Alcatel-Lucent Dental Expense Plan for Active Employees

Summary Plan Description For Active Management Employees

January 2010

Disclaimer

This is a summary of the benefits offered under to active, non-represented, 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 January 1, 2010, and replaces all previous SPDs and other descriptions of benefits provided under the Plan. If there is any conflict between the information in this SPD and the Dental Plan, the Dental Plan document will govern.

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, 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.

Questions regarding your benefits should be addressed as indicated in this document (see "Section J. 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.

> ***Please Note:*** Participation in the Dental Plan is neither an offer of nor a guarantee of continued benefits during retirement.

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Section A. Alcatel-Lucent Dental Plan — Highlights

Here's a summary of some key features of the Dental Plan.

Dental Plan Feature	Summary
Eligibility	If you are a full-time or part-time active management employee, you are eligible to enroll yourself and your Eligible Dependents on your first day of work with the Company or a Participating Company.
When Coverage Begins	If you are a Management employee working at least 20 hours per week, you are automatically enrolled for individual coverage under the Enhanced Dental Plan as of your first day of work. If you are a Managed Solutions employee, you are automatically enrolled in the Standard Dental Plan as of your first day of work. All Active Management employees will have 31 days from the date you are notified of your eligibility for the Dental Plan in which to change your coverage option or enroll your eligible dependents. Provided you make these changes within the 31-day period, coverage for you and your enrolled dependents is retroactive to your first day of work. Visit the Your Benefits Resources™[1] Web site at http://resources.hewitt.com/alcatel-lucent or call the Alcatel-Lucent Benefits Center at 1-888-232-4111 to enroll your Eligible Dependents.
Cost	Your cost will depend on the coverage option and category you select.
Coverage Options and Coverage Amounts	You are automatically enrolled in either the Enhanced or Standard Dental Plan. You also have an option of electing No Coverage. The Dental Plan includes the MetLife Preferred Dentist Program (PDP) network feature that can help reduce your out-of-pocket costs when you receive services from a participating PDP dentist. This is because participating PDP dentists agree to accept fees for services that are typically 10% to 30% lower than reasonable and customary (R&C) charges within that geographic region.
Changing Your Coverage	After you are first automatically enrolled in coverage, you can only make changes 31 days from the date you are notified of your eligibility for the Dental Plan, during the annual open enrollment period, and due to certain qualified status changes, such as marriage.

[1] Your Benefits Resources™ is a trademark of Hewitt Associates LLC.

Dental Plan Feature	Summary
Informational Resources and Important Contact	You can obtain information by visiting the Your Benefits Resources online at http://resources.hewitt.com/alcatel-lucent or by calling the Alcatel-Lucent Benefits Center (domestic: 1-888-232-4111; international: 1-847-883-0660). Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET). If you are hearing or speech impaired, please use a Relay Service when calling a representative.

Section B. Terms You Should Know

There are several words and phrases that have specific meanings under the Dental Plan. This section explains these terms so that you can better understand your benefits.

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 (domestic) or 1-847-883-0660 (international). If you are hearing or speech impaired, please use a Relay Service when calling a representative**.** Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET). You can also obtain information by visiting the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent.

Annual Maximum: The maximum benefit available from the Plan each calendar year for each covered person. Once the annual maximum benefit has been paid, no other benefits are available under any circumstances. You are responsible for all charges above the annual maximum benefit.

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[2], 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;

[2] 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 unmarried child(ren) (including those of your domestic partner or opposite-sex spouse) to the end of the month in which they reach age 20 (or to the end of the month in which they reach age 24, if they are continuously enrolled as full-time students) as follows:

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

  — Child(ren) for whom you, your spouse or your domestic partner is appointed a legal guardian as defined by a court order (this does not include 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

- Child(ren) beyond age 20 who are incapacitated, unmarried, certified by a medical Claims Administrator and who meet all of the following requirements:

  — Incapable of self-support;

  — Physically or mentally handicapped;

  — Became incapacitated prior to exceeding the child eligibility requirements; and

  — Fully dependent on you for support.

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

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.

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 one another 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; and
- Provide such other information as may be necessary for the Company to determine whether the Domestic Partner or the Child of the Domestic Partner is the Eligible Employee's dependent under the Plan.

Domestic Partnership Dependent: An individual who is either your Domestic Partner, or the unmarried Child of your Domestic Partner through the end of the month in which they reach age 20 or through the end of the month in which they reach age 24, if they are continuously enrolled as full-time students.

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

Eligible Employee: A regular active management employee who works for a participating company.

Note that 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.

In-Network Provider: This is a dental provider that has contracted with MetLife to provide dental services and supplies at a predetermined cost and is a part of the PDP network.

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.

Lifetime Maximum: The maximum benefit available from the Plan in a lifetime for each covered person. Once the lifetime maximum benefit has been paid, no other benefits are available under any circumstances. You are responsible for all charges above the lifetime maximum benefit.

