Alcatel-Lucent Dental Expense Plan for Active Employees

Summary Plan Description — Represented Occupational Employees

January 2011

Disclaimer

This is a summary of the benefits offered to eligible represented occupational employees under the Alcatel-Lucent Dental Expense Plan for Active Employees ("Dental 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 Dental Plan document.

This summary is based on Dental 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 Dental Plan, the Dental 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 Dental 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 K. Important Contacts**). Because of the many detailed provisions of the Dental 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 Dental Plan document, the Dental Plan document will govern.

The Company expects to continue the Dental Plan, but reserves the right to amend or terminate the Dental 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 dental 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.

Please note: Participation in the Dental Plan is neither an offer nor a guarantee of future employment.

Introduction

Grandfathered Status

Notice is hereby given of the Dental 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 Dental Plan is complying with this requirement effective January 1, 2011) and generally may not impose "lifetime" limits on essential benefits (the Medical Plan meets this requirement; however, dental benefits bundled with the Medical Plan are not considered "essential" benefits). On the other hand, grandfathered health plans are not required to provide coverage for "preventive" health services without cost-sharing (the Dental Plan may impose 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 Dental Plan Options

The Dental Plan is designed to promote good dental health for you and your Eligible Dependents. The Company offers a choice of Dental 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 Dental Plan. These words and phrases, which are printed in initial capital letters in this SPD, are defined in **Section J. Terms to Know**.

These Dental Plan options are:

- The Traditional option[1]; or
- The DMO® option[2].

Not all options are available in all geographic regions. For more information about the DMO® option (including availability in your area) or to switch to the DMO® option, contact the DMO® carrier directly. Note: The DMO® option will not appear as a coverage option in your enrollment materials. You must first be enrolled in the Traditional option before you can switch to the DMO® option.

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 Dental Plan, please review this summary of the options available to you, what services are Covered and how to access those services.

[1] The Traditional option is administered by Aetna Life Insurance Company.
[2] DMO® is a service mark of Aetna, Inc., registered in the U.S. Patent and Trademark Office. The DMO® is underwritten by Aetna Life Insurance Company, Aetna Dental of California Inc. (California), Aetna Dental Inc. (Texas), Aetna Dental Inc. (New Jersey), Aetna Dental Inc. (North Carolina) and/or Aetna Health Inc. (Arizona) (collectively, "Aetna").

Section A. Dental Plan Benefits At-a-Glance

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

General Plan Information Chart

Dental Plan Feature	Summary
Eligibility	If you're a regular, active (full-time or part-time) represented occupational employee of the Company or a Participating Company with at least six months of Net Credited Service, you are eligible to enroll in the Dental Plan. You may also enroll your Eligible Dependents under the same coverage option that you choose for yourself.
Enrollment	**Non-Communication Services Installers:** If you're a *full-time* Eligible Employee, you are automatically Covered under the Traditional option on the first day of the month in which you attain six months of Net Credited Service. You must actively enroll your Eligible Dependents. If you're a *part-time* Eligible Employee, you only need to enroll for coverage if you were hired *on or after* January 1, 1981 and you work *less than* 25 hours per week. If you decide to enroll, coverage for you and your Eligible Dependents can begin on the first day of the month in which you attain six months of Net Credited Service provided you have properly enrolled (see "Special Note for Part-Time Employees"). **Communication Services Installers:** If you're a full-time or part-time Eligible Employee, you must actively elect coverage for you and your Eligible Dependents. Coverage is effective on the first day of the month in which you attain six months of Net Credited Service. If you're a newly hired, regular, active full-time or part-time represented occupational employee and you were Covered as an Eligible Dependent of another Alcatel-Lucent employee on the day immediately before your date of hire, you are eligible to remain in the Dental Plan as a Dependent on your first day of active service with a Participating Company.

Dental Plan Feature	Summary
Informational Resources and Important Contacts	Call your Dental Plan Carrier for information about Covered services or predetermination of benefit requirements. For questions about eligibility or your benefit options, log on to the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent. Information is also available 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). If you are hearing or speech impaired, please use a Relay Service when calling a representative.

Dental Benefits Chart

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

Feature	Traditional Option*	DMO® Option (Participating Providers)**
Diagnostic and Preventive Care (for example: exams, cleanings and routine x-rays	100% of reasonable and customary (R&C) fees	100%
Minor Restorative Services (for example: fillings)	Based on a geographic schedule	100%
Major Restorative Services (for example: crowns)	Based on a geographic schedule	75%
Orthodontia	Based on a geographic schedule	50%
Orthodontia Lifetime Maximum	$1500/individual	Generally not applicable
Deductible	Lifetime deductible of $50/individual	Generally not applicable
Annual Maximum Benefit	$1,500/individual	Generally not applicable

* See "Appendix A" for more details on expenses Covered under the Traditional option.

**See "Appendix B" for more details on expenses Covered under the DMO® option. If you visit a non-participating dentist after you enroll in the DMO® option, your benefit will generally be lower since it will be limited to a specific dollar amount.

Section B. Joining the Dental Plan

Who Is Eligible

If you are an Eligible Employee **(a regular, active full-time or part-time represented occupational employee of a Participating Company with at least six months of Net Credited Service)**, you and your Eligible Dependents are eligible to participate in the Dental Plan.

> ***Please Note:*** Individuals who are not paid from the U.S. payroll of 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 Dental Plan.

Enrollment/When Coverage Begins

Non-Communication Services Installer

If you are a *full-time* Eligible Employee, you are automatically Covered under the *Traditional* option on the first day of the month in which you attain six months of Net Credited Service (see "Who Is Eligible"). You don't need to enroll for this option. However, for benefits to be paid for your Eligible Dependents, you must enroll your Eligible Dependents by calling the Alcatel-Lucent Benefits Center at 1-888-232-4111 or by logging on to the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent (see **Section K. Important Contacts**). You may switch to the DMO® option at any time after your coverage begins (see "Switching Between the Options") by contacting Aetna (see **Section K. Important Contacts**).

Automatic coverage also applies for certain *part-time* Eligible Employees. You will only need to enroll for coverage if you were hired *on or after* January 1, 1981 and you work *less than* 25 hours per week (see "Special Note for Part-Time Employees").

Special Note for Part-Time Employees

If you were hired *on or after* January 1, 1981 and you are scheduled to work *less than* 25 hours per week, you need to enroll for coverage under the Dental Plan.

Coverage for you and your Eligible Dependents can begin on the first day of the month in which you attain six months of Net Credited Service.

Communication Services Installer

If you are a *full-time or part-time* Eligible Employee, you must actively elect coverage for you and your Eligible Dependents. Coverage is not automatically provided.

> ***Please Note:*** If you need to enroll for coverage in the Dental Plan, you must enroll within 31 days of your eligibility date (see "Who Is Eligible"). If you do not enroll within 31 days, you will have to wait for the next Annual Open Enrollment period or a Qualified Status Change, whichever occurs earlier.

Keeping Your Information Up to Date

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

Coverage Categories

There are three coverage categories in the Dental Plan:

Your Coverage Tier (as it appears on your personalized enrollment worksheet and the Your Benefits Resources Web site)
Individual — Coverage for yourself
Two Person — When your Covered Dependent includes: • A spouse/Domestic Partner or • A child
Family — When your Covered Dependents include: • A spouse/Domestic Partner and at least one Child or • Two or more Children

Alcatel-Lucent Families

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

	You May Enroll the Following Dependent Employed with Alcatel-Lucent in Your Dental Plan option:			
If You Are An…	**Active Management or Active LBA Employee**	**Management Retiree**	**Active Represented Employee**	**Formerly Represented Retiree**
Active Management or Active LBA Employee	Yes	Yes	No[3]	No
Active Represented Employee	No[4]	No	Yes	Yes

Coverage Options

If your spouse or domestic partner who is also a Alcatel-Lucent employee or retiree can be Covered as a Dependent (see "Who Can Be Covered" above), and you wish to cover other Eligible Dependents (see **Section J. Terms to Know** for a definition of Eligible Dependent), below are some of the options that you have when enrolling in your benefits:

- One of you can enroll for "individual" coverage and the other can cover your eligible child(ren) by enrolling for "two person" or "family" coverage;
- One of you can enroll for "two person" or "family" coverage while the other elects no coverage; or
- You can both enroll for "two person" or "family" coverage if you're covering different children.

If you have questions about whom you may cover and how to enroll, contact the Alcatel-Lucent Benefits Center at 1-888-232-4111.

[3] You may cover an active represented occupational employee if that employee is not a full time employee working more than 24 hours a week or if that employee has less than 6 months of service.

[4] A represented occupational employee may cover a management employee if that Employee is not a full time Employee working 20 or more hours a week.

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 in the following situations.

Switching Between the Options

Once you're Covered under the Dental Plan, you may switch back and forth between the Traditional and DMO® options at any time, but not more than once a month. You must call Aetna to make the change. If you call by the 15th of the month, your change will become effective on the first day of the following month.

Qualified Status Changes

You may change your coverage under the Dental Plan during the year only if you have a Qualified Status Change. In order to be able to make a change during the year, Qualified Status Changes must be reported within 31 days of the event.

