

Alcatel-Lucent Medical Expense Plan
Occupational Employees
Summary Plan Description
January 2011



Disclaimer

This is a summary of the benefits offered under the Alcatel-Lucent Medical Expense Plan for Occupational 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 P. 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 future employment.

Alcatel-Lucent Medical Expense Plan for Occupational Employees

DISCLAIMER	1
INTRODUCTION.....	8
GRANDFATHERED STATUS.....	8
ABOUT THE MEDICAL PLAN OPTIONS.....	8
SECTION A. MEDICAL PLAN BENEFITS AT-A-GLANCE	10
GENERAL PLAN INFORMATION CHART	10
MEDICAL BENEFITS CHART.....	11
SECTION B. JOINING THE MEDICAL PLAN	19
WHO IS ELIGIBLE	19
Eligible Employees	19
Eligible Dependents.....	20
ENROLLING IN THE PLAN.....	23
Coverage Categories.....	23
Newly Hired Employees	23
Alcatel-Lucent Families	24
When Your Spouse or Domestic Partner Is Also an Employee or Retiree.....	24
Unique Enrollment Situations	25
If You Don't Enroll	26
Enrolling Early	27
ENROLLMENT RULES.....	27
Special Enrollment Period for Newborns, Newly Adopted Children and Children Newly Placed With You for Adoption	27
Enrollment Period for Newly Acquired Dependents Other Than Newborn, Newly Adopted Children and Children Newly Placed With You for Adoption	28
Annual Open Enrollment	29
Changing Your Coverage During the Year	30
Declining Coverage	33
Changing Your Level of Coverage.....	33
Effect of Employment Status Changes on Coverage	34
Confirmation Statements	39
MEDICAL PLAN CONTRIBUTIONS.....	40
Eligible Employees	40

January 1, 2011

Page 2

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

Newly Hired Employees Who “Enroll Early”	40
Survivors	40
Class II Dependents	40
Tax Treatment of Domestic Partner Dependent Coverage	41
Tax Treatment of a Non-Supported Dependent Child	41
SECTION C. HOW THE MEDICAL PLAN OPTIONS WORK	42
ABOUT YOUR MEDICAL PLAN OPTIONS	42
Your Share of Eligible Expenses	43
Annual Deductible	43
Out-of-Pocket Maximum	45
POS OPTION	47
How the POS Option Works	47
Required Precertification	50
Emergency Care	50
Receiving Care Away From Home	51
Your Medical ID Card	51
Member Services	51
TRADITIONAL INDEMNITY OPTION	52
How the Traditional Indemnity Option Works	52
Required Precertification	52
Your Medical ID Card	53
Filing a Claim	53
Member Services	53
HMO OPTION(S)	53
How an HMO Option Works	54
The Role of a PCP	54
BENEFIT LIMITS AND MAXIMUMS	54
SECTION D. WHAT’S COVERED	55
COVERED SERVICES AND CONDITIONS OF SERVICE	55
ACUPUNCTURIST’S SERVICES	55
AMBULANCE	56
Air Ambulance	57
BLOOD AND BLOOD DERIVATIVES	57
CENTERS OF EXCELLENCE	57
Travel and Lodging Benefit	57
CHIROPRACTIC SERVICES	57
CIRCUMCISION	58
DURABLE MEDICAL EQUIPMENT	58

January 1, 2011

Page 3

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

EMERGENCY ROOM	59
EXTENDED CARE FACILITY	59
FAMILY PLANNING SERVICES	60
HOME HEALTHCARE	61
HOSPICE	62
HOSPITALIZATION	63
MATERNITY CARE.....	65
MENTAL HEALTH AND CHEMICAL DEPENDENCY	66
NUTRITIONAL COUNSELING	66
ORGAN DONATION.....	66
ORTHOTICS.....	67
OUTPATIENT MEDICAL FACILITIES	67
PHYSICIAN'S SERVICES.....	67
PODIATRIC SERVICES.....	68
PRESCRIPTION DRUGS	68
PREVENTIVE CARE	68
PRIVATE DUTY NURSING	69
PROSTHESES.....	69
REHABILITATION THERAPY	70
RESTORATIVE OR RECONSTRUCTIVE SURGERY	70
SECOND SURGICAL OPINION	71
WIGS.....	72
SECTION E. MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAM.....	73
HOW THE MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAM WORKS	73
Precertification Requirements.....	74
In-Network Benefits	74
Outpatient Care	74
Inpatient Care	75
Covered Alternative Treatment (In-Network Only).....	76
Out-of-Network Benefits.....	77
EMERGENCY CARE	77
RECEIVING CARE AWAY FROM HOME	78
AMOUNT OF COVERAGE.....	78
SECTION F. WHEN PRECERTIFICATION IS REQUIRED.....	79
WHAT PRECERTIFICATION IS	79
WHO IS RESPONSIBLE FOR PRECERTIFICATION	79
REQUIRED PRECERTIFICATION UNDER THE TRADITIONAL INDEMNITY AND POS OPTIONS	80

REQUIRED PRECERTIFICATION UNDER THE MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAM	81
HOW TO PRECERTIFY	81
Under the POS or Traditional Indemnity Option	81
Under the Mental Health and Chemical Dependency Program	82
CONCURRENT REVIEW AFTER PRECERTIFICATION	83
PENALTIES IMPOSED IF PRECERTIFICATION PROCEDURES ARE NOT FOLLOWED	83
Under the POS Option (Out-of-Network Services) or Traditional Indemnity Option.....	83
Under the Mental Health and Chemical Dependency Program	83
SECTION G. HOW THE PRESCRIPTION DRUG PROGRAM WORKS	85
ABOUT THE PRESCRIPTION DRUG PROGRAM	85
HOW THE PRESCRIPTION DRUG PROGRAM WORKS.....	85
Filling Prescriptions by Mail, Phone or Fax	87
WHAT PRESCRIPTION DRUGS ARE COVERED	87
DRUGS REQUIRING AUTHORIZATION AND QUANTITY LIMITS	88
SPECIALTY CARE.....	88
OUT-OF-POCKET MAXIMUM.....	89
PHARMACY SERVICES	89
FILING A CLAIM.....	90
Appealing a Claim Decision.....	90
SECTION H. WHAT'S NOT COVERED.....	91
ABOUT EXCLUSIONS	91
GENERAL EXCLUSIONS	91
POS AND TRADITIONAL INDEMNITY OPTIONS EXCLUSIONS	93
MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAM EXCLUSIONS	95
PRESCRIPTION DRUG PROGRAM EXCLUSIONS	96
SECTION I. WHEN COVERAGE ENDS	98
WHEN EMPLOYEE COVERAGE ENDS	98
WHEN DEPENDENT COVERAGE ENDS	98
CREDITABLE COVERAGE CERTIFICATES	99
SECTION J. CONTINUING COVERAGE.....	100
EXTENDING COVERAGE DURING HOSPITALIZATION.....	100
COBRA CONTINUATION COVERAGE.....	100
How COBRA Continuation Coverage Is Affected by Multiple Qualifying Events.....	102
Covering a Newborn or Newly Adopted Dependent	102

January 1, 2011

Page 5

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

How Much COBRA Continuation Coverage Costs	102
Electing COBRA Continuation Coverage	103
CONTINUING COVERAGE FOR DEPENDENTS THROUGH THE FAMILY SECURITY PROGRAM (FSP)	103
SECTION K. CLAIMS AND APPEALS.....	105
TYPES OF CLAIMS.....	105
Eligibility Claims	105
Benefits Claims.....	105
ELIGIBILITY CLAIMS.....	107
Filing Deadlines.....	107
Where to Send Your Claim Form.....	107
When You Can Expect to Receive a Decision	107
What You'll Be Told if Your Eligibility Claim Is Denied	108
Appeal Procedures and Deadline	108
When You Can Expect to Receive a Decision on Appeal	109
BENEFITS CLAIMS	110
Claim Deadlines	110
When You Can Expect to Receive a Decision	111
Appeal Procedures and Deadline	113
SECTION L. HOW COORDINATION OF BENEFITS WORKS	117
WHAT COORDINATION OF BENEFITS IS	117
WHEN THE COORDINATION OF BENEFITS PROVISION APPLIES	117
WHEN THE COORDINATION OF BENEFITS PROVISION DOES NOT APPLY	117
WHICH PLAN PAYS BENEFITS FIRST	118
COORDINATION OF BENEFITS WITH MEDICARE.....	119
SECTION M. OVERPAYMENTS AND SUBROGATION	121
OBLIGATION TO REFUND.....	121
RIGHT OF RECOVERY AND SUBROGATION	121
SECTION N. EVENTS AFFECTING COVERAGE	123
IF YOU CHANGE YOUR JOB CLASSIFICATION.....	123
If You Live Within a Point of Service (POS) Area.....	123
If You Live Outside of a POS Area	124
IF YOU BECOME DISABLED DUE TO A SICKNESS	125
IF YOU TERMINATE EMPLOYMENT	126
IF YOU RETIRE	126
IF YOU BECOME DISABLED DUE TO A WORK-RELATED INJURY	127
IF YOU TAKE AN APPROVED LEAVE OF ABSENCE	128

Family and Medical Leave	128
Military Leave.....	129
IF YOU ARE LAID OFF	130
IF YOU GET MARRIED OR ENTER INTO A DOMESTIC PARTNERSHIP.....	130
IF A DEPENDENT LOSES ELIGIBILITY	131
IF YOUR PHYSICALLY OR MENTALLY HANDICAPPED CHILD REACHES THE LIMITING AGE	131
IF YOU OR A COVERED DEPENDENT BECOMES ELIGIBLE FOR MEDICARE	131
When the Medical Plan Coordinates Benefits With Medicare	132
If You or a Covered Dependent Becomes Medicare-Eligible While You're Actively Employed	132
If You Enroll in Medicare Part D	133
IF YOU DIE	134
IF YOU MOVE	135
How a Move Affects Your Healthcare Options.....	135
DECLINING COVERAGE	136
SECTION O. TERMS TO KNOW	137
SECTION P. IMPORTANT CONTACTS.....	154
SECTION Q. OTHER IMPORTANT INFORMATION	160
NEWBORN'S AND MOTHER'S PROTECTION ACT	160
THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998.....	160
QUALIFIED MEDICAL CHILD SUPPORT ORDER BENEFIT PAYMENTS	161
RIGHT WITH RESPECT TO SELECTION OF A PRIMARY CARE PROVIDER	161
MEDICAL PLAN FUNDING AND PAYMENT OF BENEFITS.....	161
PLAN DOCUMENTS.....	161
UNION AGREEMENTS.....	161
MEDICAL PLAN MAY BE AMENDED OR TERMINATED	161
PLAN ADMINISTRATOR AND CLAIMS ADMINISTRATOR	162
PLAN SPONSOR	162
NOTICE OF PRIVACY PRACTICES.....	162
Our Legal Duty.....	162
To Exercise Your Rights	163
ADMINISTRATIVE INFORMATION.....	163
SECTION R. YOUR LEGAL RIGHTS.....	165
YOUR RIGHTS UNDER ERISA	165
ASSISTANCE WITH YOUR QUESTIONS	167

Introduction

Grandfathered Status

Notice is hereby given of the Medical Plan's status as a "grandfathered health plan" within the meaning of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, "PPACA").

Under PPACA, a plan that is a grandfathered health plan is exempt from some—but not all—of the consumer protections of PPACA. For example, grandfathered health plans are generally required to make coverage available to adult children of participants until age 26 (the Medical Plan complies with this requirement and generally may not impose "lifetime" limits on benefits (the Medical Plan meets this requirement)). On the other hand, grandfathered health plans are not required to provide coverage for "preventive" health services without cost-sharing (the Medical Plan imposes some cost-sharing).

Questions regarding which consumer protections apply and which consumer protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Alcatel-Lucent Benefits Center at 1-888-232-4111 (1-212-444-0994 if calling from outside of the United States, Puerto Rico or Canada) from 9:00 a.m. to 5:00 p.m., Eastern Time (ET), Monday through Friday. Participants and beneficiaries may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. (This Web site has a table summarizing which protections do and do not apply to grandfathered health plans).

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. The Company offers a choice of Medical Plan options that enable you to choose the type of coverage that best suits your personal and family needs.

Terms to Know

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

January 1, 2011

Page 8

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

These Medical Plan options are:

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

Not all options are available in all geographic regions. The options available to you are listed in your enrollment materials, or you can obtain this information by visiting 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). Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., 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™ is a trademark of Hewitt Associates LLC.

Section A. Medical Plan Benefits At-a-Glance

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

General Plan Information Chart

Medical Plan Feature	Summary
Eligibility	If you're a regular, active (full-time or part-time) occupational employee of the Company or a Participating Company), you are eligible to enroll in the Medical Plan. You may also enroll your Eligible Dependents under the same coverage option that you choose for yourself.
Enrollment	<p>Automatic Enrollment If you are assigned a coverage option (that is, a "Default Option"), you will automatically be enrolled in that Default Option on the first day of the month in which you complete six months of Net Credited Service.</p> <p>Active Enrollment You must actively enroll in the Plan:</p> <ul style="list-style-type: none"> • To begin coverage before you complete six months of Net Credited Service (see "Enrolling Early" in Section B. Joining the Medical Plan); • To elect coverage other than your Default Option; and/or • To elect coverage for your Eligible Dependents.
Informational Resources and Important Contacts	<p>Call your Health Plan Carrier for information about Covered services or precertification requirements.</p> <p>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.</p> <p>Information is also available online at the BenefitAnswers Plus Web site: 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.</p> <p>If you are hearing or speech impaired, please use a Relay Service when calling a representative.</p>

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 P. Important Contacts** for carrier contact information.