Network: The providers in a given area who have signed a contract to participate with MetLife and offer services to members enrolled with MetLife at a contract rate.

Out-of-Network Provider: This is a dental provider that is not part of the PDP network.

Participating Company/Companies: A company or companies that participate in the Dental Plan. As of January 1, 2010, these are:

- Alcatel-Lucent Investment Management Corporation;
- Alcatel-Lucent Managed Solutions LLC;
- Alcatel-Lucent Management Services Inc.
- Alcatel-Lucent USA Inc.
- Alcatel-Lucent World Services Inc.
- Ascend Communications Inc.
- LGS Innovations International Inc.
- LGS Innovations LLC
- LGS Integrated Solutions Inc.

- Lucent Technologies GRL LLC
- Lucent Venture Partners Inc.
- Motive, Inc.
- Radio Frequency Systems, Inc.
- Reachview Technologies LLC
- Telica, Inc.

PDP: MetLife's® Preferred Dentist Program (PDP) is a network of participating dentists who have agreed to accept negotiated fees for their services. You can choose any provider at the time of treatment, but when visiting a participating PDP dentist, you have the opportunity to lower your out-of-pocket expenses.

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 Claims 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 ("Section J. Important Contacts") for more information on how QMCSOs are administered and to receive a copy of Alcatel-Lucent's QMCSO administrative procedures at no cost.

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.

Section C. Participating in the Dental Plan

Who Is Eligible

If you are an Eligible Employee (see "Section B. Terms You Should Know"), coverage under the Dental Plan is available to you. As a participant in the Dental Plan, you may also enroll your Eligible Dependents for dental coverage under the same option you choose for yourself.

Note that 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

What you need to do to enroll for dental coverage differs depending on whether you are:

- A newly hired employee;
- An employee changing your existing coverage during an annual open enrollment period; or
- An employee changing your existing coverage during the year due to a Qualified Status Change.

Coverage Categories

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

Your Coverage Tier (as it appears on the Your Benefits Resources Web site)
• **You Alone** *(individual)* • **You + Children** *(you and your eligible dependent child[ren])* • **You + Spouse** *(you and your lawful spouse or domestic partner)* • **You + Family** *(you and your eligible dependent child[ren] and spouse or domestic partner)*

Enrolling Your Domestic Partnership Dependents

If you elect to enroll your Domestic Partnership Dependents, call the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET.

The Alcatel-Lucent Benefits Center can also tell you the tax impact of enrolling Domestic Partnership Dependents (see also "Tax Treatment of Domestic Partnership Dependent Coverage" later in this section).

Couples Working for Alcatel-Lucent

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 a participant 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 Employee***	***Management Plan Design Retiree***	***Active Represented Employee***	***Formerly Represented Retiree***
Active Management Employee	Yes	Yes	No[3]	No
Active Represented Employee	No[4]	No	Yes	Yes

Newly Hired Employees

If you are a full-time or a part-time employee regularly scheduled to work 20 or more hours a week, you are assigned individual coverage under the Dental Plan as of your first day of work.

If you are scheduled to work less than 20 hours a week or if you want to change your assigned option or add Eligible Dependents to your coverage, you must actively enroll.

> ***Please Note:*** Generally, you must enroll your Eligible Dependents in the same option that you choose for yourself.

Regardless of whether you are assigned coverage, you generally will receive an e-mail from the Alcatel-Lucent Benefits Center pointing you to the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent for more

[3] You may cover an active represented 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 employee may cover a Management if that employee is not a full time employee working 20 or more hours a week.

information about your coverage options, including the cost, how to enroll yourself and your Eligible Dependents, and the date by which you must make your elections (generally, within 31 days after you receive your enrollment information).

However, if you go online before you actually start working and enroll through Alcatel-Lucent's pre-enrollment process ("Day One Process"), you will not receive an e-mail since you will already have enrolled. In this case, within 31 days after the date you start working, you may still make changes to the coverage you selected, but to do so you must call the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).If you are hearing or speech impaired, please use a Relay Service when calling a representative.

If You Don't Enroll (New Hires)

As a new hire, if you don't make any elections by the required date, here's what happens:

- If you are a regular full-time employee or a regular part-time employee **scheduled** to work 20 or more hours a week, you **alone** will continue to have coverage under a dental coverage option. You may not add any Eligible Dependents until the next annual open enrollment unless you have a qualified status change (see "Changing Your Coverage During the Year" later in this section).

- If you are scheduled to work less than 20 hours per week, you will **not** be assigned a dental coverage option. This means you and your Eligible Dependents **cannot** enroll in the Dental Plan until the following calendar year. You must wait until the next annual open enrollment to enroll, unless you have a qualified status change (see "Changing Your Coverage During the Year" later in this section).

