Alcatel-Lucent Medical Expense Plan for Retired Employees

Summary Plan Description

January 2011

Disclaimer

This is a summary of the benefits offered under the Alcatel-Lucent Medical Expense Plan for Retired Employees ("Medical Plan" or the "Plan"). It is provided for informational purposes and is intended to comply with Department of Labor requirements for summary plan descriptions (SPDs). More detailed information is provided in the official Medical Plan document.

This summary is based on Medical Plan provisions effective as of January 1, 2011, 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, the Medical Plan document will govern. The Board of Directors of Alcatel-Lucent (or its delegate) reserves the right to modify, suspend, change or terminate any provision of the Medical Plan at any time, subject to the terms of the applicable bargaining agreement. Participants should make no assumptions about any possible future changes unless a formal announcement is made by the Company.

Questions regarding your benefits should be addressed as indicated in this document (see **Section Q. Important Contacts**). Because of the many detailed provisions of the Medical Plan, no one is authorized to advise you as to your benefits, except as indicated in this SPD. Alcatel-Lucent cannot be bound by statements made by unauthorized personnel. 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 nor a guarantee of continued benefits during retirement.

Alcatel-Lucent Medical Expense Plan for Retired Employees

Introduction

About the Medical Plan Options

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 P. 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. These Medical Plan options are:

- Point-of-Service (POS) (administered by Aetna or UnitedHealthcare);
- Traditional Indemnity (TI) (administered by UnitedHealthcare); and
- Health Maintenance Organizations (HMOs).

Not all options are available in all geographic areas. The options available to you are listed in your enrollment materials, or you can obtain this information by visiting Your Benefits Resources (YBR)™* online at http://resources.hewitt.com/alcatel-lucent or by calling the Alcatel-Lucent Benefits Center at 1-888-232-4111 (at 1-212-444-0994 if calling from outside of the United States, Puerto Rico or Canada). 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.

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.

* Your Benefits Resources (YBR)™ is a trademark of Hewitt Management Company LLC.

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 special section, **Section M. What You Need to Know About Medicare**, to help you understand how your benefits are affected.

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 the following sections of this SPD.

General Plan Information Chart

Medical Plan Feature	Summary
Eligibility	You are eligible to participate in the Medical Plan if you are an Eligible Retiree (former occupational employee who terminated from the Company or a Participating Company and who is receiving a service or disability pension under the Lucent Technologies Inc. Pension Plan). You are also eligible to participate in the Medical Plan if you are the survivor of an occupational retiree on COBRA or the Family Security Program (FSP). You may also enroll your Eligible Dependents under the same Medical Plan coverage option you choose for yourself. However, depending on the option in which you enroll and your and your Dependents' Medicare eligibility status, benefits for you or your Dependents may differ (see **Section D. What's Covered**).
Enrollment	When you retire, enrollment materials and information about your coverage options will be sent to you at your preferred address. You do not need to enroll if the coverage option you had while actively employed is available to you in retirement and you wish to remain in that option. You **do** need to enroll, however, if: • 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; • You want to waive coverage; • You want to make coverage changes for your Class I Dependents**;** • You're a newly retired occupational employee and you wish to change to a POS option (if you are not currently enrolled in a POS option), are not eligible for Medicare, and are not a survivor in the FSP; and/or • During Annual Open Enrollment, you want to re-enroll your non-grandfathered Class II dependent(s) since **current non-grandfathered Class II dependent coverage does not roll over from year to year.**

Medical Plan Feature	Summary
Enrollment, continued	To make any of the above changes, you must enroll by the date specified in your enrollment package. When you make a change, your election becomes effective on the first day of the month following your date of retirement. 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**).
How Coverage Changes When You or a Dependent Becomes Medicare-Eligible	• When you or a Dependent becomes Medicare-eligible, the Alcatel-Lucent Medical Plan coverage becomes secondary for that individual. • Regardless of which Medical Plan option you are enrolled in, you will be transferred to the Traditional Indemnity option when you become Medicare-eligible. The Traditional Indemnity option is administered by UnitedHealthcare. • If you are Medicare-eligible and you have Dependents who are not yet Medicare-eligible, they will also 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 plan while you are in the POS option. • If you are Medicare-eligible, you may be able to elect coverage through a Medicare Advantage HMO if one is available in your area.
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: • Retired employees who are not Medicare-eligible (generally under age 65); and • Dependents under age 65 regardless of the age of the retired employee (except for Dependents under age 65 who are Medicare-eligible as described next in "When Medicare is Primary").

Medical Plan Feature	Summary
When Medicare Is Primary	Medicare takes over as the primary benefit plan for: • Retired employees age 65 and over; • Dependents age 65 and over regardless of the age of the retired employee; • A retired employee or Dependent, regardless of age, who has had end stage renal disease for 30 months;* and • A retired employee or Dependent, regardless of age, who is eligible for Medicare due to disability. When Medicare is the primary plan, benefits under the Traditional Indemnity option become secondary. If you are enrolled in an HMO, you will need to check directly with the HMO about benefit levels for Medicare-eligible individuals.
Informational Resources and Important Contacts	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 (YBR) Web site at http://resources.hewitt.com/alcatel-lucent. Information is also available online at the BenefitAnswers Plus Web site at www.benefitanswersplus.com. You can also call the Alcatel-Lucent Benefits Center (domestic: 1-888-232-4111; outside of the U.S., Puerto Rico or Canada: 1-212-444-0994). Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET. If you are hearing or speech impaired, please use a Relay Service when calling a representative.

* If you or a Dependent is under age 65, Medicare benefits apply only to Covered expenses associated with end stage renal disease.

Medical Benefits Chart

Please note: You may not be eligible for all of the coverage options shown in this chart. For HMO information, contact the HMO. See **Section Q. Important Contacts** for carrier contact information.

Feature	Point of Service (POS) (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are Medicare-eligible)
	In-Network	**Out-of-Network**	
Choice of Physicians	Select within a Network of Providers	Select any eligible Provider	Select any eligible Provider
Annual Deductible	**Retirees, their Dependents and COBRA beneficiaries (excluding survivors)** Individual: 1% of annual pension Two-person: 1% of annual pension per individual Family: 1% of annual pension per individual, up to a 3% maximum **Survivors and their dependents** Individual: $300 Two-person: $600 Family: $900	**Retirees, their Dependents and COBRA beneficiaries (excluding survivors)** Individual: 6% of annual pension ($600 minimum) Two-person: 6% of annual pension per individual, ($1,200 minimum) Family: 6% of annual pension per individual, up to an 18% maximum ($1,800 minimum) **Survivors and their dependents** Individual: $600 Two-person: $1,200 Family: $1,800	**Retirees, their dependents and COBRA beneficiaries:** Per individual: 2.5% of annual pension **Survivors and their dependents:** Individual: $300 Two-person: $600 Family: 900
Annual Out-of-Pocket Maximum	Individual: $1,500 Two-person: $3,000 Family: $4,500 (excludes Deductible)	Individual: $3,500 Two-person: $7,000 Family: $10,500 (excludes Deductible	Individual: $1,500 Two-person: $3,000 Family: $4,500

Feature	Point of Service (POS) (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are Medicare-eligible)
	In-Network	**Out-of-Network**	
Lifetime Maximum Benefit	Unlimited (some exclusions apply)	Unlimited (some exclusions apply)	Unlimited (some exclusions apply); Other Covered Charges are limited to $50,000 (or buy-up amount)
COPAYMENT/COINSURANCE FOR COVERED SERVICES			
Acupuncture	You pay $30 Copayment/ visit	Plan pays 70% after Deductible is satisfied; limited to 30 visits/year (In- and Out-of-Network combined)	Plan pays 80% after Deductible is satisfied; limited to 30 visits/year
Ambulance — Emergency Air Ambulance	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied.	Plan pays 90% after Deductible is satisfied
Ambulance — Emergency Use of Ambulance	Plan pays 90% (Deductible does not apply)	Plan pays 90% (Deductible does not apply)	Plan pays 80% after Deductible is satisfied
Ambulance From Hospital to Hospital (if admitted to first Hospital)	Plan pays 90% (Deductible does not apply)	Plan pays 90% (Deductible does not apply)	Plan pays 90% after Deductible is satisfied
Anesthesia	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied	Plan pays 90% after Deductible is satisfied
Birth Control (prescription birth control or medication only)	See "Prescription Drug Program" later in this section.		
Birthing Center	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied	Plan pays 90% after Deductible is satisfied
Blood and Blood Derivatives	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied

Feature	Point of Service (POS) (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are Medicare-eligible)
	In-Network	**Out-of-Network**	
Cardiac Rehabilitation (phase three maintenance not Covered)	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Chemotherapy	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied	Plan pays 90% after Deductible is satisfied
Chiropractic	You pay $30 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% after Deductible is satisfied; limited to 30 visits/year
Durable Medical Equipment	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Emergency Room — Emergency Use	You pay $75 Copayment/ visit (waived if admitted)	You pay $75 Copayment/visit (waived if admitted)	Plan pays 90% after Deductible is satisfied
Emergency Room — Nonemergency Use	Plan pays 70% after you pay $75 Copayment/visit	Plan pays 70% after you pay $75 Copayment/ visit	Plan pays 80% after Deductible is satisfied
Extended Care Facility (or Skilled Nursing Facility)	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied; limited to 60 days/year	Plan pays 90% after Deductible is satisfied; limited to 120 days/year
Home Healthcare	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied; limited to 100 visits/ year	Plan pays 90% after Deductible is satisfied; limited to 200 visits/year
Hospice Care	Plan pays 90% after Deductible is satisfied; (limited to 210 days/lifetime (In- and Out-of-Network combined)	Plan pays 70% after Deductible is satisfied; limited to 210 days/ lifetime (In- and Out-of-Network combined)	Plan pays 90% after Deductible is satisfied; limited to 210 days/lifetime
Inpatient	Plan pays 90% after	Plan pays 70% after	Plan pays 90% after

Feature	Point of Service (POS) (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are Medicare-eligible)
	In-Network	**Out-of-Network**	
Hospitalization/ Surgery	you pay $100 Copayment/admission	Deductible is satisfied and you pay $300 Copayment/ admission	Deductible is satisfied
Maternity	Plan pays 90% after you pay $30 Copayment for first Physician visit and 90% after you pay $100 Copayment/ Hospital admission	Plan pays 70% after Deductible is satisfied and you pay $300 Copayment/Hospital admission	After Deductible is satisfied, Plan pays 90% for most Inpatient and Outpatient services and 80% for Physician office visits
Mental Health and Chemical Dependency* (for those not eligible for Medicare)	**Inpatient** Plan pays 90% after you pay $100 Copayment/admission **Outpatient** You pay $30 Copayment/visit	**Inpatient** Plan pays 70% after Deductible is satisfied and you pay $300 Copayment/ admission **Outpatient** Plan pays 70% after Deductible is satisfied	**Inpatient** Plan pays 90% after Deductible is satisfied **Outpatient** Plan pays 80% after Deductible is satisfied
Mental Health and Chemical Dependency* (for those Medicare-eligible)	**Inpatient and Outpatient** Not applicable		**Inpatient** Plan pays 90% after Deductible is satisfied **Outpatient** Plan pays 80% after Deductible is satisfied
Nutritionist	You pay $30 Copayment/ visit	Not Covered	Not Covered
Outpatient Lab/X-ray	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied	Plan pays 90% after Deductible is satisfied
Physician Hospital Visits and Consultations	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied	Plan pays 90% after Deductible is satisfied

* The POS and Traditional Indemnity Deductibles and Out-of-Pocket Maximums apply to Mental Health and Chemical Dependency coverage. (They are not separate.)

