# LUCENT TECHNOLOGIES INC.

# LONG-TERM CARE INSURANCE PLAN
# FOR OCCUPATIONAL EMPLOYEES

## SUMMARY PLAN DESCRIPTION

**Effective 1/1/99**
**Last Updated 7/9/99**

This booklet is a summary plan description (SPD) of the benefits available, effective January 1, 1999, to eligible occupational employees under the Lucent Technologies Inc. Long-Term Care Insurance Plan (Long-Term Care Plan). More detailed information is provided in the official Plan documents. In all instances, the Plan documents will control and govern the operation of the Plan. The Board of Directors of Lucent Technologies Inc. (or its delegate) reserves the right to modify, suspend, change or terminate the Plan at any time, subject to the terms of applicable collective bargaining agreements. Questions regarding your benefits should be addressed to the Insurer (see “Important Contacts”). Because of the many detailed provisions of the Long-Term Care Plan, no one other than the Insurer is authorized to advise you as to your benefits. For this reason, Lucent Technologies Inc. cannot be bound by statements made by unauthorized personnel. Please note that participation in the Long-Term Care Plan is neither an offer nor a guarantee of future employment.

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## INTRODUCTION

Because long-term care can place enormous emotional and financial burdens on families, Lucent Technologies Inc. offers the Lucent Technologies Inc. Long-Term Care Insurance Plan (Long-Term Care Plan) to eligible occupational employees and their family members. The Long-Term Care Plan gives you a choice between two types of coverage -- Nursing Home and Comprehensive -- a choice of **daily benefit** limits, and an option of electing the Nonforfeiture coverage.

# THE LUCENT LONG-TERM CARE INSURANCE PLAN -- HIGHLIGHTS

Here's a summary of the key features of the Lucent Long-Term Care Insurance Plan for occupational employees.

| Plan Feature | Summary |
|---|---|
| Eligibility | If you're an **eligible employee** (a regular, active full-time or part-time occupational employee of a **participating company** with at least six months of **net credited service**), you and your eligible family members may elect coverage under the Long-Term Care Plan. |
| Benefits | The Long-Term Care Plan offers two types of coverage: Nursing Home and Comprehensive. Both types cover an initial care planning visit and nursing home services, in-patient hospice care, assisted living facilities and a transition expense benefit. Comprehensive coverage also includes additional services such as home care services and respite care. |
| Costs | You pay the full cost of insurance coverage under the Long-Term Care Plan. |
| Proof of Insurability | Newly **eligible employees** who enroll during their first enrollment opportunity do *not* need to provide proof of insurability. Employees who enroll later, and *all* eligible family members, however, must provide proof of insurability. |
| When Long-Term Care Coverage Begins | Generally, coverage is effective on the first of the month that's on or after the date the Insurer approves the request for coverage. The employee must be **actively at work** on the effective date of coverage. See "When Coverage Begins" for exceptions. |
| When Benefits Start | Benefits begin on the first day that **daily benefits** are authorized and you are receiving covered services, and after you meet any waiting period (see "When Benefits Are Payable"). |
| When Benefits Stop | Benefits stop when your condition has improved so you are no longer eligible for benefits, or when you reach the **maximum lifetime benefit** or when your coverage stops. |

## TERMS YOU SHOULD KNOW

There are several words and phrases that have a specific meaning under the Long-Term Care Plan. This section explains those terms so that you can better understand your benefits. These terms are printed in **boldface** when they appear to let you know that they're defined here.

**Actively at work:**

- Actually present on the job and physically able to perform all duties of your job, and

- Working at least the number of scheduled hours in your work week at your regular business establishment, or at some other location to which your job requires you to travel.

**Daily benefit:** the maximum amount of money that you will be paid for each day you receive a covered service.

**Eligible employee:** a regular active, full-time or part-time occupational employee of a **participating company** with at least six months of **net credited service**.

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 Long-Term Care Plan.

**Lawful spouse:** a person who is recognized as the lawful husband or lawful wife of an active employee under the laws of the state or jurisdiction of the employee's domicile.

**Maximum lifetime benefit:** the total dollar amount of benefits available to you or to your eligible family members through the Long-Term Care Plan.

**Net credited service:** your current continuous service plus all service credited under the service bridging rules (including mandatory portability, if applicable) of the Lucent Technologies Inc. Pension Plan or the Lucent Technologies Inc. Management Pension Plan.

