Alcatel-Lucent Retiree Welfare Benefits Plan:

Alcatel-Lucent Medical Expense Plan for Retired Employees

Summary Plan Description-- Management Retirees

January 2010

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Disclaimer

This is a summary of the benefits offered under the "management retiree" plan design of the Alcatel-Lucent Medical Expense Plan for Retired Employees (the "Medical Plan" or the "Plan"), a component of the Alcatel-Lucent Retiree Welfare Benefits Plan. This summary is provided for informational purposes only and is intended to comply with Department of Labor requirements for Summary Plan Descriptions ("SPDs"). More detailed information about the Plan is provided in the official Medical Plan document, a copy of which can be obtained by writing to the Plan Administrator (see **Section P. Important Contacts**, and **Section Q. Other Important Information**).

This summary is based on Medical Plan provisions effective January 1, 2010 and replaces all previous SPDs and other descriptions of benefits provided under the Plan. If there is any conflict between the information in this SPD and the Medical Plan document, the Medical Plan document will govern.

Medical Plan May Be Amended or Terminated

The Company expects to continue the Medical Plan but reserves the right to amend or terminate the Medical Plan, in whole or in part, at any time by the resolution of the Board of Directors or its properly authorized designee, subject to the terms of applicable collective bargaining agreements. In addition, the Company does not guarantee the continuation of any medical benefits during employment or at or during retirement nor does it guarantee any specific level of benefits or contributions, subject to the terms of any applicable bargaining agreement.

Questions regarding your benefits should be addressed as indicated in this SPD (see **Section P. Important Contacts**). Because of the many detailed provisions of the Medical Plan, no one other than the personnel or entities identified in this SPD (see **Section P. Important Contacts**) is authorized to advise you as to your benefits. Neither Alcatel-Lucent nor the Plan can be bound by statements made by unauthorized personnel or entities. In the event of a conflict between any verbal information provided to you by an authorized resource and information in the official Medical Plan document, the Medical Plan document will govern.

Please note: Participation in the Medical Plan is neither an offer of nor a guarantee of continued benefits during retirement.

CONTENTS PAGE

DISCLAIMER ..... Inside front cover

INTRODUCTION 1

SPECIAL NOTE ABOUT MEDICARE 2
LEARNING MORE ABOUT SECUREHORIZONS® MEDICAREDIRECT™, A MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE (PFFS) PLAN 2

SECTION A. MEDICAL PLAN BENEFITS AT-A-GLANCE 3

GENERAL PLAN INFORMATION CHART 3
MEDICAL BENEFITS CHART 6
Mental Health and Chemical Dependency 16
Prescription Drug Program 18

SECTION B. JOINING THE MEDICAL PLAN 20

WHO IS ELIGIBLE 20
Eligible Former Employees 20
Eligible Dependents 20
ENROLLING IN THE PLAN 24
Enrollment Packet 24
Coverage Categories 24
Couples Working for Alcatel-Lucent 26
Unique Enrollment Situations 26
Defaulting Into a Coverage Option When You Retire 28
Annual Open Enrollment 29
Changing Your Coverage During the Year--Qualified Status Changes and Special Enrollment Periods 30
Declining Coverage 34
Confirming Your Election 34
IF YOU MOVE 35
When You Are Not Medicare-Eligible 35
If You Are Medicare-Eligible When You Move 36
MEDICAL PLAN CONTRIBUTIONS 37
Retiree Medical Caps 37
Tax Treatment of Domestic Partner Dependent Coverage 38

SECTION C. HOW THE MEDICAL PLAN OPTIONS WORK 39

ABOUT YOUR MEDICAL PLAN OPTIONS 39
Available Medical Plan Options 40
IF YOU LIVE OUTSIDE OF A POS AREA 41
YOUR SHARE OF ELIGIBLE EXPENSES 41
Annual Deductible 41
Mental Health and Chemical Dependency Annual Deductible 43
Out-of-Pocket Maximum 43

CONTENTS PAGE

POS OPTIONS FOR NON-MEDICARE-ELIGIBLE PARTICIPANTS 44
How a POS Option Works 45
In-Network Care: Generally Higher Benefits 45
The Role of a PCP 46
Out-of-Network Care: More Flexibility, Lower Benefits 47
Required Precertification 48
Emergency Care 48
Receiving Care Away From Home 48
Your Medical ID Card 49
Member Services 49
TRADITIONAL INDEMNITY OPTION 50
How the Traditional Indemnity Option Works 50
Required Precertification 51
Your Medical ID Card 51
Filing a Claim 51
Member Services 51
HMO OPTIONS 52
The Role of a PCP 52
Domestic Partnership Dependent Coverage Availability 53
MEDICARE ADVANTAGE HMOS 53
SECUREHORIZONS MEDICAREDIRECT™ PFFS PLAN (MEDICARE-ELIGIBLE PARTICIPANTS) 54
BENEFIT LIMITS AND MAXIMUMS 54

SECTION D. WHAT'S COVERED UNDER THE POS AND TRADITIONAL INDEMNITY OPTIONS 55

COVERED SERVICES AND CONDITIONS OF SERVICE 55
ACUPUNCTURIST'S SERVICES 56
AMBULANCE 56
Air Ambulance 57
BLOOD AND BLOOD DERIVATIVES 57
CENTERS OF EXCELLENCE 57
Travel and Lodging Benefit 58
CHIROPRACTIC SERVICES 58
CIRCUMCISION 59
DURABLE MEDICAL EQUIPMENT 59
EMERGENCY ROOM 59
EXTENDED CARE FACILITY 60
FAMILY PLANNING SERVICES 61
HOME HEALTH CARE 61
HOSPICE 63
HOSPITALIZATION 64
MATERNITY CARE 66

CONTENTS PAGE

MENTAL HEALTH AND CHEMICAL DEPENDENCY 66
NUTRITIONAL COUNSELING 66
ORGAN DONATION 67
ORTHOTICS 68
OUTPATIENT MEDICAL FACILITIES 68
PHYSICIAN'S SERVICES 68
PODIATRIC SERVICES 69
PRESCRIPTION DRUGS 69
PREVENTIVE CARE 69
PRIVATE DUTY NURSING 70
PROSTHESES 71
REHABILITATION THERAPY 71
RESTORATIVE OR RECONSTRUCTIVE SURGERY 72
SECOND SURGICAL OPINION 72
WIGS 73

SECTION E. MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAM UNDER THE POS AND TRADITIONAL INDEMNITY OPTIONS 74

HOW THE MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAM WORKS 74
If You Are Not Medicare-Eligible 74
If You Are Medicare-Eligible 79
EMERGENCY CARE 79
RECEIVING CARE AWAY FROM HOME 80
AMOUNT OF COVERAGE 80

SECTION F. WHEN PRECERTIFICATION IS REQUIRED UNDER THE POS AND TRADITIONAL INDEMNITY OPTIONS 81

WHAT PRECERTIFICATION IS 81
WHO IS RESPONSIBLE FOR PRECERTIFICATION 82
COVERED SERVICES REQUIRING PRECERTIFICATION 82
Under the Mental Health and Chemical Dependency Program 83
HOW TO PRECERTIFY MEDICAL COVERAGE 84
HOW TO PRECERTIFY MENTAL HEALTH AND CHEMICAL DEPENDENCY COVERAGE 85
PRECERTIFICATION EXTENSION 86
PENALTIES IF PRECERTIFICATION PROCEDURES ARE NOT FOLLOWED 86
In-Network Care Under the Enhanced and Standard POS Option 86
Services and Supplies Under the Enhanced and Standard POS Options (for Out-of-Network Services) and Traditional Indemnity Option 86

CONTENTS PAGE

Service and Supplies Under the Mental Health and Chemical Dependency (MH/CD) Program 87

SECTION G. HOW THE PRESCRIPTION DRUG PROGRAM WORKS 88

ABOUT THE PRESCRIPTION DRUG PROGRAM 88
IF YOU ARE NOT MEDICARE-ELIGIBLE 88
How the Non-Medicare-Eligible Prescription Drug Program Works 88
Prescription Formulary 89
Participating Pharmacy 89
Nonparticipating Pharmacy 90
Filling Prescriptions by Mail, Phone or Fax 90
What Prescription Drug Items Are Covered (Non-Medicare Eligible) 91
Drugs Requiring Authorization and Quantity Limits (Non-Medicare Eligible) 92
Specialty Care (Non-Medicare Eligible) 92
Out-Of-Pocket Maximum (Non-Medicare Eligible) 92
IF YOU ARE MEDICARE-ELIGIBLE 92
How the Medicare-Eligible Prescription Drug Program Works 92
Medco's Standard Medicare Part D Formulary 94
Prescription Drug ID Cards 94
PHARMACY SERVICES 94

SECTION H. WHAT'S NOT COVERED 96

ABOUT EXCLUSIONS 96
GENERAL EXCLUSIONS 96
ENHANCED AND STANDARD POS OPTIONS AND TRADITIONAL INDEMNITY OPTION EXCLUSIONS 98
MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAM EXCLUSIONS 100
PRESCRIPTION DRUG PROGRAM EXCLUSIONS 101

SECTION I. WHEN COVERAGE ENDS 103

WHEN RETIREE COVERAGE ENDS 103
WHEN DEPENDENT COVERAGE ENDS 103
IF YOUR PHYSICALLY OR MENTALLY HANDICAPPED CHILD REACHES AGE 20 104
CREDITABLE COVERAGE CERTIFICATES 104

SECTION J. CONTINUING COVERAGE 105

EXTENDED COVERAGE DURING HOSPITALIZATION 105
COBRA CONTINUATION COVERAGE 105
If You Die 106
How COBRA Continuation Coverage Is Affected by Multiple Qualified Events 106

CONTENTS PAGE

Covering a Newborn or Newly Adopted Dependent During a COBRA Continuation Period 107
How Much COBRA Continuation Coverage Costs 107
Electing COBRA Continuation Coverage 107
THE FAMILY SECURITY PROGRAM (FSP) 107

SECTION K. CLAIMS AND APPEALS..... 109

TYPES OF CLAIMS 109
Eligibility Claims 109
Benefits Claims 109
ELIGIBILITY CLAIMS 111
Filing Deadlines 111
Where to Send Your Claim Form 111
When You Can Expect To Receive a Decision 111
What You will Be Told If Your Eligibility Claim Is Denied 112
Appeal Procedures and Deadline 112
When You Can Expect To Receive a Decision on Appeal 113
BENEFITS CLAIMS 114
Claim Deadlines 114
When You Can Expect To Receive a Decision 115
Appeal Procedures and Deadline 118
When You Can Expect To Receive a Decision on Appeal 119

SECTION L. HOW COORDINATION OF BENEFITS WORKS 122

WHAT COORDINATION OF BENEFITS IS 122
WHEN THE COORDINATION OF BENEFITS APPLIES 122
WHEN THE COORDINATION OF BENEFITS DOES NOT APPLY 122
HOW COORDINATION OF BENEFITS WORKS: WHICH PLAN PAYS FIRST 123

SECTION M. WHAT YOU NEED TO KNOW ABOUT MEDICARE..... 126

WHAT MEDICARE IS 126
MEDICARE BENEFITS AT-A-GLANCE 126
MEDICARE-ELIGIBILITY'S EFFECT ON MEDICAL PLAN COVERAGE 127
WHEN YOU OR A DEPENDENT BECOMES MEDICARE-ELIGIBLE 128
COORDINATION OF BENEFITS WHEN MEDICARE IS PRIMARY 128
IF YOU HAVE END-STAGE RENAL DISEASE 129
DETERMINING YOUR ELIGIBILITY FOR MEDICARE 129
ENROLLING IN MEDICARE 130
Medicare Part A Entitlement 130
Medicare Part B Enrollment 130
WHAT HAPPENS IF YOU ARE NOT ENROLLED IN MEDICARE PARTS A AND B 130
Understanding How Traditional Indemnity Coverage Pays 130
MEDICAL BENEFITS WHEN MEDICARE-ELIGIBLE 132

CONTENTS PAGE

Medical Benefits When You Are Not Medicare-Eligible and Your Dependent Becomes Medicare-Eligible 132
Medical Benefits When You and Your Dependent Are Eligible for Medicare 132
How Medicare and HMO Coverage Work Together 132
Enrolling In a Medicare Advantage HMO 133
Switching Plans 133
Prescription Drug Program Benefits When Medicare-Eligible 134
Creditable Coverage 134
Mental Health and Chemical Dependency Program Benefits When You or a Dependent Becomes Medicare-Eligible 135
Coverage Amounts 135

SECTION N. OVERPAYMENTS AND SUBROGATION 136

Obligation to Refund 136
Right of Recovery and Subrogation 136

SECTION O. TERMS TO KNOW 138

SECTION P. IMPORTANT CONTACTS 156

Resource Contact Information 156
What Is This? 156

SECTION Q. OTHER IMPORTANT INFORMATION 161

Your Legal Rights 161
Your Rights Under ERISA 161
Assistance With Your Questions 163
Newborn's and Mother's Protection Act 163
The Women's Health and Cancer Rights Act of 1998 163
Qualified Medical Child Support Order Benefit Payments 164
Medical Plan Funding and Payment of Benefits 164
Plan Documents 164
Medical Plan May Be Amended or Terminated 165
Plan Administrator and Claims Administrator 165
Plan Sponsor 165
Notice of Privacy Practices 165
Our Legal Duty 165
To Exercise Your Rights 166
Administrative Information 167

APPENDIX A. SECUREHORIZONS® MEDICAREDIRECT™ , A MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE (PFFS) PLAN--RETIREE BENEFITS SUMMARY INSERT 168

Introduction

The Medical Plan is designed to provide important protection against the high cost of medical care for you and your Covered Dependents.

Terms to Know
There are several words and phrases that have specific meanings under the Medical Plan. These words and phrases, which are printed in initial capital letters in this SPD, are defined in **Section O. Terms to Know**.

Your geographic location, retirement date and Medicare eligibility status all play a role in determining which of the following coverage options are available to you during retirement:

- Point-of-Service (POS)
  - Aetna Enhanced POS,
  - Aetna Standard POS,
  - UnitedHealthcare Enhanced POS, and
  - UnitedHealthcare Standard POS;
- Traditional Indemnity (administered by UnitedHealthcare);
- SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS) Plan (administered by UnitedHealthcare); and
- Health Maintenance Organizations (HMOs).

Not all options are available in all geographic regions. The options available to you are listed in your enrollment materials, or you can obtain this information by visiting the Your Benefits Resources™* Web site at http://resources.hewitt.com/alcatel-lucent or by calling the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

If there is more than one option available to you, you should select the one that best meets your needs.

* "Your Benefits Resources" is a trademark of Hewitt Management Company LLC.

January 1, 2010, published May 2010
This information is intended for individuals covered by the management plan design under the Alcatel-Lucent Medical Expense Plan for Retired Employees. More detailed information is provided in the official Plan document, which is controlling.

To get the most from the Medical Plan, please review this summary of the options available to you, what services are Covered and how to access those services. Also, take note of when you need to precertify care in order to have coverage under the Medical Plan.

Special Note About Medicare

Coverage under the Medical Plan changes when you or a Covered Dependent becomes Medicare-eligible, generally when you reach age 65. This summary includes a section, **Section M. What You Need to Know About Medicare**, to help you understand how your benefits under the Medical Plan are affected.

Learning More About SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS) Plan

If you are Medicare-eligible and meet the eligibility requirements of the SecureHorizons MedicareDirect™ Retiree Plan (PFFS) Retiree Plan, this option also may be available to you. For more information, see **Appendix A. SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS)--Retiree Benefits Summary Insert** at the end of this SPD.

Section A. Medical Plan Benefits At-a-Glance

The following charts are summaries of some key features of the Medical Plan. More details about these and other Plan provisions are included in following sections of this SPD.

General Plan Information Chart

Medical Plan Feature	Summary
Eligibility	You are eligible to participate in the Plan if you are a former management employee or former non-represented occupational employee, you terminated employment from a Participating Company, and, at the time of your termination from employment, you were: • At least 50 years old with at least 15 years of service; or • At least 55 years old with at least 10 years of service. Certain former employees who receive a disability pension also are eligible to participate in the Plan. You are also eligible to participate in this Plan if you: • retired from Alcatel USA, Inc. before January 1, 2008 and, at the time of your retirement, were eligible to participate in the retiree medical programs of Alcatel USA, Inc. as of December 31, 2009; • retired from AG Communication Systems Corp. before January 1, 2004 and, at the time of your retirement, were entitled to receive retiree medical benefits under the terms of AG Communication Systems Corp.'s retiree medical plans; or • are a former represented occupational employee who, when actively employed by a Participating Company, was represented for collective bargaining purposes by the Merrimack Valley Guards (RGA), the Merrimack Valley Powerhouse (NCFO) or Bell Laboratories (LPU) and who, at the time of your termination from employment, are: ▪ At least 50 years old with at least 15 years of service; or ▪ At least 55 years old with at least 10 years of service.

Medical Plan Feature	Summary
Enrolling in the Plan	When you retire or terminate employment as an eligible former employee, enrollment materials and information about your coverage options will be sent to you at your Preferred Address. You do not need to enroll if you wish to remain enrolled in the option reflected as your Default Option on your personalized enrollment worksheet. You do need to enroll if: • You are eligible to enroll in the Medical Plan but do not receive a subsidy from the Company; • You want to change your coverage option, the coverage option you had while actively employed is not available and you want to select an option other than the Default Option, or you want to waive coverage; • You want to make coverage changes for your Class I dependents, including your Domestic Partnership Dependents; or • You want to re-enroll your non-grandfathered Class II dependent(s) since **current non-grandfathered Class II dependent(s) coverage does not roll over from year to year.** To make any of the above changes, you must enroll by the date specified in your enrollment package. You may drop your retiree medical coverage at any time with the option of re-enrolling during the next Annual Open Enrollment period or if you have a qualified status change. You may also enroll in and disenroll from Medicare Advantage HMOs throughout the year (see "Changing Your Coverage During the Year" in **Section B. Joining the Medical Plan**).
Subsidy	If you receive a subsidy from the Company, it's likely that you will be responsible for some portion of the cost of coverage (see "Retiree Medical Caps" in **Section B. Joining the Medical Plan.**
How Coverage Changes When You or a Dependent Becomes Medicare-Eligible	Regardless of which Medical Plan option you are enrolled in, you will be transferred to the SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS) Plan on the first of the month in which you become Medicare-eligible (see **Appendix A. SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS) Plan--Retiree Benefits Summary Insert** at the end of this SPD). If you are Medicare-eligible and you have Dependents who are not yet Medicare-eligible, they will be Covered under the Traditional Indemnity option, unless there is a UnitedHealthcare POS in your area. If there is a UnitedHealthcare POS in your area, your Dependents will be enrolled in that POS. If you are not yet Medicare-eligible and you are covering Dependents who are Medicare-eligible, they will be Covered under the Traditional Indemnity option while you are in the POS plan. If you are Medicare-eligible, you may be able to elect coverage through a Medicare Advantage HMO if one is available in your area.

Medical Plan Feature	Summary
When the Medical Plan Is Primary	It is also important for you to understand when the Medical Plan is primary (pays benefits first) and when Medicare is primary, as benefits for you and your Dependents under the coverage options will vary accordingly. The Medical Plan is primary for: • Participants who are not Medicare-eligible; and • Dependents who are not Medicare-eligible (except for Dependents under age 65 who are Medicare-eligible as described in the next section "When Medicare is Primary").
When Medicare Is Primary	At the time you become eligible for Medicare, you and any Medicare-Eligible Dependents will be transferred to the SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS) Plan regardless of the coverage you had previously. This option is not treated as secondary coverage with Alcatel-Lucent. Under this option, you assign your Medicare Part A and B benefits to SecureHorizons MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS) Plan. This Plan pays Providers directly and does not coordinate payment with Medicare. If you are enrolled in an HMO, you will need to check directly with the HMO about benefit levels for Medicare-eligible individuals. If you are not Medicare-eligible and your dependent is Medicare-eligible, your dependent will receive Traditional Indemnity level benefits which coordinate with Medicare (see **Section L. How Coordination of Benefits Works**).
Informational Resources and Important Contact	Call your Health Plan Carrier for information about Covered services or precertification requirements. For questions about eligibility or your benefit options, log on to the Your Benefits Resources* Web site at http://resources.hewitt.com/alcatel-lucent. Information is also available on-line at the BenefitAnswers Plus Web site at www.benefitanswersplus.com. You can also obtain information by visiting the Your Benefits Resources™* online at http://resources.hewitt.com/alcatel-lucent or by calling the Alcatel-Lucent Benefits Center (domestic: 1-888-232-4111; international: 1-847-883-0660). Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET). If you are hearing or speech impaired, please use a Relay Service when calling a representative.

* "Your Benefits Resources" is a trademark of Hewitt Management Company LLC.

Medical Benefits Chart

Feature	Enhanced POS (If you are not eligible for Medicare)		Standard POS (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are a Medicare-Eligible Dependent of a participant not eligible for Medicare)	SecureHorizons® MedicareDirect™ PFFS Plan (If you are a Medicare-eligible participant or Medicare-Eligible Dependent of a Medicare-eligible participant)
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*		
Choice of Doctors	Select within a Network of Providers	Select any qualified Provider	Select within a Network of Providers	Select any qualified Provider	Select any qualified Provider or within a Network of Preferred Provider Organization (PPO) Providers	Select any deemed Provider who agrees to accept the plan's terms and conditions*

Please note: You may not be eligible for all of the coverage options shown in this chart. For HMO/Medicare Advantage HMO information, contact the HMO/Medicare Advantage HMO. (Carrier contact information is in Section P. Important Contacts.)

* A Medicare Advantage Private Fee-For-Service plan works differently than a Medicare Supplement plan. Your Physician or Hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your Physician or Hospital does not agree to accept the payment terms and conditions, they may choose not to provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions at www.uhcretiree.com.

Feature	Enhanced POS (If you are not eligible for Medicare)		Standard POS (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are a Medicare-Eligible Dependent of a participant not eligible for Medicare)	SecureHorizons® MedicareDirect™ PFFS Plan (If you are a Medicare-eligible participant or Medicare-Eligible Dependent of a Medicare-eligible participant)
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*		
Annual Deductible	Not applicable	Individual: $500 Two-person: $1,000 Family: $1,500	Not applicable	Not applicable	Retirees and their dependent(s): *Individual:* $150 plus 1% of annual pension ($175 min. and $300 max.) *Two-person:* 2x individual Deductible *Family:* 3x individual Deductible *For account balance participants and survivors:* *Individual:* $300 *Two-person:* $600 *Family*: $900	$290/individual
Annual Out-of-Pocket Maximum	*Individual:* $1,200 *Two-person:* $2,400 *Family:* $3,600	*Individual:* $3,000 *Two-person:* $6,000 *Family:* $9,000 (excludes Deductible)	*Individual:* $4,000 *Family:* $8,000	$7,500/ individual	*Individual:* $1,500 *Two-person:* $3,000 *Family:* $4,500 (excludes Deductible)	$2,500/individual (excludes Deductible)
Lifetime Maximum Benefit	Unlimited (some exclusions apply)					

Feature	Enhanced POS (If you are not eligible for Medicare)		Standard POS (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are a Medicare-Eligible Dependent of a participant not eligible for Medicare)	SecureHorizons® MedicareDirect™ PFFS Plan (If you are a Medicare-eligible participant or Medicare-Eligible Dependent of a Medicare-eligible participant)
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*		
Annual Maximum Benefit	Not applicable	Not applicable	$1,000,000 (in- and Out-of-Network combined)	$1,000,000 (in- and Out-of-Network combined)	Not applicable	Not applicable
Are You Responsible for Charges in Excess of Allowable Amounts?	No	Yes	No	Yes	Yes	No
Who Is Responsible for Precertification?	Your PCP	You	Your PCP	You	You	Not applicable
What Is the Penalty for Failure to Precertify Care?	Not applicable	20% reduction in benefits, up to $400 maximum per occurrence	Not applicable	20% reduction in benefits, up to $400 per occurrence	20% reduction in benefits, up to $400 per occurrence	Not applicable
Do You File Claims Forms?	No	Yes	No	Yes	Yes	No
Copayments/Coinsurance for Covered Services						
Acupuncture	Plan pays 90%	Plan pays 70% after Deductible is satisfied; limited to 30 visits/ year	Plan pays 80%	Plan pays 60%	Plan pays 80% after Deductible is satisfied; limited to 30 visits/year	Plan pays 80% after Deductible is satisfied; limited to 30 visits/year
Ambulance — Emergency Use of Air or Ground Ambulance	Plan pays 90%	Plan pays 90%	Plan pays 80%	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied

Feature	Enhanced POS (If you are not eligible for Medicare)		Standard POS (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are a Medicare-Eligible Dependent of a participant not eligible for Medicare)	SecureHorizons® MedicareDirect™ PFFS Plan (If you are a Medicare-eligible participant or Medicare-Eligible Dependent of a Medicare-eligible participant)
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*		
Ambulance — From Hospital to Hospital (if admitted to first Hospital)	Plan pays 90%	Plan pays 90%	Plan pays 80%	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Anesthesia	Plan pays 90%	Plan pays 70% after Deductible is satisfied	Plan pays 80%	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Birth Control (prescription birth control or medication only)	See "Prescription Drug Program"					
Birthing Center	Plan pays 90%	Plan pays 70% after Deductible is satisfied	Plan pays 80% after you pay a $500 Copayment	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Blood and Blood Derivatives	Plan pays 90%	Plan pays 70% after Deductible is satisfied	Plan pays 80%	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Cardiac Rehabilitation (phase three maintenance not Covered)	Plan pays 90%	Plan pays 70% after Deductible is satisfied	Plan pays 80%	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Chemotherapy	Plan pays 90%	Plan pays 70% after Deductible is satisfied	Plan pays 80%	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied

Feature	Enhanced POS (If you are not eligible for Medicare)		Standard POS (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are a Medicare-Eligible Dependent of a participant not eligible for Medicare)	SecureHorizons® MedicareDirect™ PFFS Plan (If you are a Medicare-eligible participant or Medicare-Eligible Dependent of a Medicare-eligible participant)
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*		
Chiropractic	You pay $25 Copayment/ visit; limited to 30 visits/ year (in- and Out-of-Network combined)	Plan pays 70% after Deductible is satisfied; limited to 30 visits/ year (in- and Out-of-Network combined)	Plan pays 80%; limited to 30 visits/ year (in-and Out-of-Network combined)	Plan pays 60%; limited to 30 visits/ year (in- and Out-of-Network combined)	Plan pays 80% after Deductible is satisfied; limited to 30 visits/year	Plan pays 80% after Deductible is satisfied (Covered according to Medicare guidelines)
Durable Medical Equipment	Plan pays 90%	Plan pays 70% after Deductible is satisfied	Plan pays 80%	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Emergency Room — Emergency Use	You pay $50 Copayment (waived if admitted)	You pay $50 Copayment (waived if admitted)	You pay $100 Copayment (waived if admitted)	You pay $100 Copayment (waived if admitted)	Plan pays 80% after Deductible is satisfied	You pay $50 Copayment/visit
Emergency Room — Nonemergency Use	Plan pays 70% after you pay $50 Copayment/ visit	Plan pays 70% after you pay $50 Copayment/ visit	Plan pays 60%	Plan pays 60%	Plan pays 80% after Deductible is satisfied	You pay $50 Copayment/visit
Extended Care Facility (for example, a Skilled Nursing Facility)	Plan pays 90%	Plan pays 70% after Deductible is satisfied; limited to 60 days/ year	Plan pays 80%	Plan pays 60%	Plan pays 80% after Deductible is satisfied; limited to 120 days/year	Plan pays 80% after Deductible is satisfied; limited to 100 days/ benefit period
Home Healthcare	Plan pays 90%	Plan pays 70% after Deductible is satisfied; limited to 100 visits/ year	Plan pays 80%	Plan pays 60%; limited to 100 visits/ year	Plan pays 80% after Deductible is satisfied; limited to 200 visits/year	Plan pays 100% after Deductible is satisfied (Covered according to Medicare guidelines)

Feature	Enhanced POS (If you are not eligible for Medicare)		Standard POS (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are a Medicare-Eligible Dependent of a participant not eligible for Medicare)	SecureHorizons® MedicareDirect™ PFFS Plan (If you are a Medicare-eligible participant or Medicare-Eligible Dependent of a Medicare-eligible participant)
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*		
Hospice Care	Plan pays 90%; limited to 210 days/ lifetime (in- and Out-of-Network combined)	Plan pays 70%; limited to 210 days/ lifetime (in- and Out-of-Network combined)	Plan pays 80%; limited to 210 days/ lifetime (in- and Out-of-Network combined)	Plan pays 60%; limited to 210 days/ lifetime (in- and Out-of-Network combined)	Plan pays 80% after Deductible is satisfied; limited to 210 days/ lifetime	Covered according to Medicare guidelines; care from a Medicare-certified Hospice is required
Inpatient Hospitalization	Plan pays 90%	Plan pays 70% after you pay $200 Copayment/ admission	Plan pays 80% after $500 Copayment/ admission	Plan pays 60% after $200 Copayment/ admission	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Maternity • Office visits: pre/postnatal • In-Hospital delivery services	Plan pays 90% after first office Copayment	Plan pays 70% after Deductible is satisfied	**Office visits:** You pay $15 Copayment **In-Hospital delivery services:** Plan pays 80% after you pay $500 Copayment/ admission	**Office visits:** Plan pays 60% **In-Hospital delivery services:** Plan pays 60% after you pay $200 Copayment/ admission	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Nutritionist	You pay $25 Copayment/ visit	Not Covered	You pay $40 Copayment/ visit	Plan pays 60%	Not Covered	Not Covered, except in limited situations
Outpatient Lab/X-ray	Plan pays 90% (or you pay $25 Copayment when included as part of office visit)	Plan pays 70% after Deductible is satisfied	Plan pays 80%	Plan pays 60% after you pay $200 Copayment	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied

Feature	Enhanced POS (If you are not eligible for Medicare)		Standard POS (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are a Medicare-Eligible Dependent of a participant not eligible for Medicare)	SecureHorizons® MedicareDirect™ PFFS Plan (If you are a Medicare-eligible participant or Medicare-Eligible Dependent of a Medicare-eligible participant)
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*		
Physician Hospital Visits and Consultations	Plan pays 90%	Plan pays 70% after Deductible is satisfied	Plan pays 80%	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Physician Office Visit	You pay $25 Copayment/ visit	Plan pays 70% after Deductible is satisfied	**Primary care Physician (PCP):** You pay $15 Copayment/ visit **Specialist**: You pay $40 Copayment/ visit	Plan pays 60%	Plan pays 80% after Deductible is satisfied	**Primary Physician:** You pay $15 Copayment/visit after Deductible is satisfied **Specialist:** Plan pays 80% after Deductible is satisfied
Podiatrist	Plan pays 90%	Plan pays 70% after Deductible is satisfied	Plan pays 80%	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied (Covered according to Medicare guidelines)
Private Duty Nursing	Plan pays 90%	Plan pays 70% after Deductible is satisfied; limited to 100 shifts/ year	Plan pays 80%	Plan pays 60%; limited to 100 shifts/year	Plan pays 80% after Deductible is satisfied; limited to 200 shifts/year	Plan pays 80% after Deductible is satisfied (Covered according to Medicare guidelines)
Radiation Therapy	Plan pays 90%	Plan pays 70% after Deductible is satisfied	Plan pays 80%	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied

Feature	Enhanced POS (If you are not eligible for Medicare)		Standard POS (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are a Medicare-Eligible Dependent of a participant not eligible for Medicare)	SecureHorizons® MedicareDirect™ PFFS Plan (If you are a Medicare-eligible participant or Medicare-Eligible Dependent of a Medicare-eligible participant)
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*		
Rehabilitation Therapy (Outpatient physical, occupational, speech)	You pay $25 Copayment/ visit	Plan pays 70% after Deductible is satisfied; Speech Therapy limited to 30 visits/ year	You pay $40 Copayment/ visit	Plan pays 60%	Plan pays 80% after Deductible is satisfied; Speech Therapy limited to 30 visits/year	Plan pays 80% after Deductible is satisfied
Second Surgical Opinion	You pay $25 Copayment/ visit	Plan pays 70% after Deductible is satisfied	You pay $40 Copayment/ visit	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Smoking Deterrents (prescription only)	See "Prescription Drug Program					
Surgery — In-Office	Plan pays 90%	Plan pays 70% after Deductible is satisfied	Plan pays 80% after $250 Copayment	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Surgery — Inpatient	Plan pays 90%	Plan pays 70% after you pay $200 Copayment/ admission	Plan pays 80% after you pay $500 Copayment	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Surgery — Outpatient	Plan pays 90%	Plan pays 70% after Deductible is satisfied	Plan pays 80% after you pay $250 Copayment/ individual, per procedure	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied

Feature	Enhanced POS (If you are not eligible for Medicare)		Standard POS (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are a Medicare-Eligible Dependent of a participant not eligible for Medicare)	SecureHorizons® MedicareDirect™ PFFS Plan (If you are a Medicare-eligible participant or Medicare-Eligible Dependent of a Medicare-eligible participant)
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*		
Wigs	Plan pays up to $300/year					
Preventive Care						
Routine Physical Exams	You pay $25 Copayment/ visit	Not Covered	You pay $15 Copayment/ visit	Not Covered	Not Covered	Coverage of Medicare-Covered physical exams; annual routine physical examination not Covered
Well-Child Care (including immunizations)	You pay $25 Copayment/ visit	Not Covered	You pay $15 Copayment/ visit	Not Covered	Not Covered	Not Covered
Well-Woman Care (ob/gyn exam)	You pay $25 Copayment/ visit	Not Covered	**PCP:** You pay $15 Copayment/ visit **Specialist:** You pay $40 Copayment/ visit	Not Covered	Not Covered	Not Covered
Mammogram Screening (in Physician's office)	You pay $25 Copayment/ visit	Plan pays 70% after Deductible is satisfied	**PCP:** You pay $15 Copayment/ visit **Specialist:** You pay $40 Copayment/ visit	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied

Feature	Enhanced POS (If you are not eligible for Medicare)		Standard POS (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are a Medicare-Eligible Dependent of a participant not eligible for Medicare)	SecureHorizons® MedicareDirect™ PFFS Plan (If you are a Medicare-eligible participant or Medicare-Eligible Dependent of a Medicare-eligible participant)
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*		
Pap Smear (in Physician's office)	You pay $25 Copayment/ visit	Plan pays 70% after Deductible is satisfied	**PCP:** You pay $15 Copayment/ visit **Specialist:** You pay $40 Copayment/ visit	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Digital Rectal Exam and Blood Test for PSA (in Physician's office — prostate cancer screening for men age 50 and older)	Plan pays 90%	Plan pays 70% after Deductible is satisfied	**PCP:** You pay $15 Copayment/ visit **Specialist:** You pay $40 Copayment/ visit	Plan pays 60%	Plan pays 80% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Newborn In-Hospital Care	Plan pays 90%	Plan pays 70% after Deductible is satisfied; limited to one visit	Plan pays 80%	Plan pays 60%	Plan pays 80% after Deductible is satisfied; limited to one visit	Not Covered

Mental Health and Chemical Dependency

Feature	Enhanced Point of Service (POS) (If you are not eligible for Medicare) *In-Network*	Enhanced Point of Service (POS) (If you are not eligible for Medicare) Out-of-Network	Standard POS (If you are not eligible for Medicare) *In-Network*	Standard POS (If you are not eligible for Medicare) Out-of-Network	**Traditional Indemnity** (If you are not eligible for Medicare or if you are a Medicare-Eligible Dependent of a participant not eligible for Medicare)	**SecureHorizons® MedicareDirect™ PFFS Plan** (If you are a Medicare-eligible participant or Medicare-Eligible Dependent of a Medicare-eligible participant).
Benefits for Those Who Are Not Eligible for Medicare*						
Inpatient	Plan pays 90%	Plan pays 70% after you pay $200 copayment/ admission	Plan pays 80% after you pay $500 Copayment/ admission	Plan pays 60% after you pay $200 Copayment/ admission;	Plan pays 80% after deductible is satisfied	Not applicable
Please note: You may not be eligible for all of the coverage options shown in this chart. For HMO/Medicare Advantage HMO information, contact the HMO/Medicare Advantage HMO. (See Section P. Important Contacts for carrier contact information.)						
Outpatient	You pay $25 Copayment/ visit	Plan pays 70% after Deductible is satisfied	You pay $40 Copayment/ visit	Plan pays 60%	Plan pays 80% after deductible is satisfied	Not applicable

* The Deductibles for Mental Health and Chemical Dependency benefits are separate from the Deductibles for POS and Traditional Indemnity.