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

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

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	• You, your Lawful Spouse, or other dependent becomes employed or loses employment; • Affected by a strike or lockout; • 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 Dental Plan's eligibility requirements, for example, a Child reaches the maximum age for coverage.
Change in Place of Residence	A change in permanent residence for you, your Lawful Spouse, or an Eligible Dependent.

Qualified Status Change	Description
Significant Cost or Coverage Changes	A significant change in the cost or coverage under the Dental Plan or another employer-sponsored plan in which one of your Eligible Dependents can participate.
Court-Ordered Coverage	A change in your responsibility to provide healthcare coverage for a dependent Child as stipulated in a judgment, decree or court order resulting from a divorce, legal separation, annulment or change in legal custody (for example, a Qualified Medical Child Support Order). Documentation must be submitted. 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 Dental Plan and must be removed from coverage immediately. The Dependent may be eligible for COBRA coverage and you and/or your Dependent will be sent information about the cost of this coverage after you notify the Alcatel-Lucent Benefits Center at 1-888-232-4111 about the Dependent's status change. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).
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 the Dental Plan**)
Eligible **Non-Enrolled** Employee Marries or Acquires a Child Through Birth, Legal Adoption or Placement With You for Legal Adoption	You may enroll yourself, your spouse and/or new child as of the date of your marriage, birth, legal adoption or placement with you for legal adoption. (See "Special Enrollment Period for Newborns, Newly Adopted Children and Children Newly Placed With You for Adoption" in **Section B: Joining the Dental Plan**)

Please note: Your election change under the Dental 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 Dental Plan. You may not, however, cancel coverage for your Lawful Spouse.

Additionally, if your spouse's or Domestic Partner's employer's plan has a different enrollment period, this is not considered a qualified status change. For example, if one plan's annual enrollment period is in October and the other

plan's annual enrollment period is in November, you may not make changes to your coverage under this Plan as a result of the different timing of the enrollment periods.

The Company also considers corresponding changes in Domestic Partnership Dependents as qualified status changes.

Special Enrollment Period for Newborns, Newly Adopted Children and Children Newly Placed With You for Adoption

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

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; 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 special enrollment period, you will have to wait until the next Annual Open Enrollment period to enter the Plan. If you do not enroll these new dependents and. If applicable, yourself during the 31-day special enrollment period, you will have to wait until the next Annual Open Enrollment period to enter the Plan.

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

Special Enrollment Rights as Modified by the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP")

Effective April 1, 2009, if you or your Eligible Dependent is eligible but not enrolled for coverage under the Dental Plan, you are eligible to enroll for coverage if you meet either of the following conditions and you request enrollment with the Plan no later than 60 days after the date you or your Eligible Dependent:

- Loses eligibility for Medicaid or CHIP coverage; or
- Becomes eligible for premium assistance, with respect to coverage under the Plan, due to coverage with Medicaid or a state child health plan.

You must request enrollment by notifying the Alcatel-Lucent Benefits Center. If you do not request the change within the 31- or 60-day period, you lose HIPAA special enrollment rights for that event.

How to Make Changes to Your Coverage During the Year

If you experience one of the events described in this section and need to change your coverage during the calendar year, you must report the event within the applicable timeframe online through the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent or by calling the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET). 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.

The Cost of Coverage

If you are a *full-time* Eligible Employee, the company pays the full coverage cost for you and your Eligible Dependents.

If you are a *part-time* Eligible Employee, you only pay for coverage if you were hired *on or after* January 1, 1981 and you are scheduled to work *less than* 25 hours per week (see "Special Note for Part-Time Employees"). The following chart shows the percentage of any coverage cost for you and your Eligible Dependents:

Scheduled Work Hours (for part-time employees hired after 1/1/1981)	**The Company Pays This Percentage of the Cost**	**You Pay This Percentage of the Cost**
25 or more hours per week	100%	0%
Between 17 and 24 hours	50%	50%
16 hours or less	0%	100%

Confirming Your Election

When changing your benefits online using the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent, be sure to print the "Completed Successfully" page, which will serve as your confirmation of enrollment statement. You will not receive a confirmation of enrollment statement in the mail.

If you change benefits through the Alcatel-Lucent Benefits Center at 1-888-232-4111, you will receive a confirmation of enrollment statement in the mail.

Section C. How the Dental Plan Works

Understanding Your Options Under the Dental Plan

There are two coverage options available under the Dental Plan:

- *Traditional option*—This option pays 100 percent of Reasonable and Customary (R&C) charges for Covered diagnostic and preventive services as listed under Type A, such as routine oral exams and cleaning. Benefits for other Covered expenses as listed under Type B, such as fillings, are paid based on a schedule by region up to a $1,500 annual maximum per person and after you pay a $50 lifetime deductible per person. This option also covers orthodontic treatment, up to a $1,500 lifetime maximum per person, separate from the annual benefit limit. See "Appendix A" for more information.

- *DMO® option*—This option provides coverage through Participating primary care and Specialty Dentists with lower out-of-pocket expenses for most services. This option covers 100 percent of certain basic and specialty services and 75 percent of others as detailed in the Plan and summarized in Appendix B. The DMO® covers 50 percent of eligible charges for orthodontic treatment. There is no deductible and no lifetime or annual maximum for any expenses paid under the DMO® option when you use participating dentists. (See "Appendix B" for more information and benefit limits on services provided by Nonparticipating Dentists.)

  Please note: Nonparticipating Dentist benefits may vary by state and are not available in all states. Please contact Aetna for more details.

The Traditional Option

Getting the Most From Your Coverage

To ensure you receive the maximum benefit under the Traditional option, it is important to keep the following in mind when arranging dental care.

Alternate Procedures

Often, there are several ways to treat a particular dental problem. For example, suppose in repairing your tooth, the dentist has the option of using a filling or crown, and that either treatment meets with professionally accepted dental standards. In such instances, the Traditional option will cover only the less expensive treatment—in this case, the filling. So it is important to discuss the choices for treating your problem with your dentist before work begins. If your dentist used a crown instead, you would be responsible for the charges above what the Traditional option would pay for the less expensive treatment—namely the filling.

You can avoid such unnecessary charges by discussing treatment choices with your dentist prior to beginning work or by having your dentist file a Predetermination of Benefits as described below.

Predetermination of Benefits
If you need dental work costing over $200, you should determine before treatment begins what is Covered and how much the Traditional option will pay. This procedure is called "Predetermination of Benefits." Here is how predetermination works:

- If you don't have a claim form, get one from the Claims Administrator (see **Section K. Important Contacts**) and give it to your dentist. (Note: You get a new claim form automatically each time you submit a claim.)

- Your dentist outlines the treatment plan and fees on the claim form, and sends it to Aetna.

- Aetna determines the amount the Traditional option will pay and informs you and your dentist.

If after reviewing the predetermination, you and your dentist decide to change the treatment plan, Aetna will adjust its payment accordingly. If there is a major change in the treatment plan, your dentist should submit a revised plan.

If you do not request Predetermination of Benefits for claims over $200, Aetna will pay the claim based on the information it has about your case. If it is determined that a less expensive treatment was possible, you may receive a lower benefit than you expected. Predetermination of Benefits could help you avoid expensive surprises.

If you have a treatment plan approved and then your coverage ends before the start of treatment or services being rendered, subsequent benefits are generally not payable.

Changing Your Option
You can change from the Traditional option to the DMO® option (or from the DMO® option to the Traditional option) at any time, but not more than once a month. You must call Aetna (see **Section K. Important Contacts**) to make the change. If you call by the 15th of the month, the change will take effect on the first day of the next month. (***Please note:*** There may be other requirements that vary by state.)

Services Covered Under the Traditional Option
See "Appendix A" for a list of eligible expenses Covered under the Traditional option.

Services Not Covered Under the Dental Plan
See "Appendix C" for a list of expenses not Covered under the Dental Plan.

Extension of Coverage Under the Traditional Option

No benefits are paid under the Traditional option for Covered services or supplies received after coverage ends, except for:

- **Dentures or bridgework**, if the impressions were taken and the abutment teeth prepared before coverage stopped and the device is delivered and installed within the next two months,
- **A crown**, if the dentist prepared the tooth before coverage stopped and installs the crown within the next two months, or
- **Root canal therapy**, if the tooth was opened before coverage stopped and the treatment is completed within the next two months.

The DMO® Option

The DMO® option offers dental services through participating primary care and Specialty Dentists. The DMO® option provides these added benefits when you use a DMO® participating primary care or Specialty Dentist:

- There is no annual benefit maximum or deductible.
- You generally pay less for Type B and Type C services than you would under the Traditional option.
- You do not need to file claim forms.

If you are enrolled in the DMO® option, refer to their certificate for further details.

It is your responsibility to determine if your dentist is part of the network. Check DocFind® (www.aetna.com/docfind) on Aetna's Web site for the most up-to-date list of dental providers. Or, call Aetna Member Services for help with locating a provider or to request a printed listing of providers.

You and your covered dependents can select the same or different providers, but to receive maximum benefits each person should go to their participating primary care DMO® dentist.

Out-of-Network Care

If you go to a non-participating dentist after you enroll in the DMO® option, your benefit generally will be lower since it will be limited to a specific dollar amount (see "Appendix B"). In addition, you will have to pay an annual deductible (which applies to each person covered under the DMO® option who uses a non-participating dentist). The deductible is $100 in most states, but may vary by state.