FEATURE	POINT OF SERVICE (POS)		TRADITIONAL INDEMNITY
	IN-NETWORK	OUT-OF-NETWORK	
Choice of Doctors	Select within a Network of Providers	Select any eligible Provider	Select any eligible Provider
Annual Deductible	None	Individual: \$600 Two-person: \$1,200 Family: \$1,800	Individual: \$300 Two-person: \$600 Family: \$900
Annual Out-of-Pocket Maximum	Individual: \$1,250 Two-person: \$2,500 Family: \$3,750	Individual: \$3,500 Two-person: \$7,000 Family: \$10,500 Excludes Deductible	Individual: \$1,500 Two-person: \$3,000 Family: \$4,500 Excludes Deductible
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 75% 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 95%	Plan pays 75% after Deductible is satisfied	Plan pays 95% after Deductible is satisfied
Ambulance — Emergency Use of Ambulance	Plan pays 95%	Plan pays 95% (Deductible does not apply)	Plan pays 80% after Deductible is satisfied

Section A. Medical Plan Benefits At-a-Glance

FEATURE	POINT OF SERVICE (POS)		TRADITIONAL INDEMNITY
	IN-NETWORK	OUT-OF-NETWORK	
Ambulance From Hospital to Hospital (if admitted to first Hospital)	Plan pays 95%	Plan pays 95% (Deductible does not apply)	Plan pays 95% after Deductible is satisfied
Anesthesia	Plan pays 95%	Plan pays 75% after Deductible is satisfied	Plan pays 95% after Deductible is satisfied
Birth Control (prescription birth control or medication only)	See "Prescription Drug Program"		
Birthing Center	Plan pays 95%	Plan pays 75% after Deductible is satisfied	Plan pays 95% after Deductible is satisfied
Blood and Blood Derivatives	Plan pays 95%	Plan pays 75% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Cardiac Rehabilitation (phase three maintenance not Covered)	Plan pays 95%	Plan pays 75% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Chemotherapy	Plan pays 95%	Plan pays 75% after Deductible is satisfied	Plan pays 95% after Deductible is satisfied
Chiropractic	You pay \$30 Copayment/visit; limited to 30 visits/year (In- and Out-of-Network combined)	Plan pays 75% 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 95%	Plan pays 75% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Emergency Room – Emergency Use	You pay \$60 Copayment/visit (waived if admitted)	You pay \$60 Copayment/visit (waived if admitted)	Plan pays 95% after Deductible is satisfied

January 1, 2011

Page 12

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

Section A. Medical Plan Benefits At-a-Glance

FEATURE	POINT OF SERVICE (POS)		TRADITIONAL INDEMNITY
	IN-NETWORK	OUT-OF-NETWORK	
Emergency Room – Nonemergency Use	Plan pays 75% after \$60 Copayment/visit	Plan pays 75% after \$60 Copayment/visit	Plan pays 80% after Deductible is satisfied
Extended Care Facility (or Skilled Nursing Facility)	Plan pays 95%	Plan pays 75% after Deductible is satisfied; limited to 60 days/year	Plan pays 95% after Deductible is satisfied; limited to 120 days/year
Home Healthcare	Plan pays 95%	Plan pays 75% after Deductible is satisfied; limited to 100 visits/year	Plan pays 95% after Deductible is satisfied; limited to 200 visits/year
Hospice Care	Plan pays 95%; limited to 210 days/lifetime (In- and Out-of-Network combined)	Plan pays 75% after Deductible is satisfied; limited to 210 days/lifetime (In- and Out-of-Network combined)	Plan pays 95% after Deductible is satisfied; limited to 210 days/lifetime
Inpatient Hospitalization/ Surgery	Plan pays 95% after you pay \$100 Copayment/ admission	Plan pays 75% after Deductible is satisfied and you pay \$300 Copayment/ admission	Plan pays 95% after Deductible is satisfied
Maternity	Plan pays 95% after you pay \$30 Copayment for first visit	Plan pays 75% after Deductible is satisfied	After Deductible is satisfied, Plan pays 95% for most Inpatient and Outpatient services and 80% for Physician office visits
Nutritionist	You pay \$30 Copayment/visit	Not Covered	Not Covered
Outpatient Lab/X-ray	Plan pays 95%	Plan pays 75% after Deductible is satisfied	Plan pays 95% after Deductible is satisfied
Physician Hospital Visits and Consultations	Plan pays 95%	Plan pays 75% after Deductible is satisfied	Plan pays 95% after Deductible is satisfied
Physician Office Visit (non-preventive)	You pay \$30 Copayment/visit	Plan pays 75% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied

January 1, 2011

Page 13

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

Section A. Medical Plan Benefits At-a-Glance

FEATURE	POINT OF SERVICE (POS)		TRADITIONAL INDEMNITY
	IN-NETWORK	OUT-OF-NETWORK	
Podiatrist	You pay \$30 Copayment/visit	Plan pays 75% after Deductible is satisfied	Plan pays 80% after Deductible is satisfied
Private Duty Nursing	Plan pays 95%	Plan pays 75% after Deductible is satisfied; limited to 100 shifts/year	Plan pays 95% after Deductible is satisfied; limited to 200 shifts/year
Radiation Therapy	Plan pays 95%	Plan pays 75% after Deductible is satisfied	Plan pays 95% after Deductible is satisfied
Rehabilitation Therapy (Outpatient physical, occupational, speech)	You pay \$30 Copayment/visit	Plan pays 75% 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 75% after Deductible is satisfied	Plan pays 95% after Deductible is satisfied
Smoking Deterrents (prescription only)	See "Prescription Drug Program"		
Surgery – In Office	You pay \$30 Copayment/visit	Plan pays 75% after Deductible is satisfied	Plan pays 95% after Deductible is satisfied
Surgery – Outpatient	Plan pays 95%	Plan pays 75% after Deductible is satisfied	Plan pays 95% after Deductible is satisfied
Wigs	Plan pays up to \$300/Year		
PREVENTIVE CARE			
Routine Physical Exams	You pay \$30 Copayment/visit	Not Covered	Not Covered

Section A. Medical Plan Benefits At-a-Glance

FEATURE	POINT OF SERVICE (POS)		TRADITIONAL INDEMNITY
	IN-NETWORK	OUT-OF-NETWORK	
Well-Child Care	You pay \$30 Copayment/visit	Not Covered	Not Covered
Childhood Immunizations	You pay \$30 Copayment/visit (included with the 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 75% after Deductible is satisfied	After Deductible is satisfied, Plan pays 80% if preventive or 95% if diagnostic
Pap Smear (in Physician's office)	You pay \$30 Copayment/visit (included with Physician's visit)	Plan pays 75% after Deductible is satisfied	Plan pays 95% 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 75% after Deductible is satisfied	Plan pays 95% after Deductible is satisfied
Newborn In-Hospital Care	Plan pays 95%	Plan pays 75% after Deductible is satisfied; limited to one visit	Plan pays 95% (Deductible does not apply); limited to one visit
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).		

Section A. Medical Plan Benefits At-a-Glance

FEATURE	POINT OF SERVICE (POS)		TRADITIONAL INDEMNITY
	IN-NETWORK	OUT-OF-NETWORK	
Are You Responsible for Charges in Excess of 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*			
Prescription Drug Annual Deductible*	Retail and mail order: None	Individual: \$100 Two-person: \$200 Family: \$300	In-Network (retail and mail order): None Out-of-Network: Individual: \$100 Two-person: \$200 Family: \$300
Prescription Drug Annual Out-of-Pocket Maximum*	Retail and mail order: \$1,250/individual	None	In-Network (retail and mail order): \$1,250/individual 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 POS and Traditional Indemnity options and the Mental Health and Chemical Dependency program.

January 1, 2011

Page 16

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

Section A. Medical Plan Benefits At-a-Glance

FEATURE	POINT OF SERVICE (POS)		TRADITIONAL INDEMNITY
	IN-NETWORK	OUT-OF-NETWORK	
Retail Copayments (up to 30-day supply using an In-Network pharmacy)	<ul style="list-style-type: none"> • Level One (Generic): \$10 • Level Two (Formulary Brand): \$25 • Level Three (Formulary Brand): \$35 • Level Four (Nonformulary Brand): \$40 	Plan pays 70% after Deductible is satisfied	<p>In-Network:</p> <ul style="list-style-type: none"> • Level One (Generic): \$10 • Level Two (Formulary Brand): \$25 • Level Three (Formulary Brand): \$35 • Level Four (Nonformulary Brand): \$40 <p>Out-of-Network: Plan pays 70% after Deductible is satisfied</p>
Mail-Order Copayments (up to 90-day supply)	<ul style="list-style-type: none"> • Level One (Generic): \$20* • Level Two (Formulary Brand): \$50 • Level Three (Formulary Brand): \$70 • Level Four (Nonformulary Brand): \$80 	Not applicable	<ul style="list-style-type: none"> • Level One (Generic): \$20* • Level Two (Formulary Brand): \$50 • Level Three (Formulary Brand): \$70 • Level Four (Nonformulary Brand): \$80
MENTAL HEALTH AND CHEMICAL DEPENDENCY			
Mental Health and Chemical Dependency Annual Deductible*	None	\$200/individual	<p>In-Network: None</p> <p>Out-of-Network: \$200/individual</p>

Section A. Medical Plan Benefits At-a-Glance

FEATURE	POINT OF SERVICE (POS)		TRADITIONAL INDEMNITY
	IN-NETWORK	OUT-OF-NETWORK	
Mental Health and Chemical Dependency Annual Out-of-Pocket Maximum*	\$1,250/individual	Individual: \$3,500 Two-person: \$7,000 Family: \$10,500	In-Network: \$1,250/individual Out-of-Network: Individual: \$3,500 Two-person: \$7,000 Family: \$10,500
Inpatient	You pay \$30 Copayment/day (limited to 120 days/year)	Plan pays 50% after Deductible is satisfied and you pay a \$500 Copayment/admission (limited to 30 days/year)	In-Network: \$30 Copayment/day (limited to 120 days/year) Out-of-Network: Plan pays 50% after Deductible is satisfied and you pay a \$500 Copayment/admission (limited to 30 days/year)
Outpatient	Plan pays 100% for first three visits/year; you pay \$30 Copayment/visit thereafter (limited to 60 visits/year)	Plan pays 50% after Deductible is satisfied (limited to 60 visits/year)	In-Network: Plan pays 100% for first three visits/year; you pay \$30 Copayment/visit thereafter (limited to 60 visits/year) Out-of-Network: Plan pays 50% after Deductible is satisfied (limited to 60 visits/year)
Alternative Treatment (Partial Hospitalization, Residential Treatment and services of a Halfway House or Group Home)	You pay \$30 Copayment/day (limited to 120 days/year)	Not Covered	In-Network: You pay \$30 Copayment/day (limited to 120 days/year) Out-of-Network: Not Covered

*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.

*The Deductibles and Out-of-Pocket Maximums for the Mental Health and Chemical Dependency Program are separate from the Deductibles and Out-of-Pocket Maximums for the POS and Traditional Indemnity options and the Prescription Drug Program.

Section B. Joining the Medical Plan

Who Is Eligible

Eligible Employees

The following individuals are eligible to participate in the Plan:

- **Regular, active full-time or part-time occupational employees of Alcatel-Lucent or a Participating Company.** Such employees generally are eligible to participate in the Medical Plan on the first day of the month in which they complete six months of Net Credited Service (see “If You Don’t Enroll” later in this section for more information about full-time and part-time coverage). For example, if you were hired on March 16, you would be eligible to enroll as of the following September 1.

If you would like to, you may enroll in the Plan before completing six months of Net Credited Service (see “Enrolling Early” later in this section).

- **Recipients of benefits under the Lucent Technologies Inc. Long Term Disability Plan for Occupational Employees (“LTD Plan”).** Such recipients are eligible to participate in the Medical Plan provided they are not eligible for a service or disability pension from the Lucent Technologies Inc. Pension Plan or the Lucent Technologies Inc. Retirement Plan.

Please note: LTD Plan recipients may be subject to rules and levels of coverage that differ from what is listed in this Plan. If you are an LTD Plan recipient, please contact the Alcatel-Lucent Benefits Center at 1-888-232-4111 for more information about the scope of your coverage under the Medical Plan. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET.

- **Recipients of benefits under the Alcatel-Lucent Sickness and Accident Disability Benefit Plan.** Such recipients are eligible to participate in the Medical Plan until they are no longer eligible for coverage under the Alcatel-Lucent Sickness and Accident Disability Benefit Plan.

Enrolling During the Waiting Period

If you would like, you may enroll for coverage before the end of the six-month waiting period by paying the full coverage cost during the waiting period (see “Enrolling Early” later in this section). Your contribution for coverage as an employee is waived if you meet the eligibility requirements to be Covered as a Dependent of another Alcatel-Lucent employee or retiree (see “Alcatel-Lucent Families” later in this section).

January 1, 2011

Page 19

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

If you are a new hire (you do not have six months of Net Credited Service), you will not receive any coverage for you and/or your eligible Dependent(s) if you don't enroll during your enrollment period. You and your Eligible Dependents would not have any coverage until you enroll yourself and them during an Annual Open Enrollment period and/or due to a qualified status change (see "Changing Your Coverage During the Year," later in this section).

If you currently have coverage and don't enroll during the Annual Open Enrollment period, in most cases, your current coverage and coverage level would continue the next Plan Year.

Please note: The following individuals are not eligible to participate in the Medical Plan:

- Individuals who are not paid from the U.S. payroll of a Participating Company;
- Individuals who are employed by an independent company (such as an employment agency); or
- Individuals whose services are rendered pursuant to an agreement excluding participation in Company-sponsored benefit plans.

Eligible Dependents

If you satisfy the criteria under "Eligible Employees" on the previous page, 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.

Class I and Domestic Partner 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).