Feature	Enhanced Point of Service (POS) (If you are not eligible for Medicare)		Standard POS (If you are not eligible for Medicare)		**Traditional Indemnity** (If you are not eligible for Medicare or if you are a Medicare-Eligible Dependent of a participant not eligible for Medicare)	**SecureHorizons® MedicareDirect™ PFFS Plan** (If you are a Medicare-eligible participant or Medicare-Eligible Dependent of a Medicare-eligible participant).
	In-Network	**Out-of-Network**	***In-Network***	**Out-of-Network**		
Benefits for Those Who Are Eligible for Medicare*						
Inpatient	Not applicable				Plan pays up to a total of 80% of the Medicare-approved amount (including any amounts payable by Medicare) and is secondary to Medicare; Chemical Dependency benefits are limited to 30 days/ confinement and two confinements/ lifetime	Plan pays 80% after Deductible is satisfied; subject to 190-day lifetime maximum (Covered according to Medicare guidelines)
Outpatient	Not Applicable				Plan pays up to a total of 50% of the Medicare-approved amount (including any amounts payable by Medicare) and is secondary to Medicare; limited to 50 visits/year	Plans pays 80% after Deductible is satisfied (Covered according to Medicare guidelines)

* The Deductibles for Mental Health and Chemical Dependency benefits are separate from the Deductibles for POS and Traditional Indemnity.

Prescription Drug Program

If You Are Not Eligible for Medicare ***(Coverage for the Enhanced and Standard Point-of-Service [POS] and Traditional Indemnity Options)***		
Annual Deductible: None		
Annual Out-of-Pocket Maximum: None		
Coinsurance/Copayments		
In-Network	**Retail** (up to a 30-day supply using an *In-Network* pharmacy)	**Mail Order** (up to a 90-day supply)
Tier One: Generic Drugs	$10 Copayment	$20 Copayment
Tier Two Lower-cost Formulary Brand-Name Drugs	50% Coinsurance • $ 25 minimum • $225 maximum	50% Coinsurance • $ 50 minimum • $450 maximum
Tier Three Higher-cost Formulary Brand-Name Drugs	50% Coinsurance • $ 45 minimum • $275 maximum	50% Coinsurance • $ 90 minimum • $550 maximum
Tier Four Nonformulary Brand-Name Drugs	50% Coinsurance • $ 60 minimum • $300 maximum	50% Coinsurance • $120 minimum • $600 maximum
Out-of-Network (retail only)		
Same benefit as at an *In-Network* pharmacy, but you will also be responsible for the difference in the cost of the drug purchased at an Out-of-Network pharmacy compared to the cost of the drug at an *In-Network* pharmacy.		
If You Are Medicare-Eligible* ***(Coverage for SecureHorizons® MedicareDirect™, A Medicare Advantage Private Fee-For-Service (PFFS) Plan and Traditional Indemnity)***		
Annual Deductible: $310 per individual		
Annual Out-of-Pocket Maximum: None		
How It Works: • Once total prescription drug costs reach $2,830 per individual, including the Deductible and Copayments, you pay 100 percent of the costs until you reach $4,550 in out-of-pocket costs, per individual. • After total out-of-pocket costs reach $4,550 per individual, you pay the greater of 5 percent of the cost or a Copayment of $2.50 for generics/$6.30 for Brand-Name Drugs, per prescription, for the remainder of the year.		

* The Deductibles and Out-of-Pocket Maximums for the Prescription Drug Program are separate from the Deductibles and Out-of-Pocket Maximums for POS, Traditional Indemnity and SecureHorizons MedicareDirect Retiree Plan (PFFS).

• Only drugs included on the Medco standard Medicare Part D Formulary are Covered. Out-of-pocket expenses for drugs not Covered will not count toward total prescription drug costs or the total out-of-pocket costs.		
Coinsurance/Copayments		
In-Network	**Retail (up to a 34-day supply)**[**]	**Mail Order (up to a 90-day supply)**
Tier One: Generic Drugs on Medco standard Medicare Part D Formulary	$10 Copayment	$20 Copayment
Tier Two: Plan-preferred Brand-Name Drugs on Medco standard Medicare Part D Formulary	$25 Copayment	$50 Copayment
Tier Three: Non-plan-preferred Brand-Name Drugs on Medco standard Medicare Part D Formulary	$45 Copayment	$90 Copayment
Tier Four: Specialty drugs with average costs of more than $500/month on Medco standard Medicare Part D Formulary	$60 Copayment	$120 Copayment
Out-of-Network (retail only)		
Available only in the event of an Emergency, as defined by the Centers for Medicare & Medicaid Services (CMS). If an Out-of-Network pharmacy is used for a non-qualifying Emergency, no benefit will be applied.		

Please note: HMO/Medicare Advantage HMO prescription drug coverage varies by HMO/Medicare Advantage HMO. For HMO/Medicare Advantage HMO information, contact the HMO/Medicare Advantage HMO (see **Section P. Important Contacts** for carrier contact information).

Also note: You may not be eligible for all of the plans listed in the above chart.

[**] 60- and 90-day supplies are available at double and triple Copayments, for cost savings, use mail order.

Section B. Joining the Medical Plan

Who Is Eligible

Eligible Former Employees

You are eligible to participate in the Plan if you are a former management employee or former non-represented occupational employee (e.g., a former Lucent Business Assistant), you terminated employment from a Participating Company, and, at the time of your termination from employment, you were:

- At least 50 years old with at least 15 years of service; or
- At least 55 years old with at least 10 years of service.

Certain former employees who receive a disability pension also are eligible to participate in the Plan.

You are also eligible to participate in this Plan if you:

- retired from Alcatel USA, Inc. before January 1, 2008 and, at the time of your retirement, were eligible to participate in the retiree medical programs of Alcatel USA, Inc. as of December 31, 2009;
- retired from AG Communication Systems Corp. before January 1, 2004 and, at the time of your retirement, were entitled to receive retiree medical benefits under the terms of AG Communication Systems Corp.'s retiree medical plans; or
- are a former represented occupational employee who, when actively employed by a Participating Company, was represented for collective bargaining purposes by the Merrimack Valley Guards (RGA), the Merrimack Valley Powerhouse (NCFO) or Bell Laboratories (LPU) and who, at the time of your termination from employment, are:
    - At least 50 years old with at least 15 years of service; or
    - At least 55 years old with at least 10 years of service.

Eligible Dependents

If you satisfy the criteria in "Eligible Former Employees" above, your Eligible Dependents are also eligible to participate in the Medical Plan. Generally, you must enroll your Eligible Dependents in the same option and with the same Health Plan Carrier that you choose for yourself.

Dependent Classes

The Medical Plan recognizes two Dependent classes:

- Class I Dependents; and
- Class II Dependents.

Dependent Verification
From time to time, the Company will verify dependent eligibility. Verification will include documentation requirements.

Class I Dependents

Class I Dependents eligible to be Covered under the Medical Plan include:

- Your opposite-sex Lawful Spouse (or opposite-sex common-law spouse if recognized in your state of residence);
- Your same-sex spouse, or same-sex or opposite-sex civil union partner or Domestic Partner, if you and your partner or spouse meet all of the following requirements:
  - Comply with any state or local registration process for Domestic Partners, if applicable;
  - Reside in the same household;
  - Are age 18 or over;
  - Have the mental capacity sufficient to enter into a valid contract;
  - Are unrelated by blood or marriage and are not legally married to or the Domestic Partner of another individual;
  - Consider one another to have a close and committed personal relationship and have no other such relationship with any other person; and
  - Are responsible for each other's welfare and financial obligations.

    Please note: Coverage for same-sex spouses, same-sex or opposite-sex civil union partners or Domestic Partners, and their children, ("Domestic Partnership Dependents") is available only to Eligible Retirees' Domestic Partnership Dependents who had Alcatel-Lucent-sponsored medical coverage at the time of the Eligible Retiree's retirement. An Eligible Retiree **cannot** enroll a **new** Domestic Partnership Dependent after the retiree's coverage under the Medical Plan begins, except that, if, after retirement, the Eligible Retiree drops coverage under this Plan for his or her Domestic Partnership Dependent(s) who had Alcatel-Lucent-sponsored medical coverage at the time of the Eligible Retiree's retirement, the Eligible Retiree will be permitted to re-enroll those Dependents.

- Your unmarried Children (including the unmarried children of your Lawful Spouse, same-sex spouse, or same-sex or opposite-sex civil union partner or Domestic Partner):

  — Through the end of the month in which they reach age 20 if not enrolled as full-time students; or

  — Through the end of the month in which they reach age 24 if continuously enrolled as full-time students.

- Children for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

- Children for whom you, your spouse or your Domestic Partner is appointed a legal guardian as defined by a court order (this does not include wards of the state or foster Children).

- Children beyond age 20 who are unmarried, certified by a Medical Claims Administrator as incapacitated, and who meet all of the following requirements. They are:

  — Incapable of self-support,

  — Physically or mentally handicapped, and

  — Fully dependent on you for support.

  This coverage is not automatic. Your Health Plan Carrier must certify that the Child is eligible for such coverage. To apply for coverage, contact your Medical Claims Administrator and notify the Alcatel-Lucent Benefits Center at 1-888-232-4111 of your intention to seek coverage for the Child beyond age 20. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

Please note: If your dependent Child is disabled within the meaning of the Medical Plan, he or she may be able to continue his or her coverage past age 20 (see "Class I Dependents" in this **Section B. Joining the Medical Plan** and "If Your Physically or Mentally Handicapped Child Reaches Age 20" in **Section I. When Coverage Ends**). This coverage is not automatic. Your Health Plan Carrier must certify that the Child is eligible for coverage. To apply for coverage, contact your Health Plan Carrier and notify the Alcatel-Lucent Benefits Center at 1-888-232-4111 of your intentions to seek this coverage. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

Please note: If your dependent(s) become(s) ineligible for coverage during the year due to reaching the maximum age requirement, a COBRA continuation coverage notice will be sent to your dependent(s). If your dependent(s) become(s) ineligible for coverage during the year for any other reason, you must call the Alcatel-Lucent Benefits Center at 1-888-232-4111 to receive COBRA information (see **Section J. Continuing Coverage**). Also note that dropping a dependent's(s') coverage during open enrollment is not considered a COBRA-qualifying event so, in this case, a COBRA continuation coverage notice would not be sent to your dependent(s).

Class II Dependents

The following Class II dependents are eligible to be Covered under the Medical Plan if they have been continuously Covered since before January 1, 1996 (i.e., no new Class II dependent(s) may be enrolled in the Plan):

Important!
New Class II Dependents may not be added to coverage at any time.

- Your unmarried dependent Child(ren) or stepchild(ren) not included as a Class I dependent(s);

- Your unmarried grandchild(ren), your unmarried brothers and sisters and your parents and grandparents; and

- Your Lawful Spouse's parents and grandparents.

To be a Class II dependent, the individual must:

- Receive less than $12,000 a year in income from all sources (other than your support);

- Live with you or in a nearby household (within 100 miles of your home) provided by you (unmarried dependent stepchild[ren] must live with you throughout the period of coverage); and

- Either:

  — Have been continuously re-enrolled during each Annual Open Enrollment period since January 1, 1996 and continue to be re-enrolled each year (non-grandfathered Class II dependent[s]); or

  — Were enrolled before June 1, 1986, but are not required to re-enroll in the Medical Plan annually to maintain coverage (grandfathered Class II dependent[s]).

Note: Other-Covered-Charges-Only Class II Dependents ("OCC-Only Class II Dependents") must have been continuously enrolled in the "Other Covered Charges Only" portion of the Medical Plan (or its predecessor) since January 1, 1996 (see "Traditional Indemnity Option" in **Section C. How the Medical Plan Options Work)**.

Enrolling in the Plan

Enrollment Packet

If you are an eligible terminated employee, you will receive an enrollment packet in the mail. (Materials will be sent to you at your Preferred Address.) The packet will include information about your coverage options, the cost, how to enroll yourself and your Eligible Dependents and the date by which you must make your elections.

The Medical Plan provides several coverage options from which to choose. Choose the one that best meets your needs (see **Section C. How the Medical Plan Options Work**). Your geographic location and Medicare eligibility status determine which options are available to you.

Keeping Your Information Up to Date
If your email or mailing addresses change during the year, remember to update them on the Your Benefits Resources Web site. Then follow the instructions to select which ones are preferred. This will ensure that you always receive all of your Alcatel-Lucent health and welfare benefit coverage information without delay.

You also may have an opportunity to elect a different Medical Plan option each year during the Annual Open Enrollment period (see "Annual Open Enrollment" later in this section), in the event of a qualified status change (see "Changing Your Coverage During the Year" later in this section).

You can also waive Medical Plan coverage with the option to reinstate it as of the first of the month based upon a qualified status change.

Coverage Categories

You may select from one of the following three coverage categories when enrolling yourself and your Eligible Dependents in the Medical Plan:

If You (the Retiree) Are:	**Your Coverage Tier**: (as it appears on your personalized enrollment worksheet and the Your Benefits Resources Web site)
Medicare-eligible and live inside the U.S.	**Individual – 1 Medicare** Coverage for yourself
	Two Person – 1 Medicare When your Covered Dependent includes: • A spouse/Domestic Partner not eligible for Medicare; or • A Child (Medicare-eligible or not eligible for Medicare)
	Two Person – 2 Medicare When your Covered Dependent is a Medicare-eligible spouse/Domestic Partner
	Family – 1 Medicare When your Covered Dependents include: • A spouse/Domestic Partner not eligible for Medicare and at least one Child (Medicare-eligible or not eligible for Medicare); or • Two or more Children (Medicare-eligible or not eligible for Medicare)
	Family – 2 Medicare When your Covered Dependents include: • A Medicare-eligible spouse/Domestic Partner; and • At least one Child (Medicare-eligible or not eligible for Medicare)
Age 65 or Older Living Outside of the U.S. or Are Not eligible for Medicare	**Individual – 0 Medicare** Coverage for just yourself
	Two Person – 0 Medicare When your Covered Dependents include: • A spouse/Domestic Partner not eligible for Medicare; or • A Child (Medicare-eligible or not eligible for Medicare)
	Two Person – 1 Medicare When your Covered Dependent is a Medicare-eligible spouse/Domestic Partner
	Family – 0 Medicare When your Covered Dependents include: • A spouse/Domestic Partner not eligible for Medicare and at least one Child (Medicare-eligible or not eligible for Medicare); or • Two or more Children (Medicare-eligible or not eligible for Medicare)
	Family – 1 Medicare When your Covered Dependents include a Medicare-eligible spouse/Domestic Partner and at least one Child (Medicare-eligible or not eligible for Medicare)

Please note: Class II Dependents should not be taken into account when electing a coverage category.

Couples Working for Alcatel-Lucent

Alcatel-Lucent retirees may only cover dependent(s) who are in the same plan design (for example, management or represented). The following chart explains whom you can enroll as a dependent if both you and your spouse/Domestic Partner are participants in an Alcatel-Lucent Medical Plan:

	You May Enroll the Following Dependent Employed with Alcatel-Lucent in Your Medical Plan option:			
If You Are A…	Active Management or Active LBA Employee	Management Plan Design Retiree	Active Represented Employee	Formerly Represented Retiree
Management Plan Design Retiree	Yes	Yes	No	No
Formerly Represented Retiree	No	No	Yes	Yes

Unique Enrollment Situations

Generally, you must enroll your Eligible Dependents in the same option and with the same Health Plan Carrier that you choose for yourself. However, if one of the following situations applies to you, you and your dependents may have different coverage options or Health Plan Carriers:

Situation	**Administration**
You are enrolled in the POS option and your Eligible Dependents do not live with you on a permanent basis and live outside your Health Plan Carrier's POS Network area.	• You and your Eligible Dependents may enroll in the POS option. • If your Dependents do not live in a POS Network area, the Dependents may receive Traditional Indemnity benefits provided by your POS option.
You are Medicare-eligible and you have one or more **dependents not eligible for Medicare** and you are enrolled in SecureHorizons® MedicareDirect™ PFFS Plan with the Medco Medicare Prescription Drug Plan.	• Your dependent(s) would have POS medical and prescription drug coverage if there is a UnitedHealthcare POS in your area, otherwise, they would have Traditional Indemnity medical and prescription drug coverage.
You are Medicare-eligible and you have one or more **dependents not eligible for Medicare** and you are enrolled in a Medicare Advantage HMO with Medicare Advantage prescription drug coverage.	• Your dependent(s) would have HMO medical and HMO prescription drug coverage.

Situation	Administration
You are not Medicare-eligible, but you have one or more **dependents who are eligible for Medicare** and you (and any dependents not eligible for Medicare) are enrolled in POS medical and prescription drug coverage.	• Your Medicare-Eligible Dependent(s) will have Traditional Indemnity coverage, with Medicare as primary, and the Medco Medicare Prescription Drug Plan.
You are not Medicare-eligible, but you have one or more **dependents who are eligible for Medicare** and you (and any dependents not eligible for Medicare) are enrolled in Traditional medical and prescription drug coverage.	• Your Medicare-Eligible Dependent(s) will have Traditional Indemnity coverage, with Medicare as primary, and the Medco Medicare Prescription Drug Plan.
You are not Medicare-eligible, but you have one or more **dependents who are eligible for Medicare** and you (and any dependents not eligible for Medicare) are enrolled in an HMO with HMO prescription drug coverage.	• Your Medicare-Eligible Dependent(s) will have Medicare Advantage HMO with Medicare Advantage HMO prescription drug coverage.

Effect on Benefits

Expenses incurred by you and any dependents enrolled with you under your selected option count toward the two-person or family Deductible and two-person or family Out-of-Pocket Maximum under that option.

The following rules apply for each family member who enrolls separately from you as an Alcatel-Lucent employee or retiree:

- The individual, two-person or family Out-of-Pocket Maximum limit applies separately.

- If the family Deductible does apply, it's not automatic. You will need to submit your Explanation of Benefits (EOB) statements to your Health Plan Carrier to show you paid more toward the family Deductible than required. You will also need to submit a claim for reimbursement.

Defaulting Into a Coverage Option When You Retire

When you retire, you do not need to enroll for coverage if you want to keep the Default Option reflected in your enrollment package. You will automatically remain in that option unless you want to change options. You will need to enroll, however, if any of the following apply to you:

- You were enrolled in an option while actively employed that is not available to you in retirement and you wish to select an option other than the Default Option;
- You wish to decline coverage;
- You wish to change to another option even if the option you had while actively employed is available to you;
- You want to add or drop coverage for an Eligible Dependent;
- You want to re-enroll Class II dependents since current non-grandfathered Class II dependent elections will not roll over; or
- You want to enroll in a POS option if you are not eligible for Medicare and a POS option is not listed on the Your Benefits Web site at http://resources.hewitt.com/alcatel-lucent or on your personalized enrollment worksheet (see the sidebar. "Opting Into a POS Options.")

Opting Into a POS Option

If you are not Medicare-eligible and a POS option is not listed as a coverage option in your enrollment materials, it may be because you live in an area with limited access to Physicians and Hospitals in a POS Network. In this circumstance, if you are comfortable with the distance between you and the Providers who participate in the POS Network, you can opt to enroll in the POS option by calling the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET). However, this coverage will not carry over into the next year, and your Default Option will not be your "opt-in" POS option. If you want to continue the POS coverage you have opted into for the following year, you must actively re-enroll by calling the Alcatel-Lucent Benefits Center during the Annual Open Enrollment period.

If you wish to make a change, you must enroll by the date specified in your enrollment package. If you do not enroll by the date specified, here's what happens:

- You will remain in the option you had while actively employed, provided the option is available to you, or
- If the option you had while actively employed is not available to you, you will automatically be enrolled in the Default Option.

About Your Default Option

Your Default Option is listed on the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent or on your personalized enrollment worksheet during your Annual Open Enrollment period. The Default Option may be "no coverage," in which case you must actively enroll.

Keep in mind that once the initial enrollment period expires (the deadline specified in your enrollment package), you cannot make any additional changes

until the next Annual Open Enrollment (see "Annual Open Enrollment" below), unless you have a qualified status changes (see "Changing Your Coverage During the Year" later in this section).

If You Do Not Enroll
If you are eligible to receive a service or disability pension, you are eligible for retiree medical and receive a Company subsidy. If you do not make any elections by the date shown in your enrollment package, you will be assigned the Default Option included in your enrollment package (see "Medical Plan Contributions" later in this section). You also have the option to continue the medical coverage that you had as an active employee for up to 18 months by enrolling in COBRA continuation coverage instead. You can then enroll in the retiree medical coverage when your COBRA continuation coverage period ends or during the next annual open enrollment period (see "COBRA Continuation Coverage" in Section J. Continuing Coverage)."

When Coverage Begins
Coverage you elect for yourself and/or your Eligible Dependents during retirement begins on the first day of the month following your retirement date.

Annual Open Enrollment
During Annual Open Enrollment each year, you may be able to change your Medical Plan option and the Eligible Dependents you cover. (Annual Open Enrollment is held once a year, usually in the fall.) **Elections made during Annual Open Enrollment take effect on the first day of the next calendar year.**

Before Annual Open Enrollment, you will be sent an enrollment package that will include information about the coverage options available to you under the Medical Plan in the upcoming year. In most cases, if you are currently enrolled in the Medical Plan and do not make any changes to your coverage, your current coverage elections will remain in effect unless a particular Medical Plan option is being discontinued or replaced by another option for your area.

If your Medical Plan option is being discontinued and you do not select another Medical Plan option, you will be enrolled in your Default Option.

You can enroll:

- On the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent; or

- Over the phone by calling the Alcatel-Lucent Benefits Center at 1-888-232-4111 and speaking to a representative. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET). If

you are hearing or speech impaired, please use a Relay Service when calling a representative.

Changing Your Coverage During the Year--Qualified Status Changes and Special Enrollment Periods

Generally, once you enroll for coverage, you cannot change your coverage election during the calendar year. However, you may be able to change your coverage election during the year if you incur a "Qualified Status Change".

Qualified Status Changes

A "qualified status change" is a change in eligibility for coverage under the Medical Plan or another employer's plan due to one of the events listed in the following chart.

Please note: Your election change under the Medical Plan during the year must correspond with the type of qualified status change that has occurred. For example, if you and your Covered spouse divorce, you must drop your spouse from coverage, but you may not change your Medical Plan option. As long as you enroll within the required timeframe, coverage will be retroactive to the date of the qualified status change.

Qualified Status Change	Description
Change in Marital Status	Your marriage, divorce, legal separation, annulment or the death of your Lawful Spouse.
Change in the Number of Eligible Dependents	The birth, death, legal adoption, or placement for legal adoption of one of your Eligible Dependents.
Employment Status	A termination or commencement of employment by you, your spouse or Child.
Change in Employment Status	You, your Lawful Spouse, or other dependent becomes employed or loses employment.
Your Dependent Meets or No Longer Meets the Eligibility Requirements	An event that causes a dependent to meet or to no longer satisfy the Medical Plan's eligibility requirements, for example, a Child reaches the maximum age for coverage or gets married.
Change in Residence (includes moving out of a POS area)	A change in permanent residence for you, your Lawful Spouse, or an Eligible Dependent.
Significant Cost or Coverage Changes	A significant change in the cost or coverage under the Medical Plan or another employer-sponsored plan in which one of your Eligible Dependents can participate.

Qualified Status Change	Description
Court-Ordered Coverage	A change in your responsibility to provide healthcare coverage for a dependent Child as stipulated in a judgment, decree or court order resulting from a divorce, legal separation, annulment or change in legal custody (for example, a Qualified Medical Child Support Order). Documentation must be submitted (see "Qualified Medical Child Support Order Benefit Payments" in **Section Q. Other Important Information**). If a dependent specified in the judgment, decree or court order does not meet the eligibility criteria of a Dependent as defined by the Plan, the Dependent is no longer eligible for coverage under the Medical Plan and must be removed from coverage immediately. The Dependent may be eligible for COBRA coverage and you and/or your Dependent will be sent information about the cost of this coverage after you notify the Alcatel-Lucent Benefits Center at 1-888-232-4111 about the Dependent's status change. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).
End of COBRA Continuation Coverage	You may be able to enroll in the Medical Plan during the year if COBRA coverage from another plan for you, your spouse or dependent is exhausted during the year. However, you must continue COBRA coverage for the full duration of the COBRA coverage period. If you do not exhaust the COBRA coverage, you will have to wait until Annual Open Enrollment, even if the COBRA coverage ends mid-year due to, for example, a failure to pay premiums. For more information, visit the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent or call the Alcatel-Lucent Benefits Center at telephone (1-888-) 232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).
Enrolled Retiree Marries or Acquires a Child Through Birth, Legal Adoption or Placement With You for Legal Adoption	If you are already enrolled and you marry, have a Child, legally adopt a Child, or a Child is placed with you for legal adoption, you may enroll your spouse and/or your newborn or newly adopted Child (or Child newly placed with you for adoption), provided you request the enrollment within 31 days after your marriage, or the birth, adoption, or placement for adoption of your Child (as the case may be).
Eligible **Non-Enrolled** Retiree Marries or Acquires a Child Through Birth, Legal Adoption or Placement With You for Legal Adoption	If you are eligible, but had not enrolled in the Medical Plan as of the date of your marriage, or the date of the birth, legal adoption or placement for legal adoption, you may enroll yourself, your spouse and/or your newborn or newly adopted Child (or Child placed with you for adoption), provided you request the enrollment within 31 days after your marriage or the birth, adoption or placement for adoption of your Child (as the case may be).

Please note: If your spouse's or Domestic Partner's employer's plan has a different enrollment period, this is not considered a qualified status change. For example, if one plan's annual enrollment period is in October and the other plan's annual enrollment period is in November, you may not make changes to your coverage under this Plan as a result of the different timing of the enrollment periods.

The Company also considers corresponding changes in Domestic Partnership Dependents as qualified status changes; however, a Domestic Partnership Dependent may only be Covered under the Medical Plan if he or she was Covered at some point during your active employment.

Enrolling an Eligible Dependent During the Year
To enroll a new dependent during the year, visit the Your Benefits Resources Web site and go directly to your list of plans. Choose one (in this case, medical) and choose your coverage option. Then you'll choose which of your dependents to cover under that option and update their personal information at the same time.

New Dependents/Spouse of a Non-Enrolled Retiree
If you are eligible but not enrolled, you may enroll an individual (spouse or Child) who becomes your Eligible Dependent as a result of marriage, birth, adoption or placement for adoption. However, you (the non-enrolled employee) also must be eligible to enroll and actually enroll at the same time.

Special Enrollment Period for Newborns, Newly Adopted Children and Children Newly Placed With You for Adoption
There is a special enrollment period for you to enroll your newborn Child, your newly adopted Child, a Child placed with you for adoption or a Child for whom you, or you and your Lawful Spouse or Domestic Partner, have been newly appointed as the legal guardian. The special enrollment period begins on the day the Child is born, adopted or placed with you for adoption, or the day you, or you and your Legal Spouse or Domestic Partner, are appointed legal guardian and ends on the 60th day thereafter.

Enrolling a Newborn
It is not necessary to wait to have a Social Security Number for a newborn child in order to enroll the child in the Medical Plan.

If timely enrollment occurs during the special enrollment period described above, coverage for the Child, for your Lawful Spouse or Domestic Partner and, if applicable, for you, will be retroactive to the Child's date of birth, date of adoption or placement for adoption, or date of your, or your and your Lawful Spouse's or Domestic Partner's, appointment as legal guardian, as the case may be. If you do not enroll during the 60-day special enrollment period, you will have to wait until the next Annual Open Enrollment period to enter the Plan.

Please note: To enroll your Domestic Partner and your Domestic Partner's dependent Children, your Domestic Partner must have been Covered by you as

a dependent under the Medical Plan at some time while you were an active employee.

To enroll your newly acquired Child during the special enrollment period described above, contact the Alcatel-Lucent Benefits Center at 1-888-232-4111.

Special Enrollment Period for Newly Acquired Dependents Other Than Newborn, Newly Adopted Children and Children Newly Placed With You for Adoption

There is also a special enrollment period for you to enroll a "newly acquired dependent" other than a newborn Child, newly adopted Child, a Child newly placed with you for adoption, or a Child for whom you, or you and your Lawful Spouse or Domestic Partner, have been newly appointed as legal guardian. Examples of such a newly acquired dependent are:

- If you get married, your new Lawful Spouse;
- If you enter into a Domestic Partnership relationship, your new Domestic Partner (only if this Domestic Partner was Covered by you as a Dependent under the Medical Plan at some time while you were an active Employee); or
- If you get married or enter into a Domestic Partnership relationship, your new Lawful Spouse's Children (your stepchildren) or new Domestic Partner's Children (only if this Domestic Partner was Covered by you as a Dependent under the Medical Plan at some time while you were an active Employee.

The special enrollment period begins on the day you get married or enter into a Domestic Partnership relationship, if applicable, as the case may be, and ends on the 31st day thereafter. If you are not then already enrolled in the Plan, you must also enroll yourself in the Plan.

Coverage under the Plan for your Lawful Spouse or Domestic Partner, your Lawful Spouse's or Domestic Partner's Children and, if applicable, for yourself, will be retroactive to the date of your marriage or the date of entering into the Domestic Partner relationship. If you do not enroll during the 60-day special enrollment period, you will have to wait until the next Annual Open Enrollment period to enter the Plan.

To enroll a new dependent (and, if not already enrolled in the Plan, yourself) during the special 31-day enrollment period described above, visit Your Benefits Resources online at http://resources.hewitt.com/alcatel-lucent, or contact the Alcatel-Lucent Benefits Center at 1-888-232-4111.

If you experience one of the events described in this section and need to change your coverage during the calendar year, you must report the event within **31** days of its occurrence online through the Your Benefits Resources Web site at http://resources.hewitt.com/lucent or by calling the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET). If you don't, you can't make a coverage change until the next Annual Open Enrollment, unless you once again meet one of the conditions for a qualified status change during the year.

Declining Coverage
You can decline coverage under the Medical Plan. However, you must wait until the next Annual Open Enrollment if you want to re-enroll.

Confirming Your Election
When using the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent to enroll online, be sure to print the "Completed Successfully" page, which will serve as your confirmation statement.

Review the Elections You Made
Be sure to review the elections you made carefully and report any discrepancies to the Alcatel-Lucent Benefits Center immediately.

You will receive a confirmation statement after you enroll or change benefits during Annual Open Enrollment or at any other time during the year when you enroll or change benefits through the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

If You Move

A move may require a change in your Medical Plan option or the Health Plan Carrier that administers your benefits.

Please note: If you are not Medicare-eligible and your home zip code isn't in a designated POS area, you still may be eligible to elect POS coverage in a nearby Network that is available to other Medical Plan participants. Visit the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent or contact the Alcatel-Lucent Benefits Center at 1-888-232-4111 to find out whether or not there's an eligible POS Network in your area and to elect this option. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

If You Need to Change Your Medical Plan Option
If you are not Medicare-eligible and your move requires that you change your Medical Plan option and you do not make a selection within the required time, you will be enrolled in the Default Option for that area.