**Participating company:** one of the companies that participates in the Long-Term Care Plan, as listed below. Additional subsidiary Interchange Companies may be added from time to time. MPA rules are effective for employees hired on or after the date a company becomes an Interchange Company.

- Lucent Technologies Inc.
- Lucent Technologies Management Services Inc.
- Lucent Technologies World Services Inc.
- Nassau Metals Corporation

# OVERVIEW OF LONG-TERM CARE PLAN COVERAGE OPTIONS

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<tr><td>$160</td><td>$292,000</td><td>$160</td><td>$ 96</td><td>$408,800</td></tr>
<tr><td>$200</td><td>$365,000</td><td>$200</td><td>$120</td><td>$511,000</td></tr>
<tr><td colspan="5">* Paid at 60% of daily benefit.<br>** Daily benefits are paid at 100% of reasonable and customary charges up to the scheduled amounts listed above. (See “Benefit Limits, Multiple Services” if more than one covered service is being provided at the same time.)<br><br>Note: Certain benefits begin after a waiting period (see “Once Your Benefits Are Authorized”).<br><br>A Nonforfeiture coverage option is also available to each participant.</td></tr>
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# ELIGIBILITY AND PARTICIPATION

### *Who Is Eligible*

If you're an **eligible employee** with at least six months of **net credited service** with a **participating company**, you're eligible to enroll for Long-Term Care coverage.

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 Long-Term Care Plan.

If you were assigned to Lucent before May 31, 1998, the Long-Term Care Plan will count benefits provided under the corresponding AT&T Corp. plan toward the **maximum lifetime benefit** limitation under the Long-Term Care Plan.

### *Your Eligible Family Members*

If you are eligible for the Long-Term Care Plan, some of your family members may also be eligible for coverage. Your eligible family members may enroll even if you do not. Eligible family members are:

- Your **lawful spouse**, and
- Your parents, parents-in-law, grandparents and grandparents-in-law.

A Lucent Technologies Inc. employee cannot cover another Lucent Technologies Inc. employee as a dependent under the Plan.

### *When You Enroll*

If you are a newly **eligible employee**, you do not need to provide proof of insurability if you enroll within 31 days of receiving your new employee benefits enrollment materials. If you enroll before this deadline, your coverage will be effective on the first day of the month on or after the Insurer receives your enrollment form provided you are actively at work on that date. Your eligible family member's enrollment will be effective on the first day of the month after the Insurer accepts his or her proof of insurability.

If you do not enroll when first eligible, you and your eligible family members can enroll for Long-Term Care coverage at any time during the year by providing proof of insurability.

When you enroll, you select the type of coverage, the **daily benefit**, and the optional Nonforfeiture coverage (see "Coverage and Benefits").

### *Proof of Insurability*

If you are an employee, proof of insurability is not required if you enroll for Long-Term Care coverage during the first enrollment period in which you are eligible, provided you are **actively at work** on your effective date. However, proof of insurability is always required for family members.

If you are an employee and you do not enroll when first eligible, you must provide the Insurer with satisfactory proof of insurability before you can begin to receive Long-Term Care coverage. The proof includes a statement of health and may require other evidence, such as medical records. If a physical exam is required, you will need to obtain it at your own expense.

You must provide proof of insurability to increase your type of coverage, unless you increase your **daily benefit** during the special opportunity given at least once every five years (see "Special Features of the Plan").

### *When Coverage Begins*

- If you are newly eligible and enroll within 31 days of receiving your new employee benefits enrollment materials, your coverage becomes effective on the first day of the month on or after the Insurer receives your enrollment form provided you are **actively at work** on that date.

- If you do not enroll during your first opportunity, or if your eligible family members enroll, proof of insurability needs to be provided. Coverage becomes effective on the first day of the month on or after the date the Insurer approves the request for coverage. For example, if your request is approved January 1, your coverage becomes effective that day. However, if your request is approved January 2, your coverage becomes effective February 1.

You must be **actively at work** on your effective date for coverage to begin, or you must provide proof of insurability. If the effective date is a regularly

scheduled day off, a scheduled vacation or a paid holiday, you must have been **actively at work** on the most recent prior day which was a regularly scheduled work day for you and which was not a scheduled vacation day or paid holiday.

If you are not **actively at work** when coverage is supposed to begin, coverage will begin on the first day of the month after you are actively at work.

