental provider** of your choice when you need dental care.

You can choose a **dental provider** who is in the dental network. You may pay less out of your own pocket when you choose a **network provider**.

You have the freedom to choose a **dental provider** who is not in the dental network. You may pay more if you choose an **out-of-network provider**.

The *Schedule of Benefits* shows you how the plan's level of coverage is different for **network services and supplies** and **out-of-network services and supplies**.

The Choice Is Yours
You have a choice each time you need dental care:

Using Network Providers

- Your out-of-pocket expenses will be lower when your care is provided by a **network provider**.
- The plan begins to pay benefits after you satisfy a **deductible**.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your **payment percentage**). **Network providers** have agreed to provide covered services and supplies at a **negotiated charge**. Your **payment percentage** is based on the **negotiated charge**. In no event will you have to pay any amounts above the **negotiated charge** for a covered service or supply. You have no further out-of pocket expenses when the plan covers in network services at 100%.
- You will not have to submit dental claims for treatment received from **network providers**. Your **network provider** will take care of claim submission. You will be responsible for **deductibles, payment percentage** and **copayments**, if any.
- You will receive notification of what the plan has paid toward your **covered expenses.** It will indicate any amounts you owe towards your **deductible, copayment, payment percentage** or other non**-covered expenses** you have incurred. You may elect to receive this notification by e-mail, or through the e-mail. Call or e-mail Member Services if you have questions regarding your statement.

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.

Using Out-of-Network Providers
You can obtain dental care from **dental providers** who are not in the network. The plan covers **out-of-network services and supplies**, but your expenses will generally 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 (your **payment percentage**).

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

Important Reminder
Refer to the *Schedule of Benefits* for details about any **deductibles, copays, payment percentage** and maximums that apply. There is a separate maximum that applies to **orthodontic treatment**.

Getting an Advance Claim Review

The purpose of the advance claim review is to determine, in advance, the benefits the plan will pay for proposed services. Knowing ahead of time which services are covered by the plan, and the benefit amount payable, helps you and your **dentist** make informed decisions about the care you are considering.

Important Note
The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

When to Get an Advance Claim Review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $200. Ask your **dentist** to write down a full description of the treatment you need, using either an **Aetna** claim form or an ADA approved claim form. Then, before actually treating you, your **dentist** should send the form to **Aetna**. **Aetna** may request supporting x-rays and other diagnostic records. Once all of the information has been gathered, **Aetna** will review the proposed treatment plan and provide you and your **dentist** with a statement outlining the benefits payable by the plan. You and your **dentist** can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your **dentist** can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, **Aetna** will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result. (See *Benefits When Alternate Procedures Are Available* for more information on alternate dental procedures.)

What is a Course of Dental Treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dentists** to treat a dental condition that was diagnosed by the attending **dentist** as a result of an oral examination. A course of treatment starts on the date your **dentist** first renders a service to correct or treat the diagnosed dental condition.

In Case of a Dental Emergency

The plan pays a benefit at the network level of coverage even if the services and supplies were not provided by a **network provider** up to the dental emergency maximum. The care provided must be a covered service or supply. You must submit a claim to **Aetna** describing the care given. Additional dental care to treat your **dental emergency** will be covered at the appropriate **coinsurance** level.

What The Plan Covers

PPO Dental Plan

Schedule of Benefits for the PPO Dental Plan

PPO Dental is merely a name of the benefits in this section. The plan does not pay a benefit for all dental care 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 services and supplies must be covered by the plan.
- You must be covered by the plan when you incur the expense.

Covered expenses include charges made by a **dentist** for the services and supplies that are listed in the dental care schedule.

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 of 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

The dental care schedule is a list of dental expenses that are covered by the plan. There are several categories of **covered expenses**:

- Preventive
- Diagnostic
- Restorative
- Oral surgery
- Endodontics
- Periodontics
- Orthodontics

These covered services and supplies are grouped as Type A, Type B or Type C.