If Your Home Address Changes
If you are a retiree, you should call the Pension Service Center before, or as soon as possible after, you move. This ensures that your benefits will continue uninterrupted and that you receive your pension check on time, if applicable.

If you are a dependent of a retiree, it's important to call the Alcatel-Lucent Benefits Center at 1-888-232-4111 with your new address.

When You Are Not Medicare-Eligible[3]

The following chart explains Medical Plan rules regarding Plan coverage if you are not Medicare-eligible when you move.

If...	And you move...	The rule is...
You are enrolled in the **POS** option	Into another area where your Health Plan Carrier administers the POS option	You stay in the POS option and keep the same Health Plan Carrier.
You are enrolled in the **POS** option	Into an area where a different Health Plan Carrier administers the POS option	You stay in the POS option, but you transfer to the Health Plan Carrier that administers the POS option in that area.

[3] If your move requires that you change your enrollment option and you do not make a selection within the required time, you will be enrolled in the Default Option for that area (see **Section B. Joining the Medical Plan).**

If...	And you move...	The rule is...
You are enrolled in the **POS** option	Into an area where the POS option is not available	You may select one of the options available (Traditional Indemnity or HMO option) in your new area. You may be able to opt into a nearby POS option. Your Health Plan Carrier will change as applicable. If you make no election, the Traditional Indemnity option will be assigned. Your Health Plan Carrier will change as applicable
You live outside a POS Network area and are enrolled in the Traditional Indemnity option	Into a POS Network area	You may select one of the options available in your new area — either the POS or an HMO. Your Health Plan Carrier may change, depending on your election and which Health Plan Carrier administers your selection in your new area.
You are enrolled in an HMO	Outside of the area serviced by your current HMO	You must select from the options available in your new area, including HMOs. The available options will depend on whether or not you move into a POS Network area.

If you are not Medicare-eligible, your Medicare-Eligible Dependents will remain in the Traditional Indemnity option, when you move.

Remember, POS coverage may be available to you, even if you live outside a designated POS area. Contact the Alcatel-Lucent Benefits Center at 1-888-232-4111 for details. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

For information about what happens if your coverage option changes, see "Changing Your Coverage During the Year" in **Section B. Joining the Medical Plan**.

If You Are Medicare-Eligible When You Move

If you are Medicare-eligible when you move, you will remain in whichever option you are enrolled in (unless you move outside of the United States (in which case, you would be in the Traditional Indemnity option), unless it is not available in your new location.

If you have dependents who are not yet Medicare-eligible, they will continue to be Covered under the POS option or Traditional Indemnity option — depending upon which they are enrolled in and what's available in your new location.

Medical Plan Contributions

You will be direct billed on a monthly basis for your contribution, if any, toward the cost of coverage under the Medical Plan. However, if you are receiving pension checks from Alcatel-Lucent, you may contact the Alcatel-Lucent Benefits Center to request that your contribution be deducted from your pension check.

Important Direct Bill Information
All amounts due through direct bill must be paid in full before switching to monthly pension deductions. In addition, if your monthly pension payments cannot support the monthly deductions required for healthcare and life insurance coverage, you will need to remain on direct bill.

During Annual Open Enrollment, you will find cost information for all the available options on the Your Benefits Resources Web site at http:/resources.hewitt.com/alcatel-lucent and on your personalized enrollment worksheet, included in your enrollment packet.

Retiree Medical Caps

If you are a former Lucent employee, Alcatel-Lucent may subsidize a portion of your annual medical premiums up to a certain amount, which is typically based on your status, your date of retirement and your years of service. The applicable retiree medical cap is the maximum amount contributed by the Company to the cost of the monthly premiums for your Medical Plan coverage. The Retiree Medical Caps may be changed, or eliminated, by the Company at any time in its discretion.

If You Retired On or After March 1, 1990
If you retired from Lucent on or after March 1, 1990 and your annual base salary at retirement was equal to or greater than $65,000, you will receive the retiree medical cap for individual coverage (if available according to your Medicare-eligibility), regardless of the number of dependents you cover.

Please note: Since Medicare becomes your primary coverage when you turn age 65, your retiree medical cap subsidy amount reflects that change.

Tax Treatment of Domestic Partner Dependent Coverage

Under current law, you cover your Domestic Partner and your Domestic Partner's children with after-tax contributions, and the amount of the Company's cost to cover them is reported as taxable income to you each month.

This taxable income is subject to both income tax and FICA withholding. The amount of taxable income depends on the medical option you elect and on whom you elect to cover.

For more information about the tax implications of covering a Domestic Partnership Dependent under the Medical Plan, please consult with your personal tax advisor.

Visit the Your Benefits Resources Web site at http://resources.hewitt.com/lucent, or call the Alcatel-Lucent Benefits Center at 1-888-232-4111 for your actual contributions. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

Section C. How the Medical Plan Options Work

About Your Medical Plan Options

The Medical Plan offers four coverage options:

- Point-of-Service (POS) options:
- The Traditional Indemnity option;
- The SecureHorizons® MedicareDirect™ , a Medicare Advantage Private Fee-For-Service (PFFS) Plan; and
- An HMO option (depending on your geographic area).

Check Out Section A. Medical Plan Benefits-At-a-Glance
This section, near the beginning of this SPD, provides a high-level quick reference to major Medical Plan provisions. This section provides more details about these and other Plan provisions.

While the options cover many of the same services and supplies, you will see differences between the options in how you obtain care and how you pay for that care.

The options available to you are based on your:

- Geographic location; and
- Medicare-eligibility status (eligible or non-eligible).

Available Medical Plan Options

The following chart highlights the options available to you based on Medicare-eligibility:

You **Are** Medicare-eligible and you have one or more dependents not eligible for Medicare.	**If you (and any Medicare-Eligible Dependent[s]) have the following coverage:**	**Then any dependent(s) not eligible for Medicare has the following coverage:**
	SecureHorizons® MedicareDirect™ PFFS Plan[4] with the Medco Medicare Prescription Drug Plan	POS medical and prescription drug coverage — if there is a UnitedHealthcare POS in your area; otherwise, Traditional Indemnity medical and prescription drug coverage
	Medicare Advantage HMO with Medicare Advantage HMO prescription drug coverage	HMO with HMO prescription drug coverage
You are **not** eligible for Medicare, but you have one or more Medicare-Eligible Dependents	**If you (and any dependent[s]) not eligible for Medicare have the following coverage:**	**Then any Medicare-Eligible Dependent(s) will have the following coverage:**
	POS medical and prescription drug coverage	Traditional Indemnity, with Medicare primary, and the Medco Medicare Prescription Drug Plan
	Traditional Indemnity medical and prescription drug coverage	Traditional Indemnity, with Medicare primary, and the Medco Medicare Prescription Drug Plan
	HMO, with HMO prescription drug coverage	Medicare Advantage HMO, with Medicare Advantage HMO prescription drug coverage

Please note: If you are on the Family Security Plan (FSP) and are not a Medicare-eligible survivor of a retired management employee, you have access to the Traditional Indemnity option only. If you are Medicare-eligible, you have access to SecureHorizons® MedicareDirect™ PFFS Plan or Medicare Advantage HMOs.

[Also note that SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS) Plan information is included in

[4] Former Alcatel employees who retire on or after January 1, 2008 are not eligible for SecureHorizons.

Appendix A. SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS)--Retiree Benefits Summary Insert at the end of this SPD.]

If You Live Outside of a POS Area

If you do not live in a designated POS area (based on your home zip code) and are not Medicare-eligible, you may elect coverage under a nearby POS option that is available to other Medical Plan participants. Visit the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent, or call the Alcatel-Lucent Benefits Center at 1-888-232-4111 to confirm whether or not you live in a designated POS area. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

Your Share of Eligible Expenses

Annual Deductible

The annual Deductible is the amount you will be required to pay each calendar year before the Medical Plan will begin to pay benefits for most Covered services. Up to two separate annual Deductibles may apply each year — medical (including the Mental Health and Chemical Dependency (MH/CD) Program) and the Medco Medicare Prescription Drug Program, depending on the option and your Medicare eligibility. Your Medical Plan option, the type of service or supply and whether care is received In-Network or Out-of-Network determines whether you must satisfy a particular Deductible before the Plan will pay benefits. Your Deductibles are based on your Medical Plan option (see **Section A. Medical Plan Benefits At-a-Glance** for Deductible amounts).

The individual, two-person and family Deductibles (for the Enhanced POS Out-of-Network care and the Traditional Indemnity option) are described below:

- **Individual Deductible.** This is the amount each Covered person pays during a calendar year for Covered services under the Enhanced POS (Out-of-Network care) and the Traditional Indemnity option before the Plan starts paying benefits.

- **Two-person Deductible.** When two participants in the same family have expenses that, added together, equal the two-person Deductible, the Enhanced POS (Out-of-Network) or Traditional Indemnity option begins paying benefits, regardless of whether an individual has met his or her individual Deductible.

- **Family Deductible.** When three or more participants in the same family have expenses that, added together, equal the family Deductible, under the Enhanced POS (Out-of-Network) or Traditional Indemnity option, the Plan begins paying benefits, regardless of whether an individual has met his or her individual Deductible.

  For example, let's say you are in the Enhanced POS option, which has a $500 individual Deductible, and you use Out-of-Network services for which the Deductible applies. You and your Covered Dependents Out-of-Network Services are applied to the individual Deductibles as follows:

Enrolled Family Member	Amount of Covered Expenses Applies to Their Out-of-Network Individual Deductibles
You	$ 200
Your Lawful Spouse	$ 300
Child 1	$ 400
Child 2	$ 200
Child 3	$ 400
Family Deductible Is Met	**$1,500**

  In the above example, none of your family members satisfied his or her individual Deductible of $500, but together satisfied the family Deductible of $1,500. This means that no further Annual Deductibles need to be satisfied under the Enhanced POS option (not including Deductibles under the Prescription Drug Program) for the remainder of the calendar year.

Expenses That Don't Count Toward the Annual Deductible

Certain expenses that you pay don't count toward the annual Deductibles of any of the Medical Plan options or the Prescription Drug Program. These expenses include:

- Charges for expenses that aren't Covered under your Medical Plan option or the Prescription Drug Program (see **Section H. What's Not Covered**);

- Any charges above the Allowable Amount;

- Any penalties for not obtaining Precertification (see **Section F. When Precertification Is Required Under the POS and Traditional Indemnity Options**); and

- Coinsurance for Out-of-Network services.

Prescription Drug Program Annual Deductible

The Medco Medicare Prescription Drug Program under the Enhanced and Standard POS options and the Traditional Indemnity option for participants who are **not** Medicare-eligible do not include an annual Deductible. However, the Medco Medicare Prescription Drug Program under the Traditional Indemnity option and SecureHorizons® MedicareDirect™ PFFS Plan for Medicare-eligible participants include an annual Deductible. The Deductibles and Out-of-Pocket Maximums for the Prescription Drug Program are separate from the Deductibles and Out-of-Pocket Maximums for the POS option, Traditional Indemnity option, and SecureHorizons® MedicareDirect™ PFFS Plan (see "Annual Deductible" in this section; see **Section A. Medical Plan Benefits At-a-Glance** for Deductible amounts).

Mental Health and Chemical Dependency Annual Deductible

The Deductibles and Out-of-Pocket Maximums for the Mental Health and Chemical Dependency (MH/CD) services are combined with the Deductibles and Out-of-Pocket Maximums for the POS option, Traditional Indemnity option, and SecureHorizons® MedicareDirect™ PFFS Plan (see "Annual Deductible" in this section; see **Section A. Medical Plan Benefits At-a-Glance** for Deductible amounts).

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum amount you are required to pay each calendar year for Covered expenses.

Under the POS and Traditional Indemnity options, there are individual, two-person and family medical annual Out-of-Pocket Maximums. The following explains how each type of annual Out-of-Pocket Maximum works:

- **Individual annual Out-of-Pocket Maximum.** Once a Covered person reaches the annual Out-of-Pocket Maximum, the applicable options pay 100 percent of the Allowable Amount for Covered healthcare expenses for that person for the rest of the calendar year.

- **Two-person annual Out-of-Pocket Maximum.** When two participants in the same family have expenses that, added together, equal the two-person annual Out-of-Pocket Maximum, the applicable options pay 100 percent of the Allowable Amount of Covered healthcare expenses for those persons for the rest of the calendar year.

- **Family annual Out-of-Pocket Maximum.** When at least three participants in the same family have each met their individual annual Out-of-Pocket Maximums during the calendar year, the applicable options pay 100 percent of the Allowable Amount for Covered healthcare expenses for all Covered participants for the rest of that calendar year, regardless of whether an individual has met his or her individual annual Out-of-Pocket Maximum.

Expenses That Don't Count Toward the Out-of-Pocket Maximum
Certain expenses you must pay don't count toward the Out-of-Pocket Maximums under the Medical Plan options. These include:

- Charges for expenses that aren't Covered under your Medical Plan option

- Any charges above the Allowable Amount;

- Any penalties for not obtaining precertification; and

- Expenses applied toward any required Deductibles.

Prescription Drug Program Out-of-Pocket Maximum
There is no Out-of-Pocket Maximum under the Prescription Drug Program.

POS Options for Non-Medicare-Eligible Participants

The Enhanced and Standard POS options are available to non-Medicare-Eligible Retirees and their Eligible Dependents that reside within a POS geographic location.

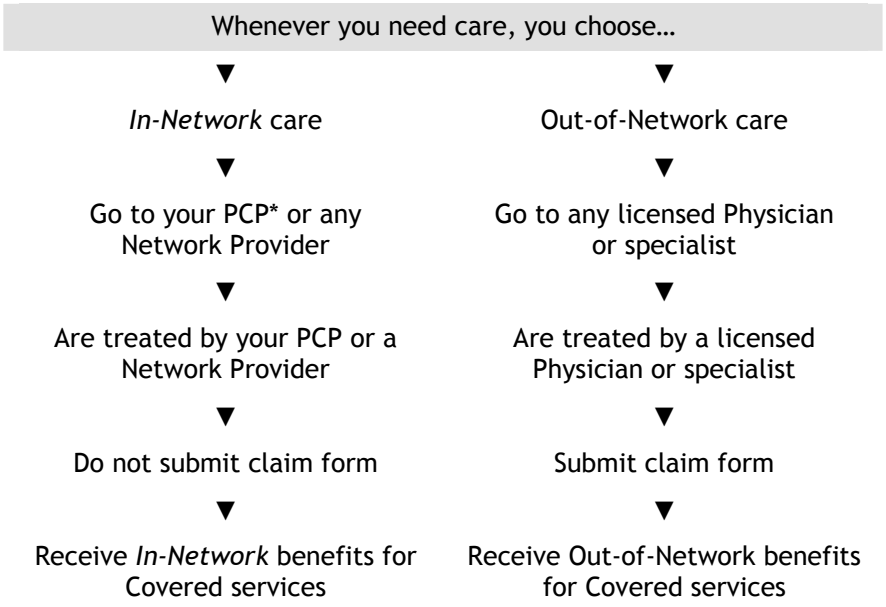
With a POS option, you have a choice each time you need medical care — you can receive *In-Network* or Out-of-Network care. When you receive *In-Network* care, your out-of-pocket costs are generally lower. In addition, the Medical Plan may cover certain preventive care services on an *In-Network* basis, but not when you receive this care Out-of-Network.

When you receive Out-of-Network care, your out-of-pocket costs are generally higher, plus you may need to satisfy a Deductible.

When you enroll in a POS option, you also have access to a Prescription Drug Program through Medco Health Solutions, Inc. (Medco) and the Mental Health and Chemical Dependency Program.

How a POS Option Works

Depending on whether you seek *In-Network* or Out-of-Network care, a POS option works differently, as shown in the chart below:



*You may, but are not required to, select a Primary Care Physician (PCP) for your *In-Network* care.

In-Network Care: Generally Higher Benefits

Generally, you will experience these advantages when you receive care on an *In-Network* basis:

- You don't pay a Deductible;
- You don't need to submit claim forms and wait to be reimbursed;
- Your Provider obtains any needed precertification for you;
- You only pay a small Copayment or lower Coinsurance for many Covered services; and
- Certain preventive care services are available that aren't Covered on an Out-of Network basis.

If You Need Specialized Care
If you need specialized care that your Medical Plan option's Health Plan Carrier determines is Medically Necessary and is not available in your area, you'll be referred to an out-of-network Provider and benefits will be paid at the *In-Network* level. Contact your Health Plan Carrier for more information.

The Provider Network

The POS options make available to you a Network of Providers — including Physicians, Hospitals, Home Health Care Agencies and Extended Care Facilities.

Through the Network, you will have access to the full range of services necessary to meet your healthcare needs.

To obtain a current listing of Network Providers, visit your Medical Plan option's Web site or call their Member Services phone line, as shown on your medical ID card.

The Role of a PCP
You are encouraged (although not required) to select a Primary Care Physician (PCP) when you enroll in a POS option. By doing so, you may establish a relationship with a Physician who can better manage your care — including helping you navigate the healthcare system. Your PCP can be a general practitioner, a family practitioner, an internist or a pediatrician. He or she can:

- Provide healthcare at the *In-Network* level;
- Arrange *In-Network* Hospitalization, testing and other services for you;
- Handle *In-Network* precertification, if needed; and
- Handle claims for most of your *In-Network* care, so there's little or no paperwork for you.

Availability of Your PCP
PCPs provide services 24 hours a day, seven days a week. When your PCP is unavailable, another Physician will be available to take your call or to see you. If you call after normal business hours, an answering service generally takes your call and asks your PCP or the covering Physician to call you.

Selecting or Changing Your PCP
You are not required to choose a PCP; however, a PCP can play an important role in your ongoing healthcare (see "The Role of a PCP" earlier in this section). You can choose the same PCP for all family members, or each Covered family member can have a different PCP. In addition, you can change your PCP at any time and for any reason.

During your initial enrollment, you may select your PCP through Your Benefits Resources Web site. After that, you can change your PCP through your Health Plan Carrier's Web site or by calling your Health Plan Carrier's Member Services at the telephone number listed on your medical ID card. The change will be effective the day you call to select or change your PCP, and you will be sent a new medical ID card. For a list of current PCPs, contact your Health Plan Carrier's Member Services or visit the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent. **(Please note:** Due to Centers of Medicare and Medicaid Services (CMS) rules, SecureHorizons® MedicareDirect™ PFFS Plan does not publish names of participating Providers or list them on a website.)

Out-of-Network Care: More Flexibility, Lower Benefits
When you receive care Out-of-Network, you may use any healthcare Provider you choose. However, the cost of your care on an Out-of-Network basis generally will be higher than if you received the same care *In-Network* (see **Section A. Medical Plan Benefits At-a-Glance**). For example:

- Each year, in most cases, you will be required to satisfy an annual Deductible before the Medical Plan begins to pay benefits under the Enhanced POS.

- After you satisfy your annual Deductible under the Enhanced POS, the Medical Plan will reimburse you for a portion of your eligible expenses; you will pay for the rest. The percentage you pay is called your Coinsurance percentage. You may also be responsible for a copayment.

- The Medical Plan will not cover any benefit reductions due to failure to precertify certain treatments.

- The Medical Plan will not cover any charges above the Allowable Amount.

There are other responsibilities that you have when you elect Out-of-Network care that are not required when you obtain care *In-Network*.

- You are responsible for the precertification of certain Covered services and supplies. (*In-Network*, your Provider obtains any needed precertification for you.) If you don't obtain the required precertification, the amount of benefits available will be reduced, or the Medical Plan may not Cover the services and supplies at all. For more information, see **Section F. When Precertification Is Required Under the POS and Traditional Indemnity Options**.

- You must complete claim forms and file claims with your Health Plan Carrier to receive payment of benefits. In many instances, the Provider will expect you to pay for a Covered service upfront and then seek reimbursement from the Medical Plan.

Required Precertification
The decision of whether or not to undergo any given treatment is for you and your Physician to make. However, since there are many types of services for which alternatives may be appropriate, the Plan may require that you precertify them. For more information, see **Section F. When Precertification Is Required Under the POS and Traditional Indemnity Options**.

Emergency Care
In an Emergency, you or your Covered Dependent should get care immediately. However, to receive benefits at the *In-Network* level:

- The care must be provided by a Network Provider; or

- The situation must qualify as an Emergency under the POS option, and

- You must precertify this care within the appropriate timeframe (see **Section F. When Precertification Is Required Under the POS and Traditional Indemnity Options**).

If these conditions aren't satisfied, benefits for Covered services will be paid at the Out-of-Network level. To avoid any misunderstandings and to determine if a condition rises to the level of an Emergency, contact your Health Plan Carrier for guidance (see the definition of "Emergency" in **Section O. Terms to Know**).

Receiving Care Away From Home
If you or a Covered Dependent needs care when away from home:

- Go to any Network Provider, and care will be Covered at *In-Network* benefit levels; or

- Go to any Out-of-Network Provider, and care will be Covered at Out-of-Network benefit levels.

Please note: In the case of an Emergency, you or your Covered Dependent can go to an Out-of-Network Provider, and care will be Covered at *In-Network* benefit levels as long as you precertify this care within the appropriate timeframe (see **Section F. When Precertification Is Required Under the POS and Traditional Indemnity Options**).

Note further that, in the case of Urgent Care, you or your Covered Dependent can go to an Out-of-Network Provider, and care will be Covered at *In-Network* benefit levels as long as you:

- Call your Health Plan Carrier anytime before the treatment and/or admission to describe the situation; and
- Follow your Health Plan Carrier's instructions regarding the Urgent Care.

Any follow-up care provided by an Out-of-Network Provider must also be authorized by your Health Plan Carrier in order to be Covered at *In-Network* benefit levels.

Your Medical ID Card
You will receive a medical ID card after you enroll in the POS option.

Separate Prescription Drug Program ID Card
You'll receive a separate ID card for prescription drug coverage.

If you need to schedule a medical visit before receiving your medical ID card, your Physician or healthcare provider can confirm your coverage directly with your Health Plan Carrier. Also, Aetna's and UnitedHealthcare's Web sites allow you to print a copy of your medical ID card:

- **Aetna (if you are registered online through Aetna Navigator):** www.aetna.com
- **UnitedHealthcare:** www.myuhc.com

Member Services
Member Services is available to assist you with issues related to the POS option Monday through Friday during normal business hours. You can contact Member Services at the telephone number printed on your medical ID card or visit your POS option's Web site (see **Section P. Important Contacts**):

Call Member Services:

- To request a new Provider Directory or the latest information about Network Providers;
- To replace a lost medical ID card;
- To find out how a claim was paid;
- If you have a service issue with a Network Provider;
- To find out how your Covered Dependent Child away at college should obtain care;
- To get claim forms (generally only required for Out-of-Network care); and
- To obtain more detailed information about your benefit coverage.

Traditional Indemnity Option

The Traditional Indemnity option is available to:

- Medical Plan participants who live in non-POS areas
- Medicare-Eligible Dependents of Non Medicare-eligible participants (see "Coordination of Benefits When Medicare Is Primary" in **Section L. How Coordination of Benefits Works)**;
- Non-Medicare-Eligible Dependents of Medicare-Eligible participants (if a UnitedHealthcare POS is not available in your area); and
- Medicare-eligible participants and their dependent(s) residing **outside** of the U.S.

How the Traditional Indemnity Option Works

Under the Traditional Indemnity option:

- You and your Covered Dependents may go to any Physician you choose. Or, you may choose to take advantage of a special feature — the Preferred Provider Organization Network (PPO) — if one is available in your area.

Advantages of Using Traditional Indemnity PPO Providers

When you receive your medical care from PPO Network Providers, the charges generally are lower and guaranteed to be within the Allowable Amount. In addition, PPO Providers must meet strict quality guidelines to join and remain in the PPO. The names of current PPO Providers are available by calling UnitedHealthcare's (the Traditional Indemnity option's Health Plan Carrier) Member Services or by accessing the information through the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent.

- For most Covered services you receive each year, you will be required to pay an annual Deductible before the Medical Plan begins to pay expenses.

- After you satisfy your annual Deductible, the Medical Plan will pay for a portion of your eligible expenses; you will pay the rest. The percentage you pay is called your Coinsurance percentage.

- The Medical Plan will not cover any benefit reductions due to failure to precertify certain treatments.

- The Medical Plan will not cover any charge above the Allowable Amount.

- You will file claim forms to be reimbursed unless you use PPO Providers.

Required Precertification
The decision of whether or not to undergo any given treatment is for you and your Physician to make. However, since there are many types of services for which alternatives may be appropriate, the Plan requires that you precertify them (see **Section F. When Precertification Is Required Under the POS and Traditional Indemnity Options**).

Your Medical ID Card
You will receive a medical ID card after you enroll in the Traditional Indemnity option.

If you need to schedule a medical visit before receiving your medical ID card, your Physician or healthcare Provider can confirm your coverage directly with your Health Plan Carrier. Also, UnitedHealthcare's Web site allows you to print a copy of your medical ID card: www.myuhc.com

Filing a Claim
You **don't** need to submit a claim when you use PPO Providers; however, you **must** file a claim to request benefits when you **don't use** PPO Providers (see "Filing Deadlines" in **Section K. Claims and Appeals** for important information).

Member Services
UnitedHealthcare's Member Services is available to help you with issues related to the Traditional Indemnity option. Contact Member Services or visit UnitedHealthcare's Web site (see **Section P. Important Contacts**):

Call Member Services at the telephone number printed on your medical ID card Monday through Friday during normal business hours:

- To request a PPO Network directory;

- To replace a lost medical ID card;
- To get an explanation about how a claim was paid;
- If you have a service issue with a PPO Provider;
- To find out how your Covered Dependent Child away at college should obtain care;
- To get claim forms; and
- To obtain further details on benefit coverage.

HMO Options

A Health Maintenance Organization (HMO) is a Medical Plan option that generally requires you to follow the HMO's rules for obtaining care, which include:

Mental Health and Chemical Dependency and Prescription Drug Coverage
If you are Covered under the HMO option, mental health and Chemical Dependency and prescription drug benefits are provided by the HMO.

- A Primary Care Physician (PCP), coordinates your care;
- You will pay a Copayment to the Provider at the time of service;
- You usually don't pay any Deductibles or Coinsurance amounts;
- You aren't responsible for paying for any charges for Covered services that exceed the Allowable Amount;
- You don't need to file claim forms; and
- Services provided outside of the HMO's Network are Covered **only in certain Emergency situations**.

Coverage may vary from one HMO to another. If you have any questions about how an HMO works, contact the HMO directly.

You can access information about what HMOs are available in your area online through the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent or by calling the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

The Role of a PCP

Generally, you are required to select a PCP when you enroll in an HMO option. By doing so, you can begin to establish a relationship with a Physician who can

then better manage your care. Your PCP can be a general practitioner, a family practitioner, an internist or a pediatrician. He or she can:

- Provide your primary healthcare;
- Refer you to specialists;
- Arrange Hospitalization, testing and other services for you; and
- Handle claims, so there's little or no paperwork for you.

Availability of Your PCP

PCPs can be reached 24 hours a day, seven days a week. When your PCP is unavailable, another Physician will be available to take your call or to see you. If you call after normal business hours, an answering service generally takes your call and asks your PCP or the covering Physician to call you.

Selecting or Changing Your PCP

You can choose the same PCP for all family members, or each Covered family member can have a different one. When you enroll for the first time through the Your Benefits Resources Web site, you can elect your PCP at that time. In general, you can change your PCP through your HMO's Web site or by calling your HMO's Member Services at the telephone number listed on your medical ID card. You can change your PCP at any time, for any reason.

How to Find a PCP
The names of current PCPs in your HMO are available by accessing your HMO's Website or by calling your HMO's Member Services.

Domestic Partnership Dependent Coverage Availability

Some HMOs do not offer coverage to Domestic Partnership Dependents. While some do, they may condition the availability of coverage on the duration of the Domestic Partnership. For more information about a particular HMO's enrollment limitations, contact the HMO directly.

Medicare Advantage HMOs

Medicare Advantage HMOs — which are available to Medicare-eligible Plan participants — cover Hospital expenses, Outpatient Hospital care, Physicians' services and other medical services. They may offer additional benefits such as preventive care, vision care, hearing care and prescription drug coverage (Medicare Part D). You must be eligible for benefits under Medicare Part A and enrolled in Part B to be eligible for a Medicare Advantage HMO (Medicare Part C).

Medicare Advantage HMOs are offered by private healthcare companies and must get special approval by the Centers for Medicare and Medicaid Services (CMS) before they can be offered to the public. Medicare Advantage HMOs may or may not be available to you, depending on where you live.

Medicare Advantage HMOs generally provide a higher level of benefit coverage then traditional Medicare if you use participating Physicians and follow plan rules. You may pay a monthly premium, which may vary depending on the Health Plan Carrier offering the HMO and the level of benefits provided, and your required share of expenses.

By enrolling in a Medicare Advantage HMO available through the Company, you are agreeing to receive standard Medicare Part A and Part B services through the Medicare Advantage HMO. Other coverage that you have outside of the Company — including prescription drug coverage — may be impacted.

If you enroll in a Medicare Advantage HMO, you must:

- Continue to pay the Medicare Part B premium. There is no coordination between Medicare and Medicare Advantage HMOs. Once you enroll in a Medicare Advantage HMO, your healthcare is provided solely through that HMO.

- Complete the necessary paperwork provided by the Alcatel-Lucent Benefits Center.

SecureHorizons® MedicareDirect™ PFFS Plan (Medicare-Eligible Participants)

[See **Appendix A. SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS)--Retiree Benefits Summary Insert** at the end of this SPD for information about coverage under SecureHorizons® MedicareDirect™ PFFS Plan.]

Benefit Limits and Maximums

Benefits for Certain Covered services may be subject to annual, occurrence or lifetime maximums. No additional benefits will be paid once the applicable limit is reached. Most are annual limits and are restored automatically at the beginning of the next calendar year. See **Section A. Medical Plan Benefits At-a-Glance** for details. Also see **Section H. What's Not Covered** for a list of services that aren't Covered under the POS option, the Traditional Indemnity option, the SecureHorizons® MedicareDirect™ PFFS Plan, the Mental Health and Chemical Dependency (MH/CD) Program or the Prescription Drug Program.

Section D. What's Covered Under the POS and Traditional Indemnity Options

Covered Services and Conditions of Service

To be a "Covered service" under the POS and Traditional Indemnity options, the service must:

What's Covered Under an HMO
If you have questions about what's Covered under an HMO, contact the HMO directly.

- Be Medically Necessary for the treatment of illness or injury or it must be for the preventive care benefits that are specifically Covered under the POS and Traditional Indemnity options;
- Be provided under the order or direction of a Physician;
- Be provided by a licensed and accredited healthcare Provider practicing within the scope of his or her license in the state where the license applies;
- Be listed as a Covered service under the POS and Traditional Indemnity options and satisfy all the required conditions of service; and
- Not be excluded under the POS and Traditional Indemnity options (see **Section H. What's Not Covered**).

In addition, you must meet certain conditions for some services in order to receive benefits. This section highlights, in alphabetical order, the Covered services and, in some instances, the conditions under which the Medical Plan will pay for these Covered services. For cost-sharing information about a specific Covered service, refer to **Section A. Medical Plan Benefits-At-a-Glance** near the beginning of this SPD

Acupuncturist's Services

The following Acupuncturist's services are Covered under the POS and Traditional Indemnity options:

- Use of acupuncture instead of traditional anesthesia during surgery, and
- Acupuncture to relieve pain, illness or impaired mobility in the muscles and joints.

Both of the following conditions of service apply to Covered services provided by an Acupuncturist:

- Limitations apply Out-of-Network under the Enhanced POS and under the Traditional Indemnity option (see **Section A. Medical Plan Benefits At-a-Glance** near the beginning of this SPD). However, use of acupuncture as a surgical anesthetic doesn't count toward the limit on your number of acupuncture visits.
- Coverage is provided only for an acute condition (one that is currently causing pain, illness or decreased mobility and for which improvement can be measured in the short term). Periodic visits for preventive care or to maintain a current state of health aren't Covered.

Ambulance

The following Ambulance services are Covered under the Enhanced and Standard POS and Traditional Indemnity options:

- Transportation to the nearest appropriate medical facility in an Emergency;
- Medically Necessary Emergency services (including administering to wounds, electrocardiograms, cardiac defibrillation, cardiopulmonary resuscitation [CPR] and administration of oxygen and intravenous [IV] solutions) delivered by appropriately licensed personnel employed by the Ambulance company;
- Transfer from an Out-of-Network to an *In-Network* Hospital (only applies if Covered under one of the POS options)
- Transfer to the closest qualified Hospital if the first Hospital isn't equipped to handle the patient's condition;

- Transfer from a Hospital to an Extended Care Facility or transfer from a Hospital or an Extended Care Facility to the patient's home if the:

  — Patient is being discharged into a Home Health Care Agency's care,

  — Patient's condition requires a medical professional's attendance, and

  — Extended Care Facility or home healthcare was precertified.

Please note: All elective (or nonemergency) transportation by Ambulance or medical van must be precertified.

Air Ambulance
Air Ambulance is Covered only when the participant is in a location that is inaccessible to ground Ambulance or the patient's status and travel conditions indicate that delays in use of ground Ambulance would create significant and unnecessary risk to the patient, and the risk would be clearly diminished with the use of an air Ambulance.

Please note: All elective (or nonemergency) transfers by air Ambulance must be precertified.

Blood and Blood Derivatives

Blood and blood derivatives are Covered when Medically Necessary for treatment or therapy due to an illness or injury, and include blood, blood plasma and other blood products.

Centers of Excellence

Each Health Plan Carrier has arrangements with certain facilities to act as Centers of Excellence to treat special conditions such as organ transplants. Under the POS options, if you are referred to a Center of Excellence through the precertification process, you will receive *In-Network* benefits. Under the Traditional Indemnity option, you must be referred through the precertification process to receive benefits.