### *Costs*

You pay the full cost of coverage under the Long-Term Care Plan. The costs are based on:

- The age of the person being covered at the time coverage becomes effective,
- The type of coverage chosen,
- The **daily benefit** chosen, and
- Election of the optional Nonforfeiture coverage.

As an employee, you pay your costs through after-tax payroll deductions. Payroll deductions will stop when you retire and you will be able to pay your costs directly to the Insurer. Retired employees and eligible family members can pay monthly, quarterly, semiannually or annually. Monthly payments must be automatically deducted from a checking account.

Each payment not made by payroll deductions has a grace period of 31 days. If you fail to pay the Insurer within the grace period, your coverage under this Long-Term Care Plan will end on the last day of the month for which the Insurer has received full payment.

Costs may be adjusted for your age group if Long-Term Care Plan expenses are higher or lower than expected. Your costs cannot be adjusted because of your individual health condition. The current rates are guaranteed until December 31, 2002.

Note: If your coverage became effective before January 1, 1993, under the corresponding plan offered by AT&T Corp., the cost for your initial coverage is based on your age on December 31, 1992. If you change your coverage, your cost may change (see “Changing Your Coverage”).

# COVERAGE AND BENEFITS

You and your eligible family members can select different types of coverage and **daily benefits** for long-term care services. When you enroll,

- First, you select the type of coverage you want (Nursing Home or Comprehensive), then

- You select the **daily benefit** you want. The daily benefit is the maximum amount of money that you will be paid for each day you are receiving a covered service. However, assisted living facilities and home care services are reimbursed up to 60% of the daily benefit.

- You also may elect the Nonforfeiture coverage option, which provides reduced maximum lifetime benefits to covered individuals who have paid premiums for at least three years and elect to stop making payments.

The type of coverage and the **daily benefit** you select determine the maximum benefit you can receive during your lifetime (see “Overview of Long-Term Care Plan Options”).

### *What Is Covered*

The Plan offers two types of coverage: Nursing Home and Comprehensive.

#### Nursing Home Coverage

After you meet any required waiting period (see “Once Your Benefits Are Authorized”), the Nursing Home coverage pays benefits for the following services:

- *One initial care planning visit.* This is an optional once-in-a-lifetime service at no additional charge. Benefits will be paid for this service after you are authorized for benefits. A professional care advisor will meet with you and your family to help you make decisions about your care. The advisor will:

  Help assess the need for services,

  Help develop a comprehensive care plan, and

  Discuss the plan with you and your family.

For help in finding a professional care advisor, call the Insurer. If the Insurer has no designated professional care advisor in your area, you can select your own advisor and be reimbursed up to $250 for the one visit.

- *Nursing home services.* These include room and board, nursing care, personal care and custodial care as routinely provided by the nursing home. The home must be a licensed nursing facility or a distinct part of a hospital which is licensed as a nursing facility. For benefits to be paid, the facility must satisfy the Insurer's criteria for a nursing home. The nursing home care benefit is paid up to the full **daily benefit** amount. Nursing home services are defined this way:

  *Nursing care.* Services requiring the professional skills of a registered nurse, licensed practical nurse or a licensed vocational nurse who is currently licensed in the state in which he or she is providing services.

  *Personal care.* Human assistance with the activities of daily living (see "When Benefits Are Payable") when the patient cannot perform these activities independently. This assistance may be provided to individuals who require custodial care.

- *In-patient hospice care.* Health care and support services provided in a licensed hospice facility for individuals who are terminally ill.

- *Assisted living facility.* Care can also be received in an assisted living facility. This facility serves the long-term needs of individuals who need more care than can be provided at home, but who do not want or need the degree of care provided at a nursing home. Assisted living facilities provide custodial care under the direction of a nurse. The maximum daily benefit for an assisted living facility is 60% of the nursing home **daily benefit**.

- *Transition Expense Benefit.* Benefits will be paid up to a scheduled benefit amount for expenses incurred during or after the waiting period if the expense was incurred when the insured was certified as chronically ill. Coverage includes items required to provide qualified long-term care services, such as personal emergency response systems or durable medical equipment. Home modifications that are otherwise qualified long-term care services will not be paid if they increase the value of the insured's living quarters, as determined by the Insurer. Payment of the Transition Expense Benefit is made after the waiting period is fulfilled and the bill is submitted. Payment of the Transition Expense Benefit will not reduce the total lifetime benefit. The Transition Expense Benefit is not available under the Nonforfeiture coverage.