<p>Dependent Verification From time to time, the Company will verify dependent eligibility. Verification will include documentation requirements.</p>
--

- 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;
 - 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.
- Your child(ren), regardless of marital status (including those of your opposite-sex spouse,) to the end of the month in which he or she reaches age 26 in the absence of other available coverage, other than from a parent's plan:
 - Biological child(ren), stepchild(ren) or legally adopted child(ren);
 - Child(ren) for whom you or your spouse 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).
- The unmarried child(ren) of your Domestic Partner, through December 31 of the year in which he or she reaches age 23, regardless of his or her eligibility to enroll in another employer's coverage.
- Your child(ren) beyond age 26 (or the child[ren] of your Domestic Partner beyond the end of the year in which he or she turns age 23) who is incapacitated, unmarried, certified by the Health Plan Carrier Claims Administrator and who meet all of the following requirements:

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

- Incapable of self-support;
- Physically or mentally handicapped; and
- Fully dependent on you for support.

This coverage is not automatic. Prior to your child reaching age 26 (or age 23 for your Domestic Partners's child), 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 the age limits stated above. 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):

<p>Important! New Class II Dependents may not be added to coverage at any time.</p>
--

Only the following relatives may qualify as a Class II Dependents:

- Your unmarried Dependent child(ren) or stepchild(ren) not included as Class I Dependents;
- 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:

January 1, 2011

Page 22

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

- **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.

Enrolling in the Plan

The Medical Plan provides several coverage options from which to choose the one that best meets your needs.

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).

What you need to do to enroll depends on whether you’re:

- A newly hired Eligible Employee;
- Enrolling during an Annual Open Enrollment period; or
- Changing coverage during the year (see “Changing Your Coverage During the Year” later in this section).

Coverage Categories

You may select from 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.

Newly Hired Employees

After you start working for Alcatel-Lucent or a Participating Company, an enrollment package will be sent to your preferred address. The package will include information about your coverage options under the Plan, including early enrollment (see “Enrolling Early” later in this section), the cost of coverage, how to enroll yourself and your Eligible Dependents and the date by which you must make your elections.

Regardless of whether you're assigned coverage, you generally will receive an e-mail from the Alcatel-Lucent Benefits Center pointing you to the Your Benefits Resources (YBR) Web site at <http://resources.hewitt.com/alcatel-lucent> for more information about your coverage options, including the cost, how to enroll yourself and your Eligible Dependents and the date by which you must make your elections (generally, within 31 days after you receive your enrollment package). However, if you go online before you actually start working and enroll through Alcatel-Lucent's Pre-Enrollment Process ("Day One Process"), you will not receive an e-mail since you will already have enrolled. In this case, within 31 days after the date you start working, you may still make changes to the coverage you selected, but to do so you must 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. If you are hearing or speech impaired, please use a Relay Service when calling a representative.

Alcatel-Lucent Families

Enrollment Rules

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

- One occupational active or retired 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 active occupational employee or retiree to cover a part-time management employee whose regularly scheduled hours are fewer than 20 hours per week.
- An active occupational employee may elect to be Covered as a dependent under a management participant's coverage only if he or she is a part-time employee regularly scheduled to work fewer than 17 hours per week or if he or she has fewer than six months of Net Credited Service.
- An active occupational employee may elect to be Covered as a dependent under another active occupational employee or under a retired occupational employee regardless of scheduled hours.

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 as "Individual" coverage and the other can cover your eligible child(ren) by enrolling in "Two-person" or "Family" coverage;

January 1, 2011

Page 24

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

- 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.

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 Point of Service (POS) option and your Eligible Dependents live outside your Health Plan Carrier’s POS Network area.	<ul style="list-style-type: none"> • You and your Eligible Dependents may enroll in the POS option. • If your Dependents do not live in a POS Network area, the Dependents may receive Traditional Indemnity benefits provided by your POS option.
You have a Class II Dependent who was 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.

If You Don't Enroll

If you don't make any elections by the date shown in your enrollment package here's what happens:

Important!

It's important to enroll your Dependents as soon as possible since claims can't be processed for Dependents until they are enrolled.

- If you're a regular full-time Eligible Employee or a regular part-time Eligible Employee scheduled to work **more than 24 hours** a week, you **alone** will be automatically Covered as of the first day of the month in which you complete six months of Net Credited Service. You may not add any eligible Dependents until the next Annual Open Enrollment unless you have a qualified status change (see "Changing Your Coverage During the Year" later in this section).
- If you're a part-time Eligible Employee scheduled to work **24 or fewer hours** per week or have fewer than six months of Net Credited Service, you will **not** be assigned coverage under the Default Option. This means you and your Eligible Dependents **cannot** enroll in the Medical Plan until the following calendar year. You must wait until the next Annual Open Enrollment to enroll, unless you have a qualified status change (see "Changing Your Coverage During the Year" later in this section).
- If you're already enrolled in the Medical Plan (see "Enrolling Early" later in this section), your current elections will remain in effect.

Default Options

As noted above, certain Eligible Employees will automatically be assigned coverage under a Default Option if they do not enroll in the Medical Plan on a timely basis after completing six months of Net Credited Service. Your eligibility for a Default Option depends upon your job classification.

About Your Default Option

Your Default Option is 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.

The option that is actually assigned is determined by whether you live in a POS area. Here's how it works.

	Your Default Medical Plan Option If You Live:	
Job Classification	Within a POS Area	Outside a POS Area
Full-time occupational	POS option*	Traditional Indemnity option*
Part-time occupational, scheduled to work 24 or fewer hours per week	No Coverage**	No Coverage**

*If you don't enroll by the deadline provided in your enrollment materials, **you, but not your Eligible Dependents**, are automatically enrolled in default coverage as of the first of the month in which you complete six months of Net Credited Service.

**If you are not assigned a Default Option, you must actively enroll in the Medical Plan by the deadline listed in your enrollment materials in order to have coverage under the Medical Plan. If you do not enroll by the deadline, neither you nor your dependents will be enrolled in the Medical Plan as of the first of the month in which you complete six months of Net Credited Service.

Enrolling Early

You may actively enroll yourself and your Eligible Dependents in the Plan while you complete six months of Net Credited Service with Alcatel-Lucent or a Participating Company. If you decide to enroll in the Medical Plan while you are completing six months of Net Credited Service, your coverage begins as follows:

- **If you enroll within 31 days of your date of hire**, coverage is effective as of your first day of work as an Eligible Employee.
- **If you do not enroll within 31 days of your date of hire**, you will not be able to enroll in the Medical Plan until the earliest of the following events:
 - The first day of the month in which you complete six months of Net Credited Service;
 - The next Annual Open Enrollment period; or
 - You qualify to change your coverage during the year (see "Changing Your Coverage During the Year" later in this section).

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 placed with you for adoption or a Child for whom you, or you and your Lawful Spouse or Domestic Partner, have been newly

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

appointed as the legal guardian. The special enrollment

period begins on the day the Child is born, adopted or placed with you for adoption, or the day you, or you and your Legal Spouse or Domestic Partner, are appointed legal guardian, and ends on the 60th day thereafter.

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

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

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

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

Examples of such a newly acquired dependent are:

- If you get married, your new Lawful Spouse;
- If you enter into a Domestic Partnership relationship, your new Domestic Partner; or
- If you get married or enter into a Domestic Partnership relationship, your new Lawful Spouse's Children (your stepchildren) or new Domestic Partner's Children.

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

Coverage under the Plan for your Lawful Spouse or Domestic Partner, your Lawful Spouse's or Domestic Partner's Children and, if applicable, for yourself, will be retroactive to the date of your marriage or the date of entering into the Domestic Partner relationship. If you do not enroll during the 31-day enrollment period, you will have to wait until the next Annual Open Enrollment period to enter the Plan.

January 1, 2011

Page 28

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

To enroll a new dependent (and, if not already enrolled in the Plan, yourself) during the 31-day enrollment period described above, 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.

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 YBR Web site at <http://resources.hewitt.com/lucent> or by calling the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., 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.

Annual Open Enrollment

During Annual Open Enrollment each year, you'll have an opportunity to select the medical coverage that best meets your needs for the coming year. This means that you may "add" or "decline" coverage for yourself and your Eligible Dependents and/or change Medical Plan options.

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 and/or job classification.

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

You can enroll:

- On the Your Benefits Resources (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

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.

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.

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 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, 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 Partner dependents as qualified status changes.

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 legally adopt a child, you may enroll the newly adopted child in the Medical Plan. You may not, however, cancel coverage for your Lawful Spouse.

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.
Change in Employment Status, Work Schedule or Worksite	<ul style="list-style-type: none"> • You, your Lawful Spouse or other dependent becomes employed or loses employment; • Affected by a strike or lockout;

Section B. Joining the Medical Plan

Qualified Status Change	Description
	<ul style="list-style-type: none"> • Change in Worksite; or • A reduction or increase in hours of employment, including a switch between part-time and full-time employment or the start of, or return from, a leave of absence.
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.
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.
Court-Ordered Coverage	<p>A change in your responsibility to provide healthcare coverage for a dependent child as stipulated in a judgment, decree or court order resulting from a divorce, legal separation, annulment or change in legal custody (for example, a Qualified Medical Child Support Order). Documentation must be submitted (see "Qualified Medical Child Support Order Benefit Payments" in Section Q. Other Important Information).</p> <p>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.</p>
Employee Loses Other Coverage (Employee Had Opted Out of Coverage Under This Plan)	Your other coverage ends due to a loss of eligibility, such as a divorce or termination of employment, or the other employer's ceasing to make contributions to the plan. You can't make a change during the year if your "other coverage" is lost due to your own fault, such as your not making your required contributions.
Enrolled Employee Marries or Acquires a Child Through Birth, Legal Adoption or Placement With You for Legal Adoption	You may enroll your new spouse at the time of his or her marriage to you. In addition, you may enroll your non-enrolled spouse if you acquire a child through birth, legal adoption or placement with you for adoption. (See Special Enrollment Period for Newborns, Newly Adopted Children and Children Newly Placed With You for Adoption" in Section B: Joining

Qualified Status Change	Description
	the Medical Plan).
Eligible Non-Enrolled Employee 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.

Special Enrollment Rights

You may be able to change your coverage election during the year under the Health Insurance Portability and Accountability Act (HIPAA), the Family and Medical Leave Act (FMLA) and/or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). For more information about your special enrollment rights under these laws, please 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.

If Your Coverage Option Changes During the Year

If your coverage option changes during the year, here’s what happens:

- Any amounts you have paid toward your annual Deductible under your prior option apply toward satisfying your Deductible under your new option during that calendar year. Deductible amounts applied Out-of-Network under the POS option apply to Deductible amounts under the Traditional Indemnity option and vice versa.
- Amounts you have paid that apply toward your Out-of-Pocket Maximum under the Traditional Indemnity option apply toward satisfying the Out-of-Network Out-of-Pocket Maximum under the POS option during that calendar year and vice versa.
- If your Health Plan Carrier changes, amounts you have paid toward satisfying your In-Network Out-of-Pocket Maximum under the POS option apply toward satisfying that limit under a subsequent POS Health Plan Carrier during that calendar year.

- Amounts you have paid as Copayments under the POS option do not apply toward satisfying either the Deductible or Coinsurance requirements under the Traditional Indemnity option.
- Amounts you have paid as Deductibles or Coinsurance amounts under the Traditional Indemnity option do not apply toward satisfying the In-Network Out-of-Pocket Maximum under the POS option.
- For any benefits with an annual limit, such as home healthcare, any services incurred in your prior option count toward the benefit limits of your new option during that calendar year.
- Your Mental Health and Chemical Dependency (MH/CD) Program and Prescription Drug Program benefits are unaffected.

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 for more information. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET.

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 — unless you have a qualified status change (see “Changing Your Coverage During the Year” earlier in this section).

When you waive medical coverage (which includes prescription drug coverage), you are also waiving dental and vision coverage. You can opt back into medical coverage (which includes prescription drug coverage) and dental and vision coverage without the requirement of a physical during a future Annual Open Enrollment period or if you have a qualified status change.

Please note: You may be required to complete additional forms, depending on the city and/or state in which you live.

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 N. Events Affecting Coverage**.