Coverage is also provided for a **dental emergency**. Services provided for a **dental emergency** will be covered at the **network** level of benefits even if services and supplies are not provided by a **network provider**. There is a maximum benefit payable. For additional information, please refer to *In Case of a Dental Emergency section.*

PPO Dental Expense Coverage Plan

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).

Payment of Benefits

The additional prophylaxis, the benefit will be payable the same as other prophylaxis under the plan.

The **payment percentage** applied to the other covered dental expenses above will be 100% for **network** expenses and 100% for out-of-network expenses. These additional benefits will not be subject to any frequency limits except as shown above or any Calendar Year maximum.

Aetna will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for **covered expenses**.

Important Reminder
The **deductible**, **payment percentage** and maximums that apply to each type of dental care are shown in the *Schedule of Benefits*.

You may receive services and supplies 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*.

Refer to *About the PPO Dental Coverage* for more information about covered services and supplies.

Type A Expenses: Diagnostic and Preventive Care

Visits and X-Rays

Prophylaxis (cleaning) (limited to 2 treatments per year)
- Adult
- Child

Topical application of fluoride (choice of 1 of these 3 treatments):
- Sodium fluoride (limited to four courses of treatment per year);
- Stannous fluoride (limited to one course of treatment per year);
- Acid fluoride phosphate (limited to one course of treatment per year).

Topical application of sealants(limited to once per tooth every 3 years, permanent molars only and to children under age 14)
Emergency palliative treatment, per visit
Bitewing X-rays (limited to 2 sets per year)
Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)
Vertical bitewing X-rays (limited to 1 set every 3 years)
Periapical x-rays (single films up to 13)
Intra-oral, occlusal view, maxillary or mandibular
Upper or lower jaw, extra-oral
Diagnostic casts

Space Maintainers Only when needed to preserve space resulting from premature loss of primary teeth (for you, your spouse/domestic partner/dependents to age 23). (Includes all adjustments within 6 months after installation.)
- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Removable inhibiting appliance to correct thumbsucking
- Fixed or cemented inhibiting appliance to correct thumbsucking

Type B Expenses: Basic Restorative Care

Visits and X-Rays

Oral Surgery
Extractions
- Erupted tooth or exposed root
- Coronafl remnants
- Surgical removal of erupted tooth/root tip

Alveolar of Gingival Reconstructions
- Alveolectomy (edentulous) per quadrant
- Alveolectomy (in addition to removal of teeth) per quadrant
- Alveoplasty with ridge extension, per arch
- Removal of exostosis
- Excision of hyperplactic tissue per arch

Excision of pericoronal gingiva
Odontogenic Cysts and Neoplasms
Incision and drainage of abscess
Removal of odontogenic cyst or tumor
Other Surgical Procedures
Sialolithotomy: removal of salivary calculus
Closure of salivary fistula
Transplantation of tooth or tooth bud
Removal of foreign body from bone (independent procedure)
Closure of oral fistula of maxillary sinus
Sequestrectomy for osteomyelitis or bone abcess, superficial
Crown exposure to aid eruption
Removal of foreign body from soft tissue
Frenectomy
Suture of soft tissue injury

Periodontics
Occlusal adjustment (other than with an appliance or by restoration)
Root planing and scaling, per quadrant (limited to 4 separate quadrants per 2 years)
Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every year)
Gingivectomy, one per quadrant (every 3 years)
Gingivectomy, 1 to 3 teeth per quadrant
Gingival flap procedure, including root planing - per quadrant
Gingival flap procedure, including root planing – 1 to 3 teeth per quadrant
Localized delivery of antimicrobial agents
Periodontal maintenance procedures following active therapy (limited to 2 per year)

Endodontics
Pulp capping
Pulpotomy
Apexification/recalcification
Apicoectomy
Root canal therapy including necessary X-rays
Anterior
Bicuspid
Molar

Restorative Dentistry Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)
Amalgam restorations
Resin-based composite restorations
Sedative fillings
Pins
Pin retention—per tooth, in addition to amalgam or resin restoration
Crowns (when tooth cannot be restored with a filling material)
Prefabricated stainless steel
Prefabricated resin crown (excluding temporary crowns)
Full and partial denture repairs
Recementation
Bridge

Type C Expenses: Major Restorative Care

Restorative. Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 5 years- see *Replacement Rule*).