Non-participating benefits are not available in certain states, except in certain emergency situations (see "Appendix B").

Electing DMO® Coverage
To participate in the DMO® option, you must enroll by contacting Aetna (see **Section K. Important Contacts**). You must be on record as having coverage under the Traditional option before you can switch to the DMO®. (Contact the Alcatel-Lucent Benefits Center at 1-888-232-4111 for more information.)

Planning Your Care
Your participating primary care dentist will provide all basic dental services and, if you need specialty services, must arrange for a specialist.

Changing Your DMO® Participating Primary Care Dentist
You may change your participating primary care dentist at any time by calling Aetna (see **Section K. Important Contacts**). If you call by the 15th of the month, the change will take effect on the first day of the next month.

Changing Your Option
You can change from the DMO® option to the Traditional option (or from the Traditional option to the DMO® option) at any time, but not more than once a month. You must call Aetna (see **Section K. Important Contacts**) to make the change. If you call by the 15th of the month, the change will take effect on the first day of the next month. There may be exceptions in certain states; please contact Aetna to determine if your state has different requirements.

Emergency DMO® Care
Emergency care consists of dental services provided by any licensed dentist, other than your Participating primary care Dentist, more than a 50-mile distance from where you live. To qualify for payment under the DMO® when you see a dentist other than your Participating primary care or Specialty Dentist, the services must be Necessary to relieve pain or to prevent the worsening of the condition. There may be exceptions in certain states; please contact Aetna to determine if your state has different requirements.

DMO® Coverage for Orthodontia
When you use a Participating Specialty Dentist for orthodontic treatment, the DMO® option covers 50 percent of eligible charges with no maximum. Orthodontic treatment from a nonparticipating specialist has a $1,000 lifetime maximum.

There may be exceptions in certain states; please contact Aetna to determine if your state has different requirements.

Coverage is limited to one complete course of treatment in a lifetime for procedures that are required to correct:

- Faulty position of teeth (malposition), or
- Abnormal bite (malocclusion).

Aetna pays the orthodontist directly. You are responsible for the copayment.

Orthodontic Treatment Plan
Aetna must approve orthodontia services prior to beginning treatment. Your dentist should submit a treatment plan to Aetna including:

- A description of the recommended treatment,
- An estimate of how long the care will last,
- The cost, and
- Supporting X-rays, study models and other evidence.

Aetna will review the treatment plan and let your dentist know what benefits will be paid.

Your Share of Eligible Expenses
Aetna makes payments directly to participating primary care and Specialty Dentists as mutually agreed between them. You are responsible for any Copayments required by the Plan. The Copayment is determined by applying the Copayment percentage to the Participating primary care or Specialty Dentist's usual fee, as approved by Aetna. (If Aetna pays the dentist on a discounted fee-for-service basis, then that discounted fee is also used to determine your Copayment.)

See Appendix B for a list of the services Covered under the DMO® option. If a service is not listed in the Appendix, but the plan does cover a service that is equally suited for the condition being treated, then the Plan will provide an alternate benefit for that service. If you wish to have the non-Covered service provided instead of the alternate service, you will be responsible for any charges in excess of the charge that would have applied for the alternate service. If there is no alternate service, you will be responsible for the full cost of treatment for any non-Covered service.

See Appendix C for a list of the services not Covered under the DMO® option.

Extension of Coverage Under the DMO® Option
Under the DMO® option, coverage is extended for charges incurred within 30 days after coverage stops for the following services only:

- **An appliance or an alteration of one**, for which an impression was made while the person was Covered under the DMO® option,
- **A crown, bridge or cast restoration**, for which the tooth was prepared while the person was Covered under the DMO® option, or
- **Root canal therapy**, for which the pulp chamber was opened while the person was Covered under the DMO® option.

Section D. When Coverage Ends

When Employee Coverage Ends

Your coverage under the Dental 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 Dental Plan;
- The company you work for ceases to be a Participating Company; or
- The Dental Plan is terminated.

When your coverage ends, you may be able to continue coverage (see **Section E. COBRA Continuation of Coverage**).

When Dependent Coverage Ends

Your Eligible Dependent's(s') coverage under the Dental 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 Dental 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 Dental 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 Dental Plan** and "If Your Physically or Mentally Handicapped Child Reaches the Limiting Age" in **Section I. 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.

Section E. 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 dental coverage at their own expense for a limited period of time if they lose coverage due to a qualifying event. The Dental Plan also provides COBRA-like rights to participants' Domestic Partners.

Coverage may be extended for up to 18 months, 29 months or 36 months, depending on the qualified even (see the chart below). 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.

Please note: It is your or your qualified beneficiary's responsibility to notify the Alcatel-Lucent Benefits Center at 1-888-232-4111 of a qualifying event other than your termination of employment (such as your divorce or the marriage of a Dependent) that makes you or a Dependent eligible for COBRA continuation coverage. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

You or your qualified beneficiary must notify the Alcatel-Lucent Benefits Center within 31 days of the qualifying event.

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…**
• Termination of your employment for any reason other than gross misconduct • A reduction in your work hours	Up to 18 months from the date of qualifying event.
• Disability occurs prior to the 60th day of the COBRA continuation coverage period	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. To be eligible for the additional period of coverage, the disabled person must call the

If This Qualifying Event Occurs…	COBRA Continuation Coverage Can Last for…
	Alcatel-Lucent Benefits Center before the end of the initial 18-month period and within 60 days of receiving notice of disability by the Social Security Administration. 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.
• Your divorce or legal separation; • Termination of your Domestic Partnership; • Your death; or • A child's loss of eligibility under the Dental Plan	Your Covered Dependents may elect COBRA continuation coverage for up to 36 months from the date of the qualifying event.
• You become entitled to Medicare while you are an active employee and you later experience a termination of employment or reduction in work hours	You may elect COBRA continuation coverage for up to 18 months following the qualifying event. Your qualified beneficiaries may elect COBRA continuation coverage for up to 36 months from the date of Medicare entitlement.
• You become entitled to Medicare after you elect COBRA continuation coverage (because of a termination of employment or reduction in hours)	Your COBRA continuation coverage will end on the date of your Medicare entitlement. 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.*

*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 Dental 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 of former employee) may be eligible for an additional period of COBRA continuation coverage, not to exceed a total of 36 months from the initial qualifying event.

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., Eastern Time (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 during your COBRA continuation coverage, 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.

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 occurrence of the following qualifying events:

- Divorce;
- Legal separation;
- A child no longer satisfying the Dental 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.

When COBRA Coverage Ends

COBRA coverage ends before the maximum continuation period if one of the following occurs:

- You or your covered dependent does not make timely premium payments or contributions as required;
- The company stops providing dental benefits to any employee; or
- You or any of your covered dependents become covered under another dental plan not offered by the company, provided the plan does not have a legally valid pre-existing condition exclusion or limitation affecting the qualified beneficiary. If it does, COBRA coverage for that pre-existing condition continues as long as you pay the premium.

Continuation coverage also may be terminated for any reason the Dental Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (for example, in the case of fraud).

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other laws affecting Group Health Plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA Web site at www.dol.gov/ebsa.

Section F. Claims and Appeals

Note: Not all claim and appeal procedures set forth in this section apply to the DMO® option. Claims and appeals for benefits under the DMO® option are controlled and governed by the terms and conditions set forth in the DMO® Option's member service agreement or other applicable documentation regarding the delivery of Plan benefits to Participants who have elected coverage under the DMO® option. DMO® option members should contact Aetna (see **Section K. Important Contacts**) for more information about claim and appeal procedures).

Types of Claims

The Dental 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 Dental 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 Dental Plan.

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

Benefits Claims

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

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

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

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

  — Could be considered a life or death situation;

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

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

Eligibility Claims

Filing Deadlines

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

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

Where to Send Your Claim Form

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

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

Fax: 1-847-554-1996

If your eligibility claim is coupled with a claim for benefits, send the benefits claim form to Aetna 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 Aetna is a post-service claim, a pre-service claim, or an Urgent pre-service claim.

When You Can Expect To Receive a Decision

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

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

What You'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 Dental 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 Dental Plan's claim review procedures, applicable time limits and your rights. If your claim is denied and your appeal is also denied, you have the right to bring a civil action in federal court under ERISA Section 502(a).

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

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

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

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

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

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

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

> ***Please note:*** If your eligibility appeal is coupled with a non-Urgent pre-service benefits appeal or an Urgent pre-service benefits appeal, as the case may be,

an effort will be made to decide your eligibility appeal within the time frames applicable to the benefits claim.

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

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

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

Benefits Claims

Under the Traditional Option

Use the claim form provided by Aetna. You are responsible for filling out Part I; your dentist is responsible for filling out Part II. Submit completed forms to Aetna. ***Submit claims within 90 days after receiving dental services or within 90 days after the calendar year in which services were provided. No benefits are payable for claims submitted later than 15 months from the date of service.*** If a claim for benefits is denied, you may appeal the decision (see "Claim Denial and Appeal Procedures").

Under the DMO® Option

When you use your personal or specialty DMO® dentist, you do not have to submit claims. Your provider will bill you for any services not Covered in full by the Dental Plan.

When you use Nonparticipating Dentists, you are responsible for submitting claim forms. The same claim procedures described for the Traditional option apply.