## Comprehensive Coverage

After you meet any required waiting period (see "Once Your Benefits Are Authorized"), the Comprehensive coverage pays for all the services described above in "Nursing Home Coverage," as well as:

- *Home care.* You may receive care in the comfort of your home from a nurse, home health aide, homemaker and/or a physical, occupational or speech therapist from a licensed home health care agency. You may also receive care from a licensed nurse who is not from a licensed agency. The maximum daily benefit for home care is 60% of the nursing home **daily benefit** (see "Overview of Long-Term Care Plan Options").

- *Adult day care center.* This includes nursing care, personal care and custodial care in a qualified adult day care center. The maximum daily benefit for adult day care is 60% of the nursing home **daily benefit** amount. Centers that primarily provide recreation or social activities do not qualify as adult day care centers.

- *Ongoing care advisory services.* These include the following services when they are provided through a qualified care management organization: coordinating various types of care, arranging for appropriate services, monitoring your care, helping you to change your care plan as your needs change, and acting as your advocate if you have problems with the care you are receiving. Services must be provided by a registered nurse, a licensed practical nurse or a social worker trained in care advisory services. The maximum daily benefit for ongoing care advisory services is 60% of the nursing home **daily benefit**.

- *At-home hospice care.* This includes health care and support services in your home if you are terminally ill. The maximum daily benefit for at-home hospice care is 60% of the nursing home **daily benefit**.

- *Alternate Plan of Service*. This means qualified long-term care services which are not otherwise specifically defined above as a covered service. Benefits will be payable for an Alternate Plan of Service only if the Insurer determines, in its sole discretion, that all of the following requirements are met with respect to each Alternate Plan of Service:

  Service falls within guidelines established by the Insurer as an approved Alternate Plan of Service,

  It effectively meets the insured's long-term care service needs,

It is, for the insured, a cost-effective alternative to services otherwise covered under this Long-Term Care Plan, and

It is not provided by a member of the insured's immediate family.

The benefit payable for an Alternate Plan of Service shall be the lesser of:

The actual cost of the services provided, or

The benefit for the most closely related defined covered service, as determined by the Insurer.

- *Respite care.* Respite care allows your usual care provider the chance to take some time off. You can choose to continue to be cared for at home or, if you would like, in a nursing home. Respite care services include care from an unlicensed care provider, such as a family member, neighbor, or friend. The Long-Term Care Plan covers 21 days of respite care in a calendar year. Respite care is reimbursed up to the full nursing home **daily benefit**.

See "Benefit Limits, Multiple Services" if more than one covered service is being provided at the same time.

### *Daily Benefit and Maximum Lifetime Benefit*

Once you choose the type of long-term care coverage you want, you must decide which **daily benefit** you want. You can choose:

- $ 80,
- $120,
- $160, or
- $200

Together, your choice of **daily benefit** and type of coverage determine the daily and lifetime maximums you can receive for covered services. The **maximum lifetime benefit** is the total amount available to you through the Long-Term Care Plan (see "Overview of Long-Term Care Plan Options").

For Nursing Home coverage, the **maximum lifetime benefit** is a dollar amount that will provide a minimum of five years of coverage. Comprehensive coverage will provide a minimum of seven years of coverage.

However, benefits may last longer than you expect because they are based on the *dollar amounts of the benefits you receive,* not on the number of days. For example, if you choose the $200 **daily benefit** and your care in a nursing home is only $100 per day, the benefit will last twice as long.

Note: If you enrolled in the corresponding plan offered by AT&T Corp. before January 1, 1996, and did not increase your **daily benefit** (e.g., $60, $100, $140), your daily benefit and cost will remain as originally elected.

### *Nonforfeiture Coverage*

After you choose your type of Long-Term Care Plan coverage and your **daily benefit**, you may elect whether or not to take the optional Nonforfeiture coverage.

This feature provides that after you pay premiums for at least three years, if you elect to stop making payments you'll be entitled to coverage equal to the full **daily benefit**, subject to a total lifetime benefit of either the total amount of premiums paid or 30 times the daily benefit -- whichever is greater. The adjusted total lifetime benefit isn't reduced by any benefits paid.

### *Changing Your Coverage*

You can change your type of coverage and **daily benefit** amount at any time. To make a change, you must contact the Insurer (see "Important Contacts").