Annual Open Enrollment

During annual open enrollment each year, you'll have the opportunity to select the dental coverage that best meets your needs for the coming year. This means that you may "add" or "cancel" coverage for yourself and your Eligible Dependents and/or change Dental Plan options. Annual open enrollment is held once a year, usually in the fall. **Elections made during annual open enrollment take effect on the first day of the next calendar year.**

Before annual open enrollment, you'll receive enrollment materials that will include information about the coverage options available to you under the Dental Plan in the upcoming year. In most cases, if you are currently enrolled in the Dental Plan and do not make any changes to your coverage, your current coverage elections will remain in effect unless a particular Dental Plan option is being discontinued or replaced by another option.

If your Dental Plan option is being discontinued and you do not select another Dental Plan option, you will be enrolled in your default option.

You can enroll:

- On the Your Benefits Resources at http://resources.hewitt.com/alcatel-lucent; or
- Over the phone by calling the Alcatel-Lucent Benefits Center at 1-888-232-4111 and speaking to a representative. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET. If you are hearing or speech impaired, please use a Relay Service when calling a representative.

Keeping Your Information Up to Date

If your e-mail 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 benefits coverage information without delay.

Changing Your Coverage During the Year

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.

Qualified Status Changes

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.
Employment Status	A termination or commencement of employment by you, your spouse or Child.
Change in Employment Status	You, your Lawful Spouse, or other dependent becomes employed or loses employment.
Your Dependent Meets or No Longer Meets the Eligibility Requirements	An event that causes a dependent to meet or to no longer satisfy the Dental Plan's eligibility requirements, for example, a Child reaches the maximum age for coverage or gets married.
Change in Residence	A change in permanent residence for you, your Lawful Spouse, or an Eligible Dependent.
Significant Cost or Coverage	A significant change in the cost or coverage under the Dental Plan or

Qualified Status Change	Description
Changes	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).
End of COBRA Continuation Coverage	You may be able to enroll in the Dental Plan during the year if COBRA coverage from another plan for you, your spouse or dependent is exhausted during the year. However, you must continue COBRA coverage for the full duration of the COBRA coverage period. If you do not exhaust the COBRA coverage, you will have to wait until annual open enrollment, even if the COBRA coverage ends mid-year due to, for example, a failure to pay premiums. For more information, visit the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent or call the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., ET.
***Enrolled* Employee Marries or Acquires a Child Through Birth, Legal Adoption or Placement With You for Legal Adoption**	If you are already enrolled and you marry, have a child, legally adopt a child, or a child is placed with you for legal adoption, you may enroll your spouse and/or your newborn or newly adopted child (or child newly placed with you for adoption), provided you request the enrollment within 31 days after your marriage, or the birth, adoption, or placement for adoption of your child (as the case may be).
Eligible *Non-Enrolled* Employee Marries or Acquires a Child Through Birth, Legal Adoption or Placement With You for Legal Adoption	If you are eligible, but had not enrolled in the Dental Plan as of the date of your marriage, or the date of the birth, legal adoption or placement for legal adoption, you may enroll yourself, your spouse and/or your newborn or newly adopted child (or child placed with you for adoption), provided you request the enrollment within 31 days after your marriage or the birth, adoption or placement for adoption of your child (as the case may be).

Please note: 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 and your Covered spouse divorce, you must drop your spouse

from coverage, but you may not change your Dental Plan option. As long as you enroll within the required timeframe, coverage will be retroactive to the date of the qualified status change.

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 open enrollment period is in October and the other plan's annual open 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.

New Dependents/Spouse of a Non-Enrolled Employee

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

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

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

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.

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

There is also a special enrollment period for you to enroll a "newly acquired dependent" other than a newborn Child, newly adopted Child, a Child newly placed with you for adoption, or a Child for whom you, or you and your Lawful Spouse or

Domestic Partner, have been newly appointed as legal guardian. Examples of such a newly acquired dependent are:

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

Coverage under the Plan for your Lawful Spouse or Domestic Partner, your Lawful Spouse's or Domestic Partner's Children and, if applicable, for yourself, will be retroactive to the date of your marriage or the date of entering into the Domestic Partner relationship. If you do not enroll during the 60-day special enrollment period, you will have to wait until the next annual open enrollment period to enter the Plan. 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 **31** days of its occurrence 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., ET. If you don't, you can't make a coverage change until the next annual open enrollment period, unless you once again meet one of the conditions for a qualified status change during the year.

The Cost of Coverage

Your cost for Dental Plan coverage is automatically deducted from your pay over the course of the year. Your payroll deduction amount for benefit coverage including the Dental Plan appears on your pay statement.

You can find information about the cost of coverage for the Dental Plan by visiting the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent or by calling the Alcatel-Lucent Benefits Center at 1-888-232-4111.

If you choose No Coverage, you will not receive any credits in your paycheck.

Tax Treatment of Domestic Partner Dependent Coverage
The cost of covering a Domestic Partnership Dependent has to be deducted from your paycheck on an after-tax basis. In addition, the Company's contribution to the Domestic Partnership Dependent's coverage is added to your taxable income, subject to both income tax and FICA withholding.