Claim Deadlines

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

To file a benefits claim:

- If you don't have a claim form, call Aetna at the number printed on your dental ID card to request a claim form. You may also be able to print out a claim form at Aetna'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 Aetna. 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 file a benefits claim, the Claims Administrator reviews the claim and makes a decision to either approve or deny the claim. The time frames within which you can expect to be advised of that decision are described below.

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

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

Pre-Service Claims (Non-Urgent)

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

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

Urgent Pre-Service Claims

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

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

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

What You'll Be Told If Your Claim Is Denied

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

- The specific reason(s) for the denial;

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

Appeal Procedures and Deadline

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

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

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

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

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

Review of your appeal will take into account all comments, documents, records and other information relating to the appeal, without regard to whether the information was submitted or considered in the initial claim decision. Your appeal will be reviewed "de novo." That means you get to "start fresh," and an independent Dental 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 Dental Plan's behalf in connection with your claim decision, without regard to whether the advice was relied upon in making the claim decision.

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

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

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

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

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 Dental 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 Dental 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 Dental 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 Dental Plan may offer you an independent, voluntary, third-party appeal review process.

If your claim is eligible for the independent review process, you (or your Covered Dependent) will be notified by the appropriate Claims Administrator.

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

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

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

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

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

Other Voluntary Options

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

Section G. How Coordination of Benefits Works

What Coordination of Benefits Is

The Dental Plan has a Coordination of Benefits (COB) provision. This feature is designed to prevent duplicate benefit payments when you or your Eligible Dependents participate in more than one group health plan.

When the Coordination of Benefits Provision Applies

The COB provision applies when you or your Eligible Dependents have dental coverage in addition to that provided under the Dental Plan, such as:

- Another employer's plan;
- A group-sponsored insurance or prepayment plan; or
- A government-sponsored plan.

When the Coordination of Benefits Provision Does Not Apply

The COB provision described in this section does not apply:

- 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 rules:
  - One person cannot receive Dental 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 Dental 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 feature, one plan is primary and determines its benefits first. The other plan(s) is secondary and determines what benefits, if any, it may pay after the primary plan determines its benefits.

If the Dental Plan through Alcatel-Lucent is primary, it pays its benefits without regard to the secondary plan. When the Dental Plan is secondary, it calculates what it would have paid if it was the primary plan. The Dental Plan then pays the remaining eligible charges not paid by the primary plan up to the amount the Dental Plan would have paid if it was the primary plan. You can receive up to 100 percent (but not more) of the allowable amount under the highest paying plan.

To claim benefits, submit your claim to the primary plan first. After that plan determines its benefits, submit a completed claim form to the secondary plan along with a copy of the original bill and a copy of the Explanation of Benefits (EOB) statement you received from the primary plan.

How the Claims Administrator Determines Which Plan Is Primary
This Dental Plan uses the following rules to determine which plan is primary and which plan(s) is secondary:

- If the other plan(s) does not have a COB feature, that plan(s) is considered primary and the Dental 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 Dental Plan is secondary.

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

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

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

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

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

  — If there is such a decree or QMCSO, the plan covering the parent who has the responsibility to provide coverage pursuant to such decree of 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 patient for the longest time is the primary plan.

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

Section H. Overpayments and Subrogation

Obligation to Refund

If the Dental Plan pays for benefits in violation of the terms of the Dental Plan (improper payments), or if all or some of the payments made exceed the benefits payable under the Dental Plan (excess payments), then those improper or excess payments must be refunded to the Dental Plan. You or your Covered Dependents are responsible for any improper or excess payments the Dental 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 Dental 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 Dental Plan may reduce the amount of any future benefits that are payable to or on behalf of you or your Covered Dependents under the Dental Plan so that the Dental Plan can recoup the full amount of the improper or excess payment, as applicable.

Right of Recovery and Subrogation

The Dental Plan provides Covered benefits to you and your Covered Dependents that are not provided by any third party. So, benefits provided under the Dental Plan as a result of 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) are excluded and are not Covered under the plan. If such benefits have been paid by the Dental Plan:

- The Dental Plan shall 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 Dental Plan.

- You and your Covered Dependents agree to reimburse the Dental Plan for the reasonable value of all benefits received under the Dental Plan out of any actual recoveries you, your Lawful Spouse or your domestic partner, or your Eligible Dependents, including Domestic Partnership Dependents, received from any third party (other than the participant's family members).

- The Dental Plan's subrogation and reimbursement rights apply to any recoveries that may be received or actually are received by you or your Covered Dependents, including, but not limited to, the following:

  — Any payments as a result of a settlement, judgment 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.

  — 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 Dependents are required to fully cooperate and perform all actions necessary to secure the Dental 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 Dental Plan's rights; and

— Refraining from assigning any rights to recover dental care expenses from any party whose negligence gives rise to liability for damages.

No court costs or attorney's fees may be deducted from the Dental Plan's recovery without the advance express written consent of the Dental Plan.

In the event that you or your Covered Dependents fail or refuse to honor these terms, the Dental Plan will be entitled to recover any cost incurred in enforcing these terms and conditions.

The right of recovery and subrogation may not be applicable in some states.

Section I. Events Affecting Coverage

If You Change Your Job Classification

Since your dental coverage is 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 the options available to you based on your new classification. You must follow all requirements for coverage under your new classification, or you and your Dependents may not be Covered for the rest of the year and you must wait until the next Annual Open Enrollment period to enroll.

If You Become Disabled

Your participation in the Dental Plan may be affected if you become disabled. Your length of service and the duration of your disability determine what happens to your coverage during a disability.

Disabilities of up to One Year

If you become totally disabled as determined under the Alcatel-Lucent Sickness and Accident Disability Benefit Plan, you will continue to be eligible for coverage under the Dental Plan for up to one year, provided your disability continues.

Different rules apply after you've been totally disabled for one year.

Disabilities of One Year or Longer

Here's what happens to your coverage under the Dental Plan after you've been totally disabled for one year.

If you're eligible for a service or disability pension at that time, then your status changes to a retired employee and the retirement benefits and options apply to you.

If you're not eligible for a service or disability pension at that time, then your current dental coverage is discontinued. However you may be eligible to continue coverage for yourself and your Eligible Dependents through COBRA. (see **Section E. COBRA Continuation of Coverage**)

If You Terminate Employment

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

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 **Section E. COBRA Continuation of Coverage**."

If You Retire

If you retire with a service or disability pension, your coverage under the Dental Plan is discontinued. At retirement, you may become Covered by the retirement dental plan the company maintains for retired employees. The benefits provided by the dental plan for retired employees may differ from the benefits provided for active employees under this Dental Plan. This Plan and the plan for retired employees are subject to modification or termination by the company at any time before or during your retirement, subject to the terms of applicable collective bargaining agreements

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

> ***Please note:*** Refer to the Alcatel-Lucent Dental Expense Plan for Retired Employees for more information about how Alcatel-Lucent-sponsored dental benefits work after retirement.

If You Take an Approved Leave of Absence

Generally, you pay for part of your Dental 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 Take Leave Under the Family and Medical Leave Act (FMLA)

If you are eligible for an FMLA leave as described in "Family and Medical Leave Act of 1993," Alcatel-Lucent will comply with this legislation in providing you with unpaid leave.

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 USERRA. The period of coverage for you and your Eligible Dependents ends on the **earlier of**:

- The end of the 24-month period (18-month period for elections made before December 10, 2004) 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.

You may be required to pay all or a portion of the cost of your coverage.

- **If your military service is 60 months 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 60 months:** 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).

Be Sure to Notify Your Human Resources Department
You also 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.

If You are Laid Off

If you are laid off, you will be able to continue Dental Plan coverage through COBRA (see **Section E. COBRA Continuation of 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.

Section J. Terms To Know

Several words and phrases have specific meanings under the Dental Plan. This section explains these terms so you can better understand your benefits. Some definitions may differ under the DMO® option so if you're covered under that option, please refer to "The DMO® Option" section of this summary plan description (SPD).

Alcatel-Lucent Benefits Center: The resource to call to enroll, to make changes to your coverage or to ask questions about your Dental Plan options. Call 1-888-232-4111 or 1-212-444-0994 (if calling from outside of the United States, Puerto Rico or Canada). If you are hearing or speech impaired, please use a Relay Service when calling a representative**.** Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET). You can also obtain information by visiting the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent.

Annual Open Enrollment: The period of time each year designated by the company in which you can generally make changes in your benefits for reasons other than a Qualified Status Change.

Class I Dependents:

- Your opposite-sex lawful spouse (or common-law spouse if recognized in your state of residence);
- Your same- or opposite-sex domestic partner[5], 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 18 years of age 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;

[5] Or any other state-recognized permanent relationship between two consenting adults, other than opposite-sex marriage, that meet the stated conditions.

— Consider one another to have a close and committed personal relationship and have no other such relationship with any 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) who live with you 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 wards 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); and

- 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 a medical Claims Administrator and who meet all of the following requirements:

  — 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.

COBRA: An acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. This refers to federal legislation which governs the offer of temporary continued dental coverage to participants who otherwise would lose

coverage due to certain reasons, such as a loss of employment.

Coinsurance: The percentage of a covered service's charge for which you are required to pay under the Plan.