## Changes You Can Request

The guidelines for requesting a change in your Long-Term Care Plan coverage are summarized in the chart below.

| Change | When | Proof of Insurability | When Effective |
|---|---|---|---|
| Nursing Home to Comprehensive coverage or increase **daily benefit** | Any time | Required* | If approved, on the first of the month on or after the date the Insurer approves your request |
| Comprehensive to Nursing Home coverage, decrease **daily benefit** or add/remove the Nonforfeiture option | Any time | Not needed | On the first of the month on or after receipt of your request by the Insurer |
| *If your request for a change is denied, the Insurer will provide the reason for the denial (see "Claim Denial and Appeal Procedures").*<br><br>* Also see "Special Plan Features" for an exception to increasing your **daily benefit**. | | | |

## How Changes Affect Cost

When you change your coverage, your cost will change on the date your new type of coverage or new **daily benefit** amount takes effect. Here is how your cost will be affected:

- If you are changing the type of coverage from Nursing Home to Comprehensive, you will pay the cost of the new option based on your age at the time the change is effective. Proof of insurability is required to make this change.

- If you are decreasing your **daily benefit** or are changing the type of coverage from Comprehensive to Nursing Home, you will pay the cost of the new type of coverage based on the age used to determine your previous Comprehensive option.

- If you are increasing the **daily benefit** within your current type of coverage (for example, if you have Nursing Home and you increase from $80 to $120) the cost for this incremental increase will be based on your age on the effective date of the change. Proof of insurability is required to make this change, unless you increase your **daily benefit** during the special

opportunity given at least once every five years (see “Special Features of the Plan”).

- If you are adding the Nonforfeiture feature, your entire premium will be based on your age on your original effective date for your coverage under the Plan. Proof of insurability is not required.

### How Changes Affect Your Maximum Lifetime Benefit

When you change your type of coverage, your **maximum lifetime benefit** also changes. Any long-term care benefits you previously received under the Long-Term Care Plan will count toward your revised maximum lifetime benefit.

### *Special Plan Features*

You should be aware of these special Long-Term Care Plan features:

- *Bed hold provision.* If you require hospitalization while you are in the nursing home, the Long-Term Care Plan will continue to pay to hold your bed in the nursing home for up to ten days per hospital stay.

- *Opportunity for increase.* At least once every five years, you and your participating family members will be notified of the opportunity to increase your **daily benefit**. Proof of insurability will not be required for this increase as long as you have not received **daily benefits** during the six months before the effective date of the increase. Any increase in your **daily benefit** will also increase your **maximum lifetime benefit**. The cost for this incremental increase will be based on your or your participating family member’s age on the effective date of the change. (This feature may vary by state; contact the Insurer for details.)

- *Portability.* You and your participating family members can continue coverage even after you retire or leave employment with Lucent Technologies Inc. In that case, your costs must be paid directly to the Insurer.

- *Cost waiver.* If you are authorized for or receiving benefits for covered services, your monthly cost will be waived. The waiver begins the first day of the month on or after you meet your waiting period requirements. Costs will resume on the first day of the month after you are no longer authorized for benefits.

- *Return of premiums in the event of your death.* If you have Comprehensive coverage, have been a Long-Term Care Plan participant for at least four years, and you die, your estate may receive a portion of the premiums you paid. The amount returned is a percentage of the premiums you paid up to age 65, reduced by any benefits paid. In no other instances will the premiums paid for Long-Term Care Plan coverage be returned to you. (This feature may not be available in every state; contact the Insurer for details.)

The percentage available for refund is:

| **Number of Complete Years Covered Under the Comprehensive Option** | **Percentage Available for Refund (before reduction for benefits paid)** |
|---|---|
| 1-3 | 0% |
| 4 | 20% |
| 5-19 | Increases by 5% annually to 95% |
| 20 | 100% |

If you increase your coverage over time, the percentage returned will be applied separately for any incremental coverage amounts you have purchased. For example, if you have been covered under the Comprehensive coverage for 20 years and had one increase four years ago, the amount returned would be 100% of the costs paid for the original amount of coverage plus 20% of the costs paid for the increase. No costs paid after age 65 will be returned.

### *When Benefits Are Payable*

For you to receive benefits, the Insurer must authorize benefits in advance. To be authorized to receive benefits, you must be unable to perform, without substantial assistance from another individual, at least two out of six of the following activities of daily living for a period of 90 days because of a loss of functional capacity:

- Feeding yourself
- Dressing yourself
- Bathing yourself
- Moving from one support to another, such as moving from a bed to a chair or wheelchair

- Using the toilet and performing personal hygiene

- Controlling your bladder and/or bowels and maintaining hygiene

Your need for assistance may be due to physical disabilities, cognitive impairments or both.