Feature	Point of Service (POS) (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are Medicare-eligible)
	In-Network	**Out-of-Network**	
Physician Office Visits (non-preventive)	You pay $30 Copayment/ visit	Plan pays 70% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Podiatrist	You pay $30 Copayment/ visit	Plan pays 70% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Private Duty Nursing	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied; limited to 100 shifts/ year	Plan pays 90% after Deductible is satisfied; limited to 200 shifts/year
Radiation Therapy	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied	Plan pays 90% after Deductible is satisfied
Rehabilitation Therapy (Outpatient physical, occupational, speech)	You pay $30 Copayment/visit	Plan pays 70% after Deductible is satisfied; Speech Therapy limited to 30 visits/year	Plan pays 80% after Deductible is satisfied; Speech Therapy limited to 30 visits/year
Second Surgical Opinion	You pay $30 Copayment/visit	Plan pays 70% after Deductible is satisfied	Plan pays 90% after Deductible is satisfied
Smoking Deterrents (prescription only)	See "Prescription Drug Program" later in this section.		
Surgery — In Office	You pay $30 Copayment/visit	Plan pays 70% after Deductible is satisfied	Plan pays 90% after Deductible is satisfied
Surgery — Outpatient	Plan pays 90% after Deductible is satisfied	Plan pays 70% after Deductible is satisfied	Plan pays 90% after Deductible is satisfied
Wigs	Plan pays up to $300/Plan Year		
PREVENTIVE CARE			
Routine Physical Exams	You pay $30 Copayment/visit	Not Covered	Not Covered
Well-Child Care	You pay $30 Copayment/visit	Not Covered	Not Covered

Feature	Point of Service (POS) (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are Medicare-eligible)
	In-Network	**Out-of-Network**	
Childhood Immunizations	You pay $30 Copayment/ visit (included with office visit)	Not Covered	Not Covered
Well-Woman Care (OB/GYN exam)	You pay $30 Copayment/visit	Not Covered	Not Covered
Mammogram Screening (in Physician's office)	You pay $30 Copayment/visit; included with Physician's visit	Plan pays 70% after Deductible is satisfied	After Deductible is satisfied, Plan pays 80% if preventive or 90% if diagnostic
Pap Smear (in Physician's office)	You pay $30 Copayment/visit; included with Physician's visit	Plan pays 70% after Deductible is satisfied	Plan pays 90% 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)	You pay $30 Copayment/ visit; included with Physician's visit	Plan pays 70% after Deductible is satisfied	Plan pays 90% after Deductible is satisfied
Newborn In-Hospital Care	Plan pays 90% (Deductible does not apply)	Plan pays 70% after Deductible is satisfied; limited to one visit	Plan pays 90% (Deductible does not apply); limited to one visit
Centers of Excellence	Yes	Yes	Yes
COST			
2011 Monthly Cost	Visit the Your Benefits Resources (YBR) Web site at http://resources.hewitt.com/alcatel-lucent or by calling the Alcatel-Lucent Benefits Center at 1-888-232-4111 (at 1-212-444-0994 if calling from outside of the United States, Puerto Rico or Canada).		

Feature	Point of Service (POS) (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are Medicare-eligible)
	In-Network	**Out-of-Network**	
Are You Responsible for Charges in Excess of the Allowable Amount?	No	Yes	Yes
Who Is Responsible for Precertification?	Your Primary Care Physician (PCP)	You	You
What Is the Penalty for Failure to Precertify Care?	Not applicable	20% reduction in benefits, up to $400 maximum/ occurrence	20% reduction in benefits, up to $400 maximum/ occurrence
Do You Have to File Claim Forms?	No	Yes	Yes
PRESCRIPTION DRUG PROGRAM[1]			
Prescription Drug Annual Deductible*	**Retail** $50/individual **Mail Order:** None	Individual: $100 Two-person: $200 Family: $300	**In-Network** **Retail** None **Mail Order** $50 per individual **Out-of-Network:** Individual: $100 Two-person: $200 Family: $300
Prescription Drug Annual Out-of-Pocket Maximum*	**Retail and mail order:** $1,500/individual (excludes Deductible)	None	**In-Network (retail and mail order):** $1,500/individual (excludes Deductible) **Out-of-Network:** None

* 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 and Traditional Indemnity options.

Feature	Point of Service (POS) (If you are not eligible for Medicare)		Traditional Indemnity (If you are not eligible for Medicare or if you are Medicare-eligible)
	In-Network	**Out-of-Network**	
Retail Copayments (up to 30-day supply using an In-Network pharmacy)	• Generic: $10 • Formulary: $33 • Nonformulary: $55 You pay the generic Copayment, plus the difference in cost between the brand-name and generic prescription if you purchase a brand-name medication when a generic equivalent is available. Also, prescription drug Copayments will double after the third time you receive a maintenance medication at an In-Network retail pharmacy. For cost savings, use mail order (see below).	Plan pays 70% after Deductible is satisfied	**In-Network:** • Generic: $10 • Formulary: $33 • Nonformulary: $55 You pay the generic Copayment, plus the difference in cost between the brand-name and generic prescription if you purchase a brand-name medication when a generic equivalent is available. Also, prescription drug Copayments will double after the third time you receive a maintenance medication at an In-Network retail pharmacy. For cost savings, use mail order (see below). **Out-of-Network:** Plan pays 70% after Deductible is satisfied
Mail-Order Copayments (up to 90-day supply)	• Generic: $25* • Formulary: $82.50 • Nonformulary: $137.50	Not applicable	**In-Network:** • Generic*: $25 • Formulary Brand: $82.50 • Nonformulary Brand: $137.50 **Out-of-Network:** Not applicable

* You may be eligible for up to a 90-day supply of a Generic Drug for $10 or less. To find out if your medication qualifies, visit www.medco.com/lowcostgenerics or call the phone number on the back of your Medco ID card.

Section B. Joining the Medical Plan

Who Is Eligible

Eligible Retirees

You're eligible to participate in the Medical Plan if you are an Eligible Retiree (former occupational employee who terminated from the Company or a Participating Company and are receiving a service or disability pension under the Lucent Technologies Inc. Pension Plan).

Eligible Dependents

If you satisfy the criteria in "Eligible Retirees" above, your Eligible Dependents also may 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 common-law spouse if recognized in your state of residence).
- Your same- or opposite-sex Domestic Partner*, if you and your partner meet all of the following requirements:
  - Comply with any state or local registration process for Domestic Partners, if applicable;

* Or any other state-recognized permanent relationship between two consenting adults, other than opposite-sex marriage, that meet the stated requirements.

— Reside in the same household;

— Are age 18 or older;

— 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: If an active employee had a Domestic Partnership Dependent Covered at some point under the Alcatel-Lucent Medical Expense Plan for Occupational Employees, he or she will be permitted to continue the coverage for the enrolled Domestic Partnership Dependent.

In addition, if the retiree later drops coverage for Domestic Partnership Dependents enrolled on the date of his or her retirement, the retiree will be permitted to subsequently re-enroll those Dependents.

The retired employee **cannot** enroll a **new** Domestic Partnership Dependent after the retiree's coverage under the Medical Expense Plan for Retired Employees begins.

- Your unmarried child(ren) (including those of your Domestic Partner or opposite-sex spouse) up to the end of the year in which they reach age 23:

  — Biological child(ren), stepchild(ren) who live with you or legally adopted child(ren);

  — Child(ren) for whom you, your spouse or your Domestic Partner is appointed a legal guardian as defined by a court order (this does not include ward[s] of the state or foster child[ren]); and

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

- Children beyond age 23 who are incapacitated, unmarried, certified by the Health Plan Carrier Claims Administrator 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 and maintenance.

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 Health Plan Carrier and notify the Alcatel-Lucent Benefits Center at 1-888-232-4111 of your intention to seek coverage for the child beyond age 23. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET.

Class II Dependents

The following Class II dependents who have been continuously Covered since before January 1, 1996 may continue to be enrolled (no new Class II dependent[s] may be enrolled):

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 Class I dependent(s);
- Your unmarried grandchild(ren);
- Your unmarried brothers and sisters; and
- Your parents and grandparents or your Lawful Spouse's parents and grandparents.

To be a Class II Dependent under the Medical Plan; an above-listed relative must meet all of the following requirements. 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 a 100-mile radius of your home) provided by you for at least the past six months (note that an unmarried dependent stepchild[ren] must live with you throughout the period of coverage); and
- Either:
  - **Non-Grandfathered Class II Dependents:** Have been continuously re-enrolled during each Annual Open Enrollment period since January 1, 1996 and continue to be re-enrolled each year; or

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

Other Covered Charges Only Class II Dependents
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 (Medicare-Eligible and Out-of-Area Participants)" in **Section C. How the Medical Plan Options Work)**.

Enrolling in the Plan

The Medical Plan provides several coverage options from which to choose the one that best meets your needs. Your geographic location and Medicare eligibility status determine which options are available to you.

You also may have the opportunity to elect a different Medical Plan option each year during the Annual Open Enrollment period (see "Annual Open Enrollment" later in this section) or in the event of a qualified status change (see "Changing Your Coverage During the Year" later in this section), or you decide to elect a Medicare Advantage HMO (see "Changing Your Coverage During the Year" later in this section and "Medicare Advantage HMOs" in **Section C. How the Medical Plan Options Work**).

You can also waive Medical Plan coverage with the option to reinstate it as of the first of any month based upon a qualified status change, but you must remain in that Medical Plan option for the remainder of that Plan Year (see "Deferring Medical Plan Coverage" later in this section).

Please note: Coverage for Domestic Partnership Dependents is available only to those Domestic Partnership Dependents of Eligible Retirees who had Alcatel-Lucent-sponsored medical coverage while the Eligible Retiree was actively employed. If you drop coverage for an eligible Domestic Partnership Dependent, you will be permitted to subsequently re-enroll that Dependent. However, you cannot add a new Domestic Partnership Dependent once you are retired.

When you retire, you will receive an enrollment package in the mail. (Materials and information about your coverage options will be sent to you at your preferred address.) The package 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.

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

- Individual;
- Two-person; or
- Family.

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

Alcatel-Lucent Families
Enrollment Rules
The following explains the Medical Plan enrollment rules for Alcatel-Lucent families:

- One occupational retired or active Alcatel-Lucent employee can't enroll a management Alcatel-Lucent employee or retiree as a dependent.
  - There is one exception to the rule which allows an occupational retiree or active employee to cover a part-time management employee whose regularly scheduled hours are fewer than 20 hours per week.
- A retired occupational employee may elect to be Covered as a Dependent under another active occupational employee or retired occupational employee.

When Your Spouse or Domestic Partner Is Also an Employee or Retiree
If your spouse or Domestic Partner who is also an Alcatel-Lucent employee or retiree can be Covered as a Dependent (see "Eligible Dependents" earlier in this section), the following are some of the options that you have when enrolling in your benefits:

- One of you can enroll for "Individual" coverage and the other can cover your eligible child(ren) by enrolling in "Two-person" or "Family" coverage;
- One of you can enroll for "Two-person" or "Family" coverage while the other elects "No Coverage;" or
- You can both elect "Two-person" or "Family" if you're covering different children.

Enrollment Rules

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 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 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 Lawful Spouse or Domestic Partner, are appointed legal guardian and ends on the 60th day thereafter.

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 fail to enroll during this 60-day special enrollment period, you will have to wait until the next 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.

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 Plan.

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

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 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.

Situation	Administration
You have a Class II Dependent enrolled as of January 1, 1996 under the corresponding plan offered by AT&T for Other Covered Charges only.	The Class II Dependent would be enrolled under the Traditional Indemnity option and Covered only for those benefits designated as "Other Covered Charges." Benefits will be administered by UnitedHealthcare whether you enroll in the POS or the Traditional Indemnity option. This same Dependent would also have prescription drug coverage through Medco.

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'll 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'll also need to submit a claim for reimbursement.

When You Retire
When you retire, you do not need to re-enroll for coverage if you want to keep the same option you had as an active employee. You will automatically remain in that option unless you want to change options.