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

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 D. How the Dental Plan Works

Understanding Your Options Under the Dental Plan

The Dental Plan offers two types of coverage options:

- The Enhanced option; and
- The Standard option.

If you elect coverage, one of the differences between the two options is that the Standard option is subject to a deductible of $50 per individual per year, or $100 per family per year.

However, both the Enhanced and Standard Dental Plan options cover 100 percent of reasonable and customary (R&C) charges for covered diagnostic and preventive services, such as routine oral exams and cleaning and scaling of teeth. Benefits for covered restorative expenses, such as fillings and crowns, are covered at 80 percent of R&C charges, and orthodontic services are covered at 50 percent of R&C charges. See "Appendix A" for more information on how benefits are paid.

Both options are also part of the MetLife Preferred Dentist Program (PDP). The PDP network may save you money on dental services from participating dentists, including specialists.

The MetLife Preferred Dentist Program (PDP)

By going to a dentist who participates in the PDP network, you and your covered dependents will receive dental care at charges lower than the average cost for care in your area. You receive the same reimbursement percentage of covered charges whether or not you visit a dentist in the program. However, since a dentist who participates may charge less for the services, the remaining cost will be less, reducing your out-of-pocket expense.

Comparing Benefits

The following example will give you an idea of how benefits are paid if you elect coverage under the Enhanced Dental Plan option, and how much you could save by using a PDP provider.

For example: You need a crown.

	If you use a PDP provider:	If you use a non-PDP provider:
Dentist's usual fee	Not applicable	$600
PDP negotiated fee	$375	Not applicable
R&C fee	Not applicable	$500
Amount Dental Plan pays	$300 *(80% of PDP negotiated fee)*	$400 *(80% of R&C)*
Amount you pay	$75	$200
Amount you save by using a PDP provider	**$125**	

Taking Advantage of the PDP

To take advantage of the PDP network you must be enrolled in the Dental Plan. Visit the MetLife Web site at www.metlife.com/mybenefits, or call 1-888-262-4876, to find a dentist who participates. You and your covered dependents can select the same or different dentists, and you don't have to select a primary dentist in the PDP to take advantage of the features. Just let your dentist know that you participate in the MetLife PDP when you schedule your appointment.

While the most up-to-date provider listings are available at www.metlife.com/mybenefits, if you do not have Web access, you can contact MetLife once you are enrolled to request a list of participating PDP dentists in your area.

If you visit a dentist who is not in the PDP, your dentist will need to complete and submit a claim form. Claim forms are available from MetLife. Or, ask your dentist to apply to join the PDP. He or she can visit www.metdental.com, or call 1-877-MET-DDS9. (Note that this Web site and phone number are for dental professionals only.)

Getting the Most from Your Coverage

In addition to using the MetLife PDP, you can ensure that you receive the maximum benefit under the Dental Plan by keeping the following in mind when arranging dental care.

Alternate Procedures

Often, there are several ways to treat a particular dental condition. For example, suppose in repairing your tooth, the dentist has the option of using a filling or a crown, and that either treatment meets with generally accepted dental standards. In such instances, the Dental Plan 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 Dental Plan 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 $300, you should determine before treatment begins what is covered and how much the Dental Plan will pay. This procedure is called "predetermination of benefits." Here is how predetermination works:

- Your dentist outlines the treatment plan and fees on the claim form, and sends it to MetLife; then
- MetLife determines the amount the Dental Plan will pay and informs you and your dentist.

If after reviewing the predetermination, you and your dentist decide to change the treatment plan, MetLife 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 $300, MetLife will pay the claim based on the information it has about your case and the alternate benefit provision. If it is determined 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.

Section E. Miscellaneous Coverage Information

Right of Recovery and Subrogation

If all or some of the expenses under the Dental Plan are not payable (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.

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. You or your covered dependents are still responsible for any improper or excess payments made to you or your covered dependents or to providers under the Dental Plan.

Failure by you or your covered dependents, or any other person or organization that was improperly or excessively paid, to promptly refund the full amount 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.

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.

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 granting 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 from assigning any rights to recover dental care expenses from any tort-feasor or other person or entity to any other party. You or your covered dependents shall not incur any expenses on behalf of the Dental Plan in pursuit of the Dental Plan's rights. 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.

Coordination of Benefits

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:

- When the other healthcare coverage is Medicare;

- To benefits under any personal policy (except no-fault or other state-mandated automobile insurance); and

- To two related people, both of whom are employees and/or Dependents of employees of the Company or a Participating Company, due to the following two 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 Medical 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.

When Your Coverage Ends

Dental coverage ends:

- On the last day of the month in which you leave the company for any reason;

- If you die;

- If your coverage is canceled; or
- If you stop making any required contributions.

Coverage for your Eligible Dependents ends:

- When your coverage ends; or
- On the last day of the month in which a dependent no longer qualifies.