You, your doctor or your representative will need to contact the Insurer to certify that you are incapable of performing these activities on your own. The Insurer must approve the request for benefits and, in doing so, may also need you to authorize access to your medical records. In evaluating your request for benefits, the Insurer may take into account:

- Your inability to perform the activities of daily living, and

- Your cognitive impairment.

You should obtain authorization from the Insurer as soon as it appears that you will need services covered by the Long-Term Care Plan. Otherwise, you may not be eligible for benefits. You must be authorized for benefits as well as receiving covered services for benefits to be paid.

However, if benefits would otherwise be authorized and it is not reasonably possible to obtain authorization before services begin, the Insurer may pay benefits beginning with the first day you received covered services after all required waiting periods have been completed.

You will be notified of the Insurer's decision within seven business days after it receives all the necessary information about your case. The Insurer cannot authorize benefits if you do not provide the necessary information. For more details on the information that must be provided, call the Insurer at 1-800-984-8651 between the hours of:

- Monday through Thursday, 8:00 a.m. to 10:00 p.m., Eastern time,

- Friday 8:00 a.m. to 9:00 p.m., Eastern time, or

- Saturday 9:00 a.m. to 4:30 p.m., Eastern time.

The notice will indicate the day your benefit period begins (see "Once Your Benefits Are Authorized"). It will also outline the concurrent review process (see "Concurrent Review"). If benefits are authorized, you may wish to schedule an initial care planning visit with a professional care advisor. This is an optional,

one-time service covered by the Long-Term Care Plan (see "What Is Covered"). If authorization is denied, see "Claim Denial and Appeal Procedures."

You, your doctor and your family will decide what care is appropriate for you. The Insurer provides *only* authorization for benefits, not medical advice about care.

### *Once Your Benefits Are Authorized*

Once you have been authorized for long-term care benefits:

- Your benefit period begins. This begins on the first day that daily benefits are authorized and you are receiving services that would be covered under the Plan. A benefit period will end if 180 consecutive days have passed during which you have not received authorized covered services.

- Each benefit period begins with a *waiting period.* During the waiting period, *benefits are not payable.* These are the waiting periods:

| **Kind of Services** | **Waiting Period*** |
|---|---|
| **Nursing Home Coverage:** | |
| • Initial Care Planning Visit | None |
| • Nursing Home, In-patient Hospice Care, Assisted Living Facility and Transition Expense Benefit | 60 days of receiving services |
| **Comprehensive Coverage:** | |
| • Initial Care Planning Visit | None |
| • Nursing Home, In-patient Hospice Care, Assisted Living Facility and Transition Expense Benefit | 30 days of receiving services |
| • Home Care Services<br>Home Health Care<br>Adult Day Care<br>Ongoing Care Advisory Services<br>At-home Hospice Care<br>Alternate Plan of Service | 30 days of receiving services |
| • Respite Care | 30 days of receiving services |

*Services received before benefits are authorized do not count toward the waiting period. Once you have fulfilled the waiting period, you will not have to fulfill another, unless you have not received authorized covered services for more than 180 consecutive days.

If you are receiving more than one kind of service, the waiting periods for each will run at the same time, rather than one after the other. If you received services before your authorization, they do not count toward the waiting period. Benefits are paid for covered services received only after the waiting period.

### *Concurrent Review*

When you are receiving covered services, the Insurer will review your case from time to time to see that you continue to meet the standards for benefits. The Insurer may review your records, or contact you, your doctor or someone else familiar with your condition. If it is determined that you are no longer eligible for benefits, you will be notified. In no event will your benefit eligibility be ended before the date of notification.

### *Reasonable and Customary Charges*

The Long-Term Care Plan pays for services up to a "reasonable and customary" amount which cannot exceed your **daily benefit**. This amount is the lowest of:

- The usual charge by the provider for the covered service,
- The usual charge of most providers of similar training or experience available in the same or similar geographic area for the same or similar services, or
- The actual charge for the covered services.

However, you will receive benefits for an initial care planning visit with a designated professional care advisor up to the amount charged. You may receive benefits up to $250 for an initial care planning visit with a professional who is not designated by the Insurer.