Covered services include Medically Necessary services certified by the Health Plan Carrier as requiring the specialized care generally associated with a Center of Excellence, such as organ transplants.

Treatment at a Center of Excellence is subject to all conditions of service that apply to any treatment of illness or injury, including the exclusion of an Experimental or Investigational Treatment, Drug or Device.

Travel and Lodging Benefit
If you or a Covered Dependent is referred to a Center of Excellence more than 50 miles from your home for non-Experimental transplant surgeries, certain travel and lodging expenses are Covered for the patient and an accompanying family member or individual essential to your ability to receive care as approved by the Health Plan Carrier. Call your Health Plan Carrier for additional information.

Chiropractic Services

The following chiropractic services are Covered under the POS and Traditional Indemnity options:

- Neuromuscular treatment and manipulation to relieve pain or restore mobility by maladjustment of the muscles and ligaments associated with the spinal column, and

- Ordering Medically Necessary X-rays.

The following conditions of service apply to Covered chiropractic services:

- A Physician's referral is not required under the POS and Traditional Indemnity options.

- Coverage is provided only for treatment of musculoskeletal conditions — meaning conditions that are related to the muscles and ligaments. Conditions such as a stiff neck and lower back pain may be Covered. Conditions such as nausea and dizziness are **not** Covered for treatment with chiropractic services.

- Coverage is provided only for the treatment of an acute condition — that is, one that is currently causing pain or decreased mobility, and for which improvement can be measured in the short term. Periodic visits for preventive care or to maintain a current state of health are not Covered.

- Care must be provided in an office setting. Services are not Covered if provided in your home, or if delivered in a Hospital or other facility.

- A Chiropractor may order X-rays when Medically Necessary. However, any other tests (for example, a magnetic resonance image, or MRI) must be ordered through a Physician.

- Under the Enhanced and Standard POS options, coverage is limited to 30 visits in a calendar year, *In-Network* and Out-of-Network combined. Under the Traditional Indemnity option, coverage is limited to 30 visits per calendar year.

Circumcision

Circumcision of a newborn male is Covered if performed by a Physician or *mohel*. Under the Enhanced and Standard POS options, Out-of-Network benefits are available only if a *mohel* performs the circumcision.

Durable Medical Equipment

Purchase or rental of durable medical equipment is Covered, if prescribed by a Physician and determined to be Medically Necessary. Examples include wheelchairs, kidney dialysis equipment and mechanical equipment for the administration of oxygen.

All of the following conditions of service apply to Covered durable medical equipment:

- Devices must be prescribed by a Physician. Under the Enhanced and Standard POS options, for *In-Network* benefits to be available, the equipment must be prescribed by a Network Provider, and you must rent or purchase the equipment from a medical supplier that participates in the Network.

- Supplies must:

  — Be manufactured specifically for medical use;

  — Be usable only by the patient (and not, for example, by the patient's Lawful Spouse); and

  — Not be for exercise, environmental control (such as air conditioners and humidifiers) or personal comfort.

- Coverage is limited to the purchase or rental of the original equipment. Total Covered charges for purchase and rental combined will not exceed the purchase price of the item.

Emergency Room

If you are enrolled in the Enhanced or Standard POS option, you pay the Emergency room Copayment for services provided in an Emergency room during an Emergency. This Emergency room Copayment is waived if you are admitted to the Hospital for continued care. If you use Emergency room services for a nonemergency, your care will be Covered at the Out-of-Network rate.

If you are enrolled in the Traditional Indemnity option, you pay your Coinsurance, after the annual Deductible.

Extended Care Facility

Extended Care Facilities services (for example, skilled nursing services) are Covered under the Enhanced and Standard POS and under the Traditional Indemnity options. Covered expenses include:

- Room and board in a semi-private room.
- Prescription drugs administered during the stay.
- Special diets/nutritional support.
- Professional nursing services provided by facility staff.
- Medically Necessary Physician's visits. The Medical Plan covers the initial consultation between your Physician and another specialist (or a number of different specialists, as Medically Necessary), as well as one Physician's visit per day in addition to normal postoperative visits by your surgeon(s). Charges for Physician visits in excess of one per day are Covered if Medically Necessary.
- Medically Necessary services provided on the order of a Physician which are normally provided by an Extended Care Facility, including, but not limited to, X-ray and laboratory tests, medical and surgical dressings, radiation therapy, and anesthetics and their administration.

The following conditions of service apply to Covered Extended Care Facility expenses:

- **To receive the full amount of benefits available,** precertification is required for Out-of-Network care under the Enhanced and Standard POS options and under the Traditional Indemnity options (see **Section F. When Precertification Is Required Under the POS and Traditional Indemnity Options**).
- Confinement must be on the order and under the supervision of a Physician.
- Confinement must be instead of Hospitalization. That is, without the Extended Care Facility, the patient would have to be confined in a Hospital.
- Confinement must not be mainly for the convenience of the patient's family.

- Under the Enhanced POS option, Out-of-Network benefits are limited to 60 days of Inpatient care in a calendar year. Traditional Indemnity option benefits are limited to 120 days of Inpatient care in a calendar year. Under both of these options, these limits are combined with the number of days of Hospital confinement if the preceding confinement was for the same condition requiring confinement in the Extended Care Facility. Under the Enhanced POS option, any days incurred *In-Network* count toward the maximum available days Out-of-Network.

Please note: Days in the Hospital count as full days toward this limit. A day in an Extended Care Facility counts as one-half day.

Family Planning Services

The following diagnostic infertility services to determine the cause of infertility and/or treatment of infertility are Covered:

- Patient history and Physician examination;
- Laboratory studies;
- Diagnostic procedures;
- Certain non-surgical treatments, including estrogen, corticosteroid and progestin therapy;
- Ovulation reduction; and
- Infertility surgery.

Contraceptive devices which are available only through prescription, such as intra-uterine devices and diaphragms are also considered as Covered expenses under the Medical Plan. Contraceptive devices that are purchased over the counter are not Covered under the Plan.

Home Health Care

Home healthcare is Covered under the POS and Traditional Indemnity options as follows:

- Speech Therapy, Physical Therapy and Occupational Therapy.
- Services of a registered nurse (RN), licensed nurse practitioner (LNP) or licensed vocational nurse (LVN).

- Services of a part-time home health aide who is not a nurse, but only if you also need the services of a professional nurse, a medical social worker, or a physical, occupational or speech therapist. Four hours of care provided by a part-time home health aide count as one home healthcare shift for purposes of the annual home healthcare visit limitation.

- Services of medical social workers.

- Medical supplies and equipment prescribed by your Physician.

- Laboratory services.

- X-rays and electrocardiograms.

- Drugs and medications administered to you by the Home Health Care Agency. This does not include drugs and medications which may be picked up from a pharmacy and/or delivered to your home. Drugs received by filling a prescription at a pharmacy may be Covered under the terms of the Prescription Drug Program (see **Section G. How the Prescription Drug Program Works**).

- Ambulance to the nearest Hospital when Medically Necessary.

The following conditions of service apply to Covered Home Health Care Agency expenses:

- To receive the full amount of benefits available for Out-of-Network care under the Enhanced or Standard POS option or under the Traditional Indemnity option, precertification is required.

- Care must be provided in accordance with a Physician's written treatment plan. The treatment plan must be re-certified by the attending Physician at least every 30 days if care continues.

- Care must be provided in the patient's home and instead of Inpatient care. This means that you are not physically able to go to a Provider's office for treatment, and without home healthcare services you would have to be confined in a Hospital or other facility.

- Services must be provided by a person who is employed by the Home Health Care Agency, or who has a subcontracting relationship with the agency.

- Under the Enhanced and Standard POS options, Out-of-Network benefits are limited to a maximum of 100 visits in a calendar year. Traditional Indemnity option benefits are limited to a maximum of 200 visits in a calendar year. Under the POS options, any visits incurred *In-Network* count toward the maximum available visits Out-of-Network. Each visit by a nurse or therapist, regardless of duration, is one visit.

Please note: Custodial and domestic services are not Covered.

Hospice

The following Hospice expenses are Covered under the Enhanced and Standard POS options and under the Traditional Indemnity option:

- Room and board when the patient is confined as a Hospice Inpatient.

- Part-time nursing services for the provision of medical and palliative care. "Palliative care" is care that is rendered to relieve the symptoms or effects of a disease without curing the disease

- Services of the Hospice's non-clinical staff, such as home health aides

- Counseling services provided to the patient and immediate family, when provided by duly licensed psychologists (Ph.D.) or pastoral counselors. These services are part of the overall charge of the Hospice; any separate charges made for these services are not Covered.

- Bereavement counseling provided to Covered Dependents, when provided by duly licensed psychologists (Ph.D.) or pastoral counselors on staff or under contract to the Hospice. Coverage is for a maximum of 15 sessions, provided within three months of the patient's death.

- Nutritional counseling and special meals.

- Administration of pain-relief medications.

- Drugs and medications administered to the patient by the Hospice. This does not include drugs and medications you may obtain from a pharmacy and have delivered to your home. Drugs received by filling a prescription at a pharmacy come under the terms of the Prescription Drug Program (see **Section G. How the Prescription Drug Program Works**).

The following conditions of service apply to Covered Hospice expenses:

- Precertification is required under the Enhanced and Standard POS and Traditional Indemnity options.

- Hospice services are Covered only when provided to terminally ill patients. There must be a written prognosis from a Physician that the patient's life expectancy will not exceed six months.

- Respite care is Covered to a maximum of five days during a period of six months. Respite care is provided by a Hospice so that an unpaid caretaker, such as a Lawful Spouse, may be temporarily relieved of caretaking duties.

- Services must be provided by a person who is employed by the Hospice or who has a subcontracting relationship with the Hospice.

- When services are provided in the patient's home, services of a nurse and home health aide are Covered on a part-time basis. Full-time (24-hour) care is not Covered.

- Under the Enhanced and Standard POS options, benefits are subject to a maximum of 210 days in a lifetime (*In-Network* and Out-of-Network combined). Under the Traditional Indemnity option benefits are subject to a maximum of 210 days in a lifetime.

Hospitalization

Hospitalization is Covered under the Enhanced and Standard POS options and under the Traditional Indemnity option. Covered Hospital expenses include:

- Room and board charges for the appropriate unit for your condition (acute care, intensive care, isolation care or a rehabilitation unit);

- Medically Necessary services provided on the order of a Physician which are normally provided by a Hospital (including, but not limited to, X-ray and laboratory tests, medical and surgical dressings, radiation therapy and anesthetics and their administration);

- Services in the Emergency room, delivery room, operating room or therapy unit;

- Diagnostic and therapeutic services provided on an Outpatient basis, such as preadmission testing or Outpatient surgery;

- Diagnostic services provided on an Inpatient basis when you are Hospitalized primarily for treatment such as for surgery;

- Medically Necessary Professional Physician and nursing services provided by facility staff (including the initial consultation between your Physician and another specialist, as well as one in-Hospital Physician's visit a day in addition to normal postoperative visits by your surgeon(s); more than one visit a day is Covered if Medically Necessary); and

- Drugs and medications administered while you are in the Hospital as an Inpatient or Outpatient

The following conditions of service apply to Covered Hospital expenses:

- **To receive the maximum amount of benefits available** for Out-of-Network Hospitalization under the Enhanced or Standard POS options and under the Traditional Indemnity option, precertification is required.

- The Hospital admission and services must be ordered by a Physician. You can't admit yourself to the Hospital.

- Room and board charges are Covered for a semi-private room. If you request a private room, you must pay the difference in cost between a semi-private room and a private room. However, if the patient's condition is contagious and a private room is Medically Necessary for the health of the other patients, eligible expenses for a private room will be Covered.

- Charges for room and board on a Saturday or Sunday won't be Covered if you enter the Hospital on Friday, Saturday or Sunday for a nonemergency condition and surgery isn't performed on the admission date.

- If you are admitted for surgery, it must be performed on the admission date (unless an earlier admission was precertified as Medically Necessary).

- If you enter a Hospital as an Inpatient primarily for diagnostic studies, lab tests or Physical Therapy, room and board charges are not Covered.

- Stays in a Hospital of more than 48 hours following Child birth by vaginal delivery or 96 hours following a cesarean section require precertification under the Enhanced and Standard POS options and under the Traditional Indemnity option (see **Section Q. Other Important Information**).

Please note: For admissions for treatment of mental health or Chemical Dependency conditions see **Section E. Mental Health and Chemical Dependency Program Under the POS and Traditional Indemnity Options**.

Maternity Care

Maternity benefits cover prenatal care (periodic exams during pregnancy), childbirth, certain routine nursery care for a newborn and postpartum care. For Enhanced or Standard POS *In-Network* benefits, care may be provided by a PCP or an *In-Network* obstetrician.

The following maternity expenses are Covered under the Enhanced and Standard POS options and under the Traditional Indemnity option:

- Prenatal visits on a schedule approved by the attending Physician.
- Hospitalization for delivery (see "Hospitalization" earlier in this section for conditions of service while confined in a Hospital; see also "Newborn's and Mother's Protection Act" in **Section Q. Other Important Information**).
- Services of a Birthing Center instead of a Hospital.
- Services of a licensed midwife. A licensed midwife may bill as an independent Provider for services provided in the Hospital, Birthing Center or home, or provide services as part of a Birthing Center's services.
- Routine nursery care provided to the newborn during the mother's stay at the Hospital. Medical services for newborns beyond routine care are considered treatment of an illness and Covered at the same benefit levels as services that treat illness, as long as the newborn is enrolled within the required timeframe (see "When Changes Take Effect" in **Section B. Joining the Medical Plan**).

Mental Health and Chemical Dependency

(See **Section E. Mental Health and Chemical Dependency Program Under the POS and Traditional Indemnity Options**.)

Nutritional Counseling

Nutritional education and planning by a certified nutritionist are Covered upon the initial diagnosis or change in severity of a medical condition that can be partially managed through special diets. Diabetes is one example of such a condition.

The following conditions of service apply to nutritional counseling services Covered ***In-Network*** under the Enhanced POS and ***In-Network*** **and Out-of-Network** under the Standard POS option:

- Services are Covered only when provided *In-Network* by a licensed nutritionist.
- Services are intended to assist a person in defining and managing a dietary plan in response to a newly recognized medical condition**.** Services are not intended to be ongoing.
- Meal preparation is not Covered.
- Services are not Covered for general health or wellness, or weight loss or gain objectives that are not associated with a diagnosed illness.

Please note: Services are **not** Covered Out-of-Network under the Enhanced POS option or under the Traditional Indemnity option.

Organ Donation

Under certain circumstances, the Covered expenses for a living person to donate an organ are Covered under the Enhanced and Standard POS options and under the Traditional Indemnity option. Covered expenses may include necessary medical and surgical charges (including Hospital charges) for extraction of the donated organ or bone marrow and necessary follow-up care.

The following conditions of service apply to Covered organ donation expenses:

- If both the donor and recipient are Covered under the Medical Plan, the recipient's Health Plan Carrier must have precertified the transplant procedure. Benefits will be provided to both the donor and the recipient.
- If the donor is Covered under the Medical Plan and the recipient is not Covered under the Medical Plan, the transplant must be one that the Health Plan Carrier would precertify if the recipient were Covered under the Medical Plan. The Plan will not provide coverage for the recipient.
- If the donor is not Covered under the Medical Plan and the recipient is Covered under the Medical Plan, the Health Plan Carrier must precertify the transplant procedure. Additionally, benefits for the donor are available from the Medical Plan only if the donor has no other coverage of his or her own for the procedure.

Orthotics

Orthotics necessary for daily living activities are Covered under the Enhanced and Standard POS options and under the Traditional Indemnity option if:

- Prescribed by a licensed medical Provider (including podiatrists) as Medically Necessary;
- Prescribed to treat an illness or injury; and
- Made in accordance with the prescription for only your use.

Outpatient Medical Facilities

The following Outpatient Medical Facility expenses are Covered under the Enhanced and Standard POS options and under the Traditional Indemnity option:

- Services of a medical laboratory in the taking and analysis of fluid or tissue samples;
- Services of an Outpatient surgical center for surgeries that may be safely performed on an Outpatient basis;
- Birthing Centers for childbirth, including the services of a licensed midwife;
- Services of an Urgent Care Facility for treatment of Emergency and Urgent medical conditions; and
- Services of an Outpatient rehabilitation facility for the rehabilitation services (see "Rehabilitation Therapy" later in this section).

Please note: Outpatient Medical Facility services must be ordered by and under the direction of a Physician. For example, if you go to a lab to request your own blood test without a Physician's order, the lab fee isn't Covered.

Physician's Services

The following Physician's services are Covered under the Enhanced and Standard POS options and under the Traditional Indemnity option:

- General medical services (the diagnosis and treatment of illness within generally accepted parameters of Physician practice);
- Obstetrical (maternity) services, including delivery (see "Maternity" earlier in this section and "Newborn's and Mother's Protection Act" in **Section Q. Other Important Information**);

- Surgery;
- Administration of anesthesia;
- Pathology (laboratory) services;
- Radiology (X-rays), chemotherapy, nuclear medicine, diagnostic ultrasound services and any imaging or scanning techniques;
- Services provided by the Physician's nursing staff;
- Preventive services (see "Preventive Care" later in this section); and
- Medical supplies such as casts and dressings provided as part of the Physician's services.

Podiatric Services

Covered podiatric services under the Enhanced and Standard POS options and under the Traditional Indemnity option include all services, except routine foot care (that is, pedicure services such as the routine cutting of nails) unless Medically Necessary, which are within the scope of a Doctor of Podiatric Medicine's license.

Prescription Drugs

(See **Section G. How the Prescription Drug Program Works**.)

Preventive Care

- **Please note:** Check with your Health Plan Carrier for any screening limitations and/or age requirements.

Covered services include:

- **Routine physical exam**: Covered only *In-Network* under the Enhanced and Standard POS options; not Covered Out-of-Network under the POS options or under the Traditional Indemnity option.
- **Well-woman care**: Covered only *In-Network* under the Enhanced and Standard POS options, not Covered Out-of-Network under the POS options or under the Traditional Indemnity option.
- **Well-Child care** (OB/GYN exam): Covered only *In-Network* under the Enhanced and Standard POS options, not Covered Out-of-Network under the POS options or under the Traditional Indemnity option.

- **Childhood immunizations**: Covered only *In-Network* under the Enhanced and Standard POS options, not Covered Out-of-Network under the POS options or under the Traditional Indemnity option.

- **Mammogram screening** (in a Physician's office): Covered *In-Network* and Out-of-Network under the Enhanced and Standard POS options and under the Traditional Indemnity option.

- **Pap smear** (in a Physician's office): Covered *In-Network* and Out-of-Network under the Enhanced and Standard POS options and under the Traditional Indemnity option.

- **Digital rectal exams and PSA tests** (in a Physician's office)**:** Covered *In-Network* and Out-of-Network under the Enhanced and Standard POS options and under the Traditional Indemnity option.

Please note: Copayments or the annual Deductible may apply, depending on your Medical Plan option (see **Section A. Medical Plan Benefits-at-a-Glance**).

Private Duty Nursing

Private Duty Nursing services are Covered under the Enhanced and Standard POS options and under the Traditional Indemnity option. Covered Private Duty Nursing services include nursing services of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) delivered to a Covered individual who is confined in the home due to a medical condition.

The following conditions of service apply to Covered Private Duty Nursing services:

- To receive the full amount of benefits available for Out-of-Network care under the Enhanced and Standard POS options or under the Traditional Indemnity option, precertification is required (see **Section F. When Precertification Is Required Under the POS and Traditional Indemnity Options**); and

- Custodial and domestic services are not Covered.

Enhanced and Standard POS Out-of-Network benefits are limited to 100 shifts in a calendar year and Traditional Indemnity benefits are limited to a maximum of 200 shifts in a calendar year. Any shifts incurred *In-Network* count toward the maximum available shifts Out-of-Network.

Prostheses

Prosthetic devices supplied by a properly licensed vendor are Covered under the Enhanced and Standard POS options and under the Traditional Indemnity option. A prosthesis is a device designed to partially compensate for the loss of a body part. Covered prostheses include artificial legs or arms (or parts thereof, such as a foot), eyes and portions of internal bodily organs. Replacement of prosthetic devices is Covered only when required due to the normal growth process of a Child or when made necessary by anatomical change caused by a medical condition or accidental injury.

Rehabilitation Therapy

The following Rehabilitation Therapy expenses are Covered under the Enhanced and Standard POS options and under the Traditional Indemnity option:

- Physical Therapy services that assist in the restoration of normal, necessary physical movement, after movement has been acutely impaired by illness or injury;

- Speech Therapy services that assist in the restoration of communication abilities that have been impaired by illness, injury or birth defect; and

- Occupational Therapy services that assist a person in regaining the ability to perform normal activities of daily living after those abilities have been acutely impaired by illness or injury.

The following conditions of service apply to Covered Rehabilitation Therapy services:

- Care must be provided under the direct order of a Physician who determines that you need the services and prescribes how many treatments are necessary. For example, if you go directly to a physical therapist and request services without seeing a Physician first, the services will not be Covered.

- The services must be likely to result in clear and reasonable improvement in your condition within three months.

- Generally, rehabilitation services provided in the home are Covered only when services are provided as part of a Home Health Care Agency's services and the home healthcare has been precertified.

- Generally, rehabilitation services provided during an Inpatient stay in a Hospital or Extended Care Facility are Covered only when the Inpatient stay has been precertified.

- Out-of-Network Enhanced POS and Traditional Indemnity option benefits for Speech Therapy are limited to a maximum of 30 Outpatient visits in a calendar year. Under the Enhanced POS option, any visits incurred *In-Network* count toward the maximum available visits Out-of-Network.

Restorative or Reconstructive Surgery

The following restorative or reconstructive surgery expenses are Covered under the Enhanced and Standard POS options and under the Traditional Indemnity option:

- Surgery, incidental to or following, surgery necessitated by accidental injury, trauma, infection and other diseases of the involved body part.

- Surgery to restore an area seriously injured in an accident.

- Surgery to correct a birth defect that causes a functional disability.

- Surgery to restore breast tissue which was surgically removed, wholly or partially, in response to an illness. Where there has been breast disfigurement for a female participant or Covered Dependent due to illness, surgery or mastectomy, the Medical Plan shall cover reconstructive surgery of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce symmetrical appearance; prostheses and treatment of physical complications in all stages of mastectomy (including lymphedema) (see "The Women's Health and Cancer Rights Act of 1998" in **Section Q. Other Important Information**).

The following conditions of service apply to Covered restorative surgery expenses:

- The treatment must be to correct a condition that represents a serious malformation; and

- Treatment must be for the least expensive medically accepted procedure that will adequately restore the malformation.

Second Surgical Opinion

Second surgical opinions aren't required, but they are Covered under the Enhanced and Standard POS options and under the Traditional Indemnity option.

The following expenses are Covered:

- A second Physician's opinion concerning the need for a surgery that was recommended by your treating Physician; and

- A third Physician's opinion if the second opinion conflicts with the first recommendation.

The second and, when warranted, third surgical opinions must be rendered by a Physician with the appropriate specialty for the recommended procedure.

Please note: Second surgical opinions do not replace precertification.

Wigs

Under special conditions, the Enhanced and Standard POS options and the Traditional Indemnity option cover the cost of a wig used for temporary hair loss due to disease or treatment of disease such as chemotherapy. Charges for a wig or wigs are Covered up to a maximum of $300 in any calendar year during which the condition is manifested.

Section E. Mental Health and Chemical Dependency Program Under the POS and Traditional Indemnity Options

If you and your Eligible Dependents enroll in the Enhanced or Standard POS or Traditional Indemnity option, the Mental Health and Chemical Dependency (MH/CD) Program covers you and your Covered Dependents for treatment of mental health and Chemical Dependency conditions according to your option's benefit provisions and allowable Medicare guidelines (depending on your Medicare eligibility).

If You Elect HMO Coverage
If you select an HMO for your Medical Plan option, you'll receive mental health and Chemical Dependency benefits through your HMO, as provided under the terms of your HMO.

Please note: Your Medical Plan administrator administers the mental health and Chemical Dependency benefits. For example, if you enroll in the Aetna Enhanced POS option, Aetna administers your mental health and Chemical Dependency benefits. If you enroll in the UnitedHealthcare (UHC) POS option, UHC administers your mental health and Chemical Dependency benefits.

If a HMO or Medicare Advantage HMO is available to you and you enroll in it, you will receive mental health and Chemical Dependency benefits directly through your HMO/Medicare Advantage HMO.

How the Mental Health and Chemical Dependency Program Works

If You Are Not Medicare-Eligible

If you are not Medicare-eligible, the MH/CD Program offers you and your Covered Dependents the flexibility to seek mental health and Chemical Dependency treatment through a Network of Providers who specialize in the treatment of Mental Illness and Chemical Dependency, or on an Out-of-Network basis. The MH/CD Program's Network includes:

- Psychiatrists (M.D.);
- Licensed psychologists (Ph.D.);

- Master's degree level Mental Health and Chemical Dependency Professionals, including:
  - Clinical social workers (LCSW or ACSW),
  - Marriage, family and Child counselors (MFCC), and
  - Certified alcoholism counselors (CAC) or certified Chemical Dependency counselors (CCDC);
- Master's degree level nurses; and
- Treatment facilities, such as Hospitals and Residential Treatment Facilities.

Precertification Requirements
To receive the full amount of benefits available under the Mental Health and Chemical Dependency (MH/CD) Program, you must precertify **all** admissions to a Hospital, acute psychiatric facility or acute Chemical Dependency facility. (See **Section F. When Precertification Is Required Under the POS and Traditional Indemnity Options** for more information about the Precertification requirements under the MH/CD Program and the penalties imposed if you do not obtain precertification.)

In-Network Care
To receive care under the MH/CD Program at the *In-Network* level, you must call your Health Plan Carrier to obtain Precertification (see **Section F. When Precertification is Required Under the POS and Traditional Indemnity Options**). When you call your Health Plan Carrier, the representative will determine the type of Provider you need to see and will offer you choices of Network Providers.

Please note: If you do not precertify your care, the Medical Plan will not pay any benefits.

Outpatient Care
Covered Services
The following Outpatient services are Covered under the MH/CD Program:

- Physician's services, including:
  - Diagnosis and treatment of mental health and Chemical Dependency conditions,
  - Psychotherapy,

  - Prescriptions of therapeutic drugs, medications or other treatments specifically required by law to be performed or supervised by a medical Physician,

  - Chemical Dependency counseling, and

  - Laboratory tests (including charges from independent medical laboratories); and

- Services by Mental Health and Chemical Dependency Professionals and through eligible facilities and/or associated Providers, including

  - Diagnosis and treatment of mental health and Chemical Dependency conditions,

  - Psychological testing,

  - Psychotherapy,

  - Chemical Dependency counseling, and

  - Laboratory testing performed by the facility.

Conditions of Coverage of Outpatient Care
If Outpatient treatment is offered through a facility, the following conditions of service apply:

- Services must be provided at a facility that is a general acute care Hospital, an acute care psychiatric Hospital, or an acute care Chemical Dependency facility; and

- A Provider may treat only those conditions, either mental health or Chemical Dependency, appropriate to his or her certification and licensing status.

Inpatient *Care*
Covered Services
The following Inpatient services are Covered under the Mental Health and Chemical Dependency (MH/CD) Program:

- Semi-private room and board charges in the appropriate unit for the participant's condition (acute care, intensive care, isolation care or rehabilitation unit). If you request a private room, you must pay the difference in cost between a semi-private room and a private room.

- Services provided in an Emergency room.

- Services and supplies normally provided by a Hospital including any professional component of those services such as those provided by a psychiatrist, other Physician or a mental health professional (may include individual or group therapy for the patient and Covered Dependents, stress management, Occupational Therapy and educational and disease management programs integrated with a course of treatment).

- Detoxification services (except for a newborn who is Covered for this service under your Medical Plan option).

- Laboratory services.

Conditions of Coverage of Inpatient *Care*
The Mental Health and Chemical Dependency (MH/CD) Program will Cover the above-listed Inpatient Care services only if those services are ordered by a Physician. (You can't admit yourself to the Hospital.)

Covered Alternative Treatment (In-Network Only)
The MH/CD Program covers Alternative Treatment **only provided by MH/CD Program Providers**. Alternative Treatment may include Partial Hospitalization, Residential Treatment and the services of a Halfway House or Group Home. **No benefits are payable for Alternative Treatment provided on an Out-of-Network basis.**

Partial Hospitalization
The following precertified Partial Hospitalization services are **only Covered *In-Network***:

- Covered services as determined through precertification by your Health Plan Carrier (may include treatments such as individual and group therapy); and

- Medications administered during the daily visit.

Residential Treatment
The following precertified Residential Treatment services are **only Covered *In-Network***:

- Room and board charges

- Drugs and medications administered to you while you are an Inpatient at the Residential Treatment facility; and

- Services normally provided by a Residential Treatment facility, including services provided by the professional staff of the facility.

Group Homes and Halfway Houses
The following precertified services of a Group Home or Halfway House are only Covered *In-Network*:

- Room and board charges; and
- Services normally provided by a Group Home or Halfway House, including services provided by the professional staff of the facility.

Out-of-Network Benefits
When you go Out-of-Network, you may use any Covered mental health or Chemical Dependency Provider you choose. However, the amount of Out-of-Network benefits available is significantly less than those available for *In-Network* care, limitations apply and certain services aren't Covered.

Generally, you will pay more out-of-pocket when you receive care on an Out-of-Network basis than when you receive care on an *In-Network* basis. You will be subject to:

- An annual Deductible, which is combined with the annual Deductible that applies under your Medical Plan option, if applicable, but separate from the Medco Medicare Prescription Drug Plan Deductible (does not apply for Medicare-eligible retired employees or Medicare-Eligible Dependents when Medicare is the primary plan);
- Higher out of pocket expenses;
- A higher Out-of-Pocket Maximum;
- Any benefit reductions due to your not precertifying a Hospital admission;
- Any charges for expenses that aren't Covered Out-of-Network; and
- Any charges above the Allowable Amount.

There are other disadvantages as well. You are responsible for getting precertification for any Hospital admissions (see **Section F. When Precertification Is Required Under the POS and Traditional Indemnity Options**) and submitting claim forms.

Please note: Out-of-Network benefits are not available if you use Network Providers but do not obtain precertification.

If You Are Medicare-Eligible
If you are Medicare-eligible, mental health and Chemical Dependency treatment is Covered under:

- The SecureHorizons® MedicareDirect™ PFFS Plan;
- UnitedHealthcare; or
- A Medicare Advantage HMO

Please note: For information about mental health and Chemical Dependency coverage under the SecureHorizons® MedicareDirect™ PFFS Plan, see **Appendix A. SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS)--Retiree Benefits Summary Insert** at the end of this SPD.

Emergency Care

In an Emergency, you or your Covered Dependent should get care immediately For example, a drug overdose is a medical Emergency, and you should seek life-saving medical treatment immediately.

To receive full benefits under the Mental Health and Chemical Dependency (MH/CD) program:

- The situation must qualify as a Mental Health Emergency under the MH/CD Program; and
- The MH/CD Emergency care must by Medically Necessary.

You, your Physician or a family member must contact your Health Plan Carrier within 24 hours of an admission. You can reach your Health Plan Carrier by phone 24 hours a day, seven days a week.

Receiving Care Away From Home

You may receive care through the MH/CD Program regardless of where you are in the United States when you need care. To receive care when you are away from home, call your Health Plan Carrier at the telephone number printed on the back of your medical ID card and follow the instructions.

If You Are Outside of the United States
If you are **temporarily** traveling outside the United States, your Health Plan Carrier won't be able to direct you to a Provider. However, Emergency care will be reimbursed at the *In-Network* benefit level **if you have the care precertified.**

If you **permanently** reside outside the United States, both Emergency and nonemergency care provided overseas will be reimbursed at the Out-of-Network level. You will need to pay for the services and send an itemized bill to your Health Plan Carrier for reimbursement.

Amount of Coverage

See **Section A. Medical Plan Benefits-At-a-Glance** for coverage amounts for Medicare-eligible and non-Medicare-eligible individuals.

Section F. When Precertification Is Required Under the POS and Traditional Indemnity Options

What Precertification Is

Precertification is the process by which a Health Plan Carrier reviews the proposed treatment and advises you and your Physician as to how benefits may be paid, if at all. There are precertification requirements under the Enhanced and Standard POS options and under the Traditional Indemnity option, including under the Mental Health and Chemical Dependency (MH/CD) Program.

Please note: For information about precertification requirements under the SecureHorizons® MedicareDirect™ PFFS Plan, see **Appendix A. SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS)--Retiree Benefits Summary Insert** at the end of this SPD.

You must certify certain Covered services in order to receive the maximum available benefits under the options. In some instances, if you do not precertify care, you will not receive any benefits (see "Penalties If Precertification Procedures Are Not Followed" later in this section).

Please note: Under the Traditional Indemnity option, Medicare-eligible retired employees or dependents may not be required to precertify for certain services unless the service is not Covered by Medicare or you are approaching the maximum benefits Medicare will pay for that service.

Generally, precertified care is paid at the highest level of coverage. If you don't follow the precertification procedures when required, and it's later determined the treatment:

- **Is** Medically Necessary, benefits generally are paid at a reduced level or no payment is made; or

- **Isn't** medically necessary, no benefits will be paid.

Who Is Responsible for Precertification

While your Network Provider precertifies care received *In-Network* under the Enhanced and Standard POS options, you are responsible for obtaining precertification from your Health Plan Carrier:

- If you receive care for certain services Out-of-Network under the Enhanced and Standard POS option;
- If you receive care for certain services under the Traditional Indemnity option; and
- For all Out-of Network Inpatient or residential services under the Mental Health and Chemical Dependency (MH/CD) Program under the Enhanced and Standard POS and Traditional Indemnity options.