You will need to enroll, however, if any of the following applies 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;

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

- 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 Resources (YBR) Web site at http://resources.hewitt.com/alcatel-lucent or on your personalized enrollment worksheet (see "Opting Into a POS Option" below).

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.

Keep in mind that once the initial enrollment period is over (31 days from the date on the cover letter 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 change (see "Changing Your Coverage During the Year" below on this page).

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 case, 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., 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.

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, depending on your circumstances, 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'll 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 medical 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'll be enrolled in your Default Option.

You can enroll:

- On the Your Benefits Resources (YBR) 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., ET. If you are hearing or speech impaired, please use a Relay Service when calling a representative.

Reminder
Your coverage may be affected if you don't act during Annual Open Enrollment; for example, **if you don't re-enroll your Class II dependents, they will not be Covered in the future.**

Changing Your Coverage During the Year
Generally, once you enroll in the Plan, you cannot change your coverage election during the calendar year. However, you may be able to change your coverage election during the year if one of the following occurs.

If you experience one of the events described in the section below and need to change your coverage during the calendar year, you must report the event within **31 days** of its occurrence online through the YBR 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., 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.

Provided you notify the Alcatel-Lucent Benefits Center within the required timeframes, any coverage change due to a qualified status change takes effect on the date of the qualified status change.

Qualified Status Change

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.

Domestic Partner Qualified Status Changes
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

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.

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 Place of 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 R. 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., ET.
End of COBRA Continuation Coverage	You may be able to enroll in the Medical Plan during the year if COBRA coverage under 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 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 (YBR) 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., ET.
Enrolled Retiree Marries or Acquires a Child Through Birth, Legal Adoption or Placement With You for Legal Adoption	If you're 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**.**	You may enroll your spouse and/or new child as of the date of marriage, birth, legal adoption or placement with you for legal adoption and enroll your new spouse and/or child — as long as you enroll. See Special Enrollment Period for Newborns, Newly Adopted Children and Children Newly Placed With You for Adoption" in **Section B. Joining the Medical Plan).**

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.

New Dependents/Spouse of a Non-Enrolled Retiree
If you're 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.

When Changes Take Effect
Provided you notify the Plan within the 31-day period, any coverage change due to a qualified status change takes effect (retroactive to a maximum of 60 days):

- On the date of a Dependent's birth;

- On the date of a Dependent's adoption or placement for adoption; and

- For all other events, on the date of the qualified status change.

How to Make Changes to Your Coverage During the Year
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 (YBR) 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., ET. If you don't make the change within the 31-day period, 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. In certain situations Special Enrollment rules may apply. See "Special Enrollment Rules" in **Section O. Events Affecting Coverage**.

Provided you notify the Alcatel-Lucent Benefits Center within the required time frames, any coverage change due to a qualified status change takes effect on the date of the qualified status change.

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.

Changing Medicare Advantage Elections

Medicare-eligible retirees can change from a Medicare Advantage HMO to the Traditional Indemnity option throughout the year. In this case, the change is not limited to qualified status changes, provided that the necessary paperwork is completed.

Changing Your Level of Coverage

You may change your level of coverage under the Medical Plan during the year only if you have an applicable qualified status change.

To be able to make a change during the year, a qualified status change must be reported within **31 days** of the event. A qualified status change may be processed online at the Your Benefits Resources (YBR) 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., ET. In certain situations, special enrollment rules may apply. See "Special Enrollment Rules" in **Section O. Events Affecting Coverage**.

Confirmation Statements

You'll 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.

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

Review Your Confirmation Statement
Be sure to review the information on your confirmation statement carefully and report any discrepancies to the Alcatel-Lucent Benefits Center immediately.

Deferring Medical Plan Coverage

You can also defer Medical Plan coverage with the option to enroll during the next Annual Open Enrollment period or as of the first of any month based upon a qualified status change. If you enroll for coverage, you must remain in that Medical Plan option for the remainder of that Plan Year unless you experience another qualified status change or elect coverage under a Medicare Advantage HMO, if eligible.

Medical Plan Contributions

Your contribution, if any, toward the cost of coverage under the Medical Plan will be direct billed on a monthly basis until your pension begins. Once pension payments begin, you can contact the Alcatel-Lucent Benefits Center to request that monthly contributions be deducted from your monthly pension check.

Please note: 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 health and life insurance coverage, you will need to remain on direct bill.

During Annual Open Enrollment, you'll find cost information for all the available options on the Your Benefits Resources (YBR) Web site at http://resources.hewitt.com/alcatel-lucent and on your personalized enrollment worksheet or confirmation of enrollment statement.

Class II Dependents

Non-Grandfathered Class II Dependents

If you do not contribute to the cost of Non-Grandfathered Class II Dependent coverage when required to do so, coverage for the Non-Grandfathered Class II Dependent will be terminated. Once such coverage is terminated, you cannot re-enroll the Non-Grandfathered Class II Dependent in the Medical Plan.

Grandfathered Class II Dependents

You are not presently required to contribute to the cost of Grandfathered Class II Dependent coverage if the Grandfathered Class II Dependent has remained continuously enrolled in this Plan since October 1, 1996.

Other Covered Charges Only Class II Dependents

You are not presently required to contribute to the cost of coverage for a Class II Dependent receiving Other Covered Charges Only coverage.

Tax Treatment of Domestic Partner Dependent Coverage

The cost of covering a Domestic Partnership Dependent has to be deducted from your pension check on an after-tax basis. In addition, the Company's contribution to the Domestic Partnership Dependent's coverage is added to your taxable income as imputed income.

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.

Tax Treatment of a Non-Supported Dependent Child

The amount that Alcatel-Lucent pays to cover your Dependent Child who does not rely on you for more than half his or her support is known as "imputed income," and is reported as taxable income to you. This income is subject to both tax and FICA withholding, and the amount depends on the medical option you elect and whom you elect to cover. If this situation applies to you, notify

the Alcatel-Lucent Benefits Center at 1-888-232-4111 during the Annual Open Enrollment period or if you have a qualified status change during the year so the appropriate tax will be applied. You may also want to consult a personal tax advisor about tax implications.

Section C. How the Medical Plan Options Work

About Your Medical Plan Options

The Medical Plan offers three coverage options:

- A Point-of-Service (POS) option;
- The Traditional Indemnity option; and
- HMOs/Medicare Advantage option.

Check Out Section A. Medical Plan Benefits-At-a-Glance
Section A, 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.

This section explains how the POS and Traditional Indemnity options work, and includes a brief summary of how an HMO works in general. If you are enrolled in an HMO, refer to your HMO's materials for information about how the HMO works.

The options available to you are based on your:

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

The following charts highlight the options available to you based on the above criteria:

If You Are NOT Eligible for Medicare

And You and Any Non-Medicare-Eligible Dependents Have:	Then Any Medicare-Eligible Dependents Have:
Traditional Indemnity option	Traditional Indemnity option, with Medicare primary
POS option	Traditional Indemnity option, with Medicare primary
HMO option	Medicare Advantage HMO

If You ARE Eligible for Medicare

And You and Any Medicare-eligible Dependents Have:	Then Any Non-Medicare-Eligible Dependents Have:
Traditional Indemnity option	POS option if there is a United Healthcare POS in your area; otherwise, Traditional Indemnity
Medicare Advantage HMO option	HMO option

Please note: If you are a survivor of a retired occupational employee on the Family Security Program (FSP), regardless of whether you are or are not eligible for Medicare you have access to the Traditional Indemnity option. If you are Medicare-eligible, you may also be eligible for Medicare Advantage HMOs.

If You Live Outside of a POS Area

You may live in an area with limited access to doctors and hospitals in a POS network. If you are not Medicare-eligible and are comfortable with the distance between you and POS network doctors and hospitals, you can still enroll in a POS option. Just 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., ET.

Your Share of Eligible Expenses

Annual Deductible

The annual Deductible is the amount you may 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 Prescription Drug Program — if you're Covered under the POS or Traditional Indemnity option. Your Medical Plan option, the type of service or supply (medical/mental health or Chemical Dependency or prescription drugs) and whether care is received In-Network or Out-of-Network determines the amount of the Deductible you must satisfy before the Plan will pay benefits. In addition your Deductible is based on your Medical Plan option and on a percent of your annual pension (see **Section A. Medical Plan Benefits At-a-Glance** for Deductible amounts).

There are individual, two-person and family Deductibles. Under the POS option, the In-Network and Out-of-Network Deductibles are separate.

- **Individual Deductible.** This is the amount each Covered person pays during a calendar year for Covered services under the POS option or for Covered services under 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 Plan 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, the Plan begins paying benefits, regardless of whether an individual has met his or her individual Deductible.

Here's how the family deductible is calculated on an in-network basis. Let's say your annual pension is $12,000. The family deductible equals 1% per covered person of your annual pension, up to a maximum of 3% or, in this example, $360 (3% x $12,000). If you have more than three covered family members, the family deductible would still be $360.

Expenses That Don't Count Toward the Annual Deductible

Certain expenses that you pay don't count toward any of the annual Deductibles (whether under the POS or Traditional Indemnity options). These expenses include:

- Charges for expenses that aren't Covered under your Medical Plan option, (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**); and

- Coinsurance for Out-of-Network services.

Prescription Drug Program Annual Deductible
The Prescription Drug Program includes separate annual Deductibles if you purchase prescription drugs from retail pharmacy under the POS or Traditional Indemnity option. These Deductibles are separate from the Medical Plan option's annual Deductible for medical services and supplies and mental health and Chemical Dependency services (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're required to pay each calendar year for Covered expenses. Two separate Out-of-Pocket Maximums apply for your medical (including mental health and Chemical Dependency coverage) option and the Prescription Drug Program.

Under the POS and Traditional Indemnity options, there are individual, two-person and family medical Out-of-Pocket Maximums:

- **Individual annual Out-of-Pocket Maximum.** Once a Covered person reaches the annual Out-of-Pocket Maximum, the POS and the Traditional Indemnity 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 Out-of-Pocket Maximum, the POS and the Traditional Indemnity 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 Out-of-Pocket Maximums during the calendar year, the POS and the Traditional Indemnity 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 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 POS or Traditional Indemnity 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
The Prescription Drug Program has a separate annual Out-of-Pocket Maximum for In-Network retail and mail order prescription drug expenses under the POS and Traditional Indemnity Medical Plan options. This Out-of-Pocket Maximum is separate from each Medical Plan option's Out-of-Pocket Maximum for medical and mental health and Chemical Dependency services and supplies (see "Out-of-Pocket Maximum" in this section; see **Section A. Medical Plan Benefits At-a-Glance** for the Out-of-Pocket Maximum amount).

POS Option for Non-Medicare-Eligible Participants

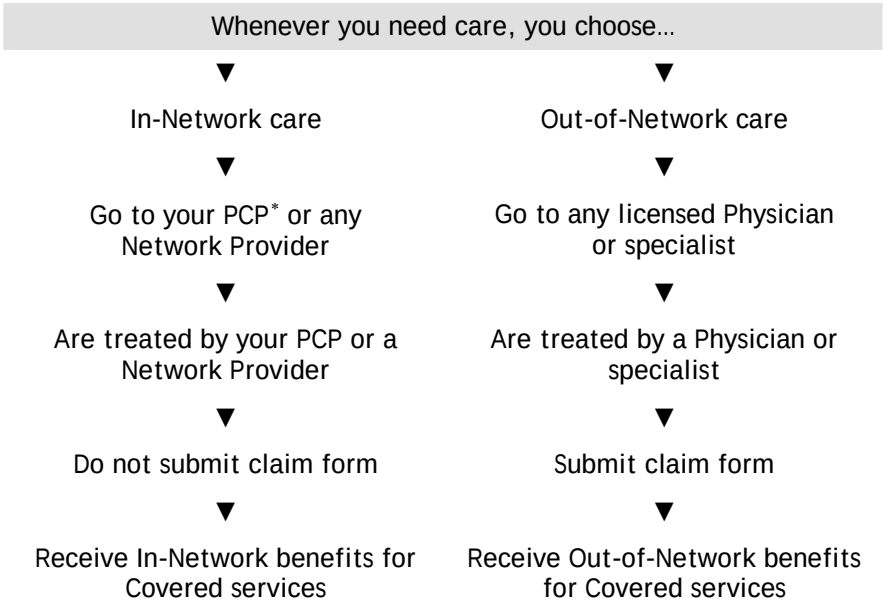
The POS option is available to non-Medicare-Eligible Retirees and their Eligible Dependents.