Effect of Employment Status Changes on Coverage

IF YOU...	THIS IS WHAT HAPPENS...
<p>Change from full time (classified by the Company as more than 24 hours per week) to part time (classified by the Company as 17 through 24 hours per week)</p>	<p>You may choose any available Medical Plan option for the remainder of the Plan Year, and you may change your coverage category.</p> <p>If you make no election, you will be defaulted to the same coverage, but your monthly contribution for coverage may change.</p> <p>A confirmation statement with your cost information will be provided by the Alcatel-Lucent Benefits Center.</p>
<p>Change from full time (classified by the Company as more than 24 hours per week) to part time (classified by the Company as less than 17 hours per week)</p>	<p>You may choose any available Medical Plan option for the remainder of the Plan Year, and you may change your coverage category.</p> <p>If you make no election, you will be defaulted to “No Coverage.” If you do elect coverage, you will be responsible for the full cost of elected coverage for you and any Covered Dependents.</p>
<p>Change from part time (classified by the Company as 24 or fewer hours per week) to full time (classified by the Company as more than 24 hours per week)</p>	<p>If you were enrolled in coverage, your current coverage option stays the same. You may change or decline coverage for the remainder of the Plan Year, and you may change your coverage category.</p> <p>If you elect coverage, you pay the required contribution for coverage.</p>
<p>Take a leave of absence</p>	<p>If you are on an approved leave of absence, including a leave under the Family and Medical Leave Act of 1993 (see “If You Take an Approved Leave of Absence” in Section N. Events Affecting Coverage), you can continue Medical Plan coverage for yourself and your Covered Dependents. You and your Covered Dependents will be notified of any continuation rights available under COBRA. When you are on a leave of absence other than an approved leave, you are no longer eligible for coverage under the Medical Plan.</p> <p>If you elect to enroll for coverage under the Medical Plan, your coverage will resume on your first day of work upon your return (see “If You Take an Approved Leave of Absence” in Section N. Events Affecting Coverage).</p>

Section B. Joining the Medical Plan

IF YOU...	THIS IS WHAT HAPPENS...
<p>Change from management classification to occupational classification</p>	<p>If you were enrolled in coverage, you will generally continue with the same option, although your Plan design may change. For some participants, the status change may affect their eligibility for Point of Service (POS) coverage since the coverage areas may be slightly different. If you're not in a POS service area after your change to occupational status, you will be assigned Traditional Indemnity coverage administered by UnitedHealthcare. If, however, you are willing to travel the distance to a provider in a nearby POS service area, you may enroll in the POS option. In this case, you would need to re-enroll in the POS option every year.</p> <p>Please note: If your status changes from management to occupational within your first six months of employment, you will have to pay 100 percent of the cost of any medical coverage you elect to continue as an occupational employee until you complete six months of service.</p>
<p>Become disabled</p>	<p>Your participation in the Medical Plan may be affected if you become disabled.</p> <p>Your length of service and the duration of your disability determine what happens to your coverage during a disability.</p> <p>If you become disabled due to a certified nonwork-related accident or disability as determined under the Short Term Disability (STD) Plan, you will continue to be eligible for coverage under the Medical Plan for as long as you are receiving STD benefits. You will be subject to the same costs as an active employee during that time.</p> <p>If you continue to be disabled after you have received the maximum number of weeks of sickness disability benefits, you may be eligible for benefits under the Alcatel-Lucent Long Term Disability (LTD) Plan.</p> <p>You are eligible for a disability or service pension, you will be Covered by the Alcatel-Lucent Medical Expense Plan for Retired Occupational Employees, and your coverage under the Alcatel-Lucent Medical Expense Plan for Occupational Employees will end.</p> <p>If you are not eligible for a disability or service pension but you are eligible for LTD benefits, your Medical Plan coverage would continue as indicated under "Long Term Disability Plan" below.</p>

Section B. Joining the Medical Plan

IF YOU...	THIS IS WHAT HAPPENS...
<p>Become disabled (cont'd)</p>	<p>Long Term Disability Plan Medical Plan coverage is available for employees eligible for the Lucent Technologies Inc. Long Term Disability (LTD) Plan who are not eligible for coverage under the Medical Expense Plan for Retired Occupational Employees as described above.</p> <p>Coverage under the Medical Plan will terminate as of the end of the month in which you are no longer eligible for LTD benefits or at age 65, whichever is earlier. If you become eligible for Medicare benefits while coverage under the Medical Plan is in effect, coverage under the Medical Plan will be administered secondary to Medicare.</p> <p>If you have less than 15 years of service at the time you terminate from active employment and are approved for LTD benefits, the Medical Plan will be available to you at no cost until you reach age 65 or are no longer eligible for LTD benefits, whichever occurs earlier.</p> <p>If you are Covered by the provisions of the Alcatel-Lucent Retirement Income Plan and have at least 15 years of service at the time you terminate from active employment and are approved for LTD benefits, you will be eligible for a disability retirement and a Company subsidy toward the cost of your retiree healthcare coverage.</p>
<p>Are laid off</p>	<p>If you are laid off, you will be able to continue Medical Plan coverage through COBRA (see "COBRA Continuation Coverage" in Section J. Continuing Coverage). Depending upon your years of service and the type of layoff, part of your cost for COBRA continuation coverage may be paid by the Company. Your Force Management Program package will provide the details.</p>
<p>Terminate employment</p>	<p>Coverage ends at the end of the month following your termination date. However, you may be able to continue coverage for yourself and your Covered Eligible Dependents through COBRA (see "COBRA Continuation Coverage" in Section J. Continuing Coverage).</p>

Section B. Joining the Medical Plan

IF YOU...	THIS IS WHAT HAPPENS...
<p>Covered Dependent becomes eligible for Medicare (cont'd.)</p>	<p>The Medicare program has four parts:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>You should apply for Medicare Part A as soon as you become eligible and plan on securing Part B when you retire, become classified as long term disabled or are participating in the Family Security Program (FSP). If you do not enroll in Medicare Part A when you are first eligible, penalties and delays may apply when you later try to enroll for coverage.</p> <p>You or a Covered Dependent may also be eligible for Medicare before age 65 due to disability. In this case, it is important to enroll in Medicare as soon as possible.</p> <p>While you are actively employed, the Medical Plan is usually your primary coverage (see "Coordination of Benefits With Medicare" in Section L. How Coordination of Benefits Works). (In the case of patients with end stage renal disease [ESRD], Medicare would be primary after the "waiting period.")</p>
<p>Retire</p>	<p>If you retire with a service or disability pension, enrollment materials and information about your</p>

Section B. Joining the Medical Plan

IF YOU...	THIS IS WHAT HAPPENS...
Retire (cont'd.)	<p>coverage options under the Medical Expense Plan for Retired Occupational Employees will be sent to you at your preferred address.</p> <p>If you're Medicare-eligible when you retire, you'll be enrolled in Traditional Indemnity (administered by UnitedHealthcare). Medicare will pay first, and your Alcatel-Lucent coverage will be the secondary payor.</p> <p>To provide coverage for your Domestic Partner dependents, they must have been enrolled as your dependents at some point in the active Medical Plan when you retire. After you retire you cannot add a Domestic Partner dependent who was not previously enrolled under active coverage.</p> <p>When you retire, you also have the option to continue your current coverage through COBRA.</p> <p>For more information applicable to your personal situation, refer to the Medical Expense Plan for Retired Occupational Employees SPD.</p>
Die	<p>Coverage for your enrolled Class I dependents, including Domestic Partner dependents and Class II dependent children, automatically continues for six months after you die, as long as your dependents' share of the cost continues to be paid. Alcatel-Lucent contributes toward the cost of this coverage for your Class I dependents who were Covered at the time of your death. After six months, your non-Medicare-Eligible Dependents (other than Class II dependents who are not children) 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.</p> <p>Class II dependents other than Class II dependent children aren't eligible to continue coverage under COBRA and are not eligible for any Company-paid coverage.</p> <p>Medicare-eligible Dependents should not enroll for COBRA to continue coverage; they can continue coverage through the FSP. For more information about COBRA and the Family Security Program (FSP), see Section J. Continuing Coverage. If your Dependents become Medicare-eligible while participating in COBRA,</p>

IF YOU...	THIS IS WHAT HAPPENS...
Die (cont'd.)	<p>they must contact the Alcatel-Lucent Benefits Center to terminate COBRA coverage and enroll in the FSP.</p> <p>At the end of the COBRA continuation period, your surviving Class I dependent may choose to continue coverage under the Traditional Indemnity option if he or she pays the full cost for this coverage under the FSP. Your spouse or Domestic Partner also may cover any Class I dependent children who were enrolled immediately before your death as long as they still qualify as eligible Class I dependents.</p> <p>As long as the required contributions are made under the Traditional Indemnity option, coverage may continue as follows:</p> <ul style="list-style-type: none"> • Spousal or Domestic Partner coverage may continue indefinitely; and • Dependent child coverage may continue until the earlier of the date that: <ul style="list-style-type: none"> — The spouse's or Domestic Partner's coverage ends, or — The dependent child ceases to be an Eligible Dependent under the Medical Plan. <p>For more information about the Traditional Indemnity option, see Section A. Medical Plan Benefits At-a-Glance and "Traditional Indemnity Option" in Section B. Joining the Medical Plan. Then, if necessary, 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.</p>

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. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET.

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.

When using the Your Benefits Resources (YBR) Web site at

<http://resources.hewitt.com/alcatel-lucent> to enroll online, be sure to print the "Completed Successfully" page, which will serve as your confirmation statement.

Medical Plan Contributions

Eligible Employees

You are required to contribute to the cost of healthcare coverage under the Medical Plan for yourself and your Covered Dependents. After you complete six months of Net Credited Service, the Company will pay for a portion of your coverage.

In most instances, your contributions are deducted from your paycheck on a pre-tax basis (that is, before taxes are deducted from your pay). Visit the Your Benefits Resources (YBR) Web site at <http://resources.hewitt.com/alcatel-lucent> or refer to your personalized enrollment worksheet for information about the current cost of your coverage. This amount will also appear on your pay statement as a deduction from your take-home pay.

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

Newly Hired Employees Who "Enroll Early"

If you choose to actively enroll before completion of six months of Net Credited Service, with limited exceptions, you are required to pay the full cost of the coverage you elect under the Medical Plan. In other words, Alcatel-Lucent will not contribute to the cost of your coverage until you complete six months of Net Credited Service.

Survivors

Please visit the YBR Web site at <http://resources.hewitt.com/alcatel%1elucent> or refer to your COBRA Enrollment Notice for details on the current cost of your coverage.

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

Under Internal Revenue Service (IRS) regulations, you contribute toward the cost of Medical Plan coverage on a pre-tax basis for yourself and for your family members other than your Domestic Partner or your Domestic Partner's children.

The same tax advantages do not currently apply when you cover your Domestic Partner or your Domestic Partner's children. Under current regulations, you cover them with after-tax contributions, and the amount of the Company's cost to cover them is reported as taxable income to you each month.

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

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

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
- HMO, if available in your area.

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 POS and Traditional Indemnity options available to you are based on your job or FSP classification and whether or not you live within a POS area, as shown below.

Job Classification	Available Medical Plan Options If You Live...	
	Within a POS Area	Outside a POS Area
Full-time or part-time active occupational employees*	<ul style="list-style-type: none"> • POS option 	<ul style="list-style-type: none"> • Traditional Indemnity option • Opt in to a nearby POS option
Survivors of occupational employees enrolled in the Family Security Program (FSP)	<ul style="list-style-type: none"> • Traditional Indemnity option 	

Note: If you live in an HMO area you will also be offered an HMO option.

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 will be required to pay each calendar year before the Medical Plan will begin to pay benefits for most Covered services. Up to three separate annual Deductibles may apply each year – medical, 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, and Chemical Dependency or prescription drugs) and whether care is received In-Network or Out-of-Network determines whether you must satisfy a particular Deductible before the Plan will pay benefits.

About the HFSA and DFSA Accounts. You may also elect to participate in one or both of the reimbursement accounts – the Health Care Flexible Spending Account (HFSA) and/or the Dependent Care Flexible Spending Account (DFSA). Both accounts allow you to set aside money, tax-free, for eligible expenses incurred during the calendar year and during the first two-and-a-half months of the next year.

While the DFSA is for tax-free reimbursements of Eligible Dependent care expenses, the HFSA is for the tax-free reimbursement of eligible healthcare expenses, such as:

- Deductibles and Copayments;
- Orthodontia, and
- Eyes examinations, frames and lenses not Covered by a vision plan.

There are individual, two-person and family Deductibles (for out-of-Network care in the POS).

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

Amount of Your Deductible
Your Deductibles are based on your Medical Plan option (see Section A. Medical Plan Benefits At-a-Glance for Deductible amounts).

- **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.

For example, let's say you're in the POS option. Your and your Covered Dependents' Out-of-Network Services are applied to their individual Deductibles as follows:

Enrolled Family Member	Amount of Covered Expenses Applies to Their Out-of-Network Individual Deductibles
You	\$ 500
Your Lawful Spouse	\$ 300
Child 1	\$ 400
Child 2	\$ 200
Child 3	\$ 400
Family Deductible Is Met	\$ 1,800

In the above example, none of your family members satisfied his or her individual Deductible of \$600, but together satisfied the family Deductible of \$1,800. This means that no further Annual Deductibles need to be satisfied under the POS option (not including Deductibles under the MH/CD Program and the Prescription Drug Program) for the remainder of the calendar year.

Please note: Separate annual Deductibles apply to Out-of-Network expenses under the Prescription Drug Program and the Traditional Indemnity Mental Health and Chemical Dependency (MH/CD) Program. For example, if you are in the POS option and you receive \$200 of eligible Out-of-Network services from your Physician, the \$200 will be applied to your \$600 POS Out-of-Network individual Deductible (if it has not already been satisfied), but the \$200 will not be applied to your Out-of-Network Prescription Drug Program or MH/CD Program Deductible. Your Deductible is based on your Medical Plan option (see Section A. Medical Plan Benefits At-a-Glance for Deductible amounts).

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 option, the Prescription Drug Program or the Mental Health and Chemical Dependency [MH/CD] Program). These expenses include:

- Charges for expenses that aren't Covered under your Medical Plan option, the Prescription Drug Program or the MH/CD Program (see **Section H. What's Not Covered**);
- Any charges above the Allowable Amount;
- Any penalties for not obtaining Precertification (see **Section F. When Precertification Is Required**); and
- Coinsurance for Out-of-Network services.

Prescription Drug Program Annual Deductible

The Prescription Drug Program includes a separate annual Deductible if you purchase prescription drugs from an Out-of-Network retail pharmacy under the POS or Traditional Indemnity option. This Deductible is separate from each Medical Plan option's annual Deductible for medical services and supplies and the MH/CD Program's Deductible (see "Annual Deductible" and "Mental Health and Chemical Dependency Program Deductible" in this section; see **Section A. Medical Plan Benefits At-a-Glance** for Deductible amounts).

Mental Health and Chemical Dependency Annual Deductible

The MH/CD Program includes a separate annual Deductible if you receive Out-of-Network MH/CD services under the POS or Traditional Indemnity option. This Deductible is separate from the Medical Plan option's annual Deductible for medical services and supplies and the Prescription Drug Program's Deductible (see "Annual Deductible" and "Prescription Drug Program Annual Deductible" in this section; see **Section A. Medical Plan Benefits At-a-Glance** for the Deductible amount).