If you don't obtain precertification when required, benefits will be reduced, or no benefits will be payable (see "Penalties If Precertification Procedures Are Not Followed" later in this section).

Covered Services Requiring Precertification

Precertification is required Out-of-Network under the Enhanced and Standard POS options and under the Traditional Indemnity option for certain services to receive the full amount of benefits available, including:

- Hospital admissions. If Medicare provides primary coverage, precertification is not required before a Hospital admission. However, you do need to precertify a continued Hospital stay before your Medicare benefits for the Hospital stay are scheduled to end.
- Hospital Inpatient stays
- Extended Care Facility (for example, Skilled Nursing and rehabilitation Facilities).
- Private Duty Nursing.
- All home healthcare services.
- Maternity care that extends beyond 48 hours in the event of a vaginal birth and 96 hours in the event of a cesarean section (see "Newborn's and Mother's Protection Act" in **Section Q. Other Important Information**).
- Reconstructive procedures (see "The Women's Health and Cancer Rights Act of 1998" in **Section Q. Other Important Information**).

- Hospice.
- Dental care (accident only).
- Durable medical equipment (such as prosthetic devices) over $1,000.
- Medical injectables, including:
  - Intravenous immunoglobulin growth hormone (IVIG);
  - Rebif®; and
  - Blood-clotting factors.
- Uvulopalatopharyngoplasty (indicated for the treatment of sleep apnea), including laser-assisted procedures.
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint.
- Elective (nonemergency) transportation by Ambulance or medical van, and all transfers via air Ambulance.
- Services that may be considered investigational or experimental.

Under the Mental Health and Chemical Dependency Program
To receive the full amount of benefits available under the Mental Health and Chemical Dependency (MH/CD) Program for Out-of-Network services in the Enhanced or Standard POS or in the Traditional Indemnity option, you must precertify:

- Admissions to a Hospital (including Partial Hospitalization admissions), acute psychiatric facility, Residential Treatment facility or acute Chemical Dependency facility;
- Intensive Outpatient care; and
- Emergency admissions. You are required to notify the MH/CD Program within 24 hours after admission.

How to Precertify Medical Coverage

If you are required to precertify care (see "Covered Services Requiring Precertification" earlier in this section), you must call the telephone number printed on your medical ID card within the following timeframes.

Category of Care	Time Frame for Notification to the Applicable Claims Administrator	
	Enhanced and Standard POS Options (Out-of-Network)	**Traditional Indemnity Option**
Elective Care	7 days before treatment	7 days before treatment
Urgent Care	Anytime before treatment/admission	Anytime before treatment/admission
Emergency Care	Within 2 business days after admission	Next business day after admission

When you call, have the following information ready:

- The patient's name, address, telephone number, age, identification number and relationship to you;
- All the information on your medical ID card;
- The type of care for which you are requesting precertification;
- The Physician's name, address and telephone number; and
- If admitted to a Hospital, the name, address and telephone number of the Hospital.

You and your Physician will be advised whether or not the care is precertified and, if applicable, the specific duration of time for which it's certified (applies for an admission to a Hospital or Extended Care Facility, home healthcare services or Private Duty Nursing).

How to Precertify Mental Health and Chemical Dependency Coverage

To precertify *In-Network* or Out-of-Network mental health and Chemical Dependency care under the Enhanced and Standard POS options and under the Traditional Indemnity option, you must call your Health Plan Carrier at the telephone number printed on the back of your medical ID card at least five business days before the scheduled date of admission.

Mental Health Emergency
For a Mental Health Emergency, you should call the Health Plan Carrier, if possible, before the admission; otherwise, within 24 hours of the admission.

When you call, have the following information ready:

- The patient's name, address, telephone number, age, identification number and his or her relationship to you, and
- All of the information on your medical ID card.

When you call about an Inpatient admission, you also will need:

- To describe the problem or the symptoms (for example, drug use, depression or uncontrolled behavior);
- The name and telephone number of the Provider currently treating the patient (for example, a psychiatrist or psychologist); and
- The name of the Hospital where the patient will be admitted.

The Claims Administrator will investigate the reason for the service or admission and either:

- Certify, if appropriate, the admission or service; or
- Suggest an Alternative Treatment or setting for the proposed treatment.

You and your Physician will be notified, in writing, by the Claims Administrator whether the proposed service or admission is precertified. If care is precertified, your Physician will receive a precertification number. This number verifies that your treatment is precertified and no precertification penalties will apply.

If the services involves admission to a Hospital, Hospice, Extended Care Facility, home health care agency, or Private Duty Nursing, you and your Physician will also be notified of the duration for which precertification applies.

Precertification Extension

Under the Enhanced and Standard POS options and Traditional Indemnity option, all precertified Inpatient admissions, including admissions under the Mental Health and Chemical Dependency (MH/CD) Program, Extended Care Facility stays, home healthcare services, and Private Duty Nursing are certified for a specific duration of time. Toward the end of the certified period, your Health Plan Carrier will follow up to see if your care will be completed as expected.

If it's determined that treatment will take longer than originally expected, another review will be performed to determine whether an extension will be precertified. If an extension isn't certified, no additional benefits will be paid for any treatment received after the expiration of the initial precertification period.

Penalties If Precertification Procedures Are Not Followed

If you do not follow the precertification procedures when required under the Enhanced or Standard POS option or under the Traditional Indemnity option, penalties (that is, benefit reductions) will apply. This means the level of benefits available will be reduced or no benefits will be paid for the treatment.

In-Network Care Under the Enhanced and Standard POS Option

If *In-Network* services under the Enhanced or Standard POS option are not precertified, no benefits are payable.

Please note: In addition, **no benefits** will be paid for care received after the expiration of the precertification period.

Services and Supplies Under the Enhanced and Standard POS Options (for Out-of-Network Services) and Traditional Indemnity Option

A 20% benefit reduction, up to a $400 maximum per occurrence, is applied if precertification isn't obtained for any of the services or supplies requiring precertification (see "Covered Services Requiring Precertification" earlier in this section).

Paying Penalties
You are responsible for paying these penalties. Your payments of any penalties will not count toward your annual Deductible or any applicable Out-of-Pocket Maximum.

Subject to the 20% benefit reduction (up to $400 per occurrence), the Medical Plan will pay for Covered services at the level set forth in **Section A. Medical Plan Benefits At-a-Glance**, near the beginning of this SPD.

Please note: In addition, no benefits will be paid for care received after the expiration of the precertification period.

You are responsible for paying these penalties. Your payments of any penalties will not count toward your annual Deductible or any applicable Out-of-Pocket limit.

Service and Supplies Under the Mental Health and Chemical Dependency (MH/CD) Program

Out-of-Network/Emergency Care

A 20% benefit reduction, up to a $400 maximum per occurrence, is applied to Covered expenses if precertification isn't obtained for an Out-of-Network care under the Enhanced or Standard POS option and/or Emergency admission to a Hospital, acute psychiatric facility, or acute Chemical Dependency facility for treatment of a mental health or Chemical Dependency condition under the Enhanced or Standard POS option or under the Traditional Indemnity option. Subject to the 20% benefit reduction (up to $400 per occurrence), the Medical Plan will pay for Covered services at the level set forth in **Section A. Medical Plan Benefits At-a-Glance** near the beginning of this SPD.

Section G. How the Prescription Drug Program Works

About the Prescription Drug Program

If you or your dependent(s) is not Medicare-eligible and enroll in the Enhanced or Standard POS option or the Traditional Indemnity option, you are automatically Covered under the Prescription Drug Program, which is administered separately from your medical option by Medco Health Solutions (Medco).

Prescription drug coverage is different if you or your dependent(s) is eligible for Medicare — even if other family members enrolled in the Medical Plan are not eligible for Medicare. This coverage, however, is also administered by Medco.

If You are in an HMO
If you select coverage under an HMO for your medical option, you do not receive benefits from the Prescription Drug Program. Instead, you'll receive the prescription drug benefits available through your HMO. Contact your HMO for specific information about prescription drug benefits.

If you are Medicare-eligible, if a Medicare Advantage HMO is available to you, and if you enroll, you'll receive prescription drug benefits directly through your Medicare Advantage HMO.

If You Are Not Medicare-Eligible

How the Non-Medicare-Eligible Prescription Drug Program Works

The Prescription Drug Program offers you three ways to fill prescriptions:

- At a participating retail pharmacy;
- At a nonparticipating retail pharmacy; or
- By mail order, phone or via fax through Medco Pharmacy.

Use a local Participating Pharmacy for short-term prescriptions of up to 30 days (90 days for insulin). If you need to take medication on an ongoing basis, you can take advantage of the mail order service and receive refills of 90-day supplies at a time.

Your cost varies depending on how you choose to fill your prescriptions, as well as by the four levels of Copayments available under the Prescription Drug Program:

- **Tier One**: Generic Drugs;
- **Tier Two**: Lower-cost Formulary Brand-Name Drugs;
- **Tier Three**: Higher-cost Formulary Brand-Name Drugs; and
- **Tier Four**: Nonformulary Brand-Name Drugs.

For information about specific Copay amounts for various Covered medications, see **Section A. Medical Plan Benefits At-a-Glance** near the beginning of this SPD.

Prescription Formulary
With the Prescription Drug Program, you receive a Formulary that lists commonly prescribed, cost-effective medications that your Physician may prescribe when appropriate. You can help control rising costs and maintain high-quality care by asking your Physician to prescribe Formulary drugs if your Physician determines such drugs are appropriate for your condition. When you need a prescription, give your Physician a copy of the Formulary list you received with your Prescription Drug Program ID card. You also can find the Formulary on the Medco Web site at www.medco.com or by calling Medco toll-free at 1-800-336-5934.

Participating Pharmacy
When you go to a Participating Pharmacy, give the pharmacist your Prescription Drug Program ID card. The pharmacist will charge you the appropriate Copayment for your Covered prescription. **That is the only amount you will pay**.

If you do not have your Prescription Drug Program ID card with you at the time of your prescription purchase, be sure to identify yourself as a participant. You or your pharmacist can contact Medco for verification of your eligibility. If you do not use your Prescription Drug Program ID card or cannot otherwise prove your eligibility, you will be responsible for paying the full cost of the prescription upfront and must file a claim form (claim forms are available on the Medco Web site at www.medco.com) for reimbursement. In addition, you may have to pay more out of your pocket because benefits may not be based on the lower *In-Network* prescription drug cost, but on the nondiscounted price of the prescription, and will be reimbursed based on the Allowable Amount.

To find a Participating Pharmacy near you:

- Call Medco at 1-800-336-5934;
- Contact Medco directly through their Web site at www.medco.com ;
- Ask your local pharmacy if it's a Participating Pharmacy.

Nonparticipating Pharmacy
When you use a nonparticipating Pharmacy (or if you don't show your ID card at a Participating Pharmacy) to fill a prescription for up to a 30-day supply (90 days for insulin), you pay the entire cost at the time of purchase. Then you file a claim with Medco for reimbursement. (Claim forms are available on the Medco Web site at www.medco.com.)

If You Use a Nonparticipating Pharmacy
If you use a nonparticipating Pharmacy, you will be responsible for the difference in the cost of the drug purchased at the nonparticipating pharmacy compared to the cost of the same drug at a Participating Pharmacy — in addition to your Copayment.

Filing a Claim
If you use a nonparticipating Pharmacy, you will need to pay the full cost for the prescription and file a claim for reimbursement. For more information, contact Medco.

Appealing a Claim Decision
To appeal a decision under the Prescription Drug Program, call Medco at 1-800-336-5934 and ask for a Medco appeals form for Alcatel-Lucent retirees. Your appeal will be reviewed and you will be notified of the decision. If you are not satisfied, you can appeal the decision. For more information, see **Section K. Claims and Appeals** later in this SPD.

Filling Prescriptions by Mail, Phone or Fax
Medco Pharmacy is a great way to fill prescriptions if you regularly take the same medication on an ongoing basis. Up to a 90-day supply is available.

You can order a home delivery order form/envelope on the Medco Web site. A new order form/envelope will also be included with your medication.

To order a prescription over the Internet, log on to www.medco.com.

Prescriptions for 90 Days or More
For prescriptions you take on an ongoing basis (90 days or more), you may use a participating retail pharmacy for your initial prescription and up to two refills (for a total of three fills), for up to a 30-day supply each time. If you remain on that medication, you must order subsequent refills through Medco Pharmacy or pay twice the retail Copayment at the retail pharmacy.

To order a prescription by mail:

- Obtain a Medco order form/envelope, follow the instructions and enclose the appropriate Copayment.

- Have your Physician call 1-888-327-9791 for instructions on faxing the prescription.

Your prescription will be filled and sent to your home within 14 days of the date you mailed the prescription to Medco.

Refills
Refills are even easier. You can order a refill online, by mail or by calling the number on your refill sticker. Use your credit card to pay.

What Prescription Drug Items Are Covered (Non-Medicare Eligible)
Generally, for participants not eligible for Medicare, the Prescription Drug Program covers:

- Drugs prescribed by a Physician and provided by a pharmacist (see **Section H. What's Not Covered** for exceptions);

- Birth control medications or contraceptive devices (including oral contraceptives, implants, or injections);

- Insulin;

- Disposable supplies ordered by a Physician for a diabetic patient, including:

  — Insulin needles and syringes, and

  — Blood- and urine-testing supplies; and

- Prescription (not over-the-counter) smoking deterrents (including nicotine products such as inhalers and nasal sprays).

Diabetic testing equipment may be Covered under the durable medical equipment benefit of your Medical Plan option.

Drugs Requiring Authorization and Quantity Limits (Non-Medicare Eligible)
Certain medications must be authorized for specific conditions before they are eligible for coverage. Medco will work with you, your pharmacist and your Physician to secure the necessary confirmation. The list of these drugs changes from time to time as new drugs are approved, new clinical guidelines for appropriate use are developed or problems are identified. In addition, some medications are subject to quantity limits. Visit the Medco Web site at www.medco.com or call Medco at 1-800-336-5934 (if you are **not** Medicare-eligible or at 1-800-230-0512 (if you **are** Medicare-eligible) for a list of medications requiring authorization or that are subject to quantity limits.

Specialty Care (Non-Medicare Eligible)
Complex conditions, such as the following, are treated with specialty medications:

- Anemia;
- Hepatitis C;
- Multiple sclerosis;
- Asthma;
- Growth hormone deficiency and
- Rheumatoid arthritis.

Specialty medications are typically injectable medications administered either by the individual or a healthcare professional. These medications require special handling.

If you are using specialty medications, you receive them through Medco's specialty care pharmacy — Accredo Health Group. This specialty care pharmacy also provides customer support related to complex conditions.

Out-Of-Pocket Maximum
The Prescription Drug Program **does not** include an annual Out-of-Pocket Maximum for non-Medicare-eligible or Medicare-eligible prescription drug coverage.

If You Are Medicare-Eligible

How the Medicare-Eligible Prescription Drug Program Works
The Prescription Drug Plan design for Medicare-Eligible Retirees and dependents is a special Medicare Part D plan, governed by the Centers for Medicare & Medicaid Services (CMS), administered by Medco and sponsored by Alcatel-Lucent.

Typically, you enroll for Medicare Part D plans during the Medicare Part D open enrollment period in the fall. You may enroll in Alcatel-Lucent's Medicare Prescription Drug Program during an Annual Open Enrollment period, when you first become Medicare-eligible or if you experience a qualified status change.)

Otherwise, all standard Medicare Part D requirements apply to this coverage. For example, if you enroll in a different Medicare Part D plan or select prescription drug coverage elsewhere, you will lose your Alcatel-Lucent Medicare Part D coverage.

Please note: The Prescription Drug Program is part of your Alcatel-Lucent medical coverage. If you are Medicare-eligible and enroll in coverage through the Company, you automatically will be enrolled in this Alcatel-Lucent Medco Medicare Prescription Drug Plan. You cannot elect the medical and prescription drug coverages separately and prescription drug coverage premiums will be included as part of your Medical Plan premiums.

The following steps explain how your Alcatel-Lucent-sponsored Medicare Part D coverage works:

- You pay an annual Deductible, which may be adjusted annually, for the cost of your prescription drugs.

- Once you reach the annual Deductible (which is separate from your Medical Plan options annual Deductible, if applicable), the Prescription Drug Program begins to contribute and you pay a Copayment for the cost of the prescription drugs (see Section A. Medical Plan Benefits At-a-Glance).

Drugs Not Included on Medco's Formulary
Prescription drugs that are not included on Medco's standard Medicare Part D formulary are not Covered, and out-of-pocket expenses for prescription drugs that are not Covered will not count toward out-of-pocket costs or the total costs of the Prescription Drug Program.

For More Information
Refer to the materials you received from Medco for detailed information about the Prescription Drug Program coverage. Also refer to the Part D disclosure included with your annual enrollment materials. You can also obtain more information about the Prescription Drug Progam and Medicare Part D by accessing Medco's website at www.medco.com or by calling Medco at 1-800-230-0512.

Please note: Prescription drugs filled at an Out-of-Network retail pharmacy are Covered **only** in the event of an Emergency, as defined by CMS. If an Out-of-Network retail pharmacy is used for a non-Emergency, no benefits will be payable.

Medco's Standard Medicare Part D Formulary
The prescription drug coverage for Medicare-Eligible Retirees and dependents will continue to categorize prescription drugs using a Formulary guide — or list. This list, which is different from the list for retirees and dependents not eligible for Medicare, is Medco's standard Medicare Part D Formulary, which contains a wide selection of medications made by the major drug companies and is divided into four tiers. Each tier has a different *In-Network* Copayment.

Obtaining a Formulary Guide
You will receive a copy of Medco's formulary guide in the mail at your Preferred Address after your enrollment in the Prescription Drug Program is confirmed and annually at Annual Open Enrollment. You can also obtain a copy by calling Medco or by visiting their website.

Prescription Drug ID Cards
If you are Medicare-eligible, you will receive a letter acknowledging your completed election in Alcatel-Lucent's Medicare Part D Prescription Drug Program after you enroll. If you don't receive your prescription drug ID card(s) by January 1 of the year of coverage, the letter will include the information you need to have prescriptions filled at a pharmacy. Once CMS approves your enrollment, you will receive your actual prescription drug ID card(s).

Pharmacy Services

You are entitled to the following additional pharmacy services under the Prescription Drug Program:

- **Drug Utilization Review**. Prescriptions filled through the Program become part of a computerized database which alerts Participating Pharmacy or mail service pharmacists to potential drug interactions each time you have a prescription filled

- **Toll-Free Prescription Drug Customer Service**. Medco maintains a special toll-free customer service number (1-800-336-5934) to help you with:

  — General questions about the Prescription Drug Program;

  — Locating a Participating Pharmacy;

  — Obtaining an order form/envelope for the mail service or a claim form for a prescription filled at a nonparticipating Pharmacy;

  — Emergency pharmacist consultations, 24 hours a day, seven days a week;

  — Large-print or Braille labels on medications filled through the mail service, upon request; and

— Telephone numbers for hearing-impaired participants (1-800-759-1089) and overseas retirees (1-972-915-6698) weekdays from 8:00 a.m. to 12 midnight, Eastern Time, and on Saturdays from 8:00 a.m. to 6:00 p.m., Eastern Time.

In addition to the services already discussed within this section, when you call, you can:

- Ask about a price or determine the coverage amount of a specific drug;
- Verify your eligibility status;
- Request a summary of your prescription drug activity; or
- Access a pharmacist for medication counseling.

Section H. What's Not Covered

About Exclusions

Certain services, supplies or charges are not Covered under the Enhanced or Standard POS options or under the Traditional Indemnity option, the Prescription Drug Program and the Mental Health and Chemical Dependency (MH/CD) Program. No benefits will be paid for excluded expenses under any circumstances.

If You are in an HMO
If you select coverage under an HMO, contact the HMO for specific information about exclusions.

Please note: For information about exclusions under the SecureHorizons® MedicareDirect™ PFFS Plan, see **Appendix A. SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS)--Retiree Benefits Summary Insert** at the end of this SPD.

General Exclusions

No benefits will be paid for any of the following services, supplies or expenses under the Enhanced or Standard POS option or under the Traditional Indemnity option, the Mental Health and Chemical Dependency Program and the Prescription Drug Program:

- Any service or supply not specifically included as a Covered expense;
- Services or supplies that aren't Medically Necessary;
- Treatment provided when coverage isn't in effect (for example, before coverage begins or after it ends);
- Inpatient care that begins before coverage is effective (even if an Inpatient stay in a Hospital or other facility continues after the Effective Date of coverage), provided that:
  - A Pre-Existing Condition limitation does not extend for more than 12 months (18 months in the case of a late enrollment date), and
  - The period of any such Pre-Existing Condition, as explained directly above, is reduced by any periods of creditable coverage (see "Creditable Coverage Certificates in **Section I. When Coverage Ends**);

- Custodial Care (including convalescent homes and rest cures);

- Charges for non-treatment purposes, including court proceedings (for example, Provider's charges to duplicate medical records, write medical assessments or perform an examination ordered as part of a legal suit; insurance physical, a condition of employment or as a component of professional certification);

- Services or supplies ordered or provided by a person or facility that doesn't qualify as a Provider under the Enhanced or Standard POS option or under the Traditional Indemnity option, the Mental Health and Chemical Dependency (MH/CD) Program or the Prescription Drug Program;

- Charges from a Provider operating outside the scope of his or her license;

- Services or supplies provided by a person or facility that isn't properly licensed in accordance with state and local law, unless the type of Provider is specifically named as Covered under the Enhanced or Standard POS option or under the Traditional Indemnity option or under the Mental Health and Chemical Dependency Program (unless the Mental Health and Chemical Dependency Provider has appropriate certification, as determined by your Health Plan Carrier, in a locality where licensure isn't available) or under the Prescription Drug Program;

- Professional services provided by a person living in your home or related to you by blood or marriage (parent, Child, Lawful Spouse or Domestic Partnership Dependent);

- Conditions related to current or past military service;

- Treatment for caffeine addiction;

- Charges for Experimental or Investigative Treatment, Drugs or Devices;

- Charges you have no legal obligation to pay;

- Charges that wouldn't be made if there weren't any healthcare coverage;

- Work-related illness or injury Covered by workers' compensation and/or the Alcatel-Lucent Short Term Disability Plan or the Alcatel-Lucent Sickness and Accident Disability Benefit Plan;

- Services and supplies that are the responsibility of a local, state or federal government agency to provide or cover;

- Charges another plan is required to pay;
- Charges third parties are required to pay;
- Capital improvements to your home, such as electrical wiring and plumbing; and
- Nutritional counseling, education, or planning services provided for general health or wellness, weight-loss, or weight-gain objectives that are not associated with a diagnosed illness. In addition, the Plan does not cover meal preparation by a nutritionist.

Enhanced and Standard POS Options and Traditional Indemnity Option Exclusions

The Enhanced and Standard POS options and the Traditional Indemnity option won't pay any benefits for the following services, supplies and expenses:

- Expenses beyond the stated limits, including:
  - Charges above the Allowable Amount;
  - Charges above the semiprivate room rate; and
  - Any charges for not obtaining precertification when required (see "Care You Must Certify" in **Section F. When Precertification Is Required Under the POS and Traditional Indemnity Options**).
- Any care delivered without the approval of a Physician, unless otherwise noted under the options.
- Treatment of developmental disorders.
- Predictable complications of non-Covered treatment.
- Routine physical exams received Out-of-Network under the Enhanced or Standard POS or Traditional Indemnity option.
- Well-Child exams, well-woman exams and childhood immunizations received Out-of-Network under the Enhanced or Standard POS option or under the Traditional Indemnity option.
- Treatment of refractive vision problems (including eye examinations, eyeglasses and contact lenses; orthoptics [eye exercises] and surgical treatment like radial keratotomy [RK], laser-assisted in situ keratomileusis [LASIK] and [photorefractive keratectomy [PRK]).

- Vocational therapy.

- Speech Therapy (unless the speech was impaired by illness, injury or birth defect).

- Routine foot care, which includes pedicure services such as the routine cutting of nails, unless Medically Necessary.

- Fertility assistance and other similar types of procedures, including, but not limited to, in vitro fertilization, artificial insemination, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).

- Nutrition services received Out-of-Network under the Enhanced POS option or under the Traditional Indemnity option.

- Treatment of obesity or a weight-loss conditions, unless it's Medically Necessary treatment of Morbid Obesity, subject to all other conditions (weight-related conditions that are diagnosed as anorexia nervosa or bulimia would be treated under the terms of the Mental Health and Chemical Dependency Program; treatment of medical conditions caused by these psychological conditions, like malnutrition or heart conditions, are Covered under the Medical Plan options).

- Cosmetic surgery or other cosmetic treatment (unless it's considered to be restorative surgery under the Medical Plan options).

- Growth hormone therapy (unless there is documented evidence of pituitary deficiency and there is adequate response).

- Dental and orthodontic treatment (except for Hospital room and board charges if Hospitalization is Medically Necessary to safeguard the patient due to a specific non-dental organic impairment).

- Dental care to replace sound, natural teeth (unless the teeth are injured through an accident other than chewing, damage isn't wholly or partially due to existing decay or damage and treatment begins within three months of the accident).

- Nonsurgical treatment of the joint of the jaw (temporomandibular joint dysfunction [TMJ]).

- Care provided to a person not Covered under the Medical Plan options who donates an organ to a Covered individual if the donor has other coverage.

- Charges for chiropractic care, Physical Therapy or physical medicine that seeks to treat conditions other than musculoskeletal conditions (that is,

conditions related to the nerves, muscles and ligaments, such as lower back pain). In addition, the Plan will not provide coverage for chiropractic, Physical Therapy, or physical medicine visits or treatments for Preventive Care or to maintain a current state of health (for example, using chiropractic care to treat nausea or dizziness). The Plan also will not cover chiropractic, Physical Therapy, or physical medicine services that are provided in a home, a Hospital, or facility other than an office setting.

- Drugs and medicines available without a prescription.
- Prescription drugs dispensed through a pharmacy (may be Covered under the Prescription Drug Program).
- Personal convenience items (regardless of whether the items are on an Outpatient basis, in the home or as part of a Hospital stay).
- Orthotics, braces and other supports not prescribed by a Physician or used for extracurricular activities such as athletics (even if they are prescribed by a Physician) and are not necessary for daily living activities.
- Hearing aids to compensate for loss of hearing due to age, repeated exposure to loud noise or congenital defect (unless hearing loss is caused by illness or injury while you are Covered under the POS or Traditional Indemnity option and hearing aid benefits are available under the conditions specified).
- Charges for items to assist in general fitness (for example, exercise equipment).
- Charges eligible for payment under a no-fault or state-mandated automobile insurance law or policy.

Mental Health and Chemical Dependency Program Exclusions

The Mental Health and Chemical Dependency (MH/CD) Program won't pay any benefits for the following excluded services, supplies and expenses:

- Expenses beyond the stated limits including:
  - Charges from Out-of-Network Providers above the Allowable Amount,
  - Room and board charges from an Out-of-Network Hospital above the semiprivate room rate,
  - Any charges for not obtaining precertification from your Health Plan Carrier for an Out-of-Network In-Patient admission, and

— Any charges for not precertifying **In-Network** services;

- Charges for missed or failed appointments;
- Treatment provided by telephone unless specifically authorized by your Health Plan Carrier;
- Inpatient stays primarily for environmental change;
- Alternative Treatment facilities accessed or provided Out-of-Network;
- Conditions other than a mental disorder or Chemical Dependency;
- Developmental disorders such as mental retardation or learning disabilities that cannot be corrected with treatment;
- Obesity or weight loss conditions (unless there is a diagnosis of anorexia nervosa or bulimia in which case treatment of those illnesses is Covered);
- Routine physical exams or tests to investigate a potential physiological cause of a mental disorder (may be Covered under the medical benefits portion of your Medical Plan option);
- Psychotherapy in conjunction with self-actualization therapy;
- Vocational therapy to teach or train a Covered individual to resume employment (unless integrated with a Covered treatment program provided to a patient in a Hospital or Alternative Treatment facility);
- Aversion treatment of Chemical Dependency (treatment that administers alcohol with drugs designed to create an adverse reaction and a long-term psychological aversion to alcohol);
- Therapies based on nutrition or dietary supplements such as vitamins; and
- All supplies (except prescription drugs administered as part of a Covered stay in an Inpatient facility; prescription drugs filled on an Outpatient basis may be Covered under the Prescription Drug Program).

Prescription Drug Program Exclusions

The Prescription Drug Program won't pay any benefits for:

- Drugs and medicines provided (or that can be obtained) without a prescription from a Physician;
- Non-federal legend drugs;

- Kutapressin;
- Ostomy supplies;
- Therapeutic devices not considered to be drugs (may be Covered under the medical benefits portion of your Medical Plan option);
- Drugs used solely to promote hair growth;
- Immunization agents, vaccines or biologicals;
- Blood or blood plasma (Covered under the medical benefits portion of your Medical Plan option);
- Drugs labeled "Caution — limited by federal law to investigational use" or Experimental Drugs even if you are charged for those drugs;
- Drugs used for Experimental or Investigational purposes;
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or local governmental agency or any drug or medical service furnished at no cost to the Covered individual;
- Medication provided to a Covered individual while a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, Extended Care Facility (for example, a Skilled Nursing Facility), convalescent Hospital, nursing home, Home Health Care Agency or similar institution that has a facility for dispensing pharmaceuticals on its premises;
- Prescriptions filled in excess of the refill number specified by the Physician or any refill dispensed one year after the original prescription;
- Charges for the administration or injection of any drug;
- Nutritional dietary supplements;
- Any drug or medicine not Medically Necessary to treat the condition;
- Prescriptions filled at a pharmacy that exceed the 30-day limit (34 days under the Prescription Drug Program for Medicare-Eligible Retirees and Dependents; 90 days for insulin) or through the mail that exceed the 90-day limit; and
- Diabetic blood testing monitors.

Section I. When Coverage Ends

When Retiree Coverage Ends

Your coverage under the Medical Plan ends on the last day of the month in which any of the following events occurs:

- You request that coverage be waived;
- You do not make any required contributions;
- The Company you retired from ceases to be a Participating Company; or
- The Medical Plan is terminated.

When your coverage ends, you may be able to continue coverage (see **Section J. Continuing Coverage**).

When Dependent Coverage Ends

Your dependent's(s') coverage under the Medical Plan will end as follows:

- If your coverage ends, coverage for your Eligible Dependents (for example, your Lawful Spouse, Domestic Partner or dependent Children) will end on the same day. (For example, if you request on June 15 to waive coverage, your and that of your Eligible Dependents(s) will end on June 30, the last day of the month in which your request to waive coverage occurs.)
- If your Eligible Dependent Child reaches age 20 and is not a full-time student or does not certify as a full-time student, coverage will end at the end of the month in which he or she reaches age 20.
- If your Eligible Dependent Child is continuously enrolled as a full-time student and reaches age 24, his or her coverage will end at the end of the month in which he or she reaches age 24.

When Dependent Coverage Ends Under an HMO
If you are Covered under an HMO, your Eligible Dependent Children might remain eligible for coverage past age 20 (if not a full-time student) and 24 (if a full-time student). Contact your HMO directly for more information.

- If your Eligible Dependent Child marries, coverage for this dependent Child will end on the last day of the month in which the marriage occurs.

- If you and your Lawful Spouse divorce, your Lawful Spouse's coverage will end on the last day of the month in which the divorce becomes final.

- If your Domestic Partner relationship ends (or you and your Domestic Partner no longer satisfy the Medical Plan's eligibility criteria for Domestic Partnership), your Domestic Partner's coverage will end on the last day of the month in which the Domestic Partnership ends (or in which the eligibility criteria are no longer satisfied).

- If your Dependent ceases to be an Eligible Dependent for any other reason, coverage for such Dependent will end on the last day of the month in which such ineligibility occurs (see **Section B. Joining the Medical Plan** for Dependent eligibility criteria).

If Your Physically or Mentally Handicapped Child Reaches Age 20

If your physically or mentally handicapped Child is incapable of self-support when he or she reaches age 20, coverage may be continued beyond that age, if the Child is fully dependent on you for support and maintenance at that time. You must apply for this coverage. It's not automatic. To apply for coverage, contact your Health Plan Carrier at the number printed on your medical ID card. Also notify the Alcatel-Lucent Benefits Center at 1-888-232-4111 of your intention to seek coverage for a Child beyond age 20. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

Creditable Coverage Certificates

When your coverage ends, you will receive a Certificate of Creditable Coverage in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You may also request, free of charge, a Certificate of Creditable Coverage up to 24 months after losing coverage. A Lawful Spouse receives his or her own certificate. Domestic Partnership Dependents and Dependent Children are listed on your certificate. A Certificate of Creditable Coverage is evidence of the fact that you and your dependents, if applicable, had coverage under the Medical Plan. It lists the beginning date and ending date of each person's coverage.

You must present your certificate to your new employer or health insurer if you or your dependents have a Pre-Existing Condition that would otherwise limit eligibility for coverage under your new employer's or health insurer's group health plan. The Certificate of Creditable Coverage will reduce the amount of time that you are subject to a Pre-Existing Condition exclusion under your new employer's or health insurer's group health plan.

Section J. Continuing Coverage

Extended Coverage During Hospitalization

If you or a Covered Dependent is Hospitalized when coverage is otherwise scheduled to end, coverage for that individual's current Hospital stay **only** may continue for a limited period of time. For a medical condition, coverage may continue for the duration of the Hospital stay, up to a maximum of 120 days. If treatment is for a mental health or Chemical Dependency condition, benefits may continue while the individual is Hospitalized, up to the applicable Inpatient maximum under the Mental Health and Chemical Dependent (MH/CD) Program. Subject to the individual's right to elect COBRA continuation coverage, benefits will end on the **earlier** of the date:

- The individual is released from the Hospital; or
- The maximum is reached.