With the 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 (MH/CD) Program.

How the 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:



In-Network Care: Generally Higher Benefits
Generally, you'll experience these advantages when you receive care on an In-Network basis:

- Your annual Deductible (which is separate from the Out-of-Network annual Deductible) is lower than the Out-of-Network annual Deductible.
- For some services, you only pay a small Copayment

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 a Non-Network Provider and benefits will be paid at the In-Network level. Contact your Health Plan Carrier for more information.

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

or your Coinsurance (percent of eligible expenses you pay) is lower, when applicable, for many Covered services;

- You don't need to submit claim forms and wait to be reimbursed;
- Your Provider obtains any needed precertification for you; and
- Certain preventive care services are available that aren't Covered on an Out-of Network basis.

The Provider Network

The POS option makes available to you a Network of Providers — including Physicians, Hospitals, Home Health Care Agencies and Extended Care Facilities. Through the Network, you'll 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're encouraged (although not required) to select a 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.

In general, you can select or 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 (YBR) Web site at http://resources.hewitt.com/alcatel-lucent.

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:

- The Out-of-Network annual Deductible (which is separate from the In-network annual Deductible) is higher that than the In-Network annual Deducible.

- After you satisfy your annual Deductible, 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, which is a higher percentage than your In-Network 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 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 (see **Section F. When Precertification Is Required).**

- 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 up front 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 requires that you precertify them.

Under the POS option, you and your Covered Dependents must obtain precertification for certain Covered services before the Medical Plan will pay benefits. When you receive care from an In-Network Provider, the In-Network Provider obtains precertification for you. If you visit an Out-of-Network Provider, you are responsible for obtaining precertification. If you don't obtain the required precertification, the Medical Plan will cover less of your costs and may even refuse to pay any benefits (see **Section F. When Precertification Is Required**).

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

- The situation must qualify as an Emergency and

- You must precertify this care within the appropriate timeframe following the Emergency care (see **Section F. When Precertification Is Required**).

If the condition treated is not considered to be an Emergency, benefits for Covered services will be paid at the non-Emergency care and/or 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 P. 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 Non-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 a Non-Network Provider, and care will be Covered at In-Network benefit levels as long as you precertify this care within the appropriate timeframe

following the Emergency care (see **Section F. When Precertification Is Required**).

Note further that, in the case of Urgent Care, you or your Covered Dependent can go to a Non-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 a Non-Network Provider must also be authorized by your Health Plan Carrier in order to be Covered at the In-Network benefit levels.

Your Medical ID Card
You'll 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.

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 Q. 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 (Medicare-eligible and Out-of-Area Participants)

The Traditional Indemnity option is available to Medicare-eligible Plan participants and participants who live in non-POS areas.

Advantages of Using Traditional Indemnity PPO Providers
When you receive your medical care from Traditional Indemnity option 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 (YBR) Web site at http://resources.hewitt.com/alcatel-lucent.

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.
- For most Covered services you receive each year, you'll 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.

Under the Traditional Indemnity option, you and your Covered Dependents must get precertification for certain Covered expenses. If you don't get the required precertification, the Medical Plan will cover less of your costs and may even refuse to pay any benefits (see **Section F. When Precertification Is Required**).

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

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
United Healthcare'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 Q. 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.

Other Covered Charges (OCC)
OCC coverage is not a medical plan. It is a separate coverage election that enhances the Traditional Indemnity option offered to participants.

Under the Traditional Indemnity Option, retirees are provided a lifetime maximum of $50,000 of OCC coverage. Medicare-eligible retirees and their Covered Dependents have a one-time option to purchase (buy-up) an additional level of OCC coverage. It can be purchased in increments of $50,000, $100,000 or $200,000 and is added on top of the original $50,000 of OCC coverage. For example, a retiree who is currently enrolled in the Traditional Indemnity option purchases $200,000 of OCC coverage. He or she would have a total of $250,000 of OCC lifetime coverage. Deductions from your pension check or payments through the direct-bill process for buy-up OCC coverage

begin once you become Medicare-eligible and the Traditional Indemnity option is your coverage.

Once an OCC coverage amount is elected, you can only decrease your coverage amount or cancel it. If you cancel OCC coverage, you can never re-enroll in it. Even if you are not enrolled in the Traditional Indemnity option after having been enrolled, the balance of your OCC will be available if you again enroll in the Traditional Indemnity option. (You do not make OCC buy-up payments when not enrolled in the Traditional Indemnity option.)

The first $3,500 of OCC expenses incurred during each calendar year does not apply toward the OCC Maximum.

The Traditional Indemnity option will pay for Other Covered Charges (OCC) as shown in the chart below, up to the $50,000 lifetime maximum or up to your elected buy-up amount, if applicable.

Provision	**Coverage Level**
Hospitalization beyond 120 days	100%
Professional nursing services by a registered or licensed practical nurse	100%
Local Ambulance Services	80%
Routine Mammograms	80%
Artificial Limbs and Eyes	80%
Rental, Repair or Replacement of Medically Necessary Medical Equipment or Durable Medical Equipment (DME)	80%
Blood and Blood Derivatives	80%
Physician Office Visits or Home Visits	80%
Physical Therapy	80%
Chiropractic Care	80%
Podiatric Care	80%
Orthotic Care	80%
Physical Therapy	80%
Hemodialysis/Personal Dialysis for Chronic Renal Disease	80%

Provision	Coverage Level
Care Received in an Extended Care Facility	80%
Home Health Care	80%

HMO Option(s)

In general, an HMO provides prepaid benefits for most health care needs, without your having to submit claim forms. An HMO provides services through a select group of doctors, Hospitals and other Providers who are under contract with the HMO.

How an HMO Option Works

If you live in an HMO's service area, as defined by your home zip code, you're eligible to join that HMO. For most HMOs, you need to choose a Primary Care Physician (PCP) or facility from a list of Providers in the service area when you enroll.

If you receive medical services outside your PCP's office without being referred by your PCP, you usually won't receive any benefit coverage. Contact the HMO directly about the benefits it may provide for Emergency care received Out-of-Network.

You can also contact the HMO to find out what types of services don't need to be coordinated by your PCP.

The Role of a PCPs

A Primary Care Physician (PCP) coordinates all of your and your enrolled family member's (s') medical care and makes referrals to specialists for any specialized care needs. Each family member can choose his or her own PCP.

A PCP is a Network Provider who is trained in one of the following areas:

- General practice;
- Family practice;
- Internal medicine; and/or
- Pediatrics.

Note: You can see any Network obstetrician or gynecologist (OB/GYN), Chiropractor, or Acupuncturist in your service area without a referral from your PCP.

For more information about your HMO option, contact the HMO directly.

Medicare Advantage HMOs

Like traditional Medicare, 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 health care companies and must get special approval from 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 pay a monthly premium, which may vary depending on the Health Plan Carrier offering the HMO and the level of benefits provided. You may also be required to pay Deductibles, Copayments, Coinsurance and/or other fees.

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 also 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 health care is provided solely through that HMO.

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

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 or the Traditional Indemnity option, the Mental Health and Chemical Dependency Program or the Prescription Drug Program.

Section D. What's Covered

Covered Services and Conditions of Service

To be a "Covered service" under the Point of Service (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 in which 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 under the Traditional Indemnity option and Out-of-Network under the POS 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 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 a Non-Network to a Network Hospital (only applies if Covered under the POS option);

- 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 Healthcare 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 option, if you're referred to a Center of Excellence through the precertification process (see **Section F. When Precertification Is Required**), you'll 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 a non-Experimental transplant surgery, 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 are 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 POS option, 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 POS option, only Out-of-Network benefits are available 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 POS option, 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're enrolled in the 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, you pay the Emergency room Copayment plus the Out-of-Network Coinsurance.

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

Extended Care Facility

Extended Care Facilities services are Covered under the POS and 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** under the Traditional Indemnity option or for Out-of-Network care under the POS option, precertification is required (see **Section F. When Precertification Is Required**).

- 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 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 the POS and Traditional Indemnity 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. 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 of a day.

Family Planning Services

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

- Patient history and Physician examination;

- Laboratory studies;

- Diagnostic procedures;

- Certain non-surgical treatments, including estrogen, corticosteroid and progestin therapy;

- Ovulation induction; 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 health care 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 Healthcare 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 Healthcare Agency expenses:

- **To receive the full amount of benefits** available under the Traditional Indemnity option or for Out-of-Network care under the POS 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 Healthcare Agency, or who has a subcontracting relationship with the agency.

- Under the POS option, 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 option, 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 POS and Traditional Indemnity options:

- 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.

- 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 POS option, 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 POS and Traditional Indemnity options. 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're 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're 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** under the Traditional Indemnity option or for Out-of-Network hospitalization under the POS 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're 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 childbirth by vaginal delivery or 96 hours following a cesarean section require precertification. (See "Newborn's and Mother's Protection Act" in **Section R. Other Important Information**)

Please note: 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 an Eligible Expense.

Please note: For admissions for treatment of mental health or Chemical Dependency conditions see **Section E. Mental Health and Chemical Dependency Program**.

Maternity Care

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

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

- 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 R. 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. Under POS Out-of-Network and Traditional Indemnity option benefits, this includes one pediatric examination. Under POS In-Network, there is no set limitation. 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 31 days of the birth.

Mental Health and Chemical Dependency

(See **Section E. Mental Health and Chemical Dependency Program**.)

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 POS option:

- Services are Covered under the POS option 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 under the Traditional Indemnity option or Out-of-Network under the POS option.

Organ Donation

Under certain circumstances, the Covered expenses for a living person to donate an organ are Covered under the POS and Traditional Indemnity options. 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 if they are:

- 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 POS and Traditional Indemnity options:

- 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 is not Covered.

Physician's Services

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

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

Covered services include:

- **Routine physical exam**: Covered only In-Network under the POS option; not Covered Out-of-Network or under the Traditional Indemnity option.
- **Well-woman care** (OB/GYN exam): Covered only In-Network under the POS option; not Covered Out-of-Network or under the Traditional Indemnity option.
- **Well-child care**: Covered only In-Network under the POS option; not Covered Out-of-Network or under the Traditional Indemnity option.
- **Childhood immunizations**: Covered only In-Network under the POS option; not Covered Out-of-Network or under the Traditional Indemnity option.
- **Mammogram screening (**in a Physician's office): Covered In-Network and Out-of-Network under the POS option and under the Traditional Indemnity option. Check with your Health Plan Carrier for any screening limitations and/or age requirements.
- **Pap smear** (in a Physician's office): Covered In-Network and Out-of-Network under the POS option 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 POS option and under the Traditional Indemnity option. Check with your Health Plan Carrier for any screening limitations and/or age requirements.

Private Duty Nursing

Private Duty Nursing services are Covered under the POS and Traditional Indemnity options. 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 under the Traditional Indemnity option or for Out-of-Network care under the POS option, precertification is required (see **Section F. When Precertification Is Required**); and

- Custodial and domestic services are not Covered.

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 POS and Traditional Indemnity options. 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 where required due to the normal growth process of a child or where made necessary by anatomical change caused by a medical condition or accidental injury.

Rehabilitation Therapy

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

- 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 Healthcare 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.