Company: Alcatel-Lucent

Copayment: A flat dollar amount (such as $25) that you are required to pay for a certain dental service (such as an office visit or supply).

Covered: Generally, means "eligible" under the terms of the Dental Plan. "Covered" is often used to modify other terms. A "Covered person" is one who has benefits available under the Dental 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.

Covered Dependent: A Class I Dependent, including a Domestic Partnership Dependent, who is Covered as the Dependent of an employee.

Deductible: The amount of eligible expenses you may be required to pay each Plan Year before the Plan will pay benefits for Covered expenses. Whether a Deductible applies, and the amount of the Deductible, depends upon the Dental 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 usually no Deductibles under the DMO® option.

Dependent: A person who is an Eligible Dependent or Domestic Partnership Dependent and who is eligible to be Covered under the Plan.

DMO®: Dental Maintenance Organization®.

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 18 years of age 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 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 the Eligible Employee's dependent under the Plan.

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.

Eligible Dependents: Your eligible Class I dependents, including Domestic Partnership Dependents.

Eligible Employee: A regular, active full-time or part-time represented occupational employee of a Participating Company with at least six months of Net Credited Service.

> ***Please Note:*** Individuals who are not paid from the U.S. payroll of 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 Dental Plan.

Lawful Spouse: A person of the opposite sex who is recognized as the lawful husband or wife of an active employee under the federal Defense of Marriage Act.

Necessary: A service or supply furnished by a dentist is Necessary if the Claims Administrator (see **Section K. Important Contacts**) determines that it is appropriate for the diagnosis, and/or the care or the treatment of the disease or injury involved.

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 Aetna and offer services to members enrolled with Aetna at a Contract Rate.

Nonparticipating Dentist: Under the DMO® option, a dentist who has *not* entered into a written agreement with the Claims Administrator (see **Section K. Important Contacts**) to provide Dental Plan coverage to Covered persons.

Participating Company/Companies: A company or companies that participate in the Dental 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

Preferred Address: The address on file with the Alcatel-Lucent Benefits Center.

Predetermination of Benefits: This procedure applies to the Traditional dental option. If you need dental work costing over $200, you should determine before treatment begins what is Covered and how much the Traditional option will pay.

Qualified Medical Child Support Order (QMCSO): a judgment, decree or order issued by a court that requires coverage for a participant's child and that has been determined by the Plan Administrator to be qualified under the Internal Revenue Code of 1986. Alcatel-Lucent has a policy to comply with the requirements of a QMCSO. Contact the Domestic Relations Matters Group for more information on how QMCSOs are administered and to receive a copy of Alcatel-Lucent's QMCSO administrative procedures at no cost (see **Section K. Important Contacts**).

Reasonable and customary (R&C): The fee determined by the Claims Administrator to be reasonable and customary on the basis of:

- The fees a dentist usually charges most patients for a similar service, and
- The range of fees charged by dentists with similar training and experience for the same or similar services within the geographic region.

The Claims Administrator may also take into account the patient's condition and any additional time or special skills needed by his or her dentist for treatment. Such determinations are conclusive and binding.

The Your Benefits Resources Web site (YBR): a Web-based resource located at http://resources.hewitt.com/alcatel-lucent where you can learn more about your healthcare benefits, access your benefit options and costs and enroll for your benefits online.

Section K. Important Contacts

Aetna

Aside from this summary, your primary source for Dental Plan information is Aetna.

By Phone

The following chart provides the number you should call depending on your request and the coverage option you selected.

To/For	Traditional Option	DMO® Option
To obtain claim forms[6]	www.aetna.com or 1-800-220-5470	N/A
To check the status of your claim	1-800-220-5470	N/A
To register a complaint or request a review of your treatment plan	1-800-220-5470	1-800-220-5479
For questions concerning Predetermination of Benefits	1-800-220-5470	N/A
To enroll in the DMO® or to select or change your participating primary care DMO® Dentist	N/A	1-800-220-5479
To request a list of Participating primary care and Specialty Dentists	N/A	www.aetna.com or 1-800-220-5470
To switch between the Traditional and the DMO® options	1-800-220-5470	1-800-220-5479

By Mail

Following is the address for all correspondence (including submitting claim forms and submitting legal actions regarding a claim for benefits), for the Traditional and DMO® options.

Aetna
P.O. Box 14094
Lexington, KY 40512-4094

When corresponding with Aetna, please indicate the coverage option you have elected.

[6] Under the DMO® option, the only time you need to file a claim is when you have services performed by a Nonparticipating Dentist. See "The DMO® Option" for more information.

Other Contacts

Here is a list of other resources to contact about your coverage under the Dental Plan:

Contact/Service Provided	Address/Telephone Number
The Your Benefits Resources Web Site • To access your benefit options and costs • When qualified status changes occur • To review or change your Dependent information on file	http://resources.hewitt.com/alcatel-lucent
The Alcatel-Lucent Benefits Center Contact for status changes and for general eligibility information about the Dental Plan.	• 1-888-232-4111 • 1-212-444-0994 (if calling from outside of the United States, Puerto Rico or Canada) Representatives are available between 9:00 a.m. and 5:00 p.m., Eastern Time (ET), Monday through Friday. If you are hearing or speech impaired, please use a Relay Service when calling a representative.
Domestic Relations Matters Group Contact for matters relating to a Qualified Medical Child Support Order (QMCSO).	Alcatel-Lucent QMCSO Administration P.O. Box 56887 Jacksonville, FL 32241-6887 1-904-791-2710
Plan Administrator Contact for legal actions, except for legal actions regarding a claim for benefits. Legal actions regarding a claim for dental benefits should be directed to the Claims Administrator (Aetna).	Alcatel-Lucent Room 2B-410 600 Mountain Ave. Murray Hill, NJ 07974 Attn.: Dental Plan Administrator

Section L. Other Important Information About Your Benefits

Qualified Medical Child Support Order Benefit Payments

Benefit payments under the Dental 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 Dental 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).

Dental Plan Funding and Payment of Benefits

Alcatel-Lucent pays certain administrative costs associated with providing benefits under the Alcatel-Lucent Dental Plan unless borne by participants. The funding for the Dental Plan is paid by Alcatel-Lucent through arrangements with third party service-providers.

Plan Documents

This summary plan description (SPD) is designed to describe the Dental Plan in easy-to-understand terms. However, it is the Dental Plan documents and contracts that determine your rights and the rights of your Eligible Dependents under the Plan. In all instances, even if the SPD and Dental Plan are in conflict, the terms of the Dental Plan documents govern.

Union Agreement

The benefits described in this SPD reflect the provisions of the Plan as outlined in various bargaining agreements between the company and the unions representing employees of the company. Copies of these agreements are distributed or made available to those employees covered by the agreements and to any other employee who submits a written request for a copy to the Plan Administrator. A reasonable duplication charge may be made for copies furnished in response to such written request.

Dental Plan May Be Amended or Terminated

The company expects to continue the Dental Plan, but reserves the right to amend or terminate the Dental Plan at any time by the resolution of the Board of Directors, subject to the terms of applicable collective bargaining agreements. In addition, the company doesn't guarantee the continuation of any dental benefits during

employment or at or during retirement nor does it guarantee any specific level of benefits or contributions.

Plan Administrator and Claims Administrator

The Plan Administrator and the Claims Administrator have the full discretionary authority and power to control and manage all aspects of the Dental Plan, to determine eligibility for Dental Plan benefits, to interpret and construe the terms and provisions of the Dental Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Dental Plan as they may deem appropriate in accordance with the terms of the Dental 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 Dental Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Dental Plan, including discretionary authority to interpret and construe the terms of the Dental Plan, to direct disbursements, and to determine eligibility for Dental 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 Dental Plan protect the confidentiality of your protected health information (PHI). A complete description of your rights under HIPAA can be found in the Dental Plan's privacy notice. For a copy of this notice, visit the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent, call the Alcatel-Lucent Benefits Center at 1-888-232-4111 (representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET) or contact the Privacy Official (contact information provided below).

The Dental Plan and the Company, as Plan Sponsor of the Dental 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 Dental Plan has also required all of its business associates to observe HIPAA's privacy rules. The Dental 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 Dental 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 Dental 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 Aetna and/or Claims Administrator to review or obtain copies of your health information and to exercise your rights regarding your health information. If you are unsure of the appropriate Healthcare Plan and/or Claims Administrator, have a general request that covers more than one Company-sponsored employee benefit plan or have other questions relating to our privacy practices or your privacy rights, please contact the Privacy Official:

Director, Health Plans
Room 2B-439
Alcatel-Lucent
600 Mountain Avenue
Murray Hill, NJ 07974-0636
1-908-582-2321

Administrative Information

Plan Name	Alcatel-Lucent Dental Expense Plan for Active Employees.
Plan Sponsor	Alcatel-Lucent
Type of Administration	The Dental Plan is administered Aetna as named in the Claims Administrator section below. Enrollment and eligibility under the Dental Plan are administered by the Alcatel-Lucent Benefits Center
Claims Administrator	The Claims Administrator is Aetna. The DMO® option is underwritten by Aetna. Claims should be submitted to: Aetna P.O. Box 14094 Lexington, KY 40512-4094
Plan Administrator	Alcatel-Lucent Room 2B-410 600 Mountain Avenue Murray Hill, NJ 07974 1-908-582-7140
Agent for Service of Legal Process	The agent for service of any legal process regarding claims is the Claims Administrator. The agent for service of any other legal process is the Plan Administrator.
Plan Records and Plan Year	The Dental 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 Dental Plan is considered a "welfare plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Plan Number	The Plan Number is 505.
Employer Identification Number	The Employer Identification Number is 22-3408857.