COBRA Continuation Coverage

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to offer "qualified beneficiaries" (certain employees and the Covered Dependents of both active and retired employees) 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. The Medical Plan also provides COBRA-like rights to participants' Domestic Partners.

Class II Dependents
Class II dependent children and Class II dependent grandchildren are eligible for COBRA continuation coverage. Any other Class II dependents are **not** eligible for COBRA continuation coverage.

Please note: If your Covered Dependents are eligible for any other continuing healthcare coverage offered by the Company, that coverage will run concurrently with their COBRA continuation coverage period.

Also note that it is your or your qualified beneficiary's(s') responsibility to notify the Alcatel-Lucent Benefits Center at 1-888-232-4111 of a qualifying event (such as your Lawful Spouse's loss of eligibility if you and your Covered Lawful Spouse divorce) that makes your dependent eligible for COBRA coverage. You or your qualified beneficiary must notify the Alcatel-Lucent Benefits Center within 31 days of the event.

The individual eligible for COBRA continuation coverage must respond by the date on his or her notice of COBRA rights to be eligible for COBRA continuation coverage.

In These Events…	Your Covered Dependents Can Receive COBRA Coverage
• Your divorce or legal separation; • Termination of your Domestic Partnership; • Your death; or • Your Class I dependent's(s') and Class II dependent Child's/Children's loss of eligibility under the Medical Plan (see "Who Is Eligible" in **Section B. Joining the Medical Plan**).	Your Covered Dependents may continue coverage for up to 36 months.

If You Die
Coverage for your enrolled Class I dependents, Domestic Partnership Dependents, and Class II dependent Children may continue for six months at the retiree rate after you die. Your surviving Dependent must contact the Alcatel-Lucent Benefits Center at 1-888-232-4111 for information about the cost of this coverage.

After six months, these dependents have the option of continuing coverage under COBRA for up to another 30 months (a total of 36 months) if they make the required contributions. Class II dependents, other than Class II dependent Children, are not eligible for the Company-paid coverage, and do not have the option to continue coverage under COBRA.

At the end of the COBRA continuation period, your surviving Lawful Spouse may choose to enroll in the Family Security Program (see "Continuing Dependent Coverage Through the Family Security Program in this **Section J. Continuing Coverage**).

Please note: If your surviving spouse is now or at any time in the future entitled to Medicare benefits, your surviving spouse must contact the Alcatel-Lucent Benefits Center immediately. Entitlement to Medicare may significantly impact your surviving spouse's Alcatel-Lucent benefits. This includes medical options for which he or she is eligible, along with your surviving spouse's monthly cost for medical coverage.

How COBRA Continuation Coverage Is Affected by Multiple Qualified Events
If your spouse, Domestic Partner or Children experience more than one qualifying event, they may be eligible for an additional period of continued coverage, not to exceed a total of 36 months from the initial qualifying status change.

A qualified beneficiary (other than you — the employee or former employee) may be eligible for an additional period of COBRA continuation coverage, not to exceed a total of 36 months from the initial qualifying event.

To be eligible for extended coverage after a second qualifying event, you or your qualified beneficiary must notify the Alcatel-Lucent Benefits Center at 1-888-232-4111 within 31 days of the date of the second qualifying event. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

Covering a Newborn or Newly Adopted Dependent During a COBRA Continuation Period
If your qualified beneficiary, while enrolled in COBRA continuation coverage, has a baby, legally adopts a Child or a Child is placed for legal adoption, the Child will be a "qualified beneficiary" and eligible for COBRA continuation coverage.

A parent or legal guardian can make COBRA elections on behalf of a minor Child.

How Much COBRA Continuation Coverage Costs
Generally, the qualified beneficiary pays the full cost of COBRA continuation coverage, plus a two percent administrative fee.

Electing COBRA Continuation Coverage
It is your or your qualified beneficiary's responsibility to notify the Alcatel-Lucent Benefits Center at 1-888-232-4111 within 31 days of the qualifying event. (You will have 60 days from the date of the qualifying event to elect COBRA continuation coverage.)

Complete details about COBRA continuation coverage, including information about election and cost, will then be sent to the Preferred Address of the qualified beneficiary within 14 days of the date the qualifying event is reported.

The Family Security Program (FSP)

If you die while covered under the Medical Plan, your surviving Lawful Spouse or Domestic Partner who has either exhausted the 36-month COBRA continuation period or is ineligible for COBRA continuation coverage because he or she is entitled to Medicare has the option to join the Family Security Program ("FSP") and continue coverage under the Traditional Indemnity option (or Medicare Advantage HMO, if available) if he or she pays the full cost of this coverage.

Your surviving Lawful Spouse or Domestic Partner also may cover any Class I dependent Children or Class II dependent Children who were enrolled in the

Plan immediately before your death and who elected COBRA continuation coverage for the duration of the applicable coverage period, as long as they still qualify as eligible Class I or Class II dependents.

As long as your surviving Lawful Spouse or Domestic Partner makes the required contributions under the Traditional Indemnity option (or Medicare Advantage HMO, if available), coverage may continue as follows:

- Surviving Lawful Spouse/Domestic Partner coverage may continue indefinitely; and
- Dependent Child coverage may continue until the earlier of the date:
  - Your surviving Lawful Spouse's or Domestic Partner's coverage ends; or
  - The dependent Child ceases to satisfy the Medical Plan's eligibility criteria (see "When Dependent Coverage Ends" in **Section I. When Coverage Ends**).

Section K. Claims and Appeals

Types of Claims

The Medical Plan contemplates two types of claims:

- Eligibility claims; and
- Benefits claims.

Eligibility Claims

An eligibility claim is a claim by you or your dependent concerning your or his or her right to participate in the Medical Plan. For example, you may believe an error was made during an Annual Open Enrollment that resulted in your being assigned incorrect coverage, or you may believe you or a dependent incurred a "qualified status change" that entitles you or your dependent to make a change in Plan coverage during the year but you are being told you or your dependent has to wait until the next Annual Open Enrollment to make the change. Another example of an eligibility claim is a claim to be included as a participant in the Medical Plan.

There is only one type of eligibility claim, and it generally will be handled within the time frame described below. However, if an eligibility claim is coupled with a (non-Urgent) pre-service benefits claim, an Urgent pre-service benefits claim, or a concurrent care benefits claim (these types of benefits claims are described below; see "Benefits Claims" immediately below), an effort will be made to handle the eligibility claim in tandem with the benefits claim.

Benefits Claims

A benefits claim is exactly what it sounds like — it is a claim for benefits under the terms of the Medical Plan. Benefits claims are further broken down into sub-types, which have relevance when it comes to the amount of time the Medical Plan has to decide the claim. The Medical Plan contemplates four benefits claim sub-types:

- **Post-Service Claims.** These are claims where you or a Covered Dependent has already received medical care and is seeking payment for that claim (whether directly to you or to a medical services Provider such as a Physician or Hospital).

- **Pre-Service Claims (Non-Urgent).** These are claims for coverage with respect to medical procedures or services that have not yet been performed because precertification — or approval — is required under the Medical Plan.

- **Urgent Pre-Service Claims.** These are claims for coverage with respect to medical procedures or services that have not yet been performed because precertification — or approval — is required under the Medical Plan **and** the delay in receiving the procedures or services that would result from the longer time frame for making a coverage determination under the Medical Plan's claim procedures for non-Urgent pre-service claims:

  — Could be considered a life or death situation;

  — Could seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or

  — In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be managed without the care or treatment that is the subject of the claim.

- **Concurrent Care Claims.** These are claims where the Medical Plan previously approved an ongoing course of treatment (to be provided over a period of time or a series of treatments) and has now decided to reduce or terminate the course of treatment (either by shortening the period of time or series of treatments or refusing to extend the period of time or series of treatments). These claims must also be "Urgent," meaning that the delay in receiving the ongoing treatment or continuing with a series of treatments that would result from the longer time frame for making a coverage determination under the Medical Plan's non-Urgent Pre-service claim procedures:

  — Could be considered a life or death situation;

  — Could seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or

  — In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be managed without the care or treatment that is the subject of the claim.

As noted, depending on the benefits claim subtype, the Medical Plan has a longer or shorter period of time within which it must act on your claim.

Eligibility Claims

Filing Deadlines

If you have an eligibility claim, contact the Alcatel-Lucent Benefits Center at 1-888-232-4111. If appropriate, a representative will provide you with an eligibility claim form, called a Claim Initiation Form ("CIF"). Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

On the CIF, you will be asked to set forth the nature of the claim (for example, failure to include someone as a Covered Dependent, failure to permit a mid-year change in elections, or incorrect coverage option), all pertinent facts and the reasons why you believe you are entitled to the relief you are requesting. Also, include with your CIF any documentation supporting your claim.

Where to Send Your Claim Form

Mail your completed CIF and any enclosures to the following address:

Alcatel-Lucent Benefits Review Team
P.O. Box 1407
Lincolnshire, IL 60069-1407

If your eligibility claim is coupled with a claim for benefits, send the benefits claim form to the appropriate Health Plan Carrier, but also include a **copy** of it with your eligibility claim submitted to the Benefits Review Team. Be sure to note, in your eligibility claim submitted to the Benefits Review Team, whether the benefits claim submitted to the Health Plan Carrier is a post-service claim, a pre-service claim, an Urgent pre-service claim, or a concurrent care claim.

When You Can Expect To Receive a Decision

When you file an eligibility claim, the Benefits Review Team reviews the claim and makes a decision to either approve or deny the claim. Generally, you will be notified of the Benefits Review Team's decision within 30 days after its receipt of your claim. The Benefits Review Team may extend the period for making the claim decision by 15 days if it determines that an extension is necessary and notifies you, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision.

If you do not provide sufficient information to allow the Benefits Review Team to make a decision with respect to your eligibility claim, you will be notified of the need for the information. You will have at least 45 days from receipt of the notice to provide the specified information. In such an instance, the Benefit Review Team's deadline for rendering a decision is suspended from the date on which it sends notice of the need for necessary information until the date on which you provide the information. For example, if the Benefits Review Team notifies you on Day 10 of the initial 30-day review period that additional information is required, you will have 45 days from your receipt of the notice to provide the necessary information. If the Benefits Review Team then receives that information on, for example, Day 30 of your 45-day response time, the time within which the Benefits Review Team is required to decide your claim picks up as if it were Day 11 of its initial 30-day review period.

What You will Be Told If Your Eligibility Claim Is Denied
If your eligibility claim is denied, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial;
- The specific Medical Plan provisions on which the denial is based;
- A description of any additional material or information needed and an explanation of why it is necessary;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the benefits claim; and
- An explanation of the Medical Plan's claim review procedures, applicable time limits and your rights. If your claim is denied and your appeal is also denied, you have the right to bring a civil action in federal court under ERISA Section 502(a).

Appeal Procedures and Deadline
If your initial eligibility claim is denied by the Benefits Review Team, you or your authorized representative may appeal the denial under the Medical Plan's administrative review procedures. The Medical Plan contemplates a single, mandatory appeals process with respect to eligibility claims.

Your appeal must be in writing and should be addressed to:

Alcatel-Lucent
Employee Benefits Committee
600-700 Mountain Avenue
Room 7C-415

Murray Hill, New Jersey 07974
You should include a copy of your initial claim denial notification, the reason(s) for the appeal and relevant documentation with your appeal request.

You must file your appeal within 180 days from the date on the claim denial letter. During the 180-day period, you or your authorized representative will be given reasonable access to all documents and information relevant to the claim, and you may request copies free of charge. You can also submit written comments, documents, records and other information relating to the appeal to the Employee Benefits Committee.

Review of your appeal will take into account all comments, documents, records and other information relating to the appeal, without regard to whether the information was submitted to or considered by the Benefits Review Team in connection with the initial claim decision. Your appeal will be reviewed "de novo," which means you get to "start fresh" with your claim on appeal. In reviewing your appeal, the Employee Benefits Committee will not place deference upon the original decision. Your appeal will be reviewed by an appropriate named fiduciary who is not the individual who made the initial decision, who is not subordinate to the initial reviewer and who will give a full and fair review of the claim and the denial.

When You Can Expect To Receive a Decision on Appeal
The Employee Benefits Committee will review your appeal and you will be notified of the decision on appeal within 60 days after receipt of your appeal.

Please note: If your eligibility appeal is coupled with a non-Urgent pre-service benefits appeal, Urgent pre-service benefits appeal, or concurrent care benefits appeal, as the case may be, an effort will be made to decide your eligibility appeal within the time frames applicable to the benefits claim.

What You will Be Told If Your Eligibility Claim Is Denied on Appeal
If your eligibility claim is denied on appeal, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial;
- The specific Medical Plan provisions on which the denial is based;
- A statement about the claimant's right to bring an action under section 502(a) of the Employee Retirement Income Security Act (ERISA);

Other Voluntary Options

There is no independent, voluntary third-party appeal review process for eligibility claims. If the Employee Benefits Committee denies your eligibility claim on appeal, you have the right to bring a civil action in federal court under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). This option is available to you only after you have exhausted all of the administrative remedies available to you through the Medical Plan's claims and appeals process as described in this section.

Benefits Claims

One of the advantages of *In-Network* care under the Point of Service (POS) options or the Mental Health and Chemical Dependency (MH/CD) Program is that you don't need to submit any claim forms. This also applies if you use Preferred Provider Organization (PPO) Providers under the Traditional Indemnity option or if you have prescriptions filled through Participating Pharmacies or the Medco Pharmacy.

However, you do need to submit a claim form to receive benefits under the Traditional Indemnity option when you don't use a PPO Provider or for Out-of-Network care under the POS options or the MH/CD Program. You also need to submit a claim to receive benefits for prescriptions filled at non-Participating Pharmacies.

Claim Deadlines

In instances where you are required to file a claim form in connection with a benefits claim, you should submit claims within 60 days of the date the service is provided. If it's not reasonably possible to submit a claim within this time frame, an extension of up to 15 months from the date of service will be allowed. However, **no benefits will be paid for claims submitted more than 15 months after the date of service.**

To file a benefits claim:

- If you don't have a claim form, call your Health Plan Carrier at the number printed on your medical (or, if applicable, Prescription Drug Program) ID card to request a claim form. You may also be able to print out a claim form at the applicable Health Plan Carrier's Web site.
- Follow the instructions printed on the form.
- Attach a copy of the Provider's itemized bill.
- Submit the completed form and attachments to the address printed on the form.

Your claim will be evaluated to determine if any benefits will be paid. You will receive an Explanation of Benefits (EOB) statement. If benefits are payable, a check will be sent to you, or to your Provider if he or she agreed to accept payment directly from your Health Plan Carrier. If your claim is denied, you will be advised of the reasons for the denial and may appeal the decision (see, respectively, "What You will Be Told If Your Benefits Claim Is Denied" and "Appeal Procedures and Deadline" later in this section).

When You Can Expect To Receive a Decision
When you file a benefits claim, the Claims Administrator reviews the claim and makes a decision to either approve or deny the claim. The time frames within which you can expect to be advised of that decision are described below.

Post-Service Claims
Generally, you will be notified of the Claims Administrator's decision with respect to a post-service claim within 30 days after the Claims Administrator's receipt of your claim. The Claims Administrator may extend the period for making the claim decision by 15 days, if it determines that an extension is necessary and notifies you, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision.

If you do not provide sufficient information to allow the Claims Administrator to determine whether, or to what extent, the claim is Covered under the Medical Plan, you will be notified of the need for the information. You will have at least 45 days from receipt of the notice to provide the specified information. In such an instance, the Claims Administrator's deadline for rendering a decision is suspended from the date on which it sends notice of the need for necessary information until the date on which you provide the information. For example, if the Claims Administrator notifies you on Day 10 of the initial 30-day review period that additional information is required, you will have 45 days from your receipt of the notice to provide the necessary information. If the Claims Administrator then receives that information on, for example, Day 30 of your 45-day response time, the time within which the Claims Administrator is required to decide your claim picks up as if it were Day 11 of its initial 30-day review period.

Pre-Service Claims (Non-Urgent)
Generally, you will be notified of the Claims Administrator's decision with respect to a non-Urgent pre-service claim within 15 days after the Claims Administrator's receipt of your claim. The Claims Administrator may extend the period for making the claim decision by another 15 days, if it determines that an extension is necessary and notifies you, before the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision.

If you do not provide sufficient information to allow the Claims Administrator to determine whether, or to what extent, the claim is Covered under the Medical Plan, you will be notified of the need for the information. You will have at least 45 days from receipt of the notice to provide the specified information. In such an instance, the Claims Administrator's deadline for rendering a decision is suspended from the date on which it sends notice of the need for necessary information until the date on which you provide the information. For example, if the Claims Administrator notifies you on Day 8 of the initial 15-day review period that additional information is required, you will have 45 days from your receipt of that notice to provide the necessary information. If the Claims Administrator then receives that information on, for example, Day 5 of your 45-day response time, the time within which the Claims Administrator is required to decide your claim picks up as if it were Day 9 of its initial 15-day review period.

Urgent Pre-Service Claims

Generally, you will be notified of the Claims Administrator's decision with respect to an Urgent pre-service claim within 72 hours after the Claims Administrator's receipt of your claim.

If you do not provide sufficient information to allow the Claims Administrator to determine whether, or to what extent, the claim is Covered under the Medical Plan, you will be notified within 24 hours after the Claims Administrator's receipt of your claim of the specific information needed to complete the claim. You will be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. You will be notified of the claim decision no later than 48 hours following the earlier of:

- The Claims Administrator's receipt of the specified information; or
- The end of the period afforded to you to provide the specified additional information.

Concurrent Care Claims

In the case of a denial of coverage involving a course of treatment (other than as a result of an amendment or termination of the Medical Plan) before the prescribed end of the period of time or number of treatments, you will be notified of the denial in advance of the reduction or termination to allow you to appeal and obtain a response to that appeal before the benefit is reduced or terminated.

If you do not provide sufficient information to allow the Claims Administrator to determine whether, or to what extent, the claim is Covered under the Medical Plan, you will be notified within 24 hours after the Claims Administrator's receipt of your claim of the specific information needed to complete the claim. You will be given a reasonable amount of time, taking into account the circumstances but not less than 48 hours, to provide the specified information. You will be notified of the claim decision no later than 48 hours following the earlier of:

- The Claims Administrator's receipt of the specified information; or
- The end of the period afforded to you to provide the specified additional information.

What You will Be Told If Your Claim Is Denied

If your benefits claim is denied, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial;
- The specific Medical Plan provisions on which the denial is based;
- A description of any additional material or information needed and an explanation of why it is necessary;
- An explanation of the Medical Plan's claim review procedures, applicable time limits and your rights to bring a civil action under ERISA Section 502(a) following exhaustion of these procedures; and
- Additionally:
  - If an internal rule, guideline or protocol was relied upon to determine a claim, a copy of the actual rule, guideline or protocol, or a statement that the rule, guideline or protocol was used and that explains that you can request a copy free of charge;
  - If the claim denial was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment relied upon in making the decision, or a statement that the explanation will be provided free of charge, upon request; and
  - In the case of a claim denial involving Urgent Care, an explanation of the expedited review process.

Appeal Procedures and Deadline

If your initial claim for benefits is denied, you or your authorized representative may appeal that denial under the Medical Plan's administrative review procedures. The Medical Plan contemplates a mandatory first-level appeals process and, with respect to some types of claims, a voluntary second-level appeals process. Responsibility for conducting the first-level review of a denied benefits claim is with the applicable Claims Administrator (see **Section P. Important Contacts**). (For information about the voluntary second-level appeal process for some claims, see "Independent Third Party Review" later in this section.)

Your appeal must be in writing and should be addressed to the appropriate Claims Administrator. You should include a copy of your initial claim denial notification, the reason(s) for the appeal and relevant documentation with your appeal request.

In the case of an Urgent Care appeal, you may file an expedited appeal verbally or in writing. All necessary information may be transmitted between you and the Medical Plan (or Claims Administrator) by telephone, facsimile or other available, similarly expeditious method.

You must file your appeal within 180 days of the date you receive notice of the denied claim. During the 180-day period, you or your authorized representative will be given reasonable access to all documents and information relevant to the claim, and you may request copies free of charge. You can also submit written comments, documents, records and other information relating to the appeal to the Claims Administrator.

In the case of an Urgent Care appeal, you may file an expedited appeal verbally or in writing. All necessary information may be transmitted between you and the Medical Plan (or Claims Administrator) by telephone, facsimile or other available, similarly expeditious method.

Review of your appeal will take into account all comments, documents, records and other information relating to the appeal, without regard to whether the information was submitted or considered in the initial claim decision. Your appeal will be reviewed "de novo." That means you get to "start fresh," and an independent Medical Plan fiduciary will review your appeal. In reviewing your appeal, he or she will not place deference upon the original decision. Your appeal will be reviewed by an appropriate named fiduciary who is not the individual who made the initial decision, who is not subordinate to the initial reviewer and who will give a full and fair review of the claim and the denial.

If your appeal involves a medical judgment, including determinations as to whether a particular treatment, drug or other item is Experimental, Investigational or not Medically Necessary or appropriate, the Claims Administrator will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The healthcare professional will be an individual who was neither consulted in connection with the claim decision nor the subordinate of any such individual. Also, the Claims Administrator will identify any medical or vocational experts whose advice was obtained on the Medical Plan's behalf in connection with your claim decision, without regard to whether the advice was relied upon in making the claim decision.

When You Can Expect To Receive a Decision on Appeal
The Claims Administrator will review your appeal and you will be notified of the decision according to these time frames:

- **Post-Service Benefits Appeal.** You will be notified of the appeal decision with respect to a post-service benefits claim within 60 days after receipt of your appeal.

- **Pre-Service Benefits Appeal (Non-Urgent).** You will be notified of the appeal decision with respect to a (non-Urgent) pre-service benefits claim within 30 days after receipt of your appeal.

- **Urgent Pre-Service Benefits Appeal**. You will be notified of the appeal decision with respect to an Urgent pre-service benefits claim as soon as possible, but no later than 72 hours after receipt of your appeal.

- **Urgent Concurrent Care Benefits Appeal.** You will be notified of the appeal decision with respect to your Urgent concurrent care benefits claim within 72 hours after receipt of your appeal.

What You will Be Told If Your Benefits Claim Is Denied on Appeal
If your benefits claim is denied on appeal, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial;

- The specific Medical Plan provisions on which the denial is based;

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the benefits claim;

- An explanation of the Medical Plan's voluntary appeal procedures (described below);

- If an internal rule, guideline or protocol was relied upon in connection with the denial of your benefits claim on appeal, a copy of the actual rule, guideline or protocol, or a statement that the rule, guideline or protocol was used and that you can request a copy free of charge;

- If the denial was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment relied upon in making the decision, or a statement that the explanation will be provided free of charge, upon request;

- A statement to the effect that "You and the Medical Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

Independent Third-Party Review

In connection with certain benefits claims, the Medical Plan may offer you an independent, voluntary, third-party appeal review process. This process generally applies only to participants enrolled in options other than the Health Maintenance Organization (HMO) option. The process also generally applies to certain claims for services that have been denied by the Point of Service (POS) or Traditional Indemnity options, or Prescription Drug and/or Mental Health and Chemical Dependency (MH/CD) Program service Providers.

Claims for which voluntary third-party review is available are reviewed by Island Peer Review Organization (IPRO), the third-party review administrator. If your claim is eligible for the independent review process, you (or your Covered Dependent) will be notified by the appropriate Claims Administrator.

Claims eligible for third-party review generally must meet all of the following:

- The claimant must have exhausted all administrative appeals or processes available through the Claims Administrator under the terms of the Medical Plan;

- The claim must relate to an extreme illness or injury;

- The appeal must have been denied either due to a lack of Medical Necessity or because the claim relates to an Experimental or Investigational Treatment, as defined in the Medical Plan; and

- The claim must otherwise be payable under the terms of the Medical Plan.

If you wish to request an independent third-party review, contact the Claims Administrator.

If your claim is again denied following third-party review, the Claims Administrator will not review your matter again.

Other Voluntary Options

If the Claims Administrator denies your benefits claim on appeal, you have the right to bring a civil action in federal court under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). This option is available to you only after you have exhausted all of the administrative remedies available to you through the Medical Plan's claims and appeals process as described in this section.

Section L. How Coordination of Benefits Works

What Coordination of Benefits Is

The Medical Plan has a Coordination of Benefits (COB) provision. This feature is designed to prevent duplicate benefit payments when you or your Eligible Dependents participate in more than one group health plan or are simultaneously covered by this Plan and a government plan such as Medicare.

> **If You are Medicare-Eligible**
> Besides reviewing this section, be sure to review the next section, **Section M. What You Need to Know About Medicare**.

Please note: Coordination of Benefits with Medicare is discussed in the next Section of this SPD (see "Effect of Medicare Eligibility on Plan Benefits" in **Section M. What You Need to Know About Medicare**). Coordination of Benefits as discussed in this Section L means coordination of benefits under this Plan with coverage under either another group health plan or under a government plan other than Medicare.

When the Coordination of Benefits Applies

The COB provision as discussed in this Section L applies when you or your Eligible Dependents have medical coverage in addition to that provided under the Medical Plan, such as:

- A group-sponsored insurance or prepayment plan; or
- A government-sponsored plan (excluding Medicare) (for coordination of benefits with Medicare, see "Effect of Medicare Eligibility on Plan Benefits" in **Section M. What You Need to Know About Medicare**).

When the Coordination of Benefits Does Not Apply

The COB provision described in this Section L does not apply:

- When the other healthcare coverage is Medicare (for coordination of benefits with Medicare, see "Effect of Medicare Eligibility on Plan Benefits" in **Section M. What You Need to Know About Medicare**);
- To benefits under any personal policy (except no-fault or other state-mandated automobile insurance); and

- To two related people, both of whom are employees or retirees of the Company or a Participating Company, due to the following two rules:

  — One person cannot receive Medical Plan benefits as both an Eligible Employee and a dependent of an Eligible Employee of the Company or a Participating Company; and

  — One person cannot receive Medical Plan benefits as an Eligible Dependent of more than one Eligible Employee or retiree of the Company or a Participating Company.

  — One person cannot receive Medical Plan benefits as both an Eligible Employee or Eligible Retiree of the Company or a Participating Company and as an Eligible Dependent of such an Eligible Employee or Eligible Retiree; and

  — One person cannot receive Medical Plan benefits as an Eligible Dependent of more than one Eligible Employee or Eligible Retiree of the Company or a Participating Company.

How Coordination of Benefits Works: Which Plan Pays First

Under the COB provision, the Claims Administrator determines that one plan is primary and pays benefits first. Any other plan is secondary. To claim benefits, submit your claim to the primary plan first. After that plan determines its benefits, submit a claim to the secondary plan(s) along with a copy of the Explanation of Benefits (EOB) statement you received from the primary plan. The secondary plan(s) will then determine whether any additional benefits are payable.

- If the Medical Plan is the primary plan, it pays its benefits without regard to the secondary plan.

- If the Medical Plan through Alcatel-Lucent is secondary, the Medical Plan coordinates benefits with the primary plan(s). Here's how this works. The Claims Administrator first calculates what the Medical Plan would have paid if it were the primary plan. Then, the Claims Administrator reviews the Explanation of Benefits (EOB) statement you received from the primary plan to determine what the primary plan paid. The Medical Plan then pays the difference, up to the Allowable Amount the Medical Plan would have paid if it were the primary plan. Therefore, among the primary and secondary plans, you can receive up to 100 percent (but not more than 100 percent) of the Allowable Amount under the highest-paying plan.

- The Claims Administrator determines which plan(s) is (are) primary and which plan(s) is (are) secondary under the following rules:

- If the other plan(s) does (do) have a COB feature, that plan(s) is (are) considered primary, and the Medical Plan is considered secondary.

- If you are actively employed by a company other than Alcatel-Lucent, and you are eligible for coverage with your new employer, that plan is primary, and the Medical Plan is secondary.

- If your Lawful Spouse or Domestic Partner is employed by a company other than Alcatel-Lucent, and he or she is eligible for coverage under his or her employer's plan, that plan is primary, and the Medical Plan is secondary.

- If you are retired from another company, in addition to being retired from Alcatel-Lucent, the company that first owed you a retiree medical benefit pays before the company that owed you a retiree medical benefit second, regardless of your eligibility for Medicare.

- For dependent Children, determination of the primary and secondary plan(s) follows these rules in this sequence:

  — The Medical Plan uses the "birthday rule." The plan covering the parent whose birthday (month and day) comes first in the year is the primary plan for the Children, and the plan covering the other parent is the secondary plan for the Children.

  — If both parents have the same birthday, the plan that has Covered one parent longer is the primary plan for the Children, while the plan that has Covered the other parent for a shorter period of time is the secondary plan; or

  — If one parent's plan follows the male-female rule and one parent's plan includes the birthday rule, the male-female rule applies to the extent permitted by law.

- If the parents of dependent Children are divorced or legally separated, the Claims Administrator will determine whether there is a court decree or a Qualified Medical Child Support Order ("QMCSO") establishing financial responsibility for medical expenses.

  — If there is such a decree or QMCSO, the plan covering the parent who has the responsibility to provide coverage pursuant to such decree or QMCSO will be the primary plan;

  — If there is no such decree or QMCSO, the plan that covers the parent with custody will be the primary plan; the other parent's plan will be secondary;

— If there is no such decree or QMCSO and the parent with custody remarries, that parent's plan remains primary, the stepparent's plan is secondary and the noncustodial parent's plan is tertiary; or

— If payment responsibilities are still unresolved, the plan that has Covered the patient for the longest time is the primary plan.

When both parents have coverage through the Company or a Participating Company, either parent (but not both) may choose to cover the Child(ren). Claims for the Child(ren) are submitted to the plan of the parent covering the Child(ren). The other parent's plan is not secondary because it does not cover the Child(ren). So expenses that are not paid by the primary plan cannot be submitted to the Medical Plan by the second parent.

Section M. What You Need to Know About Medicare

What Medicare Is

Medicare is a federal health insurance program for people age 65 and older, as well as some disabled people under age 65.

Please Note: This Section M provides a brief summary of Medicare and is not intended to be all inclusive or to answer all questions about Medicare.

Medicare Benefits At-a-Glance

The Medicare program has four parts:

- Medicare Part A, or Hospital Insurance, helps pay for care during a Hospital stay and for some follow-up care after you leave the Hospital.
- Medicare Part B, or Medical Insurance, helps pay for Physician fees, Outpatient services and many other services and supplies not Covered under Medicare Part A.
- Medicare Part C plans are health plan options (like HMOs or PPOs) approved by Medicare and run by private companies. They provide Part A (Hospital Insurance) and Part B (Medical Insurance) benefits and typically have different coverage levels and costs.
- Medicare Part D is prescription drug coverage offered by insurance companies and other private companies approved by Medicare. Each plan can vary in cost and drugs Covered.

Eligibility for SecureHorizons® MedicareDirect™ PFFS)Plan and Medicare Advantage HMOs
Secure Horizons MedicareDirect Retiree Plan (PFFS) and Medicare Advantage HMOs are Medicare Part C plans. You must be entitled to benefits under Medicare Part A and enrolled in Medicare Part B to be eligible to enroll in SecureHorizons, MedicareDirect Retiree Plan (PFFS) or a Medicare Advantage HMO.

Generally, when you or a Covered Dependent reaches age 65, you or your Covered Dependent becomes eligible for Medicare. To enroll for Medicare, you should contact your Social Security office at least three months before you or your spouse or Domestic Partner reaches age 65.

You should apply for Medicare Part A as soon as you become eligible and plan to secure Part B when you retire. If you do not enroll in Medicare Part A and

Part B when you first become eligible, penalties and delays may apply when you later enroll for coverage.

Feature	Part A	Part B	Part C	Part D
Purpose of coverage	Hospital insurance benefits, such as room and board	Medical benefits, such as doctor and Ambulance services	Typically offers the same services Covered under Parts A and B, plus additional preventive care coverage and (sometimes) prescription drug coverage	Prescription drug coverage
Enrollment	You may become automatically enrolled through Social Security (check with Medicare for your personal situation).	You may become automatically enrolled through Social Security (check with Medicare for your personal situation).	You enroll through a private health insurer or plan sponsor.	You enroll through a private health insurer or plan sponsor.
Premium	You pay no premiums if you are entitled to Medicare and Social Security or Railroad Retirement benefits because you or your spouse paid FICA taxes while you were working (before retirement).	There is a monthly premium that changes each year and is generally deducted from your Social Security check, unless otherwise paid for by Medicaid or another third-party.	There is a monthly premium, which may vary depending on the health plan offering coverage and the level of benefits provided.	There is a monthly premium, which can vary based on your geographical location and the plan you choose.
Who administers coverage	CMS	CMS	Private health plan	Private health plan

Effect of Medicare Eligibility on Medical Plan Coverage

When you or a Covered Dependent becomes eligible for Medicare, it affects your coverage under the Medical Plan in several ways. For example, such eligibility will affect:

- Your Plan options;
- How you access services;

- How you file claims; and
- Your premiums.

Also, if some members of your family are Medicare-eligible and others are not, you may have different processes for your family (see "Available Medical Plan Options" in **Section C. How the Medical Plan Options Work**).

When You or a Dependent Becomes Medicare-Eligible

When you or a Dependent, including your Domestic Partner Covered under the Medical Plan, becomes Medicare-eligible (regardless of age), Medicare takes over as the primary benefit plan.

The only exception to the Coordination of Benefits rule for Medicare-eligible Plan participants and their Covered Dependents is for end-stage renal disease (ESRD). If you or a Covered Dependent (including a Class II Dependent) becomes entitled to Medicare on the basis of ESRD, the Medical Plan will be primary for a "coordination period" of up to 30 months. The coordination period usually begins on the date an individual becomes Medicare-eligible due to kidney failure (usually the fourth month of dialysis) and ends 30 months thereafter. After completion of the coordination period, Medicare becomes primary and the Plan becomes secondary.