- POS Out-of-Network and Traditional Indemnity option benefits for Speech Therapy are limited to a maximum of 30 Outpatient visits in a calendar year. Under the 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 POS and Traditional Indemnity options:

- 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 will 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 R. 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 POS and Traditional Indemnity options.

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 POS and Traditional Indemnity options cover the cost of a wig when needed 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

If you and your Covered Dependents are non-Medicare-eligible and enrolled in the POS or the Traditional Indemnity option, you are automatically enrolled in the Mental Health and Chemical Dependency (MH/CD) Program, which is administered by the POS and Traditional Indemnity options' Health Plan Carriers (Aetna and UnitedHealthcare).

If You Elect HMO Coverage
If you elect a Health Maintenance Organization (HMO) for your Medical Plan option, your mental health and Chemical Dependency benefits will be provided through your HMO under the terms of your HMO.

If you and/or your Eligible Dependents are Medicare-eligible, your and/or their MH/CD Program benefits will be provided by the Traditional Indemnity option, be administered by UnitedHealthcare, and be secondary to Medicare.

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

How the Mental Health and Chemical Dependency Program Works

If you are non-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** for more information about the Precertification requirements under the MH/CD Program and the penalties imposed if you do not obtain precertification.)

In-Network Benefits

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**). 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'll be subject to:

- An annual Deductible and the Prescription Drug Program Deductible (does not apply for Medicare-eligible retired employees or Medicare-eligible Dependents when Medicare is the primary plan);
- Higher Copayments and Coinsurance percentage;
- 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're responsible for getting precertification for any Hospital admissions (see **Section F. When Precertification Is Required**) and submitting claim forms.

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

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 mental health/Chemical Dependency Emergency care must be 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 Mental Health and Chemical Dependency (MH/CD) Program regardless of where you are in the United States when you need care.

To receive care when you're 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're Outside of the United States
If you're **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 In-Network level. You do not need to call your Health Plan Carrier.

Amount of Coverage

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

Section F. When Precertification Is Required

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 POS option, the Traditional Indemnity option and the Mental Health and Chemical Dependency (MC/CD) Program.

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

Please note: 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 that the treatment:

- **Is** Medically Necessary, benefits generally are paid at a **reduced** level or no payment is made; or
- **Is not** Medically Necessary, no benefits will be paid.

Who Is Responsible for Precertification

While your Network Provider precertifies care received In-Network under the POS option, you're responsible for obtaining precertification from your Health Plan Carrier:

- If you receive care for certain services Out-of-Network under the POS option;
- If you receive care for certain services under the Traditional Indemnity option; and

- For all Inpatient or residential services under the Mental Health and Chemical Dependency (MH/CD) Program.

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).

Required Precertification

Under the Traditional Indemnity and POS Options

To receive the full amount of benefits available, precertification is required for certain services under the Traditional Indemnity option or Out-of-Network under the POS option. These include:

- Hospital admissions. If Medicare provides primary coverage for this service, 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.

- 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 R. Other Important Information**);

- Reconstructive procedures (see "The Women's Health and Cancer Rights Act of 1998" in **Section R. Other Important Information**).

- Hospice.

- Dental (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, 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.

- Emergency admissions. You are required to notify the MH/CD Program within 24 hours after admission.

How to Precertify

Under the POS or Traditional Indemnity Option
If you're 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 of Applicable Health Plan Carrier Claims Administrator	
	POS Option (Out-of-Network)	**POS Option (Out-of-Area); 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're 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).

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

To precertify In-Network or Out-of-Network care, you or your physician 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.

You and your Physician will be advised whether or not the admission is precertified. If it's precertified, you'll be advised as to the number of days for which it's certified. 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.

Concurrent Review After Precertification

All precertified Inpatient admissions, including admissions under the 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 precertified, **no additional benefits** will be paid for any treatment received after the expiration of the initial precertification period.

Penalties Imposed If Precertification Procedures Are Not Followed

If you do not follow the precertification procedures when required under the POS or 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.

Under the POS (for Out-of-Network Services) or Traditional Indemnity Option

A 20 percent 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).

Subject to the 20 percent 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 summary plan description (SPD).

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

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

Under the Mental Health and Chemical Dependency Program

Out-of-Network/Emergency Care

A 20 percent benefit reduction, up to a $400 maximum per occurrence, is applied to Covered expenses if precertification isn't obtained for an Out-of-Network 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. Subject to the 20 percent 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.

In-Network Care
If In-Network services 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.

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

Section G. How the Prescription Drug Program Works

About the Prescription Drug Program

If you enroll in the POS option or the Traditional Indemnity option, you're automatically Covered under the Prescription Drug Program, which is administered separately by Medco Health Solutions (Medco) (see also "If You're Medicare-Eligible" near the end of this section).

If You're in an HMO
If you select coverage under a Health Maintenance Organization (HMO), you'll receive prescription drug benefits through your HMO. Contact your HMO for specific information about prescription drug benefits.

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

How the Prescription Drug Program Works

- The Prescription Drug Program offers you the following three ways to fill prescriptions:
- At your local Participating Pharmacy;
- At your local non-participating Pharmacy; or
- By mail order, phone or fax through the Medco Pharmacy.

Use a local Participating Pharmacy for short-term prescriptions of up to 30 days. 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 (Participating Pharmacy, Mail Order), as well as by the four levels of Copayments available under the Prescription Drug Program:

- Generic;
- Formulary; and
- Nonformulary.

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

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 prescription. **That is the only amount you'll 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 up front and must file a claim form for reimbursement. (Claim forms are available on the Medco Web site at www.medco.com). 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 to locate a Participating Pharmacy; or
- Ask your local pharmacy if it's a Medco Participating Pharmacy.

Non-Participating Pharmacy
When you use a non-participating 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.

Separate Out-of-Network Annual Deductible
The Prescription Drug Program Out-of-Network annual Deductible is separate from any Deductibles you may be required to pay under your Medical Plan option.

After you meet the Program's annual Deductible, you'll pay Coinsurance figured on the Allowable Amount for Covered medications. You'll be reimbursed for the remaining amount.

Claim forms are available on the Medco Website at www.medco.com or by calling Medco at 1-800-336-5934.

Filling Prescriptions by Mail, Phone or Fax
The 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 download a home delivery order envelope on the Medco Web site. A new order 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
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 the Medco Pharmacy or pay twice the retail payment at the retail pharmacy.

To order a prescription by mail:

- Obtain a Medco order 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 Drugs Are Covered

Generally, 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 POS or Traditional Indemnity option.

Drugs Requiring Authorization and Quantity Limits

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 http://www.medco.com or call Medco at 1-800-336-5934 for a list of medications requiring authorization or that are subject to quantity limits.

Specialty Care

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 Out-of-Pocket Maximum only applies to Copayments for prescription drugs filled through Participating Pharmacies or the mail service. It doesn't apply to prescriptions filled at non-participating Pharmacies.

Once your Copayments for prescriptions filled through Participating Pharmacies or the mail service total the Out-of-Pocket Maximum amount in a calendar year, you won't be required to pay any additional Copayments for prescriptions filled through Participating Pharmacies or the mail service for the rest of that calendar year.

Separate Out-of-Pocket Maximum
The Prescription Drug Program Out-of-Pocket Maximum is separate from the Out-of-Pocket Maximum under your Medical Plan option.

Pharmacy Services

You're entitled to the following services under the Prescription Drug Program:

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

- **Toll-free Prescription Drug Customer Service.** Medco maintains a 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 envelope for the mail service or a claim form for a prescription filled at a non-participating 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 employees (1-800-759-1089) and overseas employees (1-972-915-6698) weekdays from 8:00 a.m. to 12 midnight, ET and on Saturdays from 8:00 a.m. to 6:00 p.m., ET.

- **Prescription Formulary.** With the Prescription Drug Program, you receive a Formulary that lists commonly prescribed, cost-effective medications which 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 can also find the Formulary on the Medco Web site at www.medco.com.

If Your Income Is Limited
Medicare-eligible retirees with limited income and resources may be eligible to receive extra help from Medicare in paying for prescription drugs. To learn more about the extra help, go to www.ssa.gov/prescriptionhelp, or call Social Security at 1-800-772-1213, Monday through Friday.

If You're Medicare-Eligible

If you are Medicare-eligible, you will have the opportunity to enroll in Medicare Part D prescription drug coverage during the Medicare Part D open enrollment period. This open enrollment period is held and administered separately from Alcatel-Lucent's Annual Open Enrollment period.

Before you decide whether or not to enroll in Medicare Part D, consider the following:

- **Alcatel-Lucent's coverage is "creditable."** The Company's retiree prescription drug coverage, for the majority of retirees, is equal to or better than the Medicare Part D standard prescription drug coverage.

  If you decide to enroll in a Medicare Part D plan after your initial enrollment period, you will need a copy of the Creditable Prescription Drug Coverage Notice to avoid any late enrollment penalties from Medicare. The Company has mailed this notice to Eligible Retirees.

  If you decide not to enroll in Medicare Part D, you will not need to do anything with this notice except to keep it with your files in the event that you decide to enroll in a Medicare Part D plan in the future. It is required to be distributed to retirees annually, and you may request a copy at any time during the year by calling the Alcatel-Lucent Benefits Center at 1-888-232-4111.

- **If you and/or your dependents enroll in a Medicare Part D prescription drug plan, you and/or your dependents are making the choice to opt out of the Company's Prescription Drug Program.** This means:

  — Your Alcatel-Lucent prescription drug coverage will no longer pay any portion of your prescription medication — even if the Medicare Part D coverage does not pay for a claim.

  — You and/or your dependent(s) will need to begin paying premiums for Medicare Part D coverage.

  — Your contributions for coverage under the Alcatel-Lucent Medical Plan will not be adjusted. Due to the operational complexities and costs associated with coordinating with the Medicare Part D program, Alcatel-Lucent cannot provide varying contribution structures. You will pay the same contributions as someone who still has prescription drug coverage under the Alcatel-Lucent Medical Plan.

  — The Company will continue to cover any dependent(s) not eligible for Medicare who are enrolled in the Alcatel-Lucent Medical Plan or any Medicare-eligible dependent(s) who have not enrolled in a Medicare Part D plan.

Filing a Claim

If you use a non-participating Pharmacy, you'll 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're not satisfied, you can appeal the decision. For more information, see **Section K. Claims and Appeals** later in this SPD.

Section H. What's Not Covered

About Exclusions

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

If You're in an HMO
If you select coverage under a Health Maintenance Organization (HMO), contact the HMO for specific information about exclusions.

General Exclusions

No benefits will be paid for any of the following services, supplies or expenses under the POS option, the Traditional Indemnity option, the MH/CD Program and/or 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 the 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, a 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 POS and Traditional Indemnity options, 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 POS or Traditional Indemnity option; or under the MH/CD 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 partner);

- Conditions related to current or past military service;

- Treatment of caffeine addictions;

- Charges for Experimental or Investigational 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 Sickness and Accident Disability Benefit Plan;

- Services and supplies that are the responsibility of a local, state or federal government agency (including a school system) 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.

POS and Traditional Indemnity Options Exclusions

The POS and Traditional Indemnity options 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 semi-private room rate; and

  — Any charges for not obtaining precertification when required (see "Covered Services Requiring Precertification" in **Section F. When Precertification Is Required**).

- Any care delivered without the approval of a Physician unless otherwise noted under the POS or Traditional Indemnity option.

- Treatment of developmental disorders.

- Predictable complications of non-Covered treatment.

- Routine physical exams, well-child exams, well-woman exams and childhood immunizations received Out-of-Network under the POS option or under the Traditional Indemnity option.

- Treatment of refractive vision problems (including eye examinations, eye glasses 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 POS option or under the Traditional Indemnity option.

- Treatment of obesity or a weight loss condition, 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 POS and the Traditional Indemnity options).

- Cosmetic surgery or other cosmetic treatment (unless it's considered to be restorative surgery under the POS and Traditional Indemnity options).