Section M. 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 Dental Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Dental Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Dental 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 Dental Plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Dental 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 Dental Plan as a result of a "qualifying event." You, your spouse or your Dependents will have to pay for this coverage. Review this SPD and the Plan document about the rules governing your COBRA Continuation Coverage rights.

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

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

In addition to establishing rights for Plan participants, ERISA imposes certain duties on the people responsible for the operation of a Dental Plan. The people who operate the Dental Plan, called "fiduciaries," have a duty to do so prudently and in the interest of all participants and beneficiaries.

No one, including the Company, may fire you or otherwise discriminate against you in any way to keep you from obtaining a welfare benefit or exercising your ERISA rights.

If your claim for a welfare benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Dental Plan documents or the latest annual report from the Dental 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 Dental Plan's decision or lack thereof concerning the qualified status of a medical Child support order.

If it should happen that Dental Plan fiduciaries misuse the Dental 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 Dental Plan, you should contact the Plan Administrator or the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in your telephone directory, or write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
United States Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the 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.

Appendix A: Eligible Expenses Under the Traditional Option

Please note: Dental Treatment will be paid according to the option in effect when a service is provided. For Plan purposes, a service is considered as provided when treatment begins (when a tooth is prepared or a canal opened).

Schedules reflect differences in dental charges by geographic area (see "Appendix D: Dentist Location List"). These schedules include a high-level summary of common procedures covered by the Plan and do not list all covered services. Payments for any Covered procedures not listed will be determined by the Claims Administrator and will be consistent with this list.

General Features

Annual Deductible	Lifetime deductible of $50 per person
Annual Plan Maximum	$1,500 per person
Lifetime Orthodontic Maximum Benefit	$1,500 per person

Preventive — Type A Services

Preventive — Type A Services	**Amount Traditional Option Pays**
Twice in a calendar year: • Office visit for oral evaluation • Prophylaxis (Cleaning of teeth when performed by a dentist or dental hygienist)	100% of Reasonable and Customary charges
In a calendar year: • Fluoride treatments when performed by a dentist or dental hygienist	100% of Reasonable and Customary charges
As specified: • Space maintainers for Dependent children under age 19: — Installation of fixed or removable appliances to maintain existing space by preventing movement of adjacent or opposing teeth (but only as a replacement of prematurely lost or extracted teeth) — Adjustment of appliances because of a change in the condition of the mouth	100% of Reasonable and Customary charges

• Dental X-rays and radiographs: — Full-mouth X-rays or Panoramic (not more than once in three consecutive years unless incurred within the last 30 days of the three-year period) — Supplementary bitewing X-rays (not more than two sets per calendar year) — Periapical X-rays	

Type B Services

Restorative — Type B Services	**Traditional Option Pays up to These Maximums**			
Schedule	**I**	**II**	**III**	**IV**
Amalgams:				
• One surface, primary or permanent	$ 22	$ 28	$ 30	$ 33
• Two surfaces, primary or permanent	$ 35	$ 42	$ 48	$ 52
• Three surfaces, primary or permanent	$ 52	$ 59	$ 65	$ 72
• Four or more surfaces, primary or permanent	$ 54	$ 64	$ 72	$ 80
Resin-based Composites:				
• One surface, anterior	$ 32	$ 35	$ 42	$ 44
• Two surfaces, anterior	$ 52	$ 59	$ 65	$ 72
• Three surfaces, anterior	$ 66	$ 79	$ 88	$ 97
• Four or more surfaces or involving incisal angle, anterior	$ 63	$ 71	$ 83	$ 91
• One surface, posterior	$ 32	$ 35	$ 42	$ 44
• Two surfaces, posterior	$ 52	$ 59	$ 65	$ 72
• Three surfaces, posterior	$ 66	$ 79	$ 88	$ 97
• Four surfaces, posterior	$ 89	$102	$118	$128

Restorative — Type B Services	**Traditional Option Pays up to These Maximums**			
Schedule	**I**	**II**	**III**	**IV**
Crowns:				
• Resin with noble metal	$245	$282	$320	$357
• Porcelain fused to high noble metal	$311	$358	$405	$454
• Porcelain fused to predominately base metal	$239	$275	$311	$347
• Porcelain fused to noble metal	$257	$298	$335	$374
• Full cast high noble metal	$252	$290	$328	$365
• 3/4 cast	$246	$285	$322	$359
• Stainless steel crown	$ 59	$ 69	$ 77	$ 86
Endodontics (procedures to prevent and treat diseases of the dental pulp):				
• Anterior	$186	$212	$243	$270
• Bicuspid	$227	$262	$297	$330
• Molar	$285	$329	$372	$414
• Pulp cap—direct	$ 18	$ 22	$ 24	$ 27
Periodontics (surgical and non-surgical procedures to treat the supporting area around the teeth, except periodontal splinting):				
• Gingivectomy or gingivoplasty (one to three teeth)	$ 33	$ 41	$ 43	$ 49
• Gingivectomy or gingivolplasty (per quadrant)	$132	$152	$171	$191
• Osseous surgery—including flap entry and closure (one to three teeth)	$171	$197	$222	$248
• Osseous surgery—including flap entry and closure (per quadrant)	$284	$327	$370	$412
• Bone replacement graft	$132	$152	$171	$191
• Periodontal scaling and root planning	$ 55	$ 64	$ 72	$ 81
• Periodontal maintenance following surgical periodontal therapy	$ 39	$ 44	$ 48	$ 53

Prosthodontics
To replace teeth (except wisdom teeth) extracted while Covered by the Plan.

Prosthodontic services include:

- Initial installation of fixed bridgework, including inlays and crowns to form abutments.
- Initial installation of partial or full removable dentures, including adjustments during the six-month period after they are installed.
- The addition of teeth to an existing partial removable denture or to bridgework.
- Installation of a permanent full denture that replaces and is installed within 12 months of a temporary denture.
- Replacement of an existing partial denture, full removable denture or fixed bridgework, provided the existing denture or bridge is at least five years old and cannot be made serviceable. (The five-year limitation is waived if additional extractions require the replacement.)
- Repairing or recementing inlays, crowns, bridgework or dentures, or relining of dentures.

Prosthodontics — Type B Services	**Traditional Option Pays up to These Maximums**			
Schedule	**I**	**II**	**III**	**IV**
Complete Dentures (including six months post-delivery care):				
• Complete upper	$447	$515	$584	$651
• Complete lower	$432	$500	$566	$630
• Immediate upper	$470	$540	$612	$683
• Immediate lower	$432	$500	$566	$630

Prosthodontics — Type B Services	**Traditional Option Pays up to These Maximums**			
Schedule	**I**	**II**	**III**	**IV**
Partial Dentures (including six months post-delivery care):				
• Upper resin base (including any conventional clasps, rests and teeth)	$468	$538	$608	$680
• Lower resin base (including any conventional clasps, rests and teeth)	$455	$525	$594	$662
• Upper case metal framework with resin base (including any conventional clasps, rests and teeth)	$432	$500	$566	$630
• Lower case metal framework with resin base (including any conventional clasps, rests and teeth)	$426	$490	$556	$620
Bridgework:				
• Pontic/Abutment, Porcelain fused to high noble metal	$311	$358	$405	$454
• Pontic/Abutment, Porcelain fused to predominately base metal	$239	$275	$311	$347
• Pontic/Abutment, Porcelain fused to noble metal	$260	$299	$338	$376
Oral Surgery:				
• Extraction, erupted tooth or exposed root	$ 33	$ 41	$ 43	$ 49
• Surgical extractions				
— Extraction of tooth, erupted	$ 54	$ 61	$ 69	$ 77
— Extraction of tooth, partial bony impaction	$115	$130	$150	$164
— Extraction of tooth, complete bony impaction	$136	$152	$175	$196
— General Anesthesia	$ 59	$ 66	$ 76	$ 84
— Intravenous sedation	$ 66	$ 66	$ 76	$ 84
Orthodontics (to prevent and correct malocclusion of teeth and associated facial problems):				
• Appliances for tooth guidance or to control harmful habits, fixed or removable	$164	$189	$214	$238
• Pre-orthodontic treatment visit, including X-rays and treatment plan	$100	$114	$129	$143
• First month of treatment including appliances	$502	$578	$653	$731
• Active treatment per month after first month	$ 64	$ 72	$ 82	$ 92

Appendix B: Eligible Expenses Under the DMO® Option

***Please Note*:** This section includes a high-level summary of common procedures covered by the Plan and does not list all covered services. In addition, annual updates to fee schedules may result from changes in dental procedural codes as determined by the American Dental Association.

Under the DMO® option, benefits are paid for dental services covered by the DMO®. When you receive care from your primary care or specialty DMO® participating dentist, Aetna pays benefits directly to the provider.

When you receive care from a non-participating dentist, Aetna pays benefits directly to you, up to the maximum shown in the following schedules. However, there may be exceptions in certain states. Please contact Aetna for further details.