Extension of Coverage Under the Dental Plan
In general, no benefits will be paid under the Dental Plan for covered dental services or supplies received after coverage ends, except for:

- **Dentures or bridgework**, if the final 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 and took the final impression before coverage stopped and installs the crown within the next two months; or
- **Root canal therapy**, if the tooth was opened into the chamber before coverage stopped and the treatment is completed within the next two months.

Participant Advocacy

What Is Participant Advocacy?
Participant Advocacy is a service that can help you resolve issues with your plan or provider. After you've made at least one attempt to resolve an issue yourself, this service will put you in touch with a team of Advocates who can help you with unresolved plan access or claims issues. An Advocate will research your issue and work with your plan to resolve it on your behalf. (Keep in mind that contacting an Advocate does not guarantee a resolution in your favor, since the terms of your plan always apply.)

How Does Participant Advocacy Work?
To reach an Advocate, call the Alcatel-Lucent Benefits Center at 1-888-232-4111.

As mentioned above, before you request assistance, you must make at least one attempt to resolve the issue directly with MetLife. (This attempt does not have to be in writing.) If you contact the Alcatel-Lucent Benefits Center before talking to MetLife, your issue will not be passed on to an Advocate. Instead, you will be directed to contact MetLife.

When you call the Alcatel-Lucent Benefits Center, tell the representative:

- The type of issue and a description of what is unresolved;

- The name of your provider;
- The date of service;
- The amount of the claim in question;
- The plan's response to your initial call; and
- On rare occasions, it also may be necessary to provide detailed diagnostic information.

The representative will pass your issue on to Participant Advocacy, which will begin any necessary research. An Advocate will contact you within two business days to follow up. If your issue is deemed urgent (for instance, you are calling from a provider's office), you may be transferred to an Advocate immediately.

Section F. Employment-Related Events Affecting Coverage

If You Retire

If you retire from the company and you are eligible for a service or disability pension, your coverage under the active Dental Plan is discontinued. At retirement, you may become covered by the dental plan that 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 Dental Plan and the plan for retired employees are subject to modification or termination by the company at any time before or during your retirement.

If You Terminate Employment

Your coverage under the 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" above).

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 G. COBRA Continuation Coverage."

If You Leave the Company and Return

If you leave the company and return after a break in service, you are automatically enrolled for coverage under the Dental Plan as of your first day of active employment upon your return (see "Section C. Participating in the Dental Plan").

If You Transfer

If you transfer to another Participating Company, your participation in the Dental Plan will not be affected. If you transfer to a non-participating company, you will no longer have coverage under the Dental Plan. However, you may be eligible to continue coverage for yourself and your eligible dependents through COBRA (see "Section G. COBRA Continuation Coverage").

If You Become Disabled

If you are absent due to a temporary disability and are collecting sickness disability benefits under the Short Term Disability Plan, then your coverage under the Dental Plan continues. If you are collecting benefits under the Long Term Disability Plan, you are no longer eligible for coverage under the Dental Plan. However, you may be

eligible to continue coverage for yourself and your eligible dependents through COBRA (see "Section G. COBRA Continuation Coverage").

If You Have a Change in Dependent Status

You must update your dependent information whenever you have a change in dependent status (for example, if you get married, if you have a baby, or if your dependent no longer meets eligibility requirements; see "Section C. Participating in the Dental Plan"). To update dependent information, visit the Your Benefits Resources Web site, or contact the Alcatel-Lucent Benefits Center (see "Section J. Important Contacts").

If You Take an Approved Leave of Absence

If you are on an approved leave of absence, you can continue Dental Plan coverage for yourself and your covered dependents. In some instances, you will have to pay the full cost.

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 USA Inc. 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 Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). The period of coverage for you and your Eligible Dependents ends on the **earlier of**:

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

— **If your uniformed service is between 31 and 180 days:** You are generally required to apply to return to work within 14 days of your discharge.

— **If your uniformed service is at least 181 days:** You are generally required to apply to return to work within 90 days of your discharge.

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

- **If your military service is 31 days or less:** You are required to pay no more than your usual share of the cost for this period of coverage.
- **If your military service is more than 31 days:** You must pay the entire cost of the coverage (not to exceed 102% 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.

Section G. 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; or • A reduction in your work hours.	Up to 18 months from the date of qualifying event.

If This Qualifying Event Occurs…	COBRA Continuation Coverage Can Last for…
• Disability occurs at any time during the 60 days 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 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.[5]

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

For example, suppose you terminate employment on December 31, 2008, and you are eligible to continue coverage for 18 months (until June 30, 2010). Your child, who is a Covered Dependent December 31, 2008, reaches age 24 (a second qualifying event) on December 31, 2009. 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, 2011, which is 36 months from December 31, 2008, the date of your termination of employment (the original qualifying event).

[5] 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.

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 60 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.

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.

What COBRA Coverage Costs
COBRA participants must pay monthly premiums for coverage.