Inlays/Onlays
Labial Veneers
- Laminate-chairside
- Resin laminate – laboratory
- Porcelain laminate – laboratory

Crowns
- Resin
- Resin with noble metal
- Resin with base metal
- Porcelain/ceramic substrate
- Porcelain with noble metal
- Porcelain with base metal
- Base metal (full cast)
- Noble metal (full cast)
- 3/4 cast metallic or porcelain/ceramic

Post and core
Recementation
- Inlay
- Crown
- Repairs: crowns and bridges

Broken dentures, no teeth involved
Repair cast framework
Replacing missing or broken teeth, each tooth
Occlusal guard (for bruxism only), limited to 1 every 3 years

Prosthodontics- First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 5 years old. (See *Tooth Missing But Not Replaced Rule*.) Replacement of existing bridges or dentures is limited to 1 every 5 years. (See *Replacement Rule*.)

Bridge Abutments (See Inlays and Crowns)
Pontics
- Base metal (full cast)
- Noble metal (full cast)
- Porcelain with noble metal
- Porcelain with base metal
- Resin with noble metal
- Resin with base metal

Removable Bridge (unilateral)
- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics

Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
- Complete upper denture
- Complete lower denture
- Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
- Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
- Stress breakers
- Office reline
- Laboratory reline
- Special tissue conditioning, per denture

Rebase, per denture
Adjustment to denture more than 6 months after installation
Adding teeth to existing partial denture
Each tooth
Each clasp

Oral Surgery
Impacted Teeth
Removal of tooth
Osseous surgery (including flap entry and closure), one per quadrant (limited to 3 years)
Soft tissue graft procedures

General Anesthesia and Intravenous Sedation (only when medically necessary and only when provided in conjunction with a covered surgical procedure

Orthodontics
Comprehensive orthodontic treatment of adolescent dentition
Comprehensive orthodontic treatment of adult dentition
Post treatment stabilization

Rules and Limits That Apply to the Dental Plan

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 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.

Alternate Treatment Rule

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

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

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 PPO Dental Plan Does Not Cover

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. 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. Facings on molar crowns and pontics will always be considered **cosmetic**.

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 contractholder.

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** and treatments to alter bite or the alignment or operation of the jaw, including 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 done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

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;
- Cleaning of teeth; and
- Topical application of fluoride.

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.

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.

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 not 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.

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

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 **Aetna** health benefits coverage will end if:

- The **Aetna** health benefits plan is discontinued;
- You voluntarily stop your coverage;
- 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 employer notifies **Aetna** that your employment is ended.

It is your employer's responsibility to let **Aetna** know when your employment ends.

When Coverage Ends for Dependents

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, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month 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 like benefits under this or any other group plan offered by your employer.

In addition, a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

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

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

Continuation of Coverage

Continuing Health Care Benefits

Continuing Coverage for Dependent Students on Medical Leave of Absence

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

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

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 31 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

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

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

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 contributions. 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 on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer's notice of this COBRA continuation right, if later.
- Agree to pay the required contributions.

Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

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 beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the contributions 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 by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Contributions For Continuation Coverage

Your contributions are regulated by law, based on the following:

- For the 18 or 36 month periods, contributions may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, contributions 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 contributions 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 contributions.
- You or your covered dependents become covered under another group plan that does not restrict coverage for preexisting conditions. If your new plan limits preexisting condition coverage, the continuation coverage under this plan may remain in effect until the preexisting 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.