- Growth hormone therapy (unless there is documented evidence of pituitary deficiency and there is likely to be 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 the treatment begins within three months of the accident).

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

- Care provided to a person not Covered under the POS or Traditional Indemnity option 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 used 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 not necessary for daily living activities.

- Hearing aids to compensate 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're 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 Non-Network Providers above the Allowable Amount,

  — Room and board charges from a Non-Network Hospital above the semi-private room rate,

  — Any charges for not obtaining precertification from your Health Plan Carrier for an Out-of-Network Inpatient 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;
- 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;
- 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, Skilled Nursing Facility, convalescent Hospital, nursing home, Home Healthcare 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 (90 days for insulin) or through the mail that exceed the 90-day limit;
- Drugs used for Experimental or Investigational Treatments or procedures; 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 do not make any required contribution toward coverage under the Medical Plan;
- You request that coverage be waived;
- 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 Eligible Dependent's(s') coverage under the Medical Plan will end as follows:

- If your coverage ends, your Covered Dependent's(s') (for example, your Lawful Spouse, Domestic Partner or dependent children) coverage will end on the same day.
- If your Covered Dependent child marries or his or her coverage ends for any other reason other than reaching the limiting age, for example, you drop this Dependent's coverage because your spouse or Domestic Partner enrolls this dependent in his or her employer-sponsored plan — coverage for this child will end on the last day of the month in which the event occurs. For instance, if your Dependent child marries on May 15, his or her coverage would end on May 31.
- If your Covered Dependent child reaches age 23, his or her coverage will end on December 31 of the year in which he or she reaches age 23.
- 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).

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 regardless of age (see "Class I Dependents" in **Section B. Joining the Medical Plan** and "If Your Physically or Mentally Handicapped Child Reaches Age 23" in **Section O. Events Affecting Coverage**). 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., 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 for up to 24 months after losing coverage. A Lawful Spouse receives his or her own certificate. 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 the Certificate of Creditable Coverage 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.

If you or a Dependent has a Pre-Existing Condition, HIPAA limits the period without coverage for that Pre-Existing Condition to no more than 12 months (or 18 months for late enrollees). Generally, if you or your Dependents have been covered by any health plan for the previous 12 months, you or your Dependents will be covered under the new employer's plan without regard to Pre-Existing Conditions. If you had a break in coverage of more than 63 days, you or your Dependents may be subject to the full Pre-Existing Condition exclusion period. Check with your new employer or health insurer to verify the length of your Pre-Existing Condition exclusion period.

Section J. Continuing Coverage

Extending 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 Dependency Program (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 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 responsibility to notify the Alcatel-Lucent Benefits Center at 1-888-232-4111 within 31 days of a qualifying event (such as your spouse's eligibility if you and your Covered Lawful Spouse divorce) that makes your dependent eligible for COBRA coverage. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET.

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…	You Can Receive COBRA Coverage
• Your divorce or legal separation; • Termination of your Domestic Partnership; • Your death; or • Your Class I dependents' and Class II dependent 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.

Covering a Newborn or Newly Adopted Dependent

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.

If the COBRA continuation coverage period is extended to 29 months because of a disability, the COBRA continuation coverage premium will increase to 150 percent of the cost of coverage for any period that the disabled individual receives COBRA continuation coverage, generally beginning with the 19th month of COBRA continuation coverage and continuing until COBRA continuation coverage terminates. That means that, generally, for the first 18 months of COBRA continuation coverage, the qualified beneficiary would pay 102 percent of the Plan's cost of coverage monthly, and for any portion of the remaining coverage period during which the disabled individual receives COBRA continuation coverage, the qualified beneficiary would pay 150 percent of the Plan's cost of coverage monthly.

In some instances, a portion of your qualified beneficiary's COBRA continuation period may be subsidized by Alcatel-Lucent.

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 60 days of the qualifying event. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET.

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 31 days of the date the qualifying event is reported.

Continuing Dependent Coverage Through the Family Security Program (FSP)

Your surviving Lawful Spouse or Domestic Partner who has either exhausted the 36-month COBRA continuation coverage period or is ineligible for COBRA continuation coverage because he or she is entitled to Medicare, has the option to join the FSP and continue coverage under the Traditional Indemnity option 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 immediately before your death and 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, 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.

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 — 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 doctor 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; and/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., 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 or fax your completed CIF and any enclosures to the following address:

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

Fax: 1-847-554-1996

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 Benefits 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'll 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 Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

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 mailed to:

Alcatel-Lucent
Employee Benefits Committee
600-700 Mountain Avenue
Room 2B-410
Murray Hill, New Jersey 07974

Be sure to 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'll 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 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) option 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 Medco Pharmacy.

In such cases, the Provider files the claim form directly with the Health Plan Carrier Claims Administrator. 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 option 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 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'll 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'll 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 or your Provider files a benefits claim, the Health Plan Carrier 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 due to matters beyond the control of the Medical Plan 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 Health Plan Carrier 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 due to matters beyond the control of the Medical Plan 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 Health Plan Carrier 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'll 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 Section 502(a) of ERISA 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 Q. 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 mailed to the appropriate Health Plan Carrier 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.

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 Health Plan Carrier 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'll 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. The process also generally applies to certain claims for services that have been denied by the

Point of Service (POS) or Traditional Indemnity option, 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 Health Plan Carrier 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 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 Covered Dependents participate in more than one group health plan.

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

When the Coordination of Benefits Provision Applies

The COB provision applies when you or your Covered 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).

When the Coordination of Benefits Provision Does Not Apply

The COB provision described in this section does not apply:

- When the other health care coverage is Medicare (see "Coordination of Benefits When Medicare Is Primary" later in this section);
- 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, retirees and/or dependents 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.

Which Plan Pays Benefits First

Under the COB provision, the Health Plan Carrier 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. 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 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, between the primary and secondary plan(s), 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 is primary and which plan(s) is (are) secondary under the following rules:

- If the other plan does have a COB feature, that plan is 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 (the male parent's plan is considered primary and the female parent's plan is considered secondary) 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 Health Plan 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 child 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.

If You're Disabled or Have End-Stage Renal Disease

If you or your dependent is disabled or has End-Stage Renal Disease (ESRD), the Medical Plan is primary only for the first 30 months; thereafter, Medicare is primary for that person.

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. The Traditional Indemnity option is administered by UnitedHealthcare.

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

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

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.

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. The Medical Plan will only pay up to what it would have paid had it been the primary plan (see **Section M. What You Need to Know About Medicare**).

Section M. What You Need to Know About Medicare

What Medicare Is

Medicare is a federal health insurance program that covers people age 65 and older, as well as some disabled people under age 65. Alcatel-Lucent's medical and prescription drug coverages may coordinate with Medicare, so it is important to understand how Medicare works.

There are four parts to Medicare. Here is a brief summary for your convenience.

Get to Know Your A, B, C and Ds of Medicare

Medicare is the U.S. federal government's health insurance program for people who are age 65 or older or who have certain disabilities. Alcatel-Lucent's medical and prescription drug coverages may coordinate with Medicare, so it is important to understand how Medicare works.

There are four parts to Medicare. Here is a brief summary for your reference:

Feature	Part A	Part B	Part C	Part D
Purpose of coverage	Hospital insurance benefits, such a room and board	Medical benefits, such as doctor and ambulance services	Typically offers the same services covered under Part A and B, plus additional preventive care coverage and (sometimes) prescription drug coverage	Prescription drug coverage
Enrollment	Most people are automatically enrolled at age 65 (check with Medicare for your personal situation)	You may become automatically enrolled if you receive Social Security benefits (check with Medicare for your personal situation)	You enroll through a private health insurer or other plan sponsor	You enroll through a private health insurer or other plan sponsor

Feature	Part A	Part B	Part C	Part D
Premium costs	You pay no premium costs 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 cost that may change 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 cost, which may vary depending on the health plan offering coverage and the level of benefits coverage provided	There is a monthly premium cost, which can vary based on your geographical location and the plan you choose
Who administers coverage	CMS	CMS	Private health plan	Private health plan

Medicare Eligibility's Effect 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, it will affect:

- Your options;
- Which plan pays first;
- 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. You can learn more about Medicare and how it affects your Medical Plan coverage at the Your Benefits Resources (YBR) Web site at http://resources.hewitt.com/alcatel-lucent, at BenefitAnswers Plus at http://www.benefitanswersplus.com 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., ET.

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, or Medicare Advantage HMOs, are health plan options (like HMOs or PPOs) approved by Medicare and run by private companies. Medicare Advantage HMOs provide Part A (Hospital Insurance) and Part B (Medical Insurance) benefits, but 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.

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.

Medicare and Class II Dependents
Medicare is always the primary plan for Class II Dependents age 65 and over.

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

When You or a Dependent Becomes Medicare-Eligible

When you or a Dependent, including a Domestic Partnership Dependent Covered under the Medical Plan, becomes Medicare-eligible (regardless of age), Medicare takes over as the primary benefit plan. The Medicare-eligible person will be enrolled in the Traditional Indemnity option, which becomes secondary to Medicare. This means that Medicare becomes the primary payor and the Alcatel-Lucent option becomes the secondary payor.

Ineligible Retirees and Dependents
There are times when retirees and Class I and Class II Dependents are ineligible for Medicare, such as when they are not citizens and have not lived in the United States for five or more years. In these circumstances, the Health Plan Carrier needs to confirm that they do not have Medicare as
a primary payor. If this is determined, the Medical Plan will assume primary coverage for these Plan participants until they become Medicare-eligible.

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) — kidney disease. 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.

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 end stage renal disease for 30 months, regardless of age; or
- Is eligible for Medicare due to disability, regardless of age.

Enrolling in Medicare

When Medicare-eligible, in most cases, you and your Eligible Dependents will be automatically enrolled in Medicare Part A — Hospital insurance benefits. You must enroll in Part B — Medical benefits.

Medicare 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.

Approximately three months before you reach age 65, you will receive an ID card in the mail directly from Medicare. (If Medicare doesn't contact you, be sure to contact Social Security about three months before your 65th birthday, whether you are retired or actively employed.) The card will include your Medicare effective date and information about enrolling in Medicare Part B. You also will be notified at this time if additional steps need to be taken to enroll in Medicare Part A.

You may also be eligible to enroll in a Medicare Advantage HMO if one is available in your area (see "Medicare Advantage HMOs" later in this section).

In addition, you may wish to consider Medicare Part D, which covers prescription drugs (see "Prescription Drug Program Benefits When Medicare-Eligible" later in this section).

Please note: Individuals who are eligible for Medicare due to disability should enroll for Medicare as soon as possible, regardless of age.

Medicare Part B Reimbursements

The following chart shows the current maximum amount the Company will reimburse for Medicare Part B premiums for Medicare-eligible retired employees and their Medicare-eligible spouses who are eligible for the Part B reimbursement.

Retirement Date	Current Company Reimbursement Limits (for Medicare Part B Premiums)	
	Retired Employee	Spouse/Domestic Partner of Retired Employee
Before March 1, 1990	No limit	No limit
On or After March 1, 1990 through May 30, 1998	$46 per month	$33 per month
On or After May 31, 1998	Up to $46 per month	$0 per month

Medicare Part B reimbursement checks are paid the first payment month of each quarter — January 1, April 1, July 1 and October 1. If the first of the month falls on a weekend, the payment is made on the last business day of the preceding month. Checks are mailed to your address on record at the Pension Service Center (PSC).

Medical Benefits When You or a Dependent Becomes Medicare-Eligible

Your family's Medical Plan benefits may differ depending on whether you or your Dependent is Medicare-eligible (see "About Your Medical Plan Options" in **Section C. How the Medical Plan Options Work)**.

How Medicare and Medicare-Eligible Medical Plan Coverage Work Together

Which Coverage Pays First

If you and/or your Eligible Dependent is Medicare-eligible, as you consider your medical coverage options, it's important to keep in mind the following key points about Medicare benefits and Medical Plan coverage:

- Once you are eligible for Medicare, the Medical Plan pays benefits assuming that you have Medicare Part A and B coverage—whether or not you enrolled for that coverage.