Generally, premiums are based on the full cost per covered person, set at the beginning of the year, plus two percent for administrative costs. Dependents making separate elections are charged the same rate as a single employee.

Payment is due at enrollment, but there is a 45-day grace period from the date you elect coverage to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s).

Ongoing monthly payments are due on the 10th of each month, but there is a 45-day grace period (for example, the June payment is due June 10th, but will be accepted if postmarked up to 45 days after that).

If you or your dependent elects COBRA continuation coverage:

- You or your dependent can keep the same level of coverage you had as an active employee or choose a lower level of coverage;

- Your or your dependent's coverage is effective as of the date of the qualifying event, unless you waive COBRA coverage and then revoke the waiver within the 60-day election period. In this case, your elected coverage begins on the date you revoke your waiver;

- You or your dependent may change coverage:

  — During the benefits annual open enrollment period, or

  — If you or your dependent has a qualified change in status or another change in circumstance recognized by the Internal Revenue Service (IRS) and the company; and

- You may enroll any newly eligible spouse or child under the Dental Plan's rules.

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 H. Claims and Appeals

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, an Urgent pre-service benefits claim, or a concurrent care benefits claim (these types of benefits claims are described below; see "Benefits Claims" immediately below), an effort will be made to handle the eligibility claim in tandem with the benefits claim.

Benefits Claims

A benefits claim is exactly what it sounds like — it is a claim for benefits under the terms of the 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.

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

  — Could be considered a life or death situation;

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

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

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

Eligibility Claims

Filing Deadlines

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

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

Where to Send Your Claim Form
Mail your completed CIF and any enclosures to the following address:

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

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

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

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

What You'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 USA Inc.
Employee Benefits Committee
600-700 Mountain Avenue
Room 7C-415
Murray Hill, New Jersey 07974

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

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

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

made the initial decision, who is not subordinate to the initial reviewer and who will give a full and fair review of the claim and the denial.

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

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

What You'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

Claim Deadlines
In instances where you are required to file a claim form in connection with a benefits claim, use the claim forms provided by MetLife. You are responsible for filling out Part I; your dentist is responsible for filling out Part II. You should submit claims within 12 months of the date the service is provided. **No benefits will be paid for claims submitted more than 12 months after the date of service**.

To file a benefits claim:

- If you don't have a claim form, call your Dental Plan carrier (MetLife). You may also be able to print out a claim form at the applicable Dental Plan carrier's (MetLife) Web site.

- Follow the instructions printed on the form.
- Attach a copy of the Provider's itemized bill.
- Submit the completed form and attachments to the address printed on the form.

Your claim will be evaluated to determine if any benefits will be paid. You'll receive an Explanation of Benefits (EOB) statement. If benefits are payable, a check will be sent to you, or to your Provider if he or she agreed to accept payment directly from your Dental Plan Carrier (MetLife). 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.

Concurrent Care Claims

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

If you do not provide sufficient information to allow the Claims Administrator to determine whether, or to what extent, the claim is Covered under the 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 J. 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.

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

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

- The specific reason(s) for the denial;

- The specific 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 I. Notice of Privacy Practices for the Alcatel-Lucent Health Plans

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 (see the contact information on the next page).

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 the contact information below).

To Exercise Your Rights

In most instances, you should contact your Dental Plan carrier and/or Claims Administrator to review or obtain copies of your health information and to exercise your rights regarding your health information. If you are unsure of the appropriate Healthcare Plan and/or Claims Administrator, have a general request that covers more than one Company-sponsored employee benefit plan or have other questions relating to our privacy practices or your privacy rights, please contact the Privacy Official:

Director, Health Plans
Room 7C-411A
Alcatel-Lucent
600 Mountain Avenue
Murray Hill, NJ 07974-0636
1-908-582-2321

Section J. Important Contacts

Here is a list of resources for the Dental Plan.

MetLife

Aside from this summary, your primary source for Dental Plan information is MetLife (the Claims Administrator under the Dental Plan).

Online
Preferred Dentist Program (PDP) directories, claim forms and general information on the MetLife PDP is available at www.metlife.com/mybenefits.

By Phone
Call MetLife Dental Customer Service at 1-888-262-4876. The TDD number is 1-888-638-4863.

By Mail
Following is the address for all correspondence (including submitting claim forms and submitting legal actions regarding a claim for benefits) for the Dental Plan.

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

When corresponding with MetLife, please indicate the coverage category you have selected.

For Dental Professionals Only
Your dentist can apply to join the PDP by visiting www.metdental.com or calling 1-877-MET-DDS9.