Coordination of Benefits When Medicare Is Primary

The Medical Plan is designed to provide a certain level of benefits. When the Medical Plan coordinates benefits with another plan or program, including Medicare, this does not increase the benefits payable from the Medical Plan. All Medicare COB claims with the Medical Plan are processed at Traditional Indemnity benefit levels. The Medical Plan will only pay up to what it would have paid had it been the primary plan.

The following options are not treated as secondary coverage with Alcatel-Lucent. Under these options, you assign your Medicare Part A and B benefits:

- the SecureHorizons® MedicareDirect™ PFFS Plan
- Medicare Advantage HMOs.

These options pay Providers directly for services rendered and do not coordinate payment with Medicare.

(See **Appendix A. SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS)--Retiree Benefits Summary Insert** at the end of this SPD.)

If You Have End-Stage Renal Disease

The Medical Plan is primary if you or your dependent (Including a Class II dependent) is entitled to Medicare on the basis of End-Stage Renal Disease (ESRD) for up to the first 30 months. The 30-month period begins on the date the individual becomes Medicare-eligible due to kidney failure, which is usually the fourth month of dialysis. After the 30-day period, Medicare is primary for that individual, the Medical Plan is secondary.

For Medicare-eligible employees or dependents who have had ESRD for more than 30 months, the following Medicare COB information applies:

- Regardless of which Medical Plan option you are enrolled in, you will be transferred to the Traditional Indemnity option, with Medicare as the primary payor. Traditional Indemnity coverage is administered by UnitedHealthcare.

- If you have dependents who are not yet Medicare-eligible, they will also be Covered under Traditional Indemnity, unless there is a UnitedHealthcare POS in your area. If there is a POS in your area, your dependents will be enrolled in the POS.

- When Medicare is the primary plan, benefits under Traditional Indemnity become secondary, and the total amount from Traditional Indemnity and Medicare cannot exceed the Traditional Indemnity benefit level.

- If you are enrolled in the HMO option, see your HMO for details.

You may also have the opportunity to elect a Medicare Advantage HMO for yourself and/or your dependents, if one is available in your area.

Determining Your Eligibility for Medicare

Generally, you or your Eligible Dependent is eligible for Medicare if you or your Eligible Dependent:

- Is age 65 or older;

- Has had kidney failure, which is usually considered to have occurred the fourth month of dialysis, regardless of age; or

- Is eligible for Medicare due to disability, regardless of age.

Part B Monthly Premium
You will pay a monthly premium to Medicare for Medicare Part B coverage — in addition to any premiums that you are required to pay for the Medical Plan coverage you choose.

Please note: There may be situations in which an individual is not eligible for Medicare. Contact Social Security for more information about Medicare-eligibility.

Enrolling in Medicare

Approximately three months before your 65th birthday, in addition to receiving a package from the Alcatel-Lucent Benefits Center with your Medicare-Eligible Retiree medical coverage options, you will receive a package in the mail directly from the Centers for Medicare and Medicaid Services (CMS). (Your spouse or Covered Dependent(s) also will receive packages approximately three months before their 65th birthdays.) The package from CMS will include your Medicare ID card, which notes your Medicare effective date, and information about Medicare Parts A and B coverage.

Medicare Part A Entitlement

In most cases, you are automatically enrolled in Medicare Part A, starting with the first day of the month of your 65th birthday. (Check with Medicare for your personal situation.) You usually don't pay a monthly premium for Part A coverage if you paid FICA taxes while working.

Medicare Part B Enrollment

You may automatically become enrolled in Medicare Part B through Social Security. (Check with Medicare for your personal situation.) When you become enrolled, you will pay a monthly premium for Medicare Part B coverage, and you also may be required to pay a premium for the Alcatel-Lucent retiree medical coverage that you choose.

What Happens If You Are Not Enrolled in Medicare Parts A and B

If you (and your spouse or Covered Dependent(s)) are Medicare-eligible and not enrolled in Medicare Parts A and B, you will not receive SecureHorizons® MedicareDirect™ PFFS Plan or Medicare HMO benefits (see **Appendix A. SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS)--Retiree Benefits Summary Insert** at the end of this SPD).

These options are not treated as secondary coverage with Alcatel-Lucent. Under these options, you assign your Medicare Part A and B benefits to the SecureHorizons® MedicareDirect™ PFFS Plan or Medicare HMO. These plans pay your Providers for services rendered and do not coordinate payment with Medicare.

Understanding How Traditional Indemnity Coverage Pays

The Traditional Indemnity option will coordinate with Medicare — sometimes paying an additional benefit as secondary coverage. Even if your dependent(s) do not enroll in Medicare Part A and Part B, the Traditional Indemnity coverage will pay benefits only as though they were enrolled.

The following examples show the difference in cost between when your spouse and/or dependent(s) are enrolled in Medicare Part A and Part B with

Traditional Indemnity, and when your spouse and/or dependent(s) are enrolled in Traditional Indemnity but not enrolled in Medicare Part A and Part B.

For Example:
(Assumes that the applicable annual deductibles have been met)

Your Dependent Is Medicare-Eligible and Enrolled in Medicare Part A and Part B
Medicare Part B covers a $100 claim at 80 percent, and the Plan covers the same claim at 80 percent. • Medicare is primary coverage and pays the 80 percent ($80) first. • Plan coverage is secondary and, because the Plan also covers the service at the same 80 percent level as Medicare, no additional amount is paid by the Plan. • **This means you are responsible for $20.**
Medicare Part B covers a $100 claim at 80 percent, and the Plan covers the same claim at 90 percent. • Medicare is primary coverage and pays the 80 percent ($80) first. • Plan coverage is secondary and, because the Plan covers the service at 10 percent over the Medicare level, an additional 10 percent ($10) is paid by the Plan. • **This means you are responsible for $10.**
Your Dependent Is Medicare-Eligible and Not Enrolled in Medicare Part A and Part B
Medicare Part B covers the $100 claim at 80 percent, and the Plan covers the same claim at 80 percent. • Medicare is primary coverage, but because your dependent is not enrolled in Medicare Part A and Part B, Medicare will not pay anything for the $100 claim. • Plan coverage is secondary and, because the Plan also covers the claim at the same 80 percent level as Medicare would have covered, no additional amount is payable by the Plan. • **This means you are responsible for the entire $100.**

When Medicare Pays First
In this example, since Medicare pays first (primary) and Alcatel-Lucent coverage (Traditional Indemnity) pays second (secondary), in certain situations you may receive a greater level of coverage through your Medicare benefits than what your Alcatel-Lucent medical coverage would pay. This means you will not receive any additional benefits through your Alcatel-Lucent coverage.

Please note: For more information about how the Medical Plan and Medicare work together, see Medicare Facts: Medicare and Your Alcatel-Lucent Coverage" available on BenefitAnswers Plus at www.benefitanswersplus.com, the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent or call the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

Information about Medicare is also available on Medicare's Web site at http://www.medicare.gov.

Please note: You may also be eligible to enroll in a Medicare Advantage Plan if one is available in your area (see "Medicare Advantage Plans" in **Section C. How the Medical Plan Options Work** for more information). In addition, you may wish to consider Medicare Part D, which covers prescription drugs.

Please note: If you enroll in Medicare Part D or in a Medicare Advantage HMO that covers prescription drugs, you are making the choice to opt out of medical and prescription drug coverage under the Alcatel-Lucent Medical Plan.

Medical Benefits When Medicare-Eligible

Medical Benefits When You Are Not Medicare-Eligible and Your Dependent Becomes Medicare-Eligible

Your family's Medical Plan benefits may differ depending on whether you or your Dependent is Medicare-eligible (see "Available Medical Plan Options" in **Section C. How the Medical Plan Options Work**).

Medical Benefits When You and Your Dependent Are Eligible for Medicare

Once you are eligible for Medicare, you and your Medicare-Eligible Dependents are Covered under the SecureHorizons® MedicareDirect™ PFFS Plan. That plan is not treated as secondary coverage with Alcatel-Lucent. Under this plan, you assign your Medicare Parts A and B benefits to the SecureHorizons® MedicareDirect™ PFFS Plan, which pays Providers directly and does not coordinate payment with Medicare (for more information, see **Appendix A. SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS)--Retiree Benefits Summary Insert** at the end of this SPD).

Medicare Advantage HMO Additional Documentation

For the Medical Plan to coordinate with CMS, in general, you will be required to complete additional documentation before your coverage in a Medicare Advantage HMO offered through the Plan will take effect. (You will not receive additional forms to complete under SecureHorizons MedicareDirect Retiree Plan (PFFS).) The forms will be mailed to you by the Alcatel-Lucent Benefits Center. Complete the forms and return them to the Alcatel-Lucent Benefits Center **by the deadline stated on the** forms to avoid any delays in receiving coverage.

How Medicare and HMO Coverage Work Together

If you are enrolled in an HMO, you will need to check directly with the HMO regarding benefits for Medicare-eligible individuals.

If you choose HMO coverage instead of Medical Plan coverage, you are required to follow your HMO's rules for obtaining care. Alcatel-Lucent is not responsible for the benefits provided or not provided by the HMO or claims relating to HMO coverage. Once you have elected to participate in an HMO, that HMO governs your Medical Plan coverage instead of all Medical Plan provisions that pertain to the other Plan options.

If you or a Covered Dependent is Medicare-eligible, you or your Covered Dependent may be eligible to participate in a Medicare Advantage HMO (see "Enrolling in a Medicare Advantage HMO" below and "Medicare Advantage HMOs" in **Section C. How the Medical Plan Options Work** for additional information).

Enrolling In a Medicare Advantage HMO
To be eligible for a Medicare Advantage HMO (Medicare Part C), you or your Covered Dependent must be:

- Medicare-eligible (generally age 65 or older, or disabled);
- Entitled to benefits under Medicare Part A and enrolled in Part B; and
- A permanent resident of a Medicare Advantage HMO service area.

In addition, you must complete the necessary paperwork to enroll in or disenroll from a Medicare Advantage HMO.

If you choose a Medicare Advantage HMO, it replaces coverage under Medicare Parts A and B. You must continue to pay the Part B premiums. In addition, if you or an Eligible Dependent enrolls in a Medicare Advantage HMO that covers prescription drugs, you or your Eligible Dependent is no longer eligible for the Prescription Drug Program under the Medical Plan.

You are not eligible to enroll in a Medicare Advantage HMO if you have end stage renal disease (ESRD), although if you are enrolled in a Medicare Advantage Plan and develop ESRD, you may continue to be enrolled. Also, you may not be eligible to enroll in a Medicare Advantage HMO if you live away from your permanent home for more than approximately three months in a calendar year, although some plans offer reciprocal arrangements with other plans to accommodate such individuals. If this applies to you, check with the Health Plan Carrier that administers the Medicare Advantage Plan that interests you.

Keep in mind that when you switch to a Medicare Advantage HMO, any non-Medicare-Eligible Dependents will have coverage through an **HMO** offered by the same Health Plan Carrier in that area since you must enroll your Dependents in the same coverage option and with the same Health Plan Carrier that you choose for yourself.

Switching Plans
If you select coverage through a Medicare Advantage HMO, you can switch to another Medicare Advantage HMO on a monthly basis, effective the first day of the following month. You can also switch to the **SecureHorizons® MedicareDirect™ PFFS Plan** throughout the year. And, you can also select

coverage under a Medicare Advantage HMO by switching from the **SecureHorizons® MedicareDirect™ PFFS Plan** at any time.

To switch among Medicare Advantage HMOs or to switch into or out of the **SecureHorizons® MedicareDirect™ PFFS Plan**, contact the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

Prescription Drug Program Benefits When Medicare-Eligible

If you are Medicare-eligible and do not enroll in Alcatel-Lucent medical coverage, you can enroll in Medicare Part D prescription drug coverage outside of the Plan during the Medicare Part D open enrollment period. This enrollment period is held and administered separately from Alcatel-Lucent's Annual Open Enrollment period.

If you or your dependent(s) enroll in a Medicare Part D prescription drug plan outside of the Plan, then you or your dependent(s) are making the choice to opt out of the Plan's prescription drug coverage. This means:

- Your Alcatel-Lucent prescription drug coverage will no longer pay a portion of your prescription medications — even if the Medicare Part D coverage does not pay for a claim.

- You or your dependent(s) will need to begin paying premiums to the Part D Provider for Medicare Part D coverage.

- Your contributions for coverage under the Plan will not be adjusted. Alcatel-Lucent cannot provide varying contribution structures, so you will continue to pay the same contributions as someone who still has prescription drug coverage under the Plan.

- Alcatel-Lucent prescription drug coverage will continue to cover:

  — Any dependent(s) not eligible for Medicare who are enrolled in the Plan; and

  — Any Medicare-Eligible Dependent(s) who have not enrolled in a Medicare Part D plan.

Creditable Coverage

For the majority of retirees, the Medical Plan's retiree prescription drug coverage is "creditable," or equal to or better than the Medicare Part D standard prescription drug coverage. To certify this, Medco will mail notices to newly Eligible Retirees.

Please note: Be sure to keep the Notice of Creditable Coverage because if you decide not to enroll in a Medicare Part D plan when you first become eligible, it will help you avoid any late enrollment penalties from Medicare should you decide in the future to enroll in a Medicare Part D plan outside of the Medical Plan.

Mental Health and Chemical Dependency Program Benefits When You or a Dependent Becomes Medicare-Eligible

If you are Medicare-eligible, mental health and Chemical Dependency treatment is Covered under:

- The SecureHorizons® MedicareDirect™ PFFS Plan; or
- A Medicare Advantage HMO.

Please note: For information about mental health and Chemical Dependency coverage under the SecureHorizons® MedicareDirect™ PFFS Plan, see **Appendix A. SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service (PFFS)--Retiree Benefits Summary Insert** at the end of this SPD).

Coverage Amounts

See **Section A. Medical Plan Benefits At-a-Glance** for specific coverage details.

Section N. Overpayments and Subrogation

Obligation to Refund

If the Medical Plan pays for benefits in violation of the terms of the Medical Plan (improper payments), or if all or some of the payments made exceed the benefits payable under the Medical Plan (excess payments), then those improper or excess payments must be refunded to the Medical Plan. You or your Covered Dependents are responsible for any improper or excess payments the Medical Plan made to you, your Covered Dependents, Providers or any other person or organization.

If the refund is due from another person or organization, you or your Covered Dependents must assist the Medical Plan in obtaining the refund when requested.

If you or your Covered Dependents, or any other person or organization, do not promptly refund the full amount, the Medical Plan may reduce the amount of any future benefits that are payable to or on behalf of you or your Covered Dependents under the Medical Plan so that the Medical Plan can recoup the full amount of the improper or excess payment, as applicable.

Right of Recovery and Subrogation

The Medical Plan provides benefits to you and your Covered Dependents that are not provided by any third party. This means that the Medical Plan will not Cover any illness or injury that gives rise to a claim by you or your Covered Dependents against a third party (as the result of or attributable to the negligent or wrongful acts or omission of such third party). If such benefits have been paid by the Medical Plan:

- The Medical Plan will be entitled to all of your and your Covered Dependents' rights of recovery against such third party to the extent of the reasonable value of the benefits provided under the Medical Plan;

- You and your Covered Dependents agree to reimburse the Medical Plan for the reasonable value of all benefits received under the Medical Plan out of any recoveries received from any third party (other than family members);

- The Medical Plan's subrogation and reimbursement rights apply to any recoveries that may be or actually are received by you or your Covered Dependents (including an estate), including, but not limited to, the following:

  — Any payments as a result of a settlement, judgment or arbitration award or otherwise, made by or on behalf of a third party or his or her insurance company or made under an uninsured or underinsured motorist coverage;

  — Any payments under workers' compensation, no-fault or other state-mandated motor vehicle insurance;

  — Any payments made as a result of coverage under any automobile, school or homeowners' insurance policy; and

  — Any other payments from any source designed or intended to compensate a participant for injuries sustained as a result of negligence or alleged negligence of a third party.

You and your Covered Dependents are required to fully cooperate and perform all actions necessary to secure the Medical Plan's right of recovery and subrogation, including:

- Permitting the Plan to enforce a lien on any monies recovered from a third party;

- Refraining from taking any action or negotiating any agreement with any third party that may prejudice the Medical Plan's rights; and

- Refraining from assigning any rights to recover medical expenses from any party whose negligence gives rise to liability for damages.

No court costs or attorneys' fees may be deducted from the Medical Plan's recovery without the advance express written consent of the Medical Plan.

In the event you or your Covered Dependents do not cooperate or refuse to honor these terms, the Plan will be entitled to recover any costs incurred in enforcing these terms and conditions.

Section O. Terms to Know

There are several words and phrases that have specific meanings under the Medical Plan. This section explains those terms so you can better understand your benefits. These terms are printed in initial capital letters when they appear, to let you know they are defined here.

Acupuncturist: a Provider carrying all recognized certifications applying to the practice of acupuncture who is licensed to practice acupuncture according to state laws.

Alcatel-Lucent Benefits Center: the resource to call to enroll, to make changes to your coverage or to ask questions about your Medical Plan options. Call 1-888-232-4111 (domestic) or 1-847-883-0660 (international). If you are hearing or speech impaired, please use a Relay Service when calling a representative. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET). You can also obtain information by visiting the Your Benefits Resources™* Web site at http://resources.hewitt.com/alcatel-lucent

Allowable Amount: the portion of a Provider's charge which is eligible for reimbursement, either in full or in part. Any amount by which the Provider's charge exceeds the Allowable Amount is not reimbursable under the Medical Plan.

Under the POS option, the PPO offered under the Traditional Indemnity option or the Mental Health and Chemical Dependency (MH/CD) Program, Network Providers' charges always equal the Allowable Amount so that you are not billed for any charges above the Allowable Amount.

When Out-of-Network Providers are used, the Allowable Amount for Medically Necessary services is generally based on the Reasonable and Customary Charge for a particular service.

You are responsible for the portion of the expense that is above the Reasonable and Customary Charge. Amounts in excess of Reasonable and Customary do not apply toward the annual Deductible or the Out-of-Pocket Maximum as described in the Medical Plan.

Alternative Treatment: a type of care only available *In-Network* under the Mental Health and Chemical Dependency (MH/CD) Program that is more intensive than Outpatient treatment and less intensive than Hospitalization. Alternative Treatment includes the following types of care: partial Hospitalization, Residential Treatment and care from a Halfway House or Group Home.

Ambulance: a vehicle licensed according to state laws, operated for the exclusive purpose of transporting patients with acute medical conditions and equipped to provide paramedic and stabilizing medical services.

Annual Open Enrollment: the period of time each year designated by the Company during which you generally make changes to your benefits. Elections made during the Annual Open Enrollment period are effective as of the first day of the subsequent calendar year.

Birthing Center: a facility for prenatal, delivery and postpartum care that:

- Is staffed by certified nurse-midwives;
- Has 24-hour access to consultation by an obstetrician/gynecologist with admitting privileges at a nearby Hospital;
- Is accredited by the National Association of Child Bearing Centers or the Joint Commission on the Accreditation of Healthcare Organizations; and
- Is licensed by the state.

Brand-Name Drug: a medication that has been patented and is produced by only one manufacturer.

Center of Excellence: a facility that is designated by the Health Plan Carrier as a preferable facility to handle selected services of a highly specialized nature, such as organ transplants.

Chemical Dependency: both alcoholism and drug dependency as classified by the International Classification of Diseases of the U.S. Department of Health and Human Services.

Child or **Children:** your eligible, unmarried Children under the Medical Plan's limiting age are:

- Biological Child(ren), stepchild(ren) who live with you and/or legally adopted Child(ren);
- Child(ren) for whom you, your spouse or your Domestic Partner is appointed legal guardian as defined by court order (excluding wards of the state or foster Children).
- Child(ren) for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO); and
- Child(ren) beyond age 20 who are incapacitated, certified by a medical Claims Administrator and who are:
  - Incapable of self-support,
  - Physically or mentally handicapped, and
  - Fully dependent on you for support.

Chiropractor: a Doctor of Chiropractic (D.C.) who is licensed to provide services in the state where the service is rendered.

Claims Administrator: The Health Plan Carrier authorized by Alcatel-Lucent to administer the Medical Plan.

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

Coinsurance: a cost-sharing method by which the Medical Plan pays a percentage of the Provider's Covered charge (for example, 80 percent) and you pay a percentage (for example, 20 percent). Your Coinsurance is your share of the cost.

Company: Alcatel-Lucent USA Inc.

Contract Rate: a rate for medical services to which a Network Provider and a Health Plan Carrier have contractually agreed. Network Providers agree to accept the Contract Rate as payment in full.

Copayment: a flat dollar amount (such as $25) that you are required to pay for a certain medical service (such as an office visit or supply).

Covered: generally, means "eligible" under the terms of the Medical Plan. "Covered" is often used to modify other terms. A "Covered person" is one who has benefits available under the Medical Plan. A "Covered Provider" is one who is (or which is) eligible to provide services and receive payment because of participation in a particular Network.

A "Covered service" or "Covered supply" means a medical service or supply that is eligible for payment under the terms of the Medical Plan because it is:

- Medically Necessary for the treatment of illness or injury, or it must be for the preventive care benefits that are specifically stated as Covered;
- Provided under the order or direction of a Physician;
- Prescribed by a licensed and accredited healthcare Provider practicing within the scope of his or her license in the state where the license applies; and
- Listed as a "Covered service" or "Covered Supply" under **Section D. What's Covered Under the POS and Traditional Indemnity Options**.

Covered Dependent: a Class I Dependent, Class II Dependent or Domestic Partnership Dependent who is Covered under the Medical Plan (see "Eligible Dependents" in **Section B. Joining the Medical Plan**).

Custodial Care: treatment or services, generally prescribed by a medical professional, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include, but are not limited to:

- Personal care, such as bathing or dressing;
- Help in walking, getting in and out of bed and exercising;
- Feeding by spoon or tube or gastrostomy;
- Homemaking, such as preparing meals or special diets;
- Moving the patient;
- Acting as a companion or sitter;
- Supervising medication that can usually be self-administered; and

- Treatment or services that any person may be able to perform with minimal instruction, including, but not limited to, recording temperature, pulse and respiration, or administration and monitoring of feeding systems.

Deductible: the amount of eligible expenses you may be required to pay each Plan Year before the Plan will pay benefits for Covered expenses. Whether a Deductible applies, and the amount of the Deductible, depends upon the Medical Plan option you choose, the type of service or supply you receive, and whether care is received *In-Network* or Out-of-Network. There are separate Deductibles for the Prescription Drug Plan for Medicare-eligible participants. There are usually no Deductibles under the HMO options.

Default Option: The Alcatel-Lucent Medical Plan option you and your Covered Dependent(s) will be automatically enrolled in for the next Plan Year if you don't take any action during the Annual Open Enrollment period. It may be different from your prior year's coverage and may not meet your and/or your family's health and financial needs.

Domestic Partner: An individual who is a member of the same or opposite sex as the Eligible Retired Employee and who:

- Complies with any state or local registration process for Domestic Partners, if applicable; or

- Satisfies each of the specific criteria identified below, provided that the individual and the Eligible Retired Employee complete a notarized affidavit of Domestic Partnership attesting that such individual and the Eligible Retired Employee:

  — Reside in the same household as members of the household;

  — Are each 18 years of age or older;

  — Have mental capacity sufficient to enter into a valid contract;

  — Are unrelated to each other by blood or marriage and are not legally married to another individual;

  — Consider themselves to have a close and committed personal relationship and have no other such relationship with any other person;

  — Are responsible for each other's welfare and financial obligations (e.g., joint lease or joint bank account); and

— Provide such other information as may be necessary for the Company to determine whether the Domestic Partner or the Child of the Domestic Partner is the Eligible Retired Employee's dependent under the Plan.

Domestic Partnership Dependent: an individual who is either your Domestic Partner, or the eligible unmarried Child of your Domestic Partner.

Effective Date: the date upon which coverage under the Medical Plan starts or takes effect.

Elective Care: care that can be postponed for 10 days or more without undue risk to the patient.

Eligible Dependents: a person who is a Class I Dependent**,** Class II Dependent or a Domestic Partnership Dependent and who is eligible to be Covered under the Medical Plan.

Eligible Retiree: an individual who leaves the Company and is:

- At least 50 years old with at least 15 years of service; or
- At least 55 years old with at least 10 years of service.

Former Lucent employees who receive a disability pension also are eligible to participate in the Medical Plan.

Please note: If you retired from Alcatel USA, Inc. before January 1, 2008, and were eligible to participate in the retiree medical programs of Alcatel USA, Inc. as of December 31, 2009 you are eligible to participate in this plan.

Emergency: a life-threatening medical condition suddenly and unexpectedly manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could result:

- In permanently placing the patient’s health in jeopardy;
- Causing serious and/or permanent impairment of a bodily part or function;
- Causing serious and/or permanent dysfunction of any body organ or part; or causing severe pain.

Please note: See “Emergency Care” in **Section E. Mental Health and Chemical Dependency Program Under the POS and Traditional Indemnity Options** for the definition of Emergency as it applies to a mental health condition rather than a physical condition.

The following examples are generally emergencies:

- Apparent poisoning;
- Convulsions;
- Excessive uncontrolled bleeding;
- Severe chest pain;
- Severe or multiple injuries, including fractures;
- Shortness of breath or difficulty breathing; and
- Sudden loss of consciousness.

The following examples are generally not considered to be emergencies:

- Childbirth (Childbirth is not normally considered an Emergency. However, an unexpected complication, such as premature birth, would be considered an Emergency);
- Colds, sore throat, or cough;
- Diarrhea;
- Earaches;
- Minor cuts;
- Moderate fever;
- Rashes;
- Sprains; or
- Vomiting.

Experimental or Investigative (Treatment, Drug or Device): medical, surgical and psychiatric procedures, treatments, devices, drugs and drug treatments that meet one of the following criteria at the time of prescription, as determined by your Health Plan Carrier:

- The treatment, drug, or device is under clinical investigation by health professionals and is not generally recognized by the medical profession as tested and accepted medical practice;

- The treatment, drug, or device requires approval of the United States Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time the service or supply is prescribed; or

- The treatment, drug, or device is not proven in an objective manner to have therapeutic value or benefit, restricted to use at medical facilities carrying out scientific studies, or is questionable as to its safety and effectiveness in treating the diagnosed condition.

Extended Care Facility: an institution other than a Hospital, which is licensed according to state laws to provide Inpatient medical services, and which is accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by Medicare. An Extended Care Facility provides direct medical treatment, and must have a professional nursing staff and operate under the supervision of a Physician.

An Extended Care Facility is not primarily a place for rest, for the aged, for Custodial Care or for the treatment of Mental Illness or Chemical Dependency.

The term "Extended Care Facility" encompasses facilities such as skilled nursing facilities, convalescent facilities, intermediate care facilities, sub-acute care facilities and rehabilitation centers — provided they meet all of the conditions given here.

Family Security Program (FSP): the program under which Covered Class I Dependents and Domestic Partnership Dependents may, after they have exhausted their 36-month COBRA continuation period, continue coverage under the Medical Plan under either the Traditional Indemnity option or a Medicare HMO if the surviving Lawful Spouse or Domestic Partner is Medicare-eligible and reside in an area in which a Medicare HMO is available.

The surviving Lawful Spouse or Domestic Partner (or any eligible Dependent who has survived the Lawful Spouse or Domestic Partner) also may continue coverage for any eligible Dependent children who were enrolled immediately before the enrolled Eligible Retiree's death as long as the children continue to satisfy all eligibility requirements. Continuation of Medical Plan coverage for eligible Dependent children of a surviving Lawful Spouse or Domestic Partner ends on the last day of the month in which the surviving Lawful Spouse or Domestic partner dies.

The surviving Lawful Spouse, Domestic Partner or eligible Dependent children, as applicable, must pay the full cost for Medical Plan coverage.

Formulary: a list of preferred prescription drugs in major therapeutic classes selected by Medco for participants in the Medical Plan. When your Physician writes a prescription for a Formulary drug, in most instances, your Copayment will be less than if the prescription calls for a non-Formulary drug. If you are uncertain about whether a particular drug is on the Formulary, check with Medco (see **Section P. Important Contacts**).

Generic Drug: a drug that does not bear the trademark of the original manufacturer. It is chemically identical to and generally costs less than a Brand-Name Drug.

Group Home(s) and **Halfway House(s):** settings for care that are Covered under the *In-Network* benefits of the Mental Health and Chemical Dependency Program. Group Homes and Halfway Houses are residences that:

- Provide a structured living environment;
- Deliver treatment from Mental Health and Chemical Dependency Professionals; and
- Afford the patient opportunities to transition into daily life activities for the purpose of recovery from mental health conditions or Chemical Dependency.

Adult patients typically leave the Group Home or Halfway House during the day to engage in outside activities such as work or school, and return at night.

Halfway houses: See the definition of "Group Homes and Halfway House(s)."

Health Insurance Portability and Accountability Act of 1996 (HIPAA): HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. HIPAA regulates the transmission, maintenance, security and privacy of electronic health information transmitted by healthcare Providers, payors and others. It also protects health insurance coverage for workers and their families when they change or lose their jobs.

Health Maintenance Organization (HMO): in general, an organization that offers healthcare through a Network of Hospitals, Physicians and other medical Providers. When you follow your HMO's rules for care, you usually pay no Deductible and file no claim forms (see "HMO Option" in **Section C. How the Medical Plan Options Work** for rules of care).

Health Plan Carrier(s): any Company authorized by Alcatel-Lucent to provide services under the Medical Plan, including Aetna, UnitedHealthcare and Medco Health Solutions (Medco).

HMO: (see "Health Maintenance Organization (HMO)."

Home Healthcare Agency: an organization licensed according to state laws to provide skilled nursing and certain other health services on a visiting basis in the patient's home. The agency must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations or be Medicare-approved in order to be Covered under the Medical Plan.

Hospice: an organization licensed according to state laws to provide care to terminally ill patients. A Hospice may be either an agency that performs its services in the patient's home or a facility into which the patient is admitted.

Hospital: a facility providing Inpatient and Outpatient care for the diagnosis and treatment of acute illness and injury.

Under the Mental Health and Chemical Dependency Program, "Hospital" means an acute general Hospital with:

- A psychiatric and/or Chemical Dependency unit;
- An acute psychiatric facility; or
- An acute Chemical Dependency facility.

The facility must be licensed according to state law and be staffed by Physicians (and qualified Mental Health and Chemical Dependency Professionals) and maintain 24-hour nursing services.

A Hospital is not primarily a place for rest or Custodial Care, a nursing home, convalescent home, home for the aged or similar institution, nor does it include confinement in a Residential Treatment facility under the Mental Health and Chemical Dependency Program.

***In-Network*:** the benefit choice that permits you to access the services of contracted Network Providers.

Inpatient: a patient who is confined in a Hospital or other healthcare facility as a registered bed patient and incurs room and board charges.

"Inpatient care" refers to the care rendered to an Inpatient.

An "Inpatient facility" is a facility that provides such care.

Lawful Spouse: a person of the opposite sex who is recognized as the lawful husband or wife of an Eligible Retiree under the federal Defense of Marriage Act.

Medically Necessary or **Medical Necessity:** the determination that something is "Medically Necessary" or a "Medical Necessity" is made by the applicable Health Plan Carrier. Care is considered Medically Necessary if:

- It is accepted by the healthcare profession in the U.S. as the most appropriate, safest and most effective level of care for the condition being treated;
- It is based upon recognized standards of the healthcare specialty involved,
- It represents the most appropriate level of care — the frequency of services, the duration of services, and the site of services, depending on the seriousness of the condition being treated (such as in the Hospital or in the Physician's office); and
- It is not an Experimental or Investigational Treatment, Drug or Device.

Medicare Advantage Health Maintenance Organization (HMO): a medical plan offered through Medicare Part C that includes Medicare Parts A and B services and may offer additional benefits such as preventive care. Many Medicare Advantage HMOs also offer prescription drug coverage.

Mental Health and Chemical Dependency Professional(s): a psychiatrist (M.D.), a licensed psychologist (Ph.D.) or one of the following Master's degree-level Providers: a clinical social worker; a marriage, family, and/or Child counselor; a licensed professional counselor; a certified alcoholism counselor; a certified Chemical Dependency counselor; or a registered nurse with a specialty in psychiatric and mental health nursing. The Provider must carry all recognized certifications appropriate to his or her specialty and, where state law requires, be licensed in the state in which he or she practices. The particular certification may differ in various areas of the country.

Conditions of service: the Provider may treat only those conditions, either mental health or Chemical Dependency, appropriate to his or her certification and licensing status.

Covered services:

- Diagnosis and treatment of mental health or Chemical Dependency conditions;
- Psychological testing;

- Psychotherapy; and

- Chemical Dependency counseling.

Mental Health and Chemical Dependency (MH/CD) Program: the program that provides benefits for treatment of mental health and Chemical Dependency conditions to individuals Covered under the POS and Traditional Indemnity options.

Mental Health Emergency: a mental health condition that appears or increases suddenly and is accompanied by severe symptoms. Without immediate treatment, an Emergency condition would result in:

- The person harming himself or herself, or others;

- Severe diminishment or long-term damage to the state of the person's mental health; or

- Permanent physical impairment of bodily parts or functions as a consequence of the Mental Health Emergency.

Mental Illness: for the purpose of determining benefits under the Medical Plan, means a condition that meets either of the following two conditions:

- It is classified as a Mental Illness in the latest edition of the International Classification of Diseases of the U.S. Department of Health and Human Services; or

- It is a condition generally accepted by healthcare professionals in the U.S. as one that requires psychiatric treatment and will respond to such treatment.