### *How Much You Receive*

The **daily benefit** you select determines the maximum amount you can receive each day. The amount payable per day will not exceed the total for all services you receive in a day. For possible benefit types, see "Overview of Long-Term Care Plan Options."

### *How Benefits Are Paid*

You will be reimbursed for covered services after the Insurer has reviewed your claim. You can have payment made directly to your provider, if you wish and if the provider agrees. You should submit your claim and accompanying proof not later than 90 days after the end of the calendar year in which you received the services. However, if the Insurer is satisfied that claims are submitted late for reasons beyond your control, and were submitted as soon as reasonably possible, eligible claims will not be reduced or denied because of the delay. If you owe any premiums at the time you submit a claim, your benefit will be reduced by the amount you owe the Long-Term Care Plan.

### *Benefit Limits*

Maximum **daily benefits** and **maximum lifetime benefits** are limited in some situations as explained in this section.

#### Multiple Services

The Comprehensive option provides three categories of covered services:

- Nursing Home plan services
- Home care services
- Respite care

Within a category, any combination of covered services may be received on the same day. All covered services will be considered and benefits will be payable up to your **daily benefit** for that category.

If you receive covered services from more than one category on the same day, all covered services will be considered and total benefits payable for that day will be payable in an amount up to the highest **daily benefit** amount within a single category of covered services. For example, if you receive home care and nursing home services on the same day, you can receive up to the nursing home daily benefit for all the covered services you received on that day.

If you have your initial care planning visit on the same day as one of the above categories, benefits may be payable for both services.

## Other Sources of Benefits

The Long-Term Care Plan is designed to provide the type of coverage and **daily benefit** you or your eligible family member elects. If other sources cover part or all of your eligible expenses, your benefit from the Long-Term Care Plan will be reduced to reflect those other benefits. In no event will your total benefit payable under the Plan be greater than it would have been if you had not had the other source of benefits.

Your long-term care benefit will be up to 100% of the reasonable and customary amount, reduced, to the extent permitted by law, by:

- Any benefits you received or are eligible to receive from any federal, state or other governmental health plans or law, other than Medicare or Medicaid,
- Any benefits paid or payable through another Lucent Technologies Inc. plan, such as the Lucent Technologies Inc. Medical Expense Plan, and
- Any benefits paid or payable by workers' compensation or similar law.

### *What Is Not Covered*

The Plan does not cover services:

- Received outside an authorized benefit period
- Provided at no cost
- For which there would have been no cost if you had not been covered by the Long-Term Care Plan
- For which you are not legally liable
- Provided outside the United States or its territories
- For transportation, personal convenience or companionship, including housekeeping services such as cooking, cleaning or shopping
- Provided while you are in a hospital, except for confinement in the distinct part of the hospital licensed as a nursing home, or for payment to a nursing home for up to ten days that is necessary to ensure continued availability of your nursing home accommodation

- For treatment of drug addiction or alcoholism (chemical dependency) unless such drug addiction results from a doctor's care

- Performed by a member of your immediate family, unless the service is a covered informal care service

- Provided in a government facility, unless you are legally obliged to pay the cost

- For illness, treatment or medical condition arising out of:

  War or act of war (whether declared or undeclared),

  Participation in a felony, riot or insurrection,

  Service in the armed forces or auxiliary units,

  Attempted suicide (while sane or insane) or intentionally self-inflicted injury, or

  Aviation (this applies only to non-fare paying passengers).

- Any expense reimbursable by Medicare including deductibles, coinsurance and copayments, except where Medicare is the secondary payer

### *Terminating Your Coverage*

You and your eligible family members can cancel your Long-Term Care Plan coverage at any time. This cancellation will be effective at the end of the month in which you request cancellation.

### *When Coverage Ends*

The following chart shows the circumstances under which your Long-Term Care Plan coverage will end, and when:

| **Circumstance Causing Coverage to End** | **When Coverage Ends** |
|---|---|
| You cancel your coverage | At the end of the month in which you notify the Insurer |
| This coverage is replaced by another substantially similar plan, and you become eligible for that coverage | On that date |
| You die | On that date |
| You do not pay your costs for coverage or Lucent Technologies Inc. does not forward costs to the Insurer | On the last day of the month for which a required payment is made to the Insurer |
| You reach your **maximum lifetime benefit** | On that date |

If the Long-Term Care Plan ends, you will be able to continue your coverage directly with the Insurer if:

- The Long-Term Care Plan is not being replaced with a substantially similar plan,
- The Long-Term Care Plan is being replaced with a substantially similar plan, but you are not eligible under the new plan, or
- You are no longer an **eligible employee** or eligible family member under the Long-Term Care Plan.