Conversion from a Group to an Individual Plan

You may be eligible to apply for an individual health plan without providing proof of good health:

- At the termination of employment.
- When loss of coverage under the group plan occurs.
- When loss of dependent status occurs.
- At the end of the maximum health coverage continuation period.

The individual policy will not provide the same coverage as the former group plan offered by your employer. Certain benefits may not be available. You will be required to pay the associated contribution costs for the coverage. For additional conversion information, contact your employer or call the toll-free number on your member ID card.

Coordination of Benefits - What Happens When There is More Than One Health Plan

Other Plans Not Including Medicare

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, 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;

   The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:
   - covers the person as other than a dependent; and
   - is secondary to Medicare.
3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

c. If there is not such a court decree:

   - If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
   - If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

   The benefits of a plan which covers the person on whose expenses claim is based as a:
   - laid-off or retired employee; or
   - the dependent of such person.

   Shall be determined after the benefits of any other plan which covers such person as:
   - an employee who is not laid-off or retired; or
   - dependent of such person.

   If the other plan does not have a provision:
   - regarding laid-off or retired employees; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

   The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

   If the other plan does not have a provision:
   - regarding right of continuation pursuant to federal or state law; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to Aetna for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules. If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

Other Plan
This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

When You Have Medicare Coverage

Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:
  - having refused it;
  - having dropped it;
  - having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by **Aetna**. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare 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 entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

General Provisions

Type of Coverage

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

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim 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 after 3 years from the deadline for filing claims.

Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet 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 the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna's contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). Aetna will charge the Plan for these claims in order to be able to continue providing Plan Participants with access to Sutter's services on an in-network basis.
- The plan may be changed or discontinued with respect to your coverage.

Financial Sanctions Exclusions
If any benefit provided by this plan violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Assignments

Coverage and your rights under this plan may not be assigned. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding.

Misstatements

Aetna's failure to implement or insist upon compliance with any provision of this plan 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.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this plan.

Recovery of Overpayments

Health Coverage

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan 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 the Plan 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.

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

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.

The Plan may pay up to $1,000 of any other benefit to any of your relatives whom it believes 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.

Records of Expenses

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

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 contract 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.

Discount Programs

Discount Arrangements

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

Incentives

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, we may, from time to time, offer to waive or reduce a member's **copayment**, **payment percentage**, and/or a **deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

Appeals Procedure

Definitions

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

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 previously approved course of treatment.

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

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:

- jeopardize your life;
- 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.

Claim Determinations

Urgent Care Claims

Aetna will make notification of an **urgent care claim** determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 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 of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar days claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 15 calendar days period. If this extension is needed because Aetna needs additional information to make a claim determination, 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.

Post-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of 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 additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, Aetna will make notification of a claim determination for **emergency** or **urgent care** as soon as possible but not later than 24 hours, with respect to **emergency** or **urgent care** provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 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 make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

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 Aetna Customer Service within 30 calendar days of the incident. You 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 additional 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**.

You have 180 calendar days following the receipt of notice of an **adverse benefit determination** to request your level one **appeal**. Your **appeal** may be submitted verbally or in writing and should include:

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

The notice of an **adverse benefit determination** will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna's Customer Service Unit at the toll-free phone number on your ID card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf by providing verbal or written consent to Aetna.

Level One Appeal - Group Health Claims

A level one **appeal** of an **adverse benefit determination** shall be provided by Aetna personnel not 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 may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

Level Two Appeal

If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, 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 notice of a level one **appeal**.

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 not involved in making an **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 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**.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

Exhaustion of Process
You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you:

- establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

Glossary

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

A

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

C

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.

D

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 contractholder will give you a copy of this **directory**. **Network provider** information is also available through **Aetna's** online provider **directory**, DocFind®.

E

Experimental or Investigational
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, procedure 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, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is **experimental or investigational**, or for research purposes.

H

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.