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum amount you're required to pay each calendar year for Covered expenses. Separate Out-of-Pocket Maximums apply for your Medical Plan option, the Prescription Drug Program and the Mental Health and Chemical Dependency (MH/CD) 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, the Prescription Drug Program and the MH/CD Program. These include:

- Charges for expenses that aren't Covered under your Medical Plan option, the Prescription Drug Program or the MH/CD Program;
- 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 options. This Out-of-Pocket Maximum is separate from each Medical Plan option's Out-of-Pocket Maximum for medical services and supplies and the Mental Health and Chemical Dependency (MH/CD) Program's Out-of-Pocket Maximum (see "Out-of-Pocket Maximum" and "Mental Health and Chemical Dependency Program Out-of-Pocket Maximum" in this section; see Section A. Medical Plan Benefits At-a-Glance for the Out-of-Pocket Maximum amount).

Mental Health and Chemical Dependency Out-of-Pocket Maximum

The MH/CD Program has a separate Out-of-Pocket Maximum for In-Network and Out-of-Network Covered expenses under the POS and Traditional Indemnity options. This Out-of-Pocket Maximum is separate from each Medical Plan option's Out-of-Pocket Maximum for medical services and supplies and the Prescription Drug Program's Out-of-Pocket Maximum (see "Out-of-Pocket Maximum" and "Prescription Drug Program Out-of-Pocket Maximum" in this section; see **Section A. Medical Plan Benefits At-a-Glance** for the Out-of-Pocket Maximum amounts).

POS Option

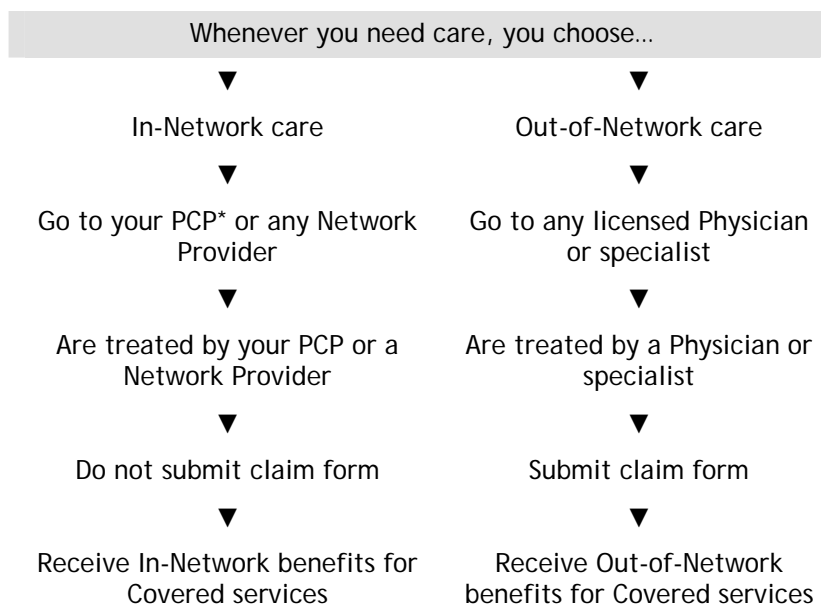
With the POS option, you have a choice each time you need medical care – you can receive In-Network or Out-of-Network care. When you receive In-Network care, your out-of-pocket costs are generally lower. In addition, the Medical Plan may cover certain preventive care services on an In-Network basis, 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 (Medco) and the 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:



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

In-Network Care: Generally Higher Benefits

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

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

If You Need Specialized Care

If you need specialized care that your Medical Plan option's Health Plan Carrier determines is Medically Necessary and is not available in your area, you'll be referred to a Non-Network Provider and benefits will be paid at the In-Network level. Contact your Health Plan Carrier for more information.

The Provider Network

The POS option makes available to you a Network of Providers — including Physicians, Hospitals, Home Healthcare 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** near the beginning of this summary plan description [SPD]). For example:

- Each year, in most cases, you'll be required to satisfy an annual Deductible before the Medical Plan begins to pay benefits.
- 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.
- 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 as follow:

January 1, 2011

Page 49

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

- 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 under the POS option; 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 O. Terms to Know**).

Receiving Care Away From Home

If you or a Covered Dependent needs care when away from home:

- Go to any Network Provider, and care will be Covered at In-Network benefit levels; or
- Go to any 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 P. Important Contacts**).

Call Member Services:

- To request a new Provider Directory or the latest information about Network Providers;
- To replace a lost medical ID card;
- To find out how a claim was paid;

January 1, 2011

Page 51

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

- If you have a service issue with a Network Provider;
- To find out how your Covered Dependent child away at college should obtain care;
- To get claim forms (generally only required for Out-of-Network care); and
- To obtain more detailed information about your benefit coverage.

Traditional Indemnity Option

The Traditional Indemnity option is available to occupational employees who live in a non-POS area.

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.

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 Web site at <http://resources.hewitt.com/alcatel-lucent>.

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

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

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

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

HMO 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 PCP

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.

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

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 (MH/CD) 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 summary plan description (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.

January 1, 2011

Page 55

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

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 your Health Plan Carrier. Call your Health Plan Carrier for additional information.

Chiropractic Services

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

- Neuromuscular treatment and manipulation to relieve pain or restore mobility by maladjustment of the muscles and ligaments associated with the spinal column; and
- Ordering Medically Necessary X-rays.

The following conditions of service apply to Covered chiropractic services:

- A Physician's referral is not required under the POS and Traditional Indemnity options.
- Coverage is provided only for treatment of musculoskeletal conditions — meaning conditions that are related to the muscles and ligaments. Conditions such as a stiff neck and lower back pain may be Covered. Conditions such as nausea and dizziness are **not** Covered for treatment with chiropractic services.
- Coverage is provided only for the treatment of an acute condition — that is, one that is currently causing pain or decreased mobility, and for which improvement can be measured in the short term. Periodic visits for preventive care or to maintain a current state of health are not Covered.
- Care must be provided in an office setting. Services are not Covered if provided in your home, or if delivered in a Hospital or other facility.
- A Chiropractor may order X-rays when Medically Necessary. However, any other tests (for example, a magnetic resonance image, or MRI) must be ordered through a Physician.
- Under the 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 also 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 Facility services are Covered under the POS and Traditional Indemnity options. Covered expenses include:

- Room and board in a semiprivate 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 Healthcare

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

- Speech Therapy, Physical Therapy and Occupational Therapy.
- Services of a registered nurse (RN), licensed nurse practitioner (LNP) or licensed vocational nurse (LVN).
- Services of a part-time home health aide who is not a nurse, but only if you also need the services of a professional nurse, a medical social worker, or a physical, occupational or speech therapist. Four hours of care provided by a part-time home health aide count as one home healthcare shift for purposes of the annual home healthcare visit limitation.
- Services of medical social workers.
- Medical supplies and equipment prescribed by your Physician.
- Laboratory services.
- X-rays and electrocardiograms.
- Drugs and medications administered to you by the Home 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:

January 1, 2011

Page 63

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

- 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 semiprivate room. If you request a private room, you must pay the difference in cost between a semiprivate 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 child birth by vaginal delivery or 96 hours following a cesarean section require precertification. (See "Newborn's and Mother's Protection Act" in Section Q. Other Important Information).

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

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 Primary Care Physician (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 Q. Other Important Information).
- Services of a Birthing Center instead of a Hospital.
- Services of a licensed midwife. A licensed midwife may bill as an independent Provider for services provided in the Hospital, Birthing Center or home, or provide services as part of a Birthing Center's services.
- Routine nursery care provided to the newborn during the mother's stay at the Hospital. 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 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 Q. Other Important Information);
- Surgery;
- Administration of anesthesia;
- Pathology (laboratory) services;
- Radiology (X-rays), chemotherapy, nuclear medicine, diagnostic ultrasound services and any imaging or scanning techniques;
- Services provided by the Physician's nursing staff;
- Preventive services (see "Preventive Care" later in this section); and
- Medical supplies such as casts and dressings provided as part of the Physician's services.

Podiatric Services

Covered podiatric services under the 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 option 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:

January 1, 2011

Page 70

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

- 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 Q. Other Important Information).

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

- The treatment must be to correct a condition that represents a serious malformation; and
- Treatment must be for the least expensive medically accepted procedure that will adequately restore the malformation.

Second Surgical Opinion

Second surgical opinions aren't required, but they are Covered under the 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 enrolled in the POS or 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).

How the Mental Health and Chemical Dependency Program Works

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);
- Masters degree level nurses; and
- Treatment facilities, such as Hospitals and Residential Treatment Facilities.

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.

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 (including Partial Hospitalization admissions), acute psychiatric facility, Residential Treatment facility, or acute Chemical Dependency facility and intensive outpatient care. (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:

- Semiprivate 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 semiprivate 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.

January 1, 2011

Page 75

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

Conditions of Coverage of Inpatient Care

The 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 lower 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, separate from the annual Deductible that applies under your Medical Plan option, if applicable, and the Prescription Drug Program Deductible;
- 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 after 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.

Amount of Coverage

See Section A. Medical Plan Benefits At-a-Glance for coverage amounts.

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 non-Emergency care provided overseas will be reimbursed at the In-Network level. You do not need to call your Health Plan Carrier.

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 (MH/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 Imposed If Precertification Procedures Are Not Followed" later in this section).

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 MH/CD Program.

If you don't obtain precertification when required, benefits will be reduced, or no benefits will be payable (see "Penalties Imposed 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 Q. Other Important Information**).
- Reconstructive procedures (see "The Women's Health and Cancer Rights Act of 1998" in **Section Q. Other Important Information**).
- Hospice.
- Dental (accident only).
- Durable medical equipment (such as prosthetic devices) over \$1,000.
- Medical injectables, including:
 - Intravenous immunoglobulin growth hormones (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.

Required Precertification 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	Timeframe 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 being 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 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.

<p>Mental Health Emergency For a Mental Health Emergency, you should call your Health Plan Carrier, if possible, before the admission; otherwise, within 24 hours of the admission.</p>
--

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 Mental Health and Chemical Dependency (MH/CD) Program, Extended Care Facility stays, home healthcare services and Private Duty Nursing are certified for a specific duration of time. Toward the end of the certified period, your Health Plan Carrier will follow up to see if your care will be completed as expected. If it's determined that treatment will take longer than originally expected, another review will be performed to determine whether an extension will be precertified. If an extension isn't 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 Option (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 Maximum.

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

January 1, 2011

Page 83

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

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 Point of Service (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 Enroll in Medicare Part D" in Section N. Events Affecting Coverage.)

If You're in an HMO

If you elect 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.

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 a 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:

- **Level One:** Generic;
- **Level Two:** Formulary Brand (less expensive category);
- **Level Three:** Formulary Brand (more expensive category); and
- **Level Four:** Nonformulary Brand.

January 1, 2011

Page 85

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

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 <http://www.medco.com> to locate a Participating Pharmacy;
- Check the list of Participating National Chain Pharmacies available from Medco; 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 or the Mental Health and Chemical Dependency (MH/CD) Program.

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 Web site at <http://www.medco.com> or by calling Medco at 1-800-336-5934.

Filling Prescriptions by Mail, Phone or Fax

Medco Pharmacy is a great way to fill prescriptions if you regularly take the same medication on an ongoing basis. Up to a 90-day supply is available.

You can 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 <http://www.medco.com>.

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 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 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.

<p>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 or the MH/CD Program.</p>
--

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 generic or 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 <http://www.medco.com>.

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 employees. 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 summary plan description (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 elect coverage under an 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 during the six-month period before the Effective Date of Plan coverage (even if an Inpatient stay in a Hospital or other facility continues after the Effective Date of coverage), provided that:
 - A Pre-Existing Condition limitation does not extend for more than 12 months (18 months in the case of a late enrollment date), and
 - The period of any such Pre-Existing Condition, as explained directly above, is reduced by any periods of creditable coverage (see "Creditable Coverage Certificates" in Section I. When Coverage Ends);
- Custodial Care (including convalescent homes and rest cures);
- Charges for non-treatment purposes, including court proceedings (for example, 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 which are the responsibility of a local, state or federal government agency to provide or cover;
- Charges another plan is required to pay;
- Charges third parties are required to pay;

- Capital improvements to your home as a result of a health condition, 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 semiprivate 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 (MH/CD) 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 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, 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 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 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 semiprivate 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;

January 1, 2011

Page 95

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

- Inpatient stays primarily for environmental change;
- Alternative Treatment facilities accessed or provided Out-of-Network;
- Conditions other than mental disorders 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;

January 1, 2011

Page 96

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

- 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 purposes; and
- Diabetic blood testing monitors.

Section I. When Coverage Ends

When Employee Coverage Ends

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

- Your employment with Alcatel-Lucent or a Participating Company terminates or you otherwise cease to be an Eligible Employee;
- You do not make a required contribution toward coverage under the Medical Plan;
- The company you work for 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 child reaches age 26, his or her coverage will end at the end of the month in which he or she reaches age 26. (For a Covered child of a Domestic Partner, coverage ends on December 31 of the year in which he or she reaches age 23.)
- If your Covered child's coverage ends for any reason other than reaching the limiting age, coverage for this child will end on the last day of the month in which the event occurs.
- If you and your Lawful Spouse divorce, your Lawful Spouse's coverage will end on the last day of the month in which the divorce becomes final.

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

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 the Limiting Age" in Section N. **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 (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.

<p>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.</p>
--

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.