Morbid Obesity: obesity that has become a direct and immediate threat to a person's life.

Network: the Providers in a given area who have signed a contract to participate with the Health Plan Carrier and offer services to members enrolled with that Health Plan Carrier at a Contract Rate. A "Network Provider" means a Provider who participates in the Network.

Occupational Therapy: treatment to increase a patient's use of fine motor skills to enable him or her to apply those skills to the tasks required for daily living, after those skills have been impaired by illness or injury.

Out-of-Network: refers to a Physician, Hospital or other healthcare Provider who does not have a contractual arrangement with the Health Plan Carrier for each of the programs offered under the Medical Plan.

For the POS option, this means obtaining services from an Out-of-Network Provider.

For the Prescription Drug Program, it means using a pharmacy that does not participate in the Medco Network.

Out-of-Pocket Maximum: the limit on the amount you spend for Covered medical expenses in Copayments and/or Coinsurance. Some charges do not count toward this maximum.

Outpatient: a patient who is treated in a Hospital or other healthcare facility for less than 18 hours, and who does not incur a room and board charge.

"Outpatient care" refers to the care rendered to an Outpatient.

An "Outpatient Facility" is one that provides such care.

Outpatient Facility: any medical diagnosis or treatment facility that:

- Doesn't offer overnight care;
- Has a staff of medical professionals (including nurses);
- Is operated under the direction of a Physician; and
- Is licensed according to state law.

Covered facilities **include**:

- Medical laboratories;
- Comprehensive Rehabilitation Facilities (CORFs);
- Outpatient surgical centers;
- Birthing Centers;
- Urgent Care Facilities; and Outpatient rehabilitation facilities.

Covered facilities **do not include** a Physician's office.

Partial Hospitalization: a type of care Covered under the *In-Network* benefits of the Mental Health and Chemical Dependency Program. "Partial Hospitalization" means Outpatient care delivered on a daily basis in a Hospital or other Covered facility. The facility must have both Physicians and nurses on staff and be authorized to administer medications. Partial Hospitalization typically provides a less intense level of care than Inpatient care, but is more intense than Outpatient care.

Participating Company/Companies: a Company or companies that participate in the Medical Plan. As of January 1, 2010, they are:

- Alcatel-Lucent Investment Management Corporation;
- Alcatel-Lucent Managed Solutions LLC;
- Alcatel-Lucent USA Inc.
- Alcatel-Lucent World Services Inc.
- Ascend Communications Inc.
- LGS Innovations International Inc.
- LGS Innovations LLC
- LGS Integrated Solutions Inc.
- Lucent Technologies GRL LLC
- Mobilitec, Inc.
- Telica, Inc.

Participating Pharmacy: a pharmacy that is a Medco Participating Pharmacy under the Prescription Drug Program.

PCP: see "Primary Care Physician (PCP)."

Pension Service Center (PSC): the contact for Pension Plan information and transactions.

Physical Therapy: treatment to increase the patient's use of large-muscle motor skills, such as those needed for walking, after those skills have been impaired by illness or injury.

Physician: a doctor of medicine (M.D.) or a doctor of osteopathy (O.D.) who is licensed to practice medicine or osteopathy in the state where the care is provided and is Covered under the Medical Plan. Under the Mental Health and Chemical Dependency Program, care should be sought from a Provider who is a psychiatrist or another Provider who is certified in the treatment of mental health and/or Chemical Dependency.

Plan Year: a twelve-month period beginning on January 1 and ending on December 31.

Point-of-Service (POS): a Medical Plan option that provides a higher level of coverage when you use *In-Network* Providers. However, you may go Out-of-Network and use any healthcare Provider you wish. Your cost usually is higher for Out-of-Network care.

POS: see "Point of Service (POS)."

PPO: see "Preferred Provider Organization."

Pre-Existing Condition: under HIPAA, a condition for which advice, diagnosis, care or treatment was recommended or received within the last six months, or less, from the date you enroll in a new plan.

Preferred Address: The address on file with the Alcatel-Lucent Benefits Center.

Preferred Provider Organization (PPO): a Network of Providers under the Traditional Indemnity option offered in many areas of the country. When you are Covered under the Traditional Indemnity option and you elect to receive medical care from Providers in the PPO Network, charges are generally lower and guaranteed to be within the Allowable Amount.

Prescription Drug Program: the program that provides benefits for prescription drugs to individuals Covered under the POS and Traditional Indemnity options (the "Medco Medicare Prescription Drug Plan" under the SecureHorizons® MedicareDirect™ PFFS Plan). The Prescription Drug Program is administered separately by Medco Health Solutions (Medco).

Primary Care Physician (PCP): a Network Physician who:

- Qualifies as a participating Provider in general practice, internal medicine, family practice or pediatrics, and

- Has been selected by you (although you are not required to do so) to provide your primary healthcare and coordinate all your other *In-Network* care.

Private Duty Nursing: nursing services provided in the home by a private duty nurse who holds a valid, recognized nursing certificate and is licensed in accordance with the laws of the state in which these services are received.

Provider: a Provider of healthcare services or supplies. A Provider may be a person, such as a Physician, physical therapist, or Chiropractor; an organization, such as a Home Health Care Agency; or a facility, such as a Hospital.

Qualified Medical Child Support Order (QMCSO): a judgment, decree or order issued by a court that requires Medical Plan coverage for a participant's Child and that has been determined by the Claims Administrator to be qualified under ERISA.

Reasonable and Customary Charge: the fee determined by the Claims Administrator on the basis of:

- The fees usually charged to most patients for a similar service; and
- The range of fees charged by Providers with similar training and experience for the same or similar services within the geographic region.

Rehabilitation Therapy: services provided by a physical therapist, speech therapist or occupational therapist. Rehabilitation services may be provided in a Hospital or Extended Care Facility or through a Home Health Care Agency. However, the need for rehabilitation can't be the primary reason for Hospital confinement. Rehabilitation therapists may work independently or be on the staff of a Hospital, Extended Care Facility or Home Health Care Agency.

Residential Treatment: a type of care Covered under the *In-Network* benefits of the Mental Health and Chemical Dependency Program. "Residential Treatment" means 24-hour-a-day Inpatient care in a facility that provides sub-acute care (sub-acute care is less intense than the treatment typically offered by a Hospital). The facility must provide regular treatment activities under the supervision of licensed and certified Mental Health Professionals, with both Physician/psychiatrist and nursing services available on either a staff or contracted basis. A Residential Treatment facility is not solely or principally an alternate residence or a place of rest. On the contrary, measurable improvement, the reasonable likelihood of future improvement, and active family or guardian participation in the treatment are important criteria for authorization of continued treatment.

SecureHorizons® MedicareDirect™, A Medicare Advantage Private Fee-For-Service (PFFS) Plan (SecureHorizons® MedicareDirect™ PFFS Plan): a coverage option offered under the Medical Plan and administered by UnitedHealthcare.

Skilled Nursing Facility: a facility that provides continuous skilled nursing care on an Inpatient basis. It must be licensed in accordance with state and local law and be accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by Medicare. A Skilled Nursing Facility is not primarily a place for rest, for the aged, for Custodial Care or for the treatment of Mental Illness or Chemical Dependency.

Speech Therapy: therapy services that assist in the restoration of communication abilities that have been acutely impaired by illness, injury or birth defect.

Traditional Indemnity: a Medical Plan option that includes a Preferred Provider Organization (PPO) Network of participating Providers. The Traditional Indemnity option will reimburse you at the same percentage whether you receive care from a PPO or non-PPO Provider, but, in most instances you will pay less out of your own pocket if you use PPO Providers since they tend to charge lower, negotiated prices for their services. Unless you use a PPO Provider, you file claim forms to be reimbursed (see "Traditional Indemnity Option [Medicare-Eligible and Out-of-Area Participants]" in **Section C. How the Medical Plan Options Work**).

Urgent or **Urgent Care:** a medical condition (or care for an Urgent medical condition) that manifests itself by acute symptoms of sufficient severity that postponing treatment for more than 48 hours would:

- Place the patient's life in jeopardy;
- Cause serious and/or permanent impairment of a bodily part or function; or
- Cause severe pain.

Care that is needed to treat such a condition is called "Urgent Care." Care rendered after the Urgent situation has passed is not considered Urgent Care.

Urgent Care Facility: a freestanding facility and not connected to a Hospital. An Urgent Care Facility is designed to respond to Urgent medical conditions and perform minor surgical procedures.

Your Benefits Resources™ Web Site: a Web-based resource located online at http://resources.hewitt.com/alcatel-lucent where you can learn more about

all of the healthcare benefits and where you can enroll for your benefits. Your Benefits Resources™ is a trademark of Hewitt Management Company LLC.

Section P. Important Contacts

This list of contacts and resources includes information about whom to contact depending on your specific need:

Resource Contact Information

What Is This?

For information about your benefit coverage during the year, contact these resources at any time.

Go Here…	To…
Alcatel-Lucent Resources	

http://resources.hewitt.com/alcatel-lucent
24 hours a day, everyday, except on Sunday between midnight and 1:00 p.m. Eastern Time (ET)
	The Your Benefits Resources Web Site
	• View your current coverage
	• During Annual Open Enrollment, you can also:
	  • Review and compare your available healthcare options and rates
	  • Enroll or make changes to your default coverage
	  • Waive coverage
	• Find a doctor or healthcare Provider
	• Learn more about Alcatel-Lucent's benefits
	• Review, add or change your dependent(s)' information on file
	• Understand how a life event may affect your benefits

1-888-232-4111 (1-847-883-0660 if calling from outside of the United States) • **Standard hours:** Monday through Friday, from 9:00 a.m. to 5:00 p.m., Easter Time (ET) • **Extended hours during the Annual Open Enrollment period:** Monday through Friday, from 8:00 a.m. to 6:00 p.m., ET	**Alcatel-Lucent Benefits Center** • During Annual Open Enrollment, you can: • Enroll or make changes to your default coverage • Resolve an issue that you have not been able t solve on your own first • Notify Alcatel-Lucent if you or your Eligible Dependent(s) are or will become Medicare-eligible due to a disability • Take care of a unique benefits issue

Go Here…	To…
www.benefitanswersplus.com	**The Alcatel-Lucent BenefitAnswers Plus Web Site** • Learn more about Alcatel-Lucent's benefits • Download Life Insurance Beneficiary Designation Forms • Obtain electronic copies of non-personalized enrollment materials and use the Interactive Plan Comparison Tool
Aetna	
www.aetna.com 1-800-872-7136	**General Information About Your Coverage** • Understand how Aetna medical coverage works • Access claims information • Find a Provider **Aetna Behavioral Health** • Understand how your mental health and Chemical Dependency coverage works • Access claims information • Find a Provider
www.aetna.com	**Aetna Navigator Tools** • Review plan, benefit and claims information • Find a network-participating Physician or dentist • Access sources of health information, such as: — Aetna InteliHealth®, which includes health, dental and wellness information provided by Harvard Medical School and the Columbia University College of Dental Medicine — Healthwise® Knowledgebase, which provides user-friendly online information so you can research your own healthcare issues • Compare Hospital outcome information • Estimate the cost of care you or a dependent may need **Aetna DocFind** • Find a Provider in the Aetna POS network (choose "Choice POS II" under "Aetna Open Access Plans")
www.aetna.com To enroll, or for members or their obstetrical healthcare professional: 1-800-CRADLE-1 (1-800-272-3531)	**Beginning Right Maternity Program** Tools and services for expectant parents, including: • An intensive focus on prevention and early treatment, including education on prenatal care • Web-based educational materials • Access to obstetrically trained nurse care managers for expectant parents

Go Here…	To…
Aetna	
1-800-556-1555 (24 hours a day, 365 days a year)	**Aetna Informed Health® Line** • Speak with a registered nurse at any time, 24 hours a day, 365 days a year • Get information about health and wellness topics • Listen to topics from an Audio Health Library, a recorded collection of more than 2,000 health topics
www.aetna.com/mskcc	**Aetna Provider Network for Cancer Specialists** • Find a cancer specialist in the expanded Aetna Provider network
UnitedHealthcare	
www.myuhc.com User ID: ALU Password: ALU • **POS:** 1-800-577-8539 • **Traditional Indemnity:** 1-800-577-8567	**General Information About Your Coverage and Dedicated Customer Care (Member Services)** • Understand how your UnitedHealthcare medical coverage works • Find network Physicians, specialists and facilities in your community • Compare average treatment costs and Hospitals in your area for medical procedures you may be considering • Manage your healthcare choices and costs through an innovative Plan Comparison Calculator • Access claims information • Speak with an experienced customer care representative who understands your plan and can answer questions quickly
www.myuhc.com 1-866-444-3011 (24 hours a day, seven days a week)	**UnitedHealthcare Optum® NurseLine℠ and Live Nurse Chat** • Speak with a registered nurse at any time • Get information about health and welfare topics • Participate in live online Nurse Chat • Both English- and Spanish-speaking registered nurses are available
www.urncrs.com 1-866-936-6002 (7:00 a.m. to 7:00 p.m., Central Time [CT], Monday through Friday, excluding holidays)	**UnitedHealthcare Cancer Resource Services (CRS)** • Get information regarding a cancer diagnosis and treatment • Find cancer centers or Physicians
www.healthy-pregnancy.com 1-800-411-7984	**Healthy Pregnancy Program** • 24-hour access to experienced maternity nurses • Education and support for women through all stages of pregnancy and delivery

Go Here…	To…
www.urncrs.com (click on the "Congenital Heart Disease" link or call the phone number on the back of your medical ID card)	**Congenital Heart Disease Program (CHD)** • Clinical consultants can provide information to assist parents, family members, case managers and Physicians in making decisions about congenital heart disease
UnitedHealthcare	
www.urncrs.com (or call the phone number on the back of your medical ID card)	**UnitedHealthcare Resources Networks (URN) Transplant Resource Services** • Services and access to medical professionals renowned for providing quality treatment in solid organ or blood/marrow transplants
www.liveandworkwell.com • **Enhanced and Standard POS:** 1-800-577-8539 • **Traditional Indemnity:** 1-800-577-8567	**United Behavioral Health** • Understand how your mental health and Chemical Dependency coverage works • Access claims information
www.liveandworkwell.com 1-800-577-8567 (Medicare-eligible participants in the United Traditional Indemnity option only)	**UnitedHealthcare Mental Health and Chemical Dependency** • Understand how your mental health and Chemical Dependency coverage works • Access claims information
Medco Prescription Drug Coverage (does not apply to HMO coverage)	
• **Participants not eligible for Medicare:** — 1-800-336-5934 — www.medco.com • **Medicare-eligible participants:** — 1-800-230-0512 (TTY: 1-800-716-3231) — www.medco.com/medd/alu	**Medco Health Solutions** • Understand how your prescription drug coverage works • Prescription coverage and pricing information, including comparisons for brand-name and generic medications received through mail order and retail • Access claims information • Find an *In-Network* pharmacy • Order medications from Medco Pharmacy (for savings opportunities)
www.medco.com/choices 1-800-319-7750	**Medco My Rx Choices** • Find lower-cost alternatives for medications you currently take

Go Here…	To…
SecureHorizons® MedicareDirect™, A Medicare Advantage Private Fee-For-Service (PFFS) Plan	
www.uhcretiree.com/alcatel-lucent • 1-888-980-8117 • TTY: 1-888-685-8480, or 711 (8:00 a.m. to 8:00 p.m., local time, Sunday through Saturday)	**SecureHorizons® MedicareDirect™ PFFS Plan Member Services** • General information about your coverage and Customer Care (Member Services) • Understand how your medical coverage works • Speak with an experienced customer care representative who understands your plan
HMO/Medicare Advantage HMO	
HMO/Medicare Advantage HMO carrier contact information is also available: • On the back of your HMO ID card, if you are currently enrolled in an HMO/Medicare Advantage HMO; • By visiting the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent; or • By calling the Alcatel-Lucent Benefits Center at 1-888-232-4111.	**Your HMO/Medicare Advantage HMO carrier** • Understand how your HMO/Medicare Advantage HMO coverage works • Access claims information

Section Q. Other Important Information

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

Your Legal Rights

Your Rights Under ERISA

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). These rights are described in this section.

ERISA provides that all Medical Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Medical Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Medical 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 Medical Plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies.

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

- Continue healthcare coverage for yourself, your spouse, or your Dependents if there is a loss of coverage under the Medical Plan as a result of a "qualifying event." You, your spouse or your Dependents will have to pay for this coverage. Review this SPD and the Plan document about the rules governing your COBRA Continuation Coverage rights.

- Receive, free of charge, a Certificate of Creditable Coverage from the Medical Plan when you, your spouse or your Dependents lose coverage under the Medical Plan or become entitled to elect COBRA Continuation Coverage under the Medical Plan, or when your, your spouse's or your Dependents' COBRA Continuation Coverage ends, if you request it before losing coverage (or up to 24 months after losing coverage). **Please note:** Without evidence of creditable coverage, if you enroll in another plan, you, your spouse and your Dependents may be subject to a Pre-Existing Condition exclusion for 12 months (18 months for late enrollees) after enrolling in the other plan.

In addition to establishing rights for Plan participants, ERISA imposes certain duties on the people responsible for the operation of a Medical Plan. The people who operate the Medical Plan, called "fiduciaries," have a duty to do so prudently and in the interest of all participants and beneficiaries.

No one, including the Company, may fire you or otherwise discriminate against you in any way to keep you from obtaining a welfare benefit or exercising your ERISA rights.

If your claim for a welfare benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right 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 example, if you request a copy of Medical Plan documents or the latest annual report from the Medical Plan and do not receive the requested materials 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 you up to $110 a 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, you may also file suit in federal court if you disagree with the Medical Plan's decision or lack thereof concerning the qualified status of a medical Child support order.

If it should happen that Medical Plan fiduciaries misuse the Medical 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 questions about the Medical Plan, you should contact the Plan Administrator or the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in your telephone directory, or write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
United States 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 Employee Benefits Security Administration at 1-866-444-3272 or by logging on to the Internet at www.dol.gov/ebsa.

Newborn's and Mother's Protection Act

Under the Newborn's and Mothers' Health Protection Act, you are entitled to minimum Hospital coverage of 48 hours following a vaginal birth and 96 hours following a cesarean birth. Care beyond this point must be certified to be a Covered expense. The Medical Plan cannot require you to obtain preauthorization for this minimum length of stay. Mother and Child may leave earlier if the care Provider, in consultation with the mother, decides to discharge the patients earlier.

The Women's Health and Cancer Rights Act of 1998

As required by The Women's Health and Cancer Rights Act of 1998, certain breast reconstruction benefits in connection with a mastectomy due to illness are Covered. If you are receiving Medical Plan benefits for a mastectomy or another surgical procedure and you elect breast reconstruction in connection with a mastectomy or other surgical procedure in response to illness, coverage is available in a manner determined in consultation with you and your Physician for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- Prostheses; and

- Treatment for physical complications for all stages of mastectomy, including lymphedemas.

This coverage is subject to all the terms of the Plan. This includes any Deductibles, Coinsurance or Copayments you are required to pay under the POS or Traditional Indemnity option.

Qualified Medical Child Support Order Benefit Payments

Benefit payments under the Medical Plan will be made according to the terms of a Qualified Medical Child Support Order (QMCSO). If the Plan Administrator determines that a medical Child support order qualifies, benefit payments from the Medical Plan may be made according to the qualified order to the Child or Children named in the order, or to the custodial parent or legal guardian, where appropriate, or healthcare Providers (if benefits have been properly assigned by the Child or Children or by the custodial parent or legal guardian).

Medical Plan Funding and Payment of Benefits

Alcatel-Lucent pays certain administrative costs associated with providing benefits under the Medical Plan unless borne by participants. The funding for the Medical Plan is paid into the Lucent Technologies Inc. Postretirement Welfare Benefits Trust for Nonrepresented Employees and managed by the Plan Trustee.

	Medical Expense Plan
Trust Name	Lucent Technologies Inc. Postretirement Welfare Benefits Trust for Nonrepresented Employees
Trustee	The Bank of New York Mellon Corporation 135 Santilli Hwy. Everett, MA 02149

Plan Documents

This summary plan description was designed to describe the Medical Plan in easy-to-understand terms. However, it is the Medical Plan documents and contracts that determine your rights and the rights of your Eligible Dependents under the Medical Plan. In all instances, even if the SPD and Medical Plan documents are in conflict, the terms of the Medical Plan documents will govern.

Medical Plan May Be Amended or Terminated

The Company expects to continue the Medical Plan, but reserves the right to amend or terminate the Medical Plan, in whole or in part, at any time by the resolution of the Board of Directors or its properly authorized designee, subject to the terms of applicable collective bargaining agreements. In addition, the Company does not guarantee the continuation of any medical benefits during employment or at or during retirement nor does it guarantee any specific level of benefits or contributions, subject to the terms of any applicable bargaining agreement.

Plan Administrator and Claims Administrator

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

Plan Sponsor

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

Notice of Privacy Practices

Our Legal Duty

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that the Medical Plan protect the confidentiality of your protected health information (PHI). A complete description of your rights under HIPAA can be found in the Medical Plan's privacy notice. For a copy of this notice, visit the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent, call the Alcatel-Lucent Benefits Center at 1-888-232-4111 (representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET) or contact the Privacy Official (contact information provided below).

The Medical Plan and the Company, as Plan Sponsor of the Medical Plan, will not use or disclose your PHI, as defined by HIPAA, except as necessary for treatment, payment and healthcare operations or as required by law.

In accordance with HIPAA, the Medical Plan has also required all of its business associates to observe HIPAA's privacy rules. The Medical Plan will not, without written authorization from you, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Company.

Under HIPAA, you have certain rights with respect to your PHI, including the right to review and copy your PHI, receive an accounting of any disclosures of your PHI and, under certain circumstances, amend any inaccurate information. You also have a right to file a complaint with the Medical Plan or with the Secretary of the Department of Health and Human Services if you believe your privacy rights under HIPAA have been violated. If you want to file a complaint with the Medical Plan, you should send your written complaint to the Privacy Official (see contact information below).

To Exercise Your Rights
In most instances, you should contact your Health Plan Carrier and/or Claims Administrator to review or obtain copies of your health information and to exercise your rights regarding your health information. If you are unsure of the appropriate Healthcare Plan and/or Claims Administrator, have a general request that covers more than one Company-sponsored employee benefit plan or have other questions relating to our privacy practices or your privacy rights, please contact the Privacy Official:

Director, Health Plans
Alcatel-Lucent
600 Mountain Avenue, Room 7C-411C
Murray Hill, NJ 07974-0636
1-908-582-2321

Administrative Information

Plan Name	Alcatel-Lucent Retiree Welfare Benefits Plan. Subplan: Medical Expense Plan for Retired Employees.
Plan Sponsor	Alcatel-Lucent USA Inc.
Type of Administration	The Plan is administered by the Health Plan Carriers identified in the Claims Administrator section below. Enrollment and eligibility under the Medical Plan are administered by the Alcatel-Lucent Benefits Center.
Claims Administrator	The following Health Plan Carriers serve as Claims Administrators for their Covered participants: • Aetna (POS), UnitedHealthcare (POS option, SecureHorizons® MedicareDirect™ PFFS Plan and Traditional Indemnity option); • Medco Health Solutions (Prescription Drug Program and Medco Medicare Prescription Drug Plan under the SecureHorizons® MedicareDirect™ PFFS Plan); and; • Alcatel-Lucent Benefits Center (COBRA administration).
Plan Administrator	Medical Plan Administrator Alcatel-Lucent 600 Mountain Avenue, Room 7C-415 Murray Hill, New Jersey 07974 1-908-582-7140
Agent for Service of Legal Process	Legal actions regarding a claim should be sent to the applicable Claims Administrator. All other legal actions should be sent to the Plan Administrator or the applicable Health Plan Carrier.
Plan Records and Plan Year	The Medical Plan and all its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Type of Plan	The Medical Plan is considered an "employee welfare benefit plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Plan Number	504
EIN	22-3408857

Appendix A

SecureHorizons® by UnitedHealthcare

Retiree Benefits Summary Insert

Prepared Exclusively For: **Alcatel-Lucent**
Group Number 39055 (H5435 849)
Effective January 1, 2010 to December 31, 2010

Insured by: United HealthCare Insurance Company

This is a highlight of benefits only and is not all inclusive of the Plan's benefits, services, limitations or exclusions. Please refer to the official Retiree Benefits Summary booklet and your Evidence of Coverage for additional details. Keep this Retiree Benefits Summary Insert, together with your Retiree Benefits Summary, handy for your reference.

For general questions prior to enrollment call 1-888-980-8117, TTY 711, 8:00 a.m. to 8:00 p.m. local time, 7 days a week

Members call Customer Service at the phone number listed on the back of your Member ID card, or on the back cover of the Retiree Benefits Summary booklet.

BENEFITS AND COVERAGE	YOUR COSTS
Annual Deductible	$290
Physician Services	
• Primary Care Physician	$15 copayment after deductible per visit
• Specialist	20% coinsurance after deductible per visit
Emergency Department Services	
• Within the United States	$50 copayment, waived if admitted to the hospital within 24 hours for the same condition.
• Outside of the United States	$50 copayment, waived if admitted to the hospital within 24 hours for the same condition.
Urgently Needed Care	
• Within the United States	$50 copayment, waived if admitted to the hospital within 24 hours for the same condition.
• Outside of the United States	$50 copayment, waived if admitted to the hospital within 24 hours for the same condition.

January 1, 2010, published May 2010
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Appendix A

SecureHorizons® by UnitedHealthcare

Retiree Benefits Summary Insert

Prepared Exclusively For: **Alcatel-Lucent**
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Effective January 1, 2010 to December 31, 2010

BENEFITS AND COVERAGE	YOUR COSTS
Ambulance Services	20% coinsurance after deductible
Inpatient Hospital Care	20% coinsurance per admission after deductible for unlimited days*
Inpatient Mental Health Care	20% coinsurance per admission after deductible, 190 day lifetime maximum
Skilled Nursing Facility Care	You pay 20% coinsurance for days 1-100 up to 100 days per benefit period**, three-day prior hospital stay is not required
Home Health Agency Care	$0 copayment per visit
Outpatient Mental Health Care	20% coinsurance after deductible per visit
Partial Hospitalization Psychiatric Program	20% coinsurance after deductible per day
Outpatient Substance Abuse Services	20% coinsurance after deductible per visit
Outpatient Hospital Services (includes observation, medical and surgical care)	20% coinsurance after deductible per surgery

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BENEFITS AND COVERAGE	YOUR COSTS
Medicare-covered Outpatient Rehabilitation Services	
• Comprehensive Outpatient Rehabilitation (CORF)	20% coinsurance after deductible per visit
• Cardiac and Pulmonary Rehabilitation	20% coinsurance after deductible per visit
• Occupational Therapy, Physical Therapy and Speech and Language Pathology Services	20% coinsurance after deductible per visit
Durable Medical Equipment (DME), Prosthetics, Orthotics (Corrective Appliances), Infusion Equipment and Supplies used in conjunction with the above	20% coinsurance after deductible for each Medicare-covered item
Diabetes Self Management Training	20% coinsurance after deductible for Medicare-covered diabetes self-management training Office Visit copayment may apply
Diabetes Monitoring Supplies	20% coinsurance after deductible per item or up to a 30-day supply
Medical Nutrition Therapy	20% coinsurance Office Visit copayment may apply
Imaging Procedures, X-rays and Portable X-rays Used in the Home	
• Medicare-covered Standard X-rays	20% coinsurance after deductible
• Complex Radiology Services and Imaging Procedures	20% coinsurance after deductible

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BENEFITS AND COVERAGE	YOUR COSTS
• Diagnostic Procedure/Test (non-radiological) Pulmonary and Cardiac Diagnostic Testing	20% coinsurance after deductible
Laboratory Services	20% coinsurance Office Visit copayment may apply
Radiation Therapy	20% coinsurance after deductible per visit Office Visit copayment may apply
Medical Supplies	20% coinsurance after deductible per item
Blood and Its Administration	20% coinsurance after deductible
Kidney Dialysis	20% coinsurance after deductible at a Medicare-certified facility within the United States
Bone Mass Measurements	$0 copayment Office Visit copayment may apply
Colorectal Screening Exams	$0 copayment Office Visit copayment may apply
Annual Screening Mammograms	20% coinsurance after deductible Office Visit copayment may apply
Pap Smears and Pelvic Exams	$0 copayment Office Visit copayment may apply
Annual Prostate Cancer Screening Exams	$0 copayment

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BENEFITS AND COVERAGE	YOUR COSTS
Cardiovascular Disease Testing	20% coinsurance after deductible
Abdominal Aortic Aneurysm Screening	20% coinsurance after deductible for a Medicare-covered screening
Medicare-covered Physical Exams **Please note:** Due to new Medicare guidelines, this benefit is amended. The Retiree Benefits Summary booklet should read, "If your coverage for Medicare Part B begins on or after January 1, 2005, you may receive a one-time physical exam within the first **twelve** months of your new Part B coverage."	$0 copayment
Immunizations • Flu, Pneumococcal Pneumonia, and Hepatitis B Vaccines	$0 copayment
Outpatient Prescription Drugs	Not covered
Medicare Part B-covered Drugs (Immunosuppressives, Oral Chemotherapy Drugs Including Anti-nausea Drugs, Inhalation Solutions)	20% coinsurance after deductible
Outpatient Injectable Medications - Self –Administered	20% coinsurance after deductible
Outpatient Injectable Medications - Administered in a Physician's Office	20% coinsurance after deductible
Outpatient Injectable Medications –	20% coinsurance after deductible

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BENEFITS AND COVERAGE	YOUR COSTS
Home Health	
Hemophilia Clotting Factors - (Self Administered, Administered in a Physician's, Office Home Health)	20% coinsurance after deductible
Antigens	20% coinsurance after deductible
Acupuncture Covered when used instead of traditional anesthesia during surgery or to relieve pain, illness or impaired mobility in the muscles and joints.	You pay 20% coinsurance after deductible. Limited to 30 visits per year.
Chiropractic Services	
• Medicare-covered	20% coinsurance after deductible per visit
Dental Services	
• Medicare – covered	20% coinsurance after deductible for each Medicare-covered dental service
Foot Care	
• Medicare-covered	$15 copayment after deductible per each Medicare-covered visit with your **primary care physician.** 20% coinsurance after deductible per each Medicare-covered visit with a **specialist** or other health care professionals.

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BENEFITS AND COVERAGE	YOUR COSTS
Hearing Services	
• Medicare-covered diagnostic hearing exam	$15 copayment after deductible per each Medicare-covered visit with your **primary care physician.** 20% coinsurance after deductible per each Medicare-covered visit with a **specialist** or other health care professionals.
Vision Services **Eye care – medical need**	
• Medicare-covered eye exam	$15 copayment after deductible for each Medicare-covered vision service with your **primary care physician.** 0% coinsurance after deductible for each Medicare-covered vision service with a **specialist** or other health care professional.
• Medicare-covered eyewear	Up to a $75 allowance for one pair of Medicare-Covered eyeglasses or contact lenses after cataract surgery
Out-of-Pocket Maximum (annual) Annual Out-of-pocket maximum does NOT include the deductible	$2,500

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BENEFITS AND COVERAGE	YOUR COSTS
Out-of-Pocket Maximum	
Applies to the following services:	Primary Care Physician Office Visit Specialist Office Visit Emergency Department Services Urgently Needed Care Ambulance Services Inpatient Hospital Care Inpatient Mental Health Skilled Nursing Facility (SNF) Home Health Services Outpatient Mental Health/Substance Abuse Partial Hospitalization Outpatient Hospital Services (including Outpatient Surgery) Comprehensive Outpatient Rehabilitation Facility (CORF) Cardiac and Pulmonary Rehabilitation Occupational Therapy Services Physical Therapy and Speech Pathology Services Durable Medical Equipment (including DME purchased in a pharmacy) Orthotics and Prosthetics Diabetes Self-Management Training Diabetes Monitoring Supplies Medical Nutrition Therapy Laboratory Services Diagnostic Procedures Outpatient X-ray Services Therapeutic and Diagnostic Radiology Medical Supplies Blood and Its Administration Kidney Dialysis Bone Mass Measurement Colorectal Screening Exams Annual Screening Mammograms Pap Smears and Pelvic Exams

January 1, 2010, published May 2010
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BENEFITS AND COVERAGE	YOUR COSTS
	Annual Prostate Cancer Screening Medicare-covered Physical Exam Annual Routine Physical Exam Immunizations Medicare Part B Drugs (including drugs purchased in a pharmacy) Medicare-covered Chiropractic Visit Medicare-covered Podiatry Visit Medicare-covered Hearing Exam Medicare-covered Eye Exam (includes glaucoma)

Underwritten by United HealthCare Insurance Company or United HealthCare Insurance Company of New York for New York residents (United HealthCare)

*Inpatient Hospital Copayments are charged on a per admission or daily basis. **Original Medicare hospital benefit periods do not apply.** For Inpatient Hospital, you are covered for an unlimited number of days as long as the hospital stay is medically necessary. When you are admitted to an Inpatient Hospital and then subsequently transferred to another Inpatient Hospital, you pay the copayment charged for the first hospital admission. You do not pay a copayment for the second hospital admission; the copayment is waived.

**A benefit period begins the first day of a Medicare-covered inpatient hospital or Skilled Nursing Facility (SNF) stay and ends with the close of a period of 60 consecutive days during which you were neither an inpatient of a hospital nor a SNF. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the skilled nursing facility care copayment, if applicable, for each benefit period. here is no limit to the number of benefit periods you can have.

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SecureHorizons® MedicareDirect™, a Medicare Advantage Private Fee-For-Service Plan, is offered by United HealthCare Insurance Company or an affiliated company, a Medicare Advantage Organization with a Medicare contract. A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our Web site at: www.UnitedHealthcareonline.com/pffs.

January 1, 2010, published May 2010
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