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

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury
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.
- An act or event must be definite as to time and place.

J

Jaw Joint Disorder
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.

L

Lifetime Maximum
This is the most the plan will pay for **covered expenses** incurred by any one covered person in their lifetime.

M

Medically Necessary or Medical Necessity
These are health care or dental services, and supplies or **prescription drug**s 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

Negotiated Charge
The maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

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**

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.

O

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**.

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.

P

Payment Percentage
Payment percentage 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 the "plan **payment percentage**," and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **payment percentage** amounts.

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.

R

Recognized Charge

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.

A service or supply provided by a **provider** is treated as **covered expenses** under the **other health care** coverage category when:

- You get services or supplies from an **out-of-network provider.** This includes when you get care from **out-of-network providers** during your **stay** in a **network hospital.**
- You could not reasonably get the services and supplies needed from a **network provider**.

The **other health care** coverage does not apply to services or supplies you receive in an **out-of-network** emergency room.

When the **other health care** coverage applies, you will pay the **other health care** cost share.

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.

R.N.
A registered nurse.

S

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 disorder**s.
- 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**.

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).

Name of Plan:
The Avaya Inc. Dental Expense Plan.

Employer Identification Number:
22-3713430

Plan Number:
550

Type of Plan:
Welfare

Type of Administration:
Administrative Services Contract with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Avaya Inc.
4655 Great America Parkway
Santa Clara, CA 95054
(866) 472-8292

Agent For Service of Legal Process:
Avaya Inc.
4655 Great America Parkway
Santa Clara, CA 95054
(866) 472-8292

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

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the Plan Administrator.

ERISA Rights

As a participant in the group benefit 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

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
- 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.

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 determined by 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.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage 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 this Plan 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 this Plan 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 this Plan only if and when this Plan 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

Employer: **Avaya Inc**

ASA: 100462

Issue Date: May 31, 2018
Effective Date: January 1, 2018
Schedule: 5A
Booklet Base: 5

For: Active PPO Dental

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

Comprehensive Dental Plan (PPO)

Schedule of Comprehensive Dental Benefits *(GR-9N-S-21-005-01)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year **Deductible**	Individual $50 Family $100	Individual $50 Family $100

The Calendar Year **deductible** applies to all covered expenses except Type A Expenses.

Please refer to the listing of **covered expenses** and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.

PLAN PAYMENT PERCENTAGE	NETWORK PAYMENT PERCENTAGE	OUT-OF-NETWORK PAYMENT PERCENTAGE
Type A Expenses	100%	90%
Type B Expenses	80%	70%
Type C Expenses	50%	50%
Orthodontic Treatment	50%	50%

Calendar Year Maximum Benefit
Calendar Year Maximum: $2,250

The most the plan will pay for **covered expenses** incurred by any one covered person in a Calendar Year is called the Calendar Year Maximum Benefit.

The Calendar Year maximum benefit applies to **network** and **out-of-network covered** dental expenses combined.

Orthodontic Lifetime Maximum Benefit
Orthodontic Lifetime Maximum: $1,750

Dental Emergency Maximum Benefit
Dental Emergency Maximum: $75

The most the plan will pay for **covered expenses** incurred by a covered person for any one Dental Emergency is called the Dental Emergency Maximum.

Expense Provisions

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Covered expenses applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Network Provider Calendar Year **Deductible**

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the Calendar Year.

Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles,** these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Out-of-Network Provider Calendar Year **Deductible**

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles,** these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Copayments and Benefit Deductible Provisions

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

Payment Provisions

Payment Percentage
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 Payment Percentage". 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 payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Maximum Benefit Provisions

Calendar Year **Maximum Benefit**
The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit applies to **network care** and **out-of-network care** expenses combined.

Lifetime Maximum Benefit
The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

The Lifetime Maximum Benefit applies to **network** and **out-of-network** expenses combined.

General

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 and should be kept with your Booklet.