Other Contacts

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

Contact/Service Provided	Address/Telephone Number
Your Benefits Resources Web Site • View your current coverage • Review and compare your healthcare options and during your enrollment period • Enroll in coverage • Make changes to your default coverage • During the annual open enrollment period, waive your coverage for the next Plan Year • Learn more about Alcatel-Lucent's benefits • Review, add or change your dependent's information on file • Understand how a Life Event may affect your benefits	http://resources.hewitt.com/alcatel-lucent
Alcatel-Lucent Benefits Center • If you do not have Internet access: —— Enroll in coverage —— Make changes to your default coverage —— During the annual open enrollment period, waive your coverage for the next Plan Year —— Review, add or change your dependent's information on file • Resolve an issue that you have not been able to solve on your own first • Notify Alcatel-Lucent if: —— Imputed income applies —— If you or your Eligible Dependent(s) will become Medicare-eligible due to a disability • Take care of a unique benefits issue	1-888-232-4111 (domestic) 1-212-444-0994 (if calling from outside the U.S., 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
Alcatel-Lucent BenefitAnswers Plus Web Site • Learn more about Alcatel-Lucent's benefits, including benefits news and updates (no password required) • Obtain electronic copies of your enrollment materials • Find carrier contact information during the year	www.benefitanswersplus.com
Alcatel-Lucent Payroll Office • Handles contribution problems and address changes	http://payroll.web.lucent.com
Domestic Relations Matters Group • Handles matters relating to Qualified Medical Child Support Orders (QMCSO)	Alcatel-Lucent QDRO/QMCSO Administration P.O. Box 56887 Jacksonville, FL 32241-6887 1-904-791-2710
Plan Administrator • Contact for all 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 [MetLife])	Alcatel-Lucent Room 7C-415 600 Mountain Ave. Murray Hill, NJ 07974 Attn.: Dental Plan Administrator

Section K. Important Information about Your Benefits

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 summary plan description (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.

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 Employee Benefits Security Administration at 1-866-444-3272 or by logging on to the Internet at www.dol.gov/ebsa.

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

With certain limited exceptions, the company pays the costs associated with providing benefits under the Alcatel-Lucent USA Inc. Dental Expense Plan for Active Employees through the Lucent Technologies Inc. Health Plans Benefit Trust, which is a trust set up under Section 501(c)(9) of the Internal Revenue Code.

State Street Bank and Trust Company is located at 2 Avenue de Lafayette, Boston, Massachusetts 02111.

Plan Documents

This summary plan description was 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 Dental Plan. In all instances, even if the SPD and Dental plan documents are in conflict, the terms of the Dental plan documents will govern.

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, 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.

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.

Plan Identification – Dental Plan

Plan Name	The official Plan Name is the Alcatel-Lucent USA Inc. Dental Expense Plan for Active Employees.
Plan Sponsor	Alcatel-Lucent USA Inc.
Type of Administration	The Dental Plan is administered on Alcatel-Lucent's behalf by: MetLife 501 US Highway 22 P.O. Box 6891 Bridgewater, NJ 08807-0891
Plan Administrator	The Dental Plan Administrator is: Alcatel-Lucent Room 7C-415 600 Mountain Avenue Murray Hill, New Jersey 07974 Attn.: Dental Plan Administrator 1-908-582-7140
Claims Administrator	The Claims Administrator is MetLife. Claims should be submitted to: MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282
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.

Appendix A: Services Covered Under the Dental Plan

Please Note: This section includes a high-level summary of common procedures covered by the Plan and does not list all covered services. For information on a particular service, which may not be listed in this section, contact MetLife.

Additional frequency limits and requirements may apply. Dental treatment that spans two Plan Years (for example: dentures, bridgework, crown or root canal therapy) will be paid according to the Reasonable & Customary (R&C) rates 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 into chamber).

Lastly, "In-Network" benefits refers to benefits when services are rendered by a participating PDP dentist. "Out-of-network" benefits refers to benefits when services are rendered by a non-participating PDP dentist. "PDP fee" refers to the typically lower negotiated fees that participating MetLife dentists accept as "payment in full" from eligible plan participants.

Enhanced and Standard Dental Plan Options

General Features	Enhanced Option		Standard Option	
Network	Using the MetLife PDP network offers negotiated rates which may be lower than Reasonable & Customary (R&C); out-of-network providers are reimbursed according to R&C rates			
Annual Deductible (Individual/Family)	$0/$0		$50/$100 (deductible does not apply to preventive or orthodontic services)	
Annual Maximum Benefit (Per Individual)	$2,250		$1,500	
Orthodontia Lifetime Maximum Benefit (Per Individual)	$1,750		$1,500	
Preventive Services	***Enhanced Option pays:***		***Standard Option pays:***	
	In-Network	***Out-of-Network***	***In-Network***	***Out-of-Network***
Twice per calendar year: • Routine oral examinations • Cleaning of teeth when performed by a dentist or dental hygienist	100% of PDP fee	100% of reasonable and customary (R&C) charges	100% of PDP fee	100% of reasonable and customary (R&C) charges
Fluoride treatments when performed by a dentist or dental hygienist:	100% of PDP fee (four times per calendar year)	100% of R&C charges (four times per calendar year)	100% of PDP fee (once in 12 months, up to age 19)	100% of R&C charges (once in 12 months, up to age 19)