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

Section J. Continuing Coverage

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

If This Qualifying Event Occurs...	COBRA Continuation Coverage Can Last For...
<ul style="list-style-type: none"> • Termination of your employment for any reason other than gross misconduct • A reduction in your work hours 	<p>Up to 18 months from the date of qualifying event.</p>
<ul style="list-style-type: none"> • Disability occurs prior to the 60th day of the COBRA continuation coverage period 	<p>The disabled person (or a dependent newly acquired by birth or adoption during the COBRA continuation coverage period) may extend continued coverage from 18 months to 29 months.</p> <p>To be eligible for the additional period of coverage, the disabled person must call the Alcatel-Lucent Benefits Center before the end of the initial 18-month period and within 60 days of receiving the notice of disability from the Social Security Administration.</p> <p>The individual must also notify the Alcatel-Lucent Benefits Center within 30 days after the Social Security Administration determines that he or she is no longer disabled.</p>
<ul style="list-style-type: none"> • Your divorce or legal separation • Termination of your Domestic Partnership • Your death • A child's loss of eligibility under the Medical Plan 	<p>Your Covered Dependents may elect COBRA continuation coverage for up to 36 months from the date of the qualifying event.</p>
<ul style="list-style-type: none"> • You become entitled to Medicare while you are an active employee and you later experience a termination of employment or reduction in work hours 	<p>You may elect COBRA continuation coverage for up to 18 months following the qualifying event.</p> <p>Your qualified beneficiaries may elect COBRA continuation coverage for up to 36 months from the date of Medicare entitlement.</p>
<ul style="list-style-type: none"> • You become entitled to Medicare after you elect COBRA continuation coverage (because of a termination of employment or reduction in hours) 	<p>Your COBRA continuation coverage will end on the date of your Medicare entitlement.</p> <p>Your Covered Dependents may be eligible for an additional 18 months of COBRA continuation coverage, for a total of 36 months of COBRA continuation coverage.*</p>

*Your Covered Dependents are eligible for an additional 18 months of COBRA continuation coverage if, assuming that the first qualifying event had not occurred, they would have lost coverage under the Medical Plan as a result of the second qualifying event.

How COBRA Continuation Coverage Is Affected by Multiple Qualifying Events

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

For example, suppose you terminate employment on December 31, 2011, and you are eligible to continue coverage for 18 months (until June 30, 2013). Your child, who is a Covered Dependent December 31, 2011, reaches age 26 (a second qualifying event) on December 31, 2012. Your child is then eligible for an additional 18 months of COBRA continuation coverage from the date of the original qualifying event. In this case, your child may continue coverage through December 31, 2014, which is 36 months from December 31, 2011, the date of your termination of employment (the original qualifying event).

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

Covering a Newborn or Newly Adopted Dependent

If, while you are enrolled in COBRA continuation coverage, you have a baby, legally adopt a child or a child is placed with you 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 you (or another qualifying beneficiary) pay the full cost for COBRA continuation coverage (that is, the employee contribution plus Company contribution, plus a two percent administrative fee).

If the COBRA continuation coverage period is extended to 29 months because of a disability, your COBRA continuation coverage premium will increase to 150 percent of the cost of coverage for active employees 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, you 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, you would pay 150 percent of the Plan’s cost of coverage monthly.

In some instances, a portion of your COBRA continuation coverage period may be subsidized by Alcatel-Lucent. For more information about the cost of COBRA continuation coverage during certain qualifying events, please refer to the information packet which is provided to employees who are part of an affected surplus universe.

Electing COBRA Continuation Coverage

Complete details about COBRA continuation coverage, including information about election and cost, are automatically sent to your preferred address if you (the employee):

- Terminate employment with the Company or a Participating Company;
- Experience a reduction in work hours;
- Become entitled to Medicare; or
- Die.

For certain qualifying events, information isn't automatically sent. It is your or your qualified beneficiary's responsibility to notify the Alcatel-Lucent Benefits Center at 1-888-232-4111 within 31 days of the occurrence of the following qualifying events:

- Divorce;
- Legal separation;
- A child no longer satisfying the Medical Plan's eligibility criteria; or
- The termination of a Domestic Partnership.

Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET.

Continuing Coverage for Dependents 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 (that is, the employee contribution and the Company contribution).

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 timeframe 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).

January 1, 2011

Page 105

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

- **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 timeframe 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 timeframe 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; 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.

As noted, depending on the benefits claim sub-type, 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

January 1, 2011

Page 107

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

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 timeframes 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; and
- A statement about the claimant's right to bring an action under Section 502(a) of 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

January 1, 2011

Page 109

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

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 timeframe, 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 timeframes 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

January 1, 2011

Page 112

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

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

January 1, 2011

Page 113

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

(see Section P. Important Contacts). (For information about the voluntary second-level appeal process for some claims, see “Independent Third Party Review” later in this section.)

Your appeal must be in writing and should be 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 timeframes:

- **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 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.

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 coverage is Medicare (see “Coordination of Benefits With Medicare” 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 and/or dependents of employees 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.

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 not have a COB feature, that plan is considered primary and the Medical Plan is considered 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.
- 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 Carrier 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 non-custodial 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.

Coordination of Benefits With Medicare

If you are actively employed and eligible for Medicare, the Medical Plan will provide primary coverage (that is, pay benefits first) and Medicare will provide secondary coverage (that is, pay benefits second) if you're enrolled. You should apply for Medicare Part A as soon as you become eligible and plan on securing Part B when you retire. When you are retired, long term disabled or participating in the Family Security Program (FSP), the Medical Plan becomes secondary and Medicare becomes primary.

Please note: Regardless of whether you elect to purchase Medicare Part B, if you are long term disabled or participating in the Family Security Program, 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

January 1, 2011

Page 119

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

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 do not enroll in Medicare Part A when you are first eligible, penalties and delays may apply when you later try to enroll for coverage.

The same rule applies, while you are actively employed, to your Covered Dependents who enroll in Medicare with the following two exceptions:

- First, Medicare will provide primary coverage to those individuals with end stage renal disease (ESRD) starting with the 31st month after the person contracted ESRD; and
- Second, Medicare is always primary for Class II Dependents who are Medicare-eligible.

If Medicare provides primary coverage, the Medical Plan (now secondary) will pay benefits for that person as if he or she were enrolled in the Traditional Indemnity option. In other words, if your Covered Dependent has had ESRD for over 30 months and is enrolled in a POS option. Medicare will pay benefits first and the POS Health Care Company paying claims will review the benefit schedule for the Traditional Indemnity option to see if any additional benefits are payable.

Section M. 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 N. Events Affecting Coverage

If You Change Your Job Classification

Since your Medical Plan options are based, in part, on your job classification, it's possible a change in your job classification may affect your coverage. However, you'll have access to all of the Medical Plan options available to you based on your new classification. If your current Medical Plan option isn't available to you under your new job classification, you should select one of the available Medical Plan options. If you don't elect a new Medical Plan option, you'll automatically be enrolled in your Default Option (see "Default Option" in Section B. **Joining the Medical Plan**). However, if you aren't eligible for a Default Option, you won't be enrolled in any Medical Plan option. This means you and your Dependents won't be Covered under the Medical Plan for the rest of the year, and you must wait until the next Annual Open Enrollment to enroll.

If You Live Within a Point of Service (POS) Area

If...	The Rule Is...
You change from full time (classified by the Company as more than 24 hours per week) to part time (classified by the Company as 17 through 24 hours per week)	You may choose any available option for the remainder of the Plan Year, and you may change your coverage category. If you do not elect coverage, you will be defaulted to the same coverage, but your monthly contribution for coverage may change. A confirmation statement with your cost information will be provided by the Alcatel-Lucent Benefits Center.

Section N. Events Affecting Coverage

If...	The Rule Is...
<p>You change from full time (classified by the Company as more than 24 hours per week) to part time (classified by the Company as less than 17 hours per week)</p>	<p>You may choose any available option for the remainder of the year, and you may change your coverage category.</p> <p>If you do not elect coverage, you will be defaulted to "No Coverage." If you do elect coverage, you will be responsible for the full cost of elected coverage for you and any Covered Dependents.</p> <p>A confirmation statement with your cost information will be provided by the Alcatel-Lucent Benefits Center.</p>
<p>You change from part time (classified by the Company as 24 or fewer hours per week) to full time (classified by the Company as more than 24 hours per week)</p>	<p>If you were enrolled in coverage, your current coverage option stays the same. You may change or decline coverage for the remainder of the Plan Year, and you may change your coverage category. If you make no election, the POS option will be assigned for the remainder of the Plan Year.</p> <p>If you elect coverage, you pay the required contribution for coverage. A confirmation statement with your cost information will be provided by the Alcatel-Lucent Benefits Center.</p>
<p>You change from occupational to management</p>	<p>You may elect to enroll in one of the Medical Plan options available to management employees in your geographic area. If you make no election, the POS option will be assigned for the remainder of the Plan Year.</p> <p>A confirmation statement with your cost information will be provided by the Alcatel-Lucent Benefits Center.</p>

If You Live Outside of a POS Area

If...	The Rule Is...
<p>You change from full-time (more than 24 hours per week) to part time (17 through 24 hours per week)</p>	<p>You may choose any available option for the remainder of the Plan Year, and you may change your coverage category.</p> <p>You will be defaulted to the same coverage, but your monthly contribution for coverage may change.</p> <p>A confirmation statement with your cost information will be provided by the Alcatel-Lucent Benefits Center.</p>

Section N. Events Affecting Coverage

If...	The Rule Is...
You change from full time (more than 24 hours per week) to part time (less than 17 hours per week)	<p>You may choose any available option for the remainder of the Plan Year, and you may change your coverage category.</p> <p>If you make no election, you will be defaulted to "No Coverage." If you do elect coverage, you will be responsible for the full cost of any elected coverage for you and any Covered Dependents. A confirmation statement with your cost information will be provided by the Alcatel-Lucent Benefits Center.</p>
You change from part time (24 or fewer hours per week) to full time (more than 24 hours per week)	<p>If you were enrolled in another Medical Plan option or not enrolled at all, you may enroll in any available Medical Plan option. If you make no election, the Traditional Indemnity option will be assigned for the remainder of the Plan Year.</p> <p>A confirmation statement with your cost information will be provided by the Alcatel-Lucent Benefits Center.</p>
You change from occupational to management	<p>You may elect to enroll in one of the Medical Plan options available to management employees in your geographic area. If you make no election, the POS option will be assigned.</p> <p>A confirmation statement with your cost information will be provided by the Alcatel-Lucent Benefits Center.</p>

If 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 Alcatel-Lucent occupational employees. 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 Medical Plan option. 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 "If Your Coverage Option Changes During the Year" in **Section B. Joining the Medical Plan.**

If You Become Disabled Due to a Sickness

If you become disabled due to a non-work-related sickness, you, your spouse and your Covered Dependent(s) will continue to be eligible for coverage under the Medical Plan for as long as you continue to receive sickness disability

January 1, 2011

Page 125

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

benefits under the Alcatel-Lucent Sickness and Accident Disability Benefits Plan (formerly called the Lucent Technologies Inc. Sickness and Accident Disability Benefits Plan [the "SADBP"]).

However, if at the time you become disabled, you are eligible for a service pension under the Lucent Technologies Inc. Retirement Plan or the Lucent Technologies Inc. Pension Plan, your, your spouse's and your Covered Dependent's(s') coverage under the Medical Plan will stop.

To continue to receive medical coverage under a Company-sponsored plan, you will need to retire (with a service pension) to begin coverage under the Alcatel-Lucent Medical Expense Plan for Retired Employees, and waive further coverage under the SADBP.

Similarly, if while you are receiving sickness disability benefits under the SADBP, you become service-pension eligible under the Lucent Technologies Inc. Retirement Plan or the Lucent Technologies Inc. Pension Plan, your, your spouse's and your Covered Dependent's(s') coverage under the Medical Plan will stop, and you will have to retire (with a service pension) to begin coverage under the Alcatel-Lucent Medical Expense Plan for Retired Employees, and waive further coverage under the SADBP to continue medical coverage under a Company-sponsored plan.

If You Terminate Employment

Your coverage under the active Medical Plan ends on the last day of the month in which your employment ends. Different rules apply if you retire (see "If You Retire" below).

When coverage ends, you may be eligible to continue coverage for yourself and your eligible Covered Dependents under COBRA. Following COBRA, conversion to an individual policy also may be available. For more information, see "COBRA Continuation Coverage" in **Section J. Continuing Coverage**.

If You Retire

If you retire with a service or disability pension, enrollment material and information about your coverage options will be sent to you at your preferred address.

If you don't enroll by the enrollment deadline, you'll automatically be enrolled in the Default Option that applies to you under the Alcatel-Lucent Medical Expense Plan For Retired Employees. No changes, other than qualified status changes (see "Changing Your Coverage During the Year" in **Section B. Joining the Medical Plan**), will be permitted until the next Annual Open Enrollment unless you become Medicare-eligible.

If you're Medicare-eligible and enrolled in the POS option when you retire, the default medical coverage will switch to the Traditional Indemnity option, with Medicare as the primary payor and your Alcatel-Lucent coverage as the secondary payor.

If you're Medicare-eligible and enrolled in the Traditional Indemnity option when you retire, you will continue with the same Carrier but with Medicare as the primary payor and your Alcatel-Lucent coverage as the secondary payor.

To continue coverage for a Domestic Partner or for children of a Domestic Partner, they must be currently enrolled in your active Medical Plan option when you retire. You cannot add another Domestic Partner after you retire.

When you retire, you also have the option to continue your active Medical Plan option coverage under COBRA.

Please note: Refer to the Alcatel-Lucent Medical Expense Plan for Retired Employees for more information about how Alcatel-Lucent-sponsored medical coverage works after retirement.