  Please note: Regardless of whether you elect to purchase Medicare Part B, the Medical Plan will apply Medicare Carve-Out to your claims. "Medicare Carve-Out" means the Health Plan Carrier reduces its benefits by (or "carves out") the amount that would have been payable by Medicare (Part A and Part B) for the same expenses as the primary coverage.

- If you chose to use a Provider who does not participate in Medicare, the Medical Plan will still coordinate your benefits as if the Provider does participate in Medicare.

- Medicare pays for medical costs first (Medicare is the primary plan). The Medical Plan (which is the secondary plan) won't duplicate the coverage you receive from Medicare. The Medical Plan will only pay for Covered expenses up to what it would pay if it were your primary plan.

  Medicare often pays a higher percentage of the cost of some services. The Traditional Indemnity option pays 90 percent of the cost of many services. If you have Medicare Part A and Part B coverage, you may find that most, even all, of your benefits are provided through Medicare, even if you are enrolled in the Medial Plan.

- If you're Medicare-eligible and have an actively employed spouse or Domestic Partner in a company other than Alcatel-Lucent or a Participating Company and your Lawful Spouse or Domestic Partner covers you under his or her plan, your actively employed Lawful Spouse or domestic partner's medical plan is primary, Medicare is secondary and the Traditional Indemnity option is tertiary.

Please note: Medicare is the secondary payor for Medicare-eligible individuals age 65 and older who are actively employed.

An Example: Coordination of Benefits With Medicare

The following chart provides examples of how Medicare and the Medical Plan coordinate benefits, depending on whether the Medicare-eligible individual is enrolled in Medicare Part A and Part B or not. (The examples assume the applicable annual deductibles have been met.)

You Are Medicare-Eligible and Enrolled in Medicare Part A and Part B	**Medicare Part B covers a $100 claim at 80 percent, and the Medical Plan covers the same claim at 80 percent.** • Medicare is your primary coverage and pays the 80 percent ($80) first. • The Medical Plan is secondary and, because the Medical Plan also Covers the service at the same 80 percent level as Medicare, no additional amount is paid by the Medical Plan. • **This means you are responsible for $20.**

	Medicare Part B covers a $100 claim at 80 percent, and the Medical Plan covers the same claim at 90 percent. • Medicare is your primary coverage and pays the 80 percent ($80) first. • The Medical Plan is secondary and, because the Medical Plan covers the service at 10 percent over the Medicare level, an additional 10 percent ($10) is paid by the Medical Plan. • **This means you are responsible for $10.**
You Are Medicare-Eligible and Not Enrolled in Medicare Part A and Part B	**Medicare Part B covers a $100 claim at 80 percent, and the Medical Plan covers the same claim at 80 percent.** • Medicare is your primary coverage but, because you are not enrolled in Medicare Part A and Part B, Medicare will not pay any portion of the $100 claim. • Medical Plan coverage is secondary and, because the Medical Plan also Covers the claim at the same 80 percent level as Medicare would have covered, no additional amount is payable by the Medical Plan. • **This means you are responsible for the entire $100.**

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 (YBR) 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., 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 HMO if one is available in your area (see "Enrolling in a Medicare Advantage HMO" and "Medicare Advantage HMOs" in **Section C. How the Medical Plan Options Work** for additional information). In addition, you may wish to consider Medicare Part D, which covers prescription drugs. Note that 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 prescription drug coverage available under the Alcatel-Lucent Medical Plan.

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 cover the other Plan options.

In addition to an HMO, 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 will continue to pay the Part B premiums. In addition, if you or an Eligible Dependent enrolls in a Medicare Advantage HMO outside of Alcatel-Lucent, you or your Eligible Dependent is making the choice to opt out of the Alcatel-Lucent Medical Plan. Similarly, if you enroll in a Medicare Advantage HMO that covers prescription drugs, you or your Eligible Dependent is making the choice to opt out of prescription drug coverage available under the Medical Plan.

In addition, you are not eligible to enroll in a Medicare Advantage HMO if you have end stage renal disease, although if you are enrolled in a Medicare Advantage HMO and develop end stage renal disease, 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 90 consecutive days (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 HMO that interests you.

Keep in mind that when you switch to a Medicare Advantage HMO, any non-Medicare-eligible Dependents will have coverage through a regular 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 Traditional Indemnity option throughout the year. You can also select coverage under a Medicare Advantage HMO by switching from the Traditional Indemnity option at any time. To switch among Medicare Advantage HMOs or to switch into or out of the Traditional Indemnity option, 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., ET.

Prescription Drug Program Benefits When Medicare-Eligible

Your eligibility for Medicare does not affect your benefits under the Prescription Drug Program. However, if you are enrolled in a Medicare Advantage HMO, prescription drug coverage is provided directly by that plan.

Medicare Part D
Medicare Part D is a program that provides Outpatient prescription drug benefits for Covered drugs. Part D is voluntary and you must enroll to receive coverage.

Part D benefits are administered by private healthcare companies. There is a monthly premium for Medicare Part D.

It is important to understand that if you enroll in Medicare Part D, you are making the choice to opt out of the prescription drug coverage available to you under the Alcatel-Lucent Medical Plan. Similarly, if a Medicare-eligible Dependent enrolls in Part D, he or she will no longer have coverage under the Medical Plan Prescription Drug Program. In addition, if you or an Eligible Dependent enrolls in a Medicare Advantage HMO that covers prescription drugs, you or your Eligible Dependent is making the choice to opt out of the prescription drug coverage available under the Medical Plan.

If you or your Dependent disenrolls from Medicare Part D, you will once again be Covered under Alcatel-Lucent's Medical Plan Prescription Drug Program. Regardless of whether you or your Medicare-eligible Dependent chooses to enroll in Part D, the Medical Plan will continue to provide prescription drug coverage to non-Medicare-eligible participants.

Mental Health and Chemical Dependency Program Benefits When You or a Dependent Becomes Medicare-Eligible

If you and/or your Eligible Dependents are Medicare-eligible, your Mental Health and Chemical Dependency (MH/CD) Program benefits under the Traditional Indemnity option will be administered by United Healthcare, but will be secondary to Medicare. You will not be eligible for In-Network benefits.

If you select a Medicare Advantage HMO for your Medical Plan option, the MH/CD Program doesn't apply for you. Instead, you'll receive mental health and Chemical Dependency benefits directly through your Medicare Advantage HMO. Contact your Medicare Advantage HMO for specific information about the coverage available for treatment of these conditions.

Coverage Amounts

Mental health and Chemical Dependency benefits under the Medical Plan for Medicare-eligible retired employees and their Medicare-eligible Dependents are secondary to Medicare and are payable up to Traditional Indemnity option benefit levels. In addition, any payments made by Medicare are deducted from the benefits payable under the MH/CD Program.

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 or refuse to honor these terms, the Plan will be entitled to recover any costs incurred in enforcing these terms and conditions.

Section O. Events Affecting Coverage

If a Dependent Loses Eligibility

See "Creditable Coverage Certificates" in **Section I. When Coverage Ends** and also **Section J. Continuing Coverage**.

If Your Physically or Mentally Handicapped Child Reaches Age 23

If your physically or mentally handicapped child is incapable of self-support as of December 31 of the year in which he or she reaches age 23, coverage may be continued beyond that date, 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 December 31 of the year in which he or she reaches age 23. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET.

If You or a Covered Dependent Becomes Eligible for Medicare

(See **Section M. What You Need to Know About Medicare.**)

If You Die

Coverage for your enrolled Class I dependents, Domestic Partnership Dependents, and Class II dependent children may continue at your retiree contribution rate for six months 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. Representatives are available Monday through Friday, from 9:00 a.m. to
5:00 p.m., ET.

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. For more information about continuing coverage under COBRA, see "COBRA Continuation Coverage" in **Section J. Continuing Coverage**.)

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 [FSP] in **Section J. Continuing Coverage**).

If You Move

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

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.

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 (YBR) 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., ET.

If Your Home Address Changes
If you are a retiree, you should call the Pension Service Center at 1-866-429-5764 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.

If You Are Medicare-Eligible When You Move

If you are Medicare-eligible and enrolled in Traditional Indemnity (TI) when you move, you will remain in TI. If you are enrolled in a Medicare HMO and you lose eligibility for that Medicare HMO as a result of your move, you will have the opportunity to change your medical coverage, to another Medicare HMO if available, or TI. If you do not make an election you will be defaulted to TI, but you will still be required to complete and return a disenrollment form for the Medicare HMO option you are no longer eligible for as a result of your move. If you have dependents who are not yet Medicare-eligible, they will also be Covered under the Traditional Indemnity option, unless there is a United Healthcare POS in your new area. If there is a United Healthcare POS in your area, your dependents will be enrolled in that POS option.

To report your move, go online at Your Benefits Resources (YBR)™* http://resources.hewitt.com/alcatel-lucent or call the Alcatel-Lucent Benefits Center.

How a Move Affects Your Health Care Options When You Are *Not* Medicare-Eligible*

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 your POS option is no longer available, but another POS option is available	You stay in the POS option, but you transfer to the Health Plan Carrier that administers the POS option in that area. If you are comfortable with the distance between you and POS network doctors and hospitals, you can still enroll in a POS option. You can call the ALBC to request an override into the POS option, even if you fall outside the service area, but you must call during each Annual Open Enrollment if you want to continue in that plan because this coverage will not automatically carry over to the next plan year.

* If your move requires that you change your enrollment option and you do not make an election within 31 days of your move, 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 and no other POS option is available to you	You may select one of the options available (Traditional Indemnity or HMO option if you fall in any HMO service areas) in your new area. If you are comfortable with the distance between you and POS network doctors and hospitals, you can still enroll in a POS option. You can call the ALBC to request an override into the POS option, even if you fall outside the service area, but you must call during each Annual Open Enrollment if you want to continue in that plan because this coverage will not automatically carry over to the next plan year. 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 stay in the Traditional Indemnity option.
You are enrolled in an HMO option	Into an area where your current HMO is no longer available	You may select one of the options available (Traditional Indemnity, POS or HMO option) in your new area. If you make no election, a POS option will be assigned if that is available to you. Otherwise you will be defaulted to Traditional Indemnity.

Remember, POS coverage may be available to you if you elect that coverage, 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., 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**.

Section P. Terms to Know

There are several words and phrases that have a specific meaning 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're defined here.

Acupuncturist: a Provider carrying all recognized certifications applying to the practice of acupuncture that 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., ET.

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 Non-Network Providers are used under the POS or Traditional Indemnity PPO option, 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 Program that is more intensive than Outpatient treatment and less intensive than Hospitalization. Alternative Treatment includes the following main 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 can 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 Health Care 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.

Chiropractor: a Doctor of Chiropractic (D.C.) who is licensed to provide services in the state where the service is rendered.

Claims Administrator: a Health Plan Carrier authorized by Alcatel-Lucent Technologies Inc. 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 offers 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, 90%) and you pay a percentage (for example, 10%). 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 $30) 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**.

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 Program, Out-of-Network benefits under the POS option and the Traditional Indemnity option. There are usually no Deductibles under the HMO options.

Default Option: The Medical Plan option you are assigned automatically if you do not make enrollment elections during the Annual Open Enrollment period. In most cases, it is the same coverage you had in the previous year, unless the Medical Plan option is no longer available.

Domestic Partner: an individual who is a member of the same or opposite sex; complies with any state or local registration process for Domestic Partners, if applicable; and satisfies each of the specific criteria identified below. You and your Domestic Partner each:

- Reside in the same household as members of the household;
- Are each age 18 or older;
- Have mental capacity sufficient to enter into a valid contract;
- Are unrelated to each other by blood and are not legally married to another individual;
- Consider yourselves 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 (for example, 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 unmarried children of a Domestic Partner are your dependents.