Aetna also pays benefits directly to you for services, such as emergency care, when such services are performed by someone other than your primary care or specialty DMO® dentist, even if the provider participates in the DMO®.

A copayment is required for certain basic and specialty services.

The copayment is a percentage of the DMO® primary care or specialty dentist's usual fee for that service, as set forth in the provider's usual fee schedule. The usual fee, which is reviewed by Aetna for reasonableness, is used only for the purposes of calculating a copayment.

Aetna compensates participating primary care or specialty DMO® dentists based on separate, negotiated agreements which may be less than or unrelated to the dentist's usual fee. These agreements may also vary among participating DMO® providers.

The percentage of the DMO® primary care or specialty dentist's eligible charges paid directly to the provider by Aetna is shown in the Schedule of Allowances.

A copayment is required when the benefit paid directly by Aetna under the DMO® option is less than 100 percent.

General Features

Annual Deductible	Generally not applicable for DMO® Participating Dentists
Annual Plan Maximum	Generally not applicable for DMO® Participating Dentists
Lifetime Orthodontic Maximum Benefit	Generally not applicable for DMO® Participating Dentists

Basic Type A Services

	Non-Participating Dentists	DMO® Participating primary care and Specialty Dentists
Basic Services - Type A	**Maximum Benefit Payable**	**Plan Pays* (Percentage of dentist's eligible charge)**
Visits and Exams:		
• Office visit for oral examination (limited to four visits per year)	$12	100%
• Emergency palliative treatment	$12	100%
• Prophylaxis treatment (cleaning) (limited to six treatments per year)		
— Adult	$26	100%
— Child	$14	100%
• Topical application of fluoride (limited to one course of treatment per year and to children under age 18)	$16	100%
• Oral hygiene instruction	$12	100%
• Sealants (limited to once each tooth every three years, permanent molars only)	$10	100%
• Pulp vitality test	$8	100%
• Consultation	$12	100%
• Diagnostic casts	$20	100%
X-rays and Pathology:		
• Bitewing X-rays (limited to twice per year)	$ 8	100%
• Entire series including bitewings; panoramic film (limited to once every three years)	$14	100%

	Non-Participating Dentists	DMO® Participating primary care and Specialty Dentists
Basic Services - Type A	**Maximum Benefit Payable**	**Plan Pays* (Percentage of dentist's eligible charge)**
• Vertical bitewing X-ray (limited to one set every three years)	$12	100%
• Periapical X-rays	$ 6	100%
• Intra-oral, occlusal view, maxillary or mandibular	$ 8	100%
• Extra-oral upper or lower jaw	$12	100%
• Biopsy and histopathologic examination of oral tissue	$27	100%

Basic Type B Services

	Non-Participating Dentists	DMO® Participating primary care and Specialty Dentists
Basic Services - Type B	**Maximum Benefit Payable**	**Plan Pays* (Percentage of dentist's eligible charge)**
Endodontics:		
• Pulp capping	$ 3	100%
• Pulpotomy	$27	100%
• Root canal therapy (including Necessary X-rays):		
— Anterior	$80	100%
— Bicuspid	$96	100%
Restoration and Repairs:		
• Amalgam restoration		
— One surface	$12	100%
— Two surfaces	$16	100%
— Three surfaces	$24	100%

	Non-Participating Dentists	DMO® Participating primary care and Specialty Dentists
Basic Services - Type B	**Maximum Benefit Payable**	**Plan Pays* (Percentage of dentist's eligible charge)**
— Four or more surfaces	$26	100%
• Resin restoration (other than for molars)		
— One surface	$12	100%
— Two surfaces	$16	100%
— Three surfaces	$26	100%
— Four or more surfaces or incisal angle	$30	100%
• Retention pins	$14	100%
• Sedative fillings	$12	100%
• Stainless steel crowns	$26	100%
• Prefabricated resin crowns (excluding temporary crowns)	$60	100%
• Recementing inlays, crowns, bridges, space maintainers	$16	100%
• Tissue conditioning for dentures	$26	100%
Periodontics:		
• Emergency treatment (abscess, acute periodontitis, etc.)	$26	100%
• Scaling and root planing (limited to four separate quadrants per year)	$40	100%
• Periodontal maintenance procedures following surgical therapy (limited to two per year	$40	100%
Oral Surgery (includes local anesthetics and routine post-operative care):		
• Extractions, uncomplicated	$ 27	100%
• Surgical removal of erupted tooth	$ 32	100%
• Surgical removal of impacted tooth (soft tissue)	$ 40	100%
• Excision of hyperplastic tissue	$ 32	100%
• Excision of pericoronal gingival	$ 40	100%

	Non-Participating Dentists	DMO® Participating primary care and Specialty Dentists
Basic Services - Type B	**Maximum Benefit Payable**	**Plan Pays* (Percentage of dentist's eligible charge)**
• Incision and drainage of abscess	$ 20	100%
• Crown exposure to aid eruption	$ 26	100%
• Removal of foreign body from soft tissue	$ 20	100%
• Suture of soft tissue injury	$ 20	100%

Basic Type C Services

	Non-Participating Dentists	DMO® Participating primary care and Specialty Dentists
Basic Services - Type C	**Maximum Benefit Payable**	**Plan Pays* (Percentage of dentist's eligible charge)**
Restorations:		
• Inlays		
— One surface	$ 60	75%
— Two or more surfaces	$ 80	75%
• Onlays		
— Two surfaces	$ 80	75%
— Three or more surfaces	$ 80	75%
• Crowns (including build-ups when Necessary)	$120	75%
• Posts and core	$ 27	75%
• Pontics	$ 20	75%

	Non-Participating Dentists	DMO® Participating primary care and Specialty Dentists
Basic Services - Type C	**Maximum Benefit Payable**	**Plan Pays* (Percentage of dentist's eligible charge)**
Dentures and Partials (includes relines, rebases and adjustments within six months after installation):		
• Complete (upper or lower)	$120	75%
• Partial	$120	75%
• Stress breakers (per unit)	$ 40	75%
• Interim partial dentures (Stay plates); anterior only	$ 40	75%
• Crown and bridge repairs	$ 27	75%
• Adding teeth to an existing partial denture	$ 40	75%
• Full and partial denture repairs	$ 27	75%
• Relining/rebasing dentures (includes adjustments within six months after installation)	$ 40	75%
• Occlusal guard (for bruxism only)	$ 40	75%
Space Maintainers (includes all adjustments within six months after installation):		
• Fixed, band type	$ 40	75%
• Removable acrylic with round wire clasp	$ 32	75%
• Recement space maintainer	$ 10	75%
• Removal of fixed space maintainer (by dentist who did not place appliance)	$ 10	75%

Specialty Care Dental Services - Type B

	Non-Participating Dentists	DMO® Participating primary care and Specialty Dentists
Specialty Services — Type B	**Maximum Benefit Payable**	**Plan Pays* (Percentage of dentist's eligible charge)**
Endodontics (includes local anesthetics when Necessary):		
• Apexification/recalcification—per visit	$ 32	100%
• Apicoectomy (per tooth)—first root	$ 60	100%
• Apicoectomy (per tooth)—each additional root	$ 40	100%
• Retrograde filling	$ 14	100%
• Root amputation	$ 27	100%
• Hemisection	$ 27	100%
Oral Surgery (includes local anesthetics when Necessary and post-operative care):		
• Removal of residual root	$ 27	100%
• Removal of odontogenic cyst	$ 40	100%
• Closure of oral fistula	$ 48	100%
• Removal of foreign body from bone	$ 20	100%
• Sequestrectomy	$ 20	100%
• Frenectomy	$ 40	100%
• Transplantation of tooth or tooth bud	$ 48	100%
• Alveolectomy (in conjunction with extractions) — per quadrant	$ 27	100%
• Alveolectomy not in conjunction with extractions—per quadrant	$ 40	100%
• Removal of exostosis	$ 60	100%
• Sialolithotomy; removal of salivary calculus	$ 36	100%
• Closure of salivary fistula	$ 36	100%

	Non-Participating Dentists	DMO® Participating primary care and Specialty Dentists
Specialty Services — Type B	**Maximum Benefit Payable**	**Plan Pays* (Percentage of dentist's eligible charge)**
Periodontics:		
• Gingivectomy or gingivoplasty—per quadrant	$ 40	100%
• Gingivectomy or gingivoplasty—1 to 3 teeth – per quadrant	$ 20	100%
• Gingival flap procedures—per quadrant	$ 60	100%
• Occlusal adjustment (other than with an appliance or by restoration):		
— Limited	$ 20	100%
— Entire mouth	$ 40	100%

Specialty Care Dental Services - Type C

	Non-Participating Dentists	DMO® Participating primary care and Specialty Dentists
Specialty Services — Type C	**Maximum Benefit Payable**	**Plan Pays* (Percentage of dentist's eligible charge)**
Endodontics (includes local anesthetics when necessary)		
• Complex Molar Root Canal Therapy	$120	75%
Intravenous Sedation and General Anesthesia • Per 15-minute segment	$20	75%
Oral Surgery (includes local anesthesia when necessary and postoperative care)		
• Surgical removal of impacted		
— Partially bony	$53	75%
— Completely bony	$60	75%
— Completely bony with unusual surgical complications	$64	75%

	Non-Participating Dentists	DMO® Participating primary care and Specialty Dentists
Specialty Services — Type C (continued)	**Maximum Benefit Payable**	**Plan Pays* (Percentage of dentist's eligible charge)**
Periodontics:		
• Osseous surgery (including flap entry and closure) - per quadrant	$80	75%
• Osseous surgery (including flap entry and closure) - 1 to 3 teeth per quadrant	$40	75%
• Clinical crown lengthening - hard tissue	$40	75%
Orthodontics:		
• Comprehensive orthodontic treatment • Post treatment stabilization • Interceptive orthodontic treatment • Limited orthodontic treatment • Lifetime Maximum per covered person	Lifetime maximum of $1,000 per Covered Person	50%

Cleft Lip and Cleft Palate Rule

Coverage for the treatment of a cleft lip or cleft palate is provided as follows:

Dental related oral surgery of a cleft lip or cleft palate for a child under age 18 is Covered as a Type B Service.