If You Become Disabled Due to a Work-Related Injury

If you become disabled due to a work-related injury, you, your spouse and your Covered Dependent(s) will continue to be eligible for coverage under the Medical Plan for as long as you continue to receive accident benefits under the Alcatel-Lucent Disability Benefit Plan (formerly called the Lucent Technologies Inc. Sickness and Accident Disability Benefits Plan) (the SADBP).

However, if at the time you become disabled you are already eligible for a service pension under the Lucent Technologies Inc. Retirement Plan or the Lucent Technologies Inc. Pension Plan, your, your spouse's and your Covered Dependent's(s') coverage under the Medical Plan will stop.

To continue to receive medical coverage under a Company-sponsored plan, you will need to retire (with a service pension) to begin coverage under the Alcatel-Lucent Medical Expense Plan for Retired Employees, and waive further coverage under the SADBP.

Similarly, if while you are receiving accident disability benefits under the SADBP you become service-pension eligible under the Lucent Technologies Inc. Retirement Plan or the Lucent Technologies Inc. Pension Plan, your, your spouse's and your Covered Dependent's(s') coverage under the Medical Plan will stop, and you will have to retire (with a service pension) to begin coverage under the Alcatel-Lucent Medical Expense Plan for Retired Employees, and waive further coverage under the SADBP to continue to receive medical coverage under a Company-sponsored plan.

If You Take an Approved Leave of Absence

Generally, you pay for part of your Medical Plan coverage during a leave of absence. There are exceptions, including care of a newborn, newly legally adopted child, a child legally placed with you for adoption and a leave under the Family and Medical Leave Act of 1993 (FMLA).

If you are eligible for an FMLA leave as described in "Family and Medical Leave" (see below), Alcatel-Lucent will comply with this legislation in providing you with unpaid leave.

Family and Medical Leave

If you are eligible under the Family and Medical Leave Act of 1993 (FMLA), Alcatel-Lucent provides you with unpaid leave for up to a total of 12 work weeks within a 12-month period for any of the following reasons:

- Birth of your child and to care for your newborn child;
- To care for your Lawful Spouse, Domestic Partnership Dependent, child or parent who has a Serious Health Condition;
- For a Serious Health Condition that makes you unable to perform the essential functions of your job; or
- Placement with you of a child for legal adoption or foster care and to care for the newly placed child.

In addition, in compliance with the National Defense Authorization Act of 2008, if you are an eligible employee, you can take up to 12 combined weeks of FMLA in a single 12-month period for a Qualifying Exigency to spend time with your spouse, child, or parent on active duty or notified of call to duty.

Also, if you are an eligible employee caring for your spouse, child, parent, or next of kin who is a recovering service member (meaning they have suffered a serious illness or injury sustained in the line of duty while on active duty, you can take up to 26 combined weeks of FMLA leave in a single 12-month period to care for the service member. The military caregiver leave described above does not limit the availability of FMLA leave for other purposes during the other 12-month period.

You are eligible if you have worked for the Company for at least one year and had at least 1,250 hours of service over the previous 12 months. You may be required to provide advance leave notice and medical certification.

Taking a leave may be denied if the following requirements are not met:

January 1, 2011

Page 128

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

- You ordinarily must provide 30 days' advance notice when your leave is "foreseeable."
- To determine if your absence due to a serious health condition qualifies as an FMLA leave, you must provide certain information. Alcatel-Lucent may require second or third opinions (at the Company's expense) and a fitness for duty report to return to work.
- During the FMLA leave, the Company must maintain your health coverage for up to 12 weeks of leave (and contribute up to the amount normally paid by the Company, under the same terms and conditions as apply to active employees who are not on an FMLA leave). You must continue to pay any required employee contributions in order to continue coverage.
- Upon return from an FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other terms and conditions of employment.
- The use of an FMLA leave cannot result in the loss of any employment benefit that accrued before the start of your leave.

The FMLA makes it unlawful for any employer to:

- Interfere with, restrain or deny the exercise of any right provided under the FMLA; or
- Discharge or discriminate against any person for opposing any practice made unlawful by the FMLA or for involvement in any proceeding under or relating to the FMLA.

The FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights.

Military Leave

Health Coverage Continuation Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If you are absent from work because of your service in the uniformed services (including Reserve and National Guard duty), you may choose to continue health coverage (that is, medical, dental and vision) for yourself and your Eligible Dependents under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). The period of coverage for you and your Eligible Dependents ends on the earlier of:

Be Sure to Notify Your Human Resources Department

You must notify your local Human Resources department that you will be absent from employment due to military service (unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable). You also must notify your local Human Resources department that you want to elect continuation coverage for yourself and/or your Eligible Dependents under the USERRA provisions.

- The end of the five-year period starting on the day your military leave of absence begins.
- The day after the day on which you are required to, but do not, apply for or return to work. Under USERRA, you must apply to return to work within different time periods – depending on the duration of your uniformed service:
 - **If your uniformed service is less than 31 days:** You are generally required to apply to return to work on the first full calendar day of the first full scheduled work period following your period of uniformed service. (Your period of uniformed service ends after you return from your place of service to your residence.)
 - **If your uniformed service is between 31 and 180 days:** You are generally required to apply to return to work within 14 days of your discharge.
 - **If your uniformed service is at least 181 days:** You are generally required to apply to return to work within 90 days of your discharge.

Your contributions for coverage will be based on the active rates during your military leave under USERRA.

- **If your military service is 31 days or less:** You are required to pay no more than your usual share of the cost for this period of coverage.
- **If your military service is more than 31 days:** You must pay the entire cost of the coverage (not to exceed 102 percent of the applicable premium similar to the manner in which the cost for COBRA continuation coverage is calculated).

If You Are Laid Off

If you are laid off, you will be able to continue Medical Plan coverage through COBRA (see “COBRA Continuation Coverage” in **Section J. Continuing Coverage**). Depending upon your years of service and the type of layoff, part of your cost for COBRA coverage may be paid by the Company. Your Force Adjustment package will provide the details.

If You Get Married or Enter Into a Domestic Partnership

If you get married or enter into a Domestic Partnership, you may enroll your Lawful Spouse or Domestic Partnership Dependent in the Medical Plan if you do so within **31 days of the date he or she became your Eligible Dependent**. Contact the Alcatel-Lucent Benefits Center at 1-888-232-4111 for additional

information. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET.

If you enroll your Lawful Spouse or Domestic Partnership Dependent within the specified timeframe, he or she will be Covered under the Medical Plan no later than the first day of the calendar month following the month in which the request for enrollment is received by the Alcatel-Lucent Benefits Center.

If a Dependent Loses Eligibility

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

If Your Physically or Mentally Handicapped Child Reaches the Limiting Age

If your physically or mentally handicapped child is incapable of self support when he or she reaches age 26 (or as of December 31 of the year in which a child of your Domestic Partner reaches age 23) , coverage may be continued beyond that age, if the child is fully dependent on you for support and maintenance at that time. You must apply for this coverage. It's not automatic. To apply for coverage, contact your Health Plan Carrier at the phone 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 the child beyond age 26 (or beyond December 31 of the year in which a child of your Domestic Partner reaches age 23).

If You or a Covered Dependent Becomes Eligible for Medicare

Medicare, a federal health insurance program that covers people age 65 and older (as well as some disabled people under age 65), provides benefits whether you are still working or retired. Generally, when you or a Covered Dependent reaches age 65, that person becomes eligible for Medicare.

To enroll for Medicare, you should contact your Social Security office at least three months before you or your spouse reaches age 65. If you are still actively employed, for maximum benefits you should enroll for Part A as soon as you become eligible. If you are retired, long term disabled or in the Family Security Program (FSP) you should enroll for both Parts A and B as soon as you become eligible.

You or your Dependent may also be eligible for Medicare before age 65 due to disability. In this case, it is important to enroll for Medicare as soon as possible.

Generally, three parts of the Medicare program impact Medical Plan coverage for Medicare-eligible persons:

- 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's fees, Outpatient services and many other services and supplies not Covered under Medicare Part A.
- Medicare Part D, prescription drug coverage, helps pay for prescription drugs.

When the Medical Plan Coordinates Benefits With Medicare

While you are actively employed, this Plan will be primary (pay benefits first) for Medicare-eligible employees and their Dependents, except for those who have end stage renal disease (ESRD) for more than 30 months. In those cases, Medicare will be primary after the initial 30-month period.

For Medicare-eligible participants and/or Dependents on Long Term Disability (LTD), Medicare will be primary (pay benefits first) and Alcatel-Lucent coverage will be secondary. Any Medicare-eligible LTD participant and/or Dependent of an LTD participant will receive Traditional Indemnity level benefits.

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.

If You or a Covered Dependent Becomes Medicare-Eligible While You're Actively Employed

If you are actively employed and Medicare-eligible (or if you are the spouse of an active employee who is Medicare-eligible), your Medical Plan will pay benefits first and Medicare will pay benefits second. The same rule applies to your Covered Class I Dependents who become Medicare-eligible, except for those with end stage renal disease (ESRD) beyond 30 months. Medicare is primary after 30 months. However, Medicare is always the primary plan for Class II Dependents who are Medicare-eligible.

- If you are enrolled in the POS option, the POS option continues to cover you and your Dependents not eligible for Medicare. However, the Medical Plan works differently for the Dependents eligible for Medicare due to ESRD:
 - Medicare becomes the primary payer for that person; and
 - The Alcatel-Lucent Medical Plan coverage (now secondary) for that person will be paid as if that person were enrolled in the Traditional Indemnity option. In other words, Medicare will pay first, then your Health Plan

Carrier will review the benefit schedule for the Traditional Indemnity option to see if any additional benefits are payable.

- If you are enrolled in the Traditional Indemnity option, the Medicare-eligible person will continue in the Traditional Indemnity option (regardless of age), with the Medical Plan as primary payer and Medicare paying benefits second.

If you're enrolled in an HMO option, see your HMO for details.

Please refer to the SPD for the Alcatel-Lucent Technologies Inc. Medical Expense Plan for Retired Employees for information about how Alcatel-Lucent-sponsored medical coverage works after retirement.

If You Enroll in Medicare Part D

If you are a long term disabled, survivor in the Family Security Program (FSP) or a Class II dependent who enrolls in a Medicare Part D Prescription Drug Plan (not sponsored by Alcatel-Lucent), you are making the choice to opt out of Alcatel-Lucent's Prescription Drug Program. This means:

- The Plan will not pay any prescription drug benefits – even if the Medicare Part D coverage doesn't pay any benefits for a prescription drug claim.
- You or your Class II dependent will need to begin paying premiums to the Medicare Part D insurer – unless you or he or she qualifies for low-income assistance.
- Your contributions for coverage under the Medical Plan will not be adjusted. You will continue to pay the same contributions as someone who still has complete prescription drug coverage under the Medical Plan.
- Your Medical Plan prescription drug coverage through Medco will no longer pay any portion of your or your Class II dependent's prescription medication, but will continue to cover any dependents not eligible for Medicare who are enrolled in the Medical Plan or any Medicare-eligible dependents who have not enrolled in a Medicare Part D Prescription Drug Plan.

Enrolling and Disenrolling in Medicare Part D

In most cases, a Plan participant can only enroll in or disenroll from a Medicare Part D Prescription Drug Plan during the Medicare Part D open enrollment period (held annually from November 15 through December 31). To determine if an exception applies, contact Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY:1-877-486-2048).

Reinstating Medical Plan Prescription Drug Coverage

If you or your Class II dependent Covered in the Medical Plan enrolls in a Medicare Part D Prescription Drug Plan (not sponsored by Alcatel-Lucent) and wants to reinstate your or his or her Medical Plan prescription drug coverage, you or your Covered Dependent must disenroll from the Medicare Part D Prescription Drug Plan by contacting that plan directly to disenroll.

January 1, 2011

Page 133

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

Please note: Medical Plan prescription drug coverage will not be reinstated until the first day of the month in which the disenrollment from Medicare Part D becomes effective. In addition, other requirements may apply.

For Questions About Medicare or Medicare Part D

Contact Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048) to speak with a customer service representative or visit Medicare's Web site at <http://www.medicare.gov>.

Questions About Medicare Part D Enrollment's Impact on Your Medical Plan Coverage

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.

Please note: Alcatel-Lucent Benefits Center representative do not have information about Medicare Part D providers who are sponsoring Medicare Part D Prescription Drug Plans nor can they advise you about which coverage to choose.

If You Die

Coverage for your enrolled Class I Dependents, Domestic Partnership Dependents, and Class II Dependents may continue at the active 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 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 or Domestic Partner may choose to enroll in the Family Security Program (see "Continuing Coverage for Dependents Through the Family Security Program [FSP]" in **Section J. Continuing Coverage**).

January 1, 2011

This information is intended for active occupational employees who are covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

If Your Move Requires a Change in Your Medical Plan Option

If your move requires that you change your Medical Plan option and you do not make a selection within the required time, you will be enrolled in the Default Option for that area.

If You Move

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

How a Move Affects Your Healthcare Options

If...	And You Move...	The Rule Is...
You are enrolled in the POS option	Into another area where your Health Plan Carrier administers the POS option	You stay in the POS option and keep the same Health Plan Carrier.
You are enrolled in the POS option	Into an area where a different Health Plan Carrier administers the POS option	You stay in the POS option, but you transfer to the Health Plan Carrier that administers the POS option in that area. You can select a new Primary Care Physician (PCP).
You are enrolled in the POS option	Into an area where the POS option is not available	You may select one of the options available (Traditional Indemnity or an HMO, if available) in your new area. An opt-in POS option also may be available. If you make no election, the Traditional Indemnity option will be assigned. Your Health Plan Carrier will change, as applicable.
You are outside a POS Network area and are enrolled in the Traditional Indemnity option	Into a POS Network area	You may select one of the options available in your new area – either the POS option or an HMO, if available. Your Health Plan Carrier may change, depending on your election and on which Health Plan Carrier administers your selection in your new area.