To continue your coverage after the Long-Term Care Plan ends, you must *pay the required premiums directly to the Insurer.*

## IMPORTANT CONTACTS

| Contact / Service Provided | Address / Telephone Number |
|---|---|
| **Insurer:**<br>Approves or denies claims and interprets the Long-Term Care Plan | MetLife<br>Long-Term Care Group<br>PO Box 937<br>Westport, CT 06881-0937<br><br>1-800-984-8651<br><br>• Monday through Thursday, 8:00 a.m. to 10:00 p.m., Eastern time<br>• Friday, 8:00 a.m. to 9:00 p.m., Eastern time<br>• Saturday, 9:00 a.m. to 4:30 p.m., Eastern time<br>TDD available at 1-800-638-1004 |

# OTHER IMPORTANT INFORMATION

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

### *Long-Term Care Plan Document Governs*

This summary plan description was designed to describe the Lucent Technologies Inc. Long-Term Care Insurance Plan in easy-to-understand terms. It is shorter and less technical than the legal Long-Term Care Plan document. However, the Long-Term Care Plan document determines your rights and the rights of other covered persons under the Plan. In all instances, the Long-Term Care Plan document governs.

### *Union Agreement*

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

### *Long-Term Care Plan Contributions and Benefits*

The Long-Term Care Plan is insured by the Insurer. Lucent Technologies Inc. forwards the contributions it receives from employees through payroll deductions for the Long-Term Care Plan to the Insurer. Costs not collected through payroll deductions are paid directly to the Insurer. The expenses of administering the Long-Term Care Plan and benefit payments are the responsibility of the Insurer.

You may wish to consult your tax advisor about the taxability of your long-term care benefits.

### *Long-Term Care Plan Administration*

The Insurer shall serve as the final review committee under the Plan and shall have sole and complete discretionary authority to determine conclusively for all parties, and in accordance with the terms of the documents or instruments governing the Plan, any and all questions arising from administration of the Plan and interpretation of all Plan provisions, determination of all questions relating to participation of eligible employees and eligibility for benefits, determination of all relevant facts, the amount and type of benefits payable to any participant, **lawful spouse** or eligible family member, and construction of all terms of the Plan. Notwithstanding the foregoing, the Plan Administrator shall have sole and complete discretionary authority to determine questions relating to eligibility of participants for membership in the Plan and to amend or terminate the Plan at any time subject to the terms of any applicable insurance contract. Respective decisions by the Insurer and Lucent Technologies Inc. shall be conclusive and binding on all parties and not subject to further review.

### *Long-Term Care Plan May Be Amended or Terminated*

The company expects to continue the Long-Term Care Plan, but reserves the right to amend or terminate the Long-Term Care Plan at any time by the resolution of the Board of Directors of Lucent Technologies Inc. (or its properly authorized designee), subject to the terms of the insurance contract and applicable collective bargaining agreements. Certain provisions of the Long-Term Care Plan are subject to approval by state insurance departments. In addition, the company doesn't guarantee the continuation of any long-term care benefits during employment or at or during retirement nor does it guarantee any specific level of benefits or contributions.

### *Claim Denial and Appeal Procedures*

#### Claim Denial Procedures

Participants, their beneficiaries (if applicable) or any individual duly authorized by them have the right under ERISA and the Long-Term Care Plan to file a written claim for benefits with the Insurer (see "Important Contacts").

If a claim is denied in whole or in part, the claimant will receive a written notice from the Insurer of the Insurer's decision, including the specific reason for the

decision, within 90 days after the Insurer received the claim. The written notice will include:

- The specific reason(s) for the denial,
- Reference to the specific Long-Term Care Plan provisions, statutes or regulations on which the denial was based,
- A description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary, and
- Information about the steps to be taken if you, your dependent, or an authorized representative wishes to submit the claim for review.

If the Insurer needs more than 90 days to make a decision, a representative will notify you in writing within the initial 90-day period and explain why more time is required. An additional 90 days (for a total of 180 days) may be taken if the Insurer sends this notice. The extension notice will show the date by which the Insurer's decision will be sent.

If you submit your claim according to the procedures described in this section and you do not hear from the Insurer within the time limits given here, your claim is considered denied.

If a claim for benefits is denied in whole or in