Domestic Partnership Dependent: the unmarried child of your domestic or civil union partner or same-sex spouse, up to the end of the year in which the child reaches age 23 or marries, regardless of his or her eligibility to enroll in another employer's plan.

Effective Date: the date upon which your 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 Dependent(s): 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: a former occupational employee who terminated from the Company or a Participating Company and who is receiving a service or disability pension under the Lucent Technologies Inc. Pension 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; and
- Causing severe pain.

Please note: See "Emergency Care" in **Section E. Mental Health and Chemical Dependency Program** 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, and cough;
- Diarrhea;
- Earaches;
- Minor cuts;
- Moderate fever;

- Rashes;
- Sprains; and
- 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 are eligible to continue coverage under the Medical Plan after they have exhausted their 36-month COBRA continuation period. Traditional Indemnity option coverage is available for survivors of retired employees on FSP and can be continued indefinitely.

Formulary: a list of preferred prescription drugs 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're uncertain about whether a particular drug is on the Formulary, check with Medco (see **Section Q. 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.

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).

Health Plan Carrier Claims Administrator: a Health Plan Carrier authorized by Alcatel-Lucent to administer the Medical Plan.

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 either be accredited by the Joint Commission on the Accreditation of Health Care 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.

Medco Health Solutions (Medco): the company that administers the Prescription Drug Program.

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, 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.

Non-Network: refers to a Physician, Hospital or other healthcare Provider that has not signed a Network Provider agreement with the Health Plan Carrier.

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 your selection of a service 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 a Non-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, 2011, these are:

- Alcatel-Lucent Investment Management Corporation
- Alcatel-Lucent Managed Solutions LLC
- Alcatel-Lucent USA Inc.
- Alcatel-Lucent Management Services Inc.
- LGS Innovations International Inc.
- LGS Innovations LLC
- Lucent Technologies GRL LLC

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.

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 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 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 Healthcare 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 Health Plan Carrier Claims Administrator to be qualified under ERISA.

Reasonable and Customary Charge: the fee determined by the Health Plan Carrier 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 Healthcare 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 Healthcare 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.

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'll 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 (YBR)™ 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 (YBR)™ is a trademark of Hewitt Management Company LLC.

Section Q. Important Contacts

The following is a list of resources for the Medical Plan.

WHERE	WHAT YOU WILL FIND:
Alcatel-Lucent Resources	
http://resources.hewitt.com/alcatel-lucent 24 hours a day, except on Sunday between midnight and 1:00 p.m., ET	**The Your Benefits Resources (YBR) Web site** • View your current coverage • Review and compare your 2011 healthcare options and premium costs • Enroll in coverage for 2011 • Make changes to your default coverage for 2011 • Waive your 2011 coverage • Find a doctor or healthcare Provider • Learn more about Alcatel-Lucent's benefits • Review dependent eligibility rules • Review, add or change your dependent(s)' information on file • Understand how a qualified status change may change your benefits
1-888-232-4111 (1-212-444-0994 if calling from outside of the United States, Puerto Rico or Canada) **Standard hours:** Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET **Extended hours during the annual open enrollment period:** Monday through Friday, from 9:00 a.m. to 6:00 p.m., ET	**Alcatel-Lucent Benefits Center** • *If you do not have Internet access:* — Enroll in coverage for 2011 — Make changes to your default coverage for 2011 — Waive your 2011 coverage — Review dependent eligibility rules — Review, add or change your dependent(s)' information on file • Resolve a unique benefits issue that you have not been able to solve on your own • Notify Alcatel-Lucent if: — Imputed income applies — You or your Eligible Dependent(s) will become Medicare-eligible due to a disability

WHERE	WHAT YOU WILL FIND:
www.benefitanswersplus.com **(Retirees only)**	**The Alcatel-Lucent BenefitAnswers Plus Web Site** • Learn more about Alcatel-Lucent's benefits, including benefits news and updates (no password required) • Obtain electronic copies of your enrollment materials • Find carrier contact information during the year • Access a short video about the YBR Web site
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, benefits and claims information • Find a Network-participating doctor 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 (including cancer specialists) in the Aetna POS Network (choose "Aetna Choice POS II [Open Access]" 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

WHERE	WHAT YOU WILL FIND:
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
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
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

WHERE	WHAT YOU WILL FIND:
www.urncrs.com (click on the "Transplantation" link or call the phone number on the back of your medical ID card)	**Transplant Resource Services** • Services and access to medical professionals renowned for providing quality treatment in solid organ or blood/marrow transplants
www.liveandworkwell.com **POS:** 1-800-577-8539 **(Participants not eligible for Medicare)** **Traditional Indemnity:** 1-800-577-8567 **(Medicare-eligible participants in the UnitedHealthcare Traditional Indemnity option only)**	**UnitedHealthcare Behavioral Health** • Understand how your mental health and Chemical Dependency coverage works • Access claims information
Medco Prescription Drug Coverage (does not apply to HMO coverage)	
www.medco.com 1-800-336-5934	**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 the Medco Pharmacy for savings opportunities
www.medco.com/choices 1-800-319-7750	**Medco My Rx Choices** • Find lower-cost options for the medications you currently take on an ongoing basis
www.medco.com/lowcostgenerics (or call the phone number on the back of your Medco ID card)	**Medco Low Cost Generics** • Determine if your medications are eligible for an additional discount through mail order • 24/7 access to specialist pharmacists

WHERE	WHAT YOU WILL FIND:
Other Resources (Union Contacts)	
1-678-502-1442 E-mail: sbrumbelow@att.net	**CWA Managed Care Program Coordinator: Steve Brumbelow** • Not a representative of the Alcatel-Lucent Medical Plan • Assists current and former union members
1-877-878-5957 E-mail: bryan1599@att.net	**IBEW Managed Care Program Coordinator: Bryan Flickinger** • Not a representative of the Alcatel-Lucent Medical Plan • Assists current and former union members
HMO/MEDICARE Advantage HMO (see carrier contact information on next two pages)	
Contact information is also available: • On the back of your medical ID card, if you are currently enrolled in an HMO; • By visiting the YBR Web site at http://resources.hewitt.com/alcatel-lucent; or • By calling the Alcatel-Lucent Benefits Center at 1-888-232-4111.	**Your HMO carrier** • Understand how your HMO/Medicare Advantage HMO coverage works • Access claims information

HMOs Available to Participants Not Eligible for Medicare

HMO OPTION	PHONE NUMBER	WEB SITE
Aetna Pennsylvania	1-800-323-9930	www.aetna.com
Blue Advantage of Illinois Blue Cross/Blue Shield of Illinois	1-800-892-2803	www.bcbsil.com
Group Health of Puget Sound	1-888-901-4636	www.ghc.org
HIP Health Plan of New York	1-800-HIP-TALK (1-800-447-8255)	www.hipusa.com
Horizon Blue Cross/Blue Shield of New Jersey	1-800-355-2583	www.horizonblue.com
Kaiser Mid-Atlantic	• Washington, D.C.: 1-301-468-6000 • Outside the Washington, D.C. metro area: 1-800-777-7902	http://my.kp.org/alcatellucent
Kaiser Northwest	• Portland, OR area only: 1-503-813-2000 • 1-800-813-2000	
Kaiser of Northern California Kaiser of Southern California	1-800-464-4000	
Kaiser Permanente of Colorado	• 1-800-632-9700 • Colorado Springs: 1-888-681-7878	
Kaiser Permanente of Georgia	• 1-888-865-5813 • Local: 1-404-261-2590	
Kaiser Permanente of Hawaii	• Oahu: 1-808-432-5955 • Other Islands: 1-800-966-5955	
Keystone Health Plan Central	• 1-800-669-7061 • TDD: 1-800-669-7075	www.capbluecross.com
MVP of New York	1-888-687-6277	www.mvphealthcare.com
PacifiCare of California	1-800-624-8822	www.pacificare.com
PacifiCare of Oklahoma	1-800-825-9355	
UnitedHealthcare Choice of Arizona	1-866-633-2446	www.unitedhealthcare.com
Univera Health of Western NY	1-800-337-3338	www.univerahealthcare.com

Medicare Advantage HMOs Available to Medicare-Eligible Participants

HMO OPTION	PHONE NUMBER	WEB SITE
Aetna Health Plans of New Jersey Aetna Health Plans of Pennsylvania	1-800-282-5366	www.aetna.com
Blue Advantage of Illinois Blue Cross/Blue Shield of Illinois	1-800-892-2803	www.bcbsil.com
BlueCross BlueShield of North Carolina	1-888-310-4110	www.bcbsnc.com/member/medicare
Group Health of Puget Sound	1-888-901-4636	www.ghc.org
HIP Health Plan of New York	1-800-HIP-TALK (1-800-447-8255)	www.hipusa.com
Horizon Blue Cross/Blue Shield of New Jersey	1-800-365-2223	www.horizonblue.com
Humana Health Plan of Florida Humana Health Plan of Illinois Humana Health Plan of Kansas City	1-866-396-8810	www.humana.com
Kaiser Mid-Atlantic	• 1-888-777-5536 • TTY: 1-866-513-0008	http://my.kp.org/alcatellucent
Kaiser Northwest	• Portland, OR area only: 1-503-813-2000 • 1-800-813-2000	
Kaiser of Northern California Kaiser of Southern California	1-800-443-0815	
Kaiser Permanente of Colorado	• 1-800-476-2167 • TTY: 1-866-513-9964	
Kaiser Permanente of Georgia	• Toll free: 1-800-232-4404 • Local: 1-404-233-3700	
Kaiser Permanente of Hawaii	• Oahu: 1-808-432-5955 • Other Islands: 1-800-966-5955	
Keystone Health Plan Central	1-800-779-6962	https://seniorbluehmo.capbluecross.com

HMO OPTION	PHONE NUMBER	WEB SITE
MVP of New York	1-800-209-3945	www.mvphealthcare.com
PacifiCare of Arizona	1-800-610-2660	www.securehorizons.com
PacifiCare of California	1-800-228-2144	
PacifiCare of Colorado	1-800610-2660	
PacifiCare of Oklahoma	1-800-950-9355	
Univera Health of Western NY	1-800-337-3338	www.univerahealthcare.com

Section R. 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).

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're 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).

Right With Respect to Selection of a Primary Care Provider

The Medical Expense Plans generally allow for the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Plan network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your health plan's Member Services. Note: For children, you may designate a pediatrician as the primary care provider.

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 by Alcatel-Lucent through arrangements with third party service-provider(s).

	Medical Expense Plan
Trust Name	Lucent Technologies Inc. Postretirement Welfare Benefits Trust for Represented 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.

Union Agreements

The benefits described in this SPD reflect the provisions of the Medical Plan as outlined in various applicable bargaining agreements.

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 HealthPlan Carrier 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 (YBR) 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., 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 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 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
Room 2B-439
Alcatel-Lucent
600 Mountain Avenue
Murray Hill, NJ 07974-0636
1-908-582-2321

Administrative Information

Plan Name

Medical Expense Plan for Retired Employees

Plan Sponsor

Alcatel-Lucent

Type of Administration

The Medical Plan is administered by the applicable Health Plan Carrier as named 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, UnitedHealthCare (POS and Traditional Indemnity option);
- Medco Health Solutions (Prescription Drug Program); and;
- Alcatel-Lucent Benefits Center (COBRA administration).

If you are enrolled in an HMO, your HMO Health Plan Carrier is the Claims Administrator. Contact your HMO if you have any questions.

Plan Administrator

Alcatel-Lucent
Room 2B-410
600 Mountain Avenue
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 Health Plan Carrier 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 a "welfare plan" under ERISA.
Plan Number	504
Employer Identification Number	22-3463671

Section S. 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 Plan 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 you, your spouse 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 instance, if you request a copy of Medical Plan documents or the latest annual report from the Medical Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay 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., 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.