General Features	Enhanced Option		Standard Option	
As specified: • *Space maintainers for dependent children up to, but not including, 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 primary teeth) • *Dental X-rays and radiographs:* —— Full-mouth X-rays (not more than once in three years for Enhanced or once in 36 months for Standard) —— Supplementary bitewing X-rays (not more than twice in a calendar year for children up to, but not including, age 19; once per calendar year for adults) —— Diagnostic dental X-rays required for a specific condition, except X-rays in conjunction with orthodontics (which are covered at 50%) • *Sealants for dependent children up to, but not including, age 19:* —— Molars (limited to once in 60 months)	100% of PDP fee	100% of R&C charges	100% of PDP fee	100% of R&C charges

Restorative Services	Enhanced Option pays:		Standard Option pays:	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*
Fillings: • Amalgam one surface • Amalgam two surfaces • Amalgam three surfaces • Silicate Cement – per restoration Acrylic or Plastic • Composite Resin one anterior surface • Composite Resin two anterior surfaces • Composite Resin three anterior surfaces **Inlay/Onlay, gold** *(once in five years)*: • Two surfaces • Three surfaces **Crowns** *(once in five years):* • Plastic with semiprecious metal crowns • Porcelain crown • Porcelain with semiprecious metal crown • Gold full cast crown • Gold 3/4 cast crown • Stainless steel crown	80% of PDP fee	80% of R&C charges	80% of PDP fee	80% of R&C charges
Root Canal Therapy • **Procedures used to prevent and treat diseases of the dental pulp:** — One canal (traditional) — Two canals (traditional) — Three canals (traditional) — Pulp cap – direct	80% of PDP fee	80% of R&C charges	50% of PDP fee (once in 24 months)	50% of R&C charges (once in 24 months)

Restorative Services	Enhanced Option pays:		Standard Option pays:	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*
Oral Surgery • Simple extractions: —— Single tooth —— Each additional tooth • Surgical extractions: —— Extraction of tooth, erupted —— Extraction of tooth, partial bony impaction —— Extraction of tooth, complete bony impaction	80% of PDP fee (subject to Annual Maximum Benefit)	80% of R&C charges (subject to Annual Maximum Benefit)	80% of PDP fee (not subject to Annual Maximum Benefit)	80% of R&C charges (not subject to Annual Maximum Benefit)
Complete Dentures (once in five years; including six months post-delivery care): • Complete upper • Complete lower • Immediate upper • Immediate lower	80% of PDP fee	80% of R&C charges	50% of PDP fee	50% of R&C charges
Partial Dentures (including six months post-delivery care): • Upper with two chrome clasps with rests, acrylic base (includes all clasps and teeth) • Lower with chrome lingual bar, two clasps, acrylic base • Lower with chrome lingual bar, two clasps, cast base • Upper with chrome palatal bar, two clasps, acrylic base • Upper with chrome palatal bar, two clasps, cast base • Full cast partial with two chrome clasps (upper)	80% of PDP fee	80% of R&C charges	50% of PDP fee	50% of R&C charges
Implants (once in five years): • Cast gold • Slotted pontic • Porcelain fused to semiprecious metal	80% of PDP fee	80% of R&C charges	50% of PDP fee	50% of R&C charges
Occlusal Guards:	80% of PDP fee	80% of R&C charges	Not covered	Not covered

Restorative Services	Enhanced Option pays:		Standard Option pays:	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*
Bridge Pontics: • Relines and Rebases • Cast gold (once in five years) • Slotted pontic (once in five years) • Porcelain fused to semiprecious metal (once in five years) • Plastic processed to semiprecious metal	80% of PDP fee	80% of R&C charges	50% of PDP fee (once in 36 months)	50% of R&C charges (once in 36 months)
Periodontics*: Surgical and nonsurgical procedures to treat the supporting area around the teeth, except periodontal splinting: • Scaling and root planing • Gingival curettage (per quadrant) • Gingivectomy (per quadrant or area) • Osseous surgery — including flap entry and closure (per quadrant) • Osseous graft-single site • Guided Tissue Regeneration	80% of PDP fee	80% of R&C charges	50% of PDP fee	50% of R&C charges
Orthodontics: To prevent and correct malocclusion of teeth and associated facial problems: • Comprehensive full-banded treatment, preliminary study including X-rays and treatment plan • First month of treatment including appliances • Active treatment per month after first month	50% of PDP fee	50% of R&C charges	50% of PDP fee	50% of R&C charges

** Frequency limits may apply. Contact MetLife for frequency limitations.*

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

The following services are not Covered under the Dental Plan:

- Treatment for temporomandibular joint disorder (TMJ);
- 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 dimensions 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;
- 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;

- 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 oral surgery;
- Drugs or their administration;
- Experimental and investigational procedures, as determined by the Claims Administrator; and
- Any services or supplies not specifically defined as Covered dental expenses in the Plan.