Please note: If 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.

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

Declining Coverage

You can decline coverage under the Medical Plan. However, unless you have a Qualified Status Change you must wait until the next Annual Open Enrollment if you want to re-enroll.

Section O. Terms to Know

There are several words and phrases that have specific meanings under the Medical Plan. This section explains those terms so you can better understand your benefits. These terms are printed in initial capital letters when they appear to let you know they'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 Traditional Indemnity option or the Mental Health and Chemical Dependency 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 Charges 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 Charges do not apply toward the annual Deductible or the Out-of-Pocket Maximums 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 (DC) who is licensed to provide services in the state where the service is rendered.

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

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

Coinsurance: the cost-sharing method through which the Medical Plan pays a percentage of the Provider's Covered charge (for example, 75 percent) and you pay a percentage (for example, 25 percent). Your Coinsurance is your share of the cost.

Company: Alcatel-Lucent.

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 depend 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 Mental Health and Chemical Dependency Program and Prescription Drug Program Out-of-Network benefits under the POS option and the Traditional Indemnity option.

Default Option: the Medical Plan option you are assigned automatically upon the completion of six months of Net Credited Service if you are an Eligible Employee and have not actively enrolled in the Medical Plan. Some Eligible Employees are not assigned a Default Option; these Eligible Employees must actively enroll in the Medical Plan to have coverage after completing six months of Net Credited Service.

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 partner, up to the end of the year in which the child reaches age 23 or marries, whichever occurs first, 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 Employee: a regular, active full-time or part-time occupational employee who works for Alcatel-Lucent or a Participating Company.

Please note: Individuals who are not paid from the U.S. payroll of the Company or a Participating Company, who are employed by an independent company (such as an employment agency) or whose services are rendered pursuant to an agreement excluding participation in benefit plans are not eligible to participate in the Medical 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.);

January 1, 2011

Page 142

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

- Colds, sore throat and cough;
- Diarrhea;
- Earaches;
- Minor cuts;
- Moderate fever;
- Rashes;
- Sprains; and
- Vomiting.

Experimental or Investigational (Treatment, Drug or Device): medical, surgical and psychiatric procedures and treatments, devices 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 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 active 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 P. Important Contacts).

Generic Drug: a drug that does not bear the trademark of the original manufacturer. It is chemically identical to, and generally costs less than, a Brand-Name Drug.

Group Home(s) and Halfway House(s): settings for care that are Covered under the In-Network benefits of the Mental Health and Chemical Dependency Program. Group Homes and Halfway Houses are residences that:

- Provide a structured living environment;
- Deliver treatment from Mental Health and Chemical Dependency Professionals; and
- Afford the patient opportunities to make the 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 Care Flexible Spending Account (HFSA): an account you may elect to establish when you first become eligible to do so, or during Annual Open Enrollment, for a calendar year. This account allows you to set aside money from each paycheck, on a before-tax basis, to pay eligible healthcare expenses.

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.

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 either be an agency that performs its services in the patient's home or a facility in 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 (MH/CP) 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 or 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 for at least 18 hours (out of 24) 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 Employee 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 “Medical 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.

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;

January 1, 2011

Page 146

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

- 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.

Net Credited Service: your current continuous service plus all service credited under the service bridging rules (including mandatory portability, if applicable) of the Lucent Technologies Inc. Retirement Plan.

Network: the Providers in a given area who have signed a contract to participate with the Health Plan Carrier and offer their 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 in 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 Mental Health and Chemical Dependency (MH/CD) Program, it means obtaining services from a Provider who does not participate in the MH/CD Program.

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 which provides such care.

Outpatient Facility: any medical diagnosis or treatment facility which:

- 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;

January 1, 2011

Page 148

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

- 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 facility. The facility must have both Physicians and nurses on staff and be authorized to administer medications. Partial Hospitalization is typically a less intense level of care than Inpatient care, but 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(ies): a pharmacy that is a Medco Participating Pharmacy under the Prescription Drug Program.

PCP: see "Primary Care Physician."

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 (D.O.) 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

January 1, 2011

Page 149

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

a psychiatrist or another Provider who is certified in the treatment of mental health and/or Chemical Dependency.

Plan Year: a 12-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 eligible 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 offered under the Traditional Indemnity option 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 under the POS or Traditional Indemnity option) to provide your primary healthcare and coordinate 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 an Eligible Employee's child and that has been determined by the Health Plan Carrier Claims Administrator to be qualified under ERISA.

Qualifying Exigency: includes the following:

- Short-notice deployment;
- Military events and related activities;
- Child care and school activities;
- Financial and legal arrangements;
- Counseling;
- Rest and recuperation;
- Post-deployment activities; and
- Additional activities related to the active duty or call to duty, and for which the leave is agreed to by the Company.

Reasonable and Customary Charge: the fee determined by the Claims Administrator on the basis of:

- The fees usually charged to most patients for a similar service; and
- The range of fees charged by Providers with similar training and experience for the same or similar services within the geographic region.

Rehabilitation Therapy: services provided by a physical therapist, speech therapist or occupational therapist. Rehabilitation services may be provided in a Hospital, 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.

Serious Health Condition: an illness, injury, impairment or physical or mental condition that involves either any period of incapacity or treatment connected with inpatient care in a Hospital, Hospice or residential medical care facility, and any period of incapacity or subsequent treatment in connection with the inpatient care; or continuing treatment by a health care provide which includes any period of incapacity due to any of the following:

- A health condition (including prior treatment and recovery) lasting more than three consecutive days, and any subsequent treatment or period of incapacity relating to the same condition that also includes:
 - Treatment of two or more times by or under the supervision of a healthcare Provider (both visits must occur within 30 days of the start of the incapacity, and the first visit must occur within seven days of the first day of incapacity, or
 - One treatment by a healthcare Provider with a continuing regimen of treatment (the first and only visit must occur within seven days of the first day of incapacity).
- Pregnancy or prenatal care. A visit to the healthcare Provider is not necessary for each absence.
- A chronic, serious health condition which continues over an extended period of time, requires periodic visits to a healthcare Provider (at least two visits per year), and may involve occasional episodes of incapacity. A visit to a healthcare Provider is not necessary for each absence.
- A permanent or long-term condition for which treatment may not be effective (only supervision by a healthcare Provider is required, rather than active treatment).
- Any absences to receive multiple treatments for restorative surgery or for a condition which would likely result in a period of incapacity of more than three days if not treated.

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

January 1, 2011

Page 152

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

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" 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 to 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™ is a trademark of Hewitt Associates LLC.

Section P. IMPORTANT CONTACTS

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

WHERE	WHAT YOU WILL FIND:
Alcatel-Lucent Resources	
<p>http://resources.hewitt.com/alcatel-lucent</p> <p>24 hours a day, except on Sunday between midnight and 1:00 p.m., ET</p>	<p>The Your Benefits Resources (YBR) Web site</p> <ul style="list-style-type: none"> • 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
<p>1-888-232-4111</p> <p>(1-212-444-0994 if calling from outside of the United States, Puerto Rico or Canada)</p> <p>Standard hours: Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET</p> <p>Extended hours during the annual open enrollment period: Monday through Friday, from 9:00 a.m. to 6:00 p.m., ET</p>	<p>Alcatel-Lucent Benefits Center</p> <ul style="list-style-type: none"> • <i>If you do not have Internet access:</i> <ul style="list-style-type: none"> — 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: <ul style="list-style-type: none"> — Imputed income applies — You or your Eligible Dependent(s) will become Medicare-eligible due to a disability

Section P. Important Contacts

WHERE	WHAT YOU WILL FIND:
www.benefitanswersplus.com	<p>The Alcatel-Lucent BenefitAnswers Plus Web Site</p> <ul style="list-style-type: none"> • 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	
<p>http://www.aetna.com</p> <p>1-800-872-7136</p>	<p>General Information About Your Coverage</p> <ul style="list-style-type: none"> • Understand how Aetna medical coverage works • Access claims information • Find a Provider <p>Aetna Behavioral Health</p> <ul style="list-style-type: none"> • Understand how your mental health and Chemical Dependency coverage works • Access claims information • Find a Provider
<p>www.aetna.com</p>	<p>Aetna Navigator Tools</p> <ul style="list-style-type: none"> • Review plan, benefits and claims information • Find a Network-participating doctor or dentist • Access sources of health information, such as: <ul style="list-style-type: none"> — Aetna IntelliHealth[®], 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 <p>Aetna DocFind</p> <ul style="list-style-type: none"> • Find a Provider (including cancer specialists) in the Aetna POS Network (choose “Aetna Choice POS II [Open Access]” under “Aetna Open Access Plans”)
<p>www.aetna.com</p> <p>To enroll, or for members or their obstetrical healthcare professional:</p> <p>1-800-CRADLE-1 1-800-272-3531</p>	<p>Beginning Right Maternity Program</p> <ul style="list-style-type: none"> • Tools and services for expectant parents, including: <ul style="list-style-type: none"> — 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

Section P. Important Contacts

WHERE	WHAT YOU WILL FIND:
<p>1-800-556-1555 (24 hours a day, 365 days a year)</p>	<p>Aetna Informed Health® Line</p> <ul style="list-style-type: none"> • 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	
<p>www.myuhc.com</p> <p>User ID: ALU Password: ALU</p> <p>POS: 1-800-577-8539</p> <p>Traditional Indemnity: 1-800-577-8567</p>	<p>General Information about your coverage and dedicated Customer Care (Member Services)</p> <ul style="list-style-type: none"> • 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
<p>www.myuhc.com</p> <p>1-866-444-3011 (24 hours a day, seven days a week)</p>	<p>UnitedHealthcare Optum® NurseLineSM and Live Nurse Chat</p> <ul style="list-style-type: none"> • 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
<p>www.urncrs.com</p> <p>1-866-936-6002 (7:00 a.m. to 7:00 p.m., Central Time [CT], Monday through Friday, excluding holidays)</p>	<p>UnitedHealthcare Cancer Resource Services (CRS)</p> <ul style="list-style-type: none"> • Get information regarding a cancer diagnosis and treatment • Find cancer centers or Physicians
<p>www.healthy-pregnancy.com</p> <p>1-800-411-7984</p>	<p>Healthy Pregnancy Program</p> <ul style="list-style-type: none"> • 24-hour access to experienced maternity nurses • Education and support for women through all stages of pregnancy and delivery
<p>www.urncrs.com (click on the "Congenital Heart Disease" link or call the phone number on the back of your medical ID card)</p>	<p>Congenital Heart Disease Program (CHD)</p> <ul style="list-style-type: none"> • Clinical consultants can provide information to assist parents, family members, case managers and Physicians in making decisions about congenital heart disease

Section P. Important Contacts

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 <ul style="list-style-type: none"> • 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 Traditional Indemnity: 1-800-577-8567	UnitedHealthcare Behavioral Health <ul style="list-style-type: none"> • Understand how your mental health and Chemical Dependency coverage works • Access claims information
Mayo Clinic	
www.alcatel-lucenthealth.com	Mayo Clinic EmbodyHealth Web Site <ul style="list-style-type: none"> • Access valuable Web-based health programs and tools all year
Medco Prescription Drug Coverage (does not apply to HMO coverage)	
www.medco.com 1-800-336-5934	Medco Health Solutions <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Determine if your medications are eligible for an additional discount through mail order • 24/7 access to specialist pharmacists

Section P. Important Contacts

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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Not a representative of the Alcatel-Lucent Medical Plan • Assists current and former union members
HMO (see carrier contact information on next page)	
Contact information is also available: <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Understand how your HMO coverage works • Access claims information

Section P. Important Contacts

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	
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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 1-800-632-9700 • Colorado Springs: 1-888-681-7878 		
Kaiser Permanente of Georgia	<ul style="list-style-type: none"> • 1-888-865-5813 • Local: 1-404-261-2590 		
Kaiser Permanente of Hawaii	<ul style="list-style-type: none"> • Oahu: 1-808-432-5955 • Other Islands: 1-800-966-5955 		
Keystone Health Plan Central	<ul style="list-style-type: none"> • 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	

January 1, 2011

Page 159

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

Section Q. Other Important Information

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

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).

Plan Documents

This summary plan description (SPD) 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 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 collective 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.

January 1, 2011

Page 161

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

Plan Administrator and Claims Administrator

The Plan Administrator and the Health Plan 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 on the following page).

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 Health Plan Carrier 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 Occupational 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: <ul style="list-style-type: none">• Aetna (POS option);• UnitedHealthcare (POS and Traditional Indemnity options);• Medco Health Solutions (Prescription Drug Program);

January 1, 2011

Page 163

This information is intended for active occupational employees who are Covered under the Represented Occupational Employee Design of the Alcatel-Lucent Medical Expense Plan for Occupational Employees. More detailed information is provided in the official Plan document, which is controlling.

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	503
Employer Identification Number	22-3408857

Section R. 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, such as worksites and union halls, 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 to learn about the rules governing your COBRA continuation coverage rights.

- Receive, free of charge, a Certificate of Creditable Coverage from the Medical Plan when you, your spouse or your Dependents lose coverage under the Medical Plan or become entitled to elect COBRA Continuation Coverage under the Medical Plan, or when your, your spouse's or your Dependents' COBRA Continuation Coverage ends, if you request it before losing coverage (or up to 24 months after losing coverage).

Please note: Without evidence of creditable coverage, if you enroll in another plan, you, your spouse and your Dependents may be subject to a Pre-Existing Condition exclusion for 12 months (18 months for late enrollees) after enrolling in the other plan.

In addition to establishing rights for Medical Plan participants, ERISA imposes certain duties on the people responsible for the operation of the 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 prevent 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 (EBSA), 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 NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272 or by logging on to the Internet at <http://www.dol.gov/ebsa>.