If coverage for orthodontic treatment is not otherwise specified in the Booklet-Certificate, orthodontic treatment of a cleft lip or cleft palate for a child under 18 is Covered as an orthodontic expense.

Note: Dental treatment will be paid according to the option in effect when a service is provided. For Plan purposes, a service is considered as provided when treatment begins (when a tooth is prepared or a canal is opened).

Appendix C: Services/Charges Not Covered Under the Dental Plan

General Exclusions

The following services are not Covered under the Traditional option:

- Work done for appearance (cosmetic purposes).
- Fees in excess of Reasonable and Customary (R&C) charges.
- Replacement of lost or stolen appliances.
- Work furnished or payable by the armed forces of any government or by any civil unit of any government.
- Treatment resulting from declared or undeclared war, insurrection, participation in a riot, or service in the armed forces of any government.
- Appliances, restorations or procedures to alter vertical dimension or restore occlusion, or for the purpose of splinting or correcting attrition or abrasion.
- Services payable under workers' compensation or similar laws.
- Services Covered by any other company-provided health plan.
- Work done while not Covered under the Dental Plan, except for certain services as explained in this summary plan description (SPD) under "Extension of Coverage" sections.
- Replacement of teeth removed before coverage is effective.
- Extra sets of dentures or other appliances.
- Work that is otherwise free of charge.
- Services or supplies not Necessary for proper dental care, as determined by the Claims Administrator.
- Charges for broken appointments.
- Charges for completing or filing claim forms.

- Educational training programs, dietary instructions, plaque control programs.
- Sealants.
- Implantology.
- Treatment resulting from or caused by the negligent or wrongful act of a third party.
- Periodontal splinting.
- Anesthesia, except general anesthesia when medically Necessary in connection with Covered oral surgery.
- Drugs or their administration.
- Experimental and investigational procedures, as determined by the Claims Administrator.
- Services or supplies not specifically defined as Covered dental expenses under the Plan.

DMO® Option Exclusions

The following services are not covered under the DMO® option:

- Charges for a service to the extent that it is:
  - Not reasonably Necessary or customarily performed.
  - More than the usual charge made when there is no insurance.
  - Above the prevailing charge in the area for dental care of a comparable nature, as determined by Aetna.
  - Covered under any other program paid for in full or in part, directly or indirectly, by a plan sponsored by Alcatel-Lucent or any Participating Company, including insured and uninsured programs.
  - Above any limits shown in the applicable list of dental services unless otherwise specified.
  - Provided by someone other than a dentist except a licensed dental hygienist under the direction of a dentist.
- Charges for:

— Replacement of a lost or stolen appliance.

— Replacement of appliances that have been damaged due to abuse, misuse or neglect.

— Appliances or restorations needed to alter vertical dimension or restore occlusion, or for the purpose of splinting or correcting attrition or abrasion.

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

— General anesthesia and intravenous sedation, unless done in conjunction with another necessary covered service.

— Services, procedures, drugs or other supplies that are determined by the Claims Administrator to be experimental, or still under clinical investigation by health professionals.

— Replacing or modifying a partial or full removable denture, bridge, or fixed bridgework, or for adding teeth to any of these, or for replacing or modifying a crown or gold restoration, within five years after that denture, bridge, bridgework, crown or gold restoration was installed.

— A partial or full removable denture, bridge or fixed bridgework if it includes the replacement of one or more natural teeth missing before coverage under the Dental Plan was effective (unless the appliance also includes replacement of a natural tooth that is removed while the person is Covered by the Dental Plan, *and* which was not an abutment to a partial denture, removable bridge or fixed bridge installed during the prior five years).

— An appliance or modification of one if an impression for it was made before the person became Covered under the DMO® option.

— A crown, bridge or cast restoration if a tooth was prepared for it before the person became Covered under the DMO® option.

— Root canal therapy if the pulp chamber for it was opened before the person became Covered under the DMO® option.

— A cast restoration or crown, unless required for the treatment of decay or an injury that makes it impossible to restore the tooth with a filling material; or unless the tooth is an abutment to a Covered partial denture or fixed bridge.

— Pontics, crowns, cast or processed restorations made with high noble metals, unless otherwise specified.

— Surgical removal of wisdom teeth only for orthodontic reasons, unless otherwise specified.

— Services needed solely in connection with a non-covered service.

— Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.

— Services for the treatment of problems of the jaw joint, including temporomandibular joint disorder (TMJ), craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint.

— Services furnished for cosmetic purposes (unless the services are needed as the result of accidental injuries sustained while a person is Covered under the DMO® feature). Facings on molar crowns or pontics (those behind the second bicuspid) will be considered cosmetic.

— Injury arising out of, or in the course of, any work for wages or profit (whether or not with the employer), or diseases covered with respect to such work, by any workers' compensation law, occupational disease law or similar law.

Additional DMO® Option Exclusions

A charge for a service to the extent that it is:

- Furnished by or on behalf of the United States Government or any other government, unless payment of the charge is required by law.

- Provided by any law or governmental plan under which the person is or could be covered**.** This does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

You may be eligible for reimbursement for expenses not Covered by the Dental Plan through the Alcatel-Lucent Health Care Flexible Spending Account.

Appendix D: Dentist Location List

How to Use This List

The fee schedules listed below apply to Type B other Covered services under the Traditional option only. The list is arranged alphabetically by state. In states with more than one fee schedule, the numbers in parentheses to the right of the location indicate the first three numbers of the zip code range for which that particular schedule applies.

Please note that the fee schedule is based on your dentist's office location and not your home location.

Dentist's Location	Schedule Number
Alabama	I
Alaska	II
Arizona	II
Arkansas	I
California	IV
Colorado	III
Connecticut • New London Area (063) • Waterbury Area (067) • Remainder of State	 III III IV
Delaware • Wilmington (198) • Remainder of State	 IV III
District of Columbia	III

Dentist's Location	Schedule Number
Florida	
• Pensacola Area (324-325)	II
• Orlando Area (327-329)	II
• Remainder of State	III
Georgia	
• Atlanta (303)	III
• Atlanta Area (300-302)	II
• Remainder of State	I
Hawaii	III
Idaho	II
Illinois	II
Indiana	
• Indianapolis Area (460-462)	II
• Gary, South Bend, Ft. Wayne and Surrounding Areas (463-469 and 473)	II
• Remainder of State	I
Iowa	I
Kansas	II
Kentucky	
• Louisville (402)	II
• Remainder of State	I
Louisiana	
• Baton Rouge (708)	II
• Remainder of State	I
Maine	II
Maryland	III
Massachusetts	III

Dentist's Location	Schedule Number
Michigan	
• Detroit Area (480-483)	III
• Remainder of State	II
Minnesota	
• Minneapolis/St. Paul (550-554)	III
• Remainder of State	I
Mississippi	
• Jackson (392)	II
• Remainder of State	I
Missouri	
• St. Louis Area (630-633)	II
• Kansas City Area (640-641)	II
• Remainder of State	I
Montana	II
Nebraska	I
Nevada	III
New Hampshire	II
New Jersey	
• Newark Area (070, 079)	IV
• Southern New Jersey (080-084)	II
• Remainder of State	III
New Mexico	II
New York	
• New York City Area and Westchester and Putnam Counties (100-112)	III
• Remainder of State	II
North Carolina	II
North Dakota	I

Dentist's Location	Schedule Number
Ohio	
• Cleveland Area (440-441)	II
• Cincinnati Area (450-452)	II
• Remainder of State	I
Oklahoma	
• Oklahoma City Area (730-731)	II
• Tulsa Area (740 and 741)	II
• Remainder of State	I
Oregon	III
Pennsylvania	
• Philadelphia (189, 190)	III
• Remainder of State	II
Rhode Island	III
South Carolina	II
South Dakota	I
Tennessee	
• Nashville (372)	II
• Memphis (381)	II
• Remainder of State	I
Texas	
• Houston (770-772)	III
• Austin (787)	III
• Remainder of State	II
Utah	I
Vermont	III
Virginia	
• Washington, DC Area (201, 220-223)	III
• Remainder of State	II

Dentist's Location	Schedule Number
Washington	
• Seattle, Tacoma Areas (980-984)	IV
• Remainder of State	III
West Virginia	
• Wheeling Area (260)	II
• Remainder of State	I
Wisconsin	II
Wyoming	II
Outside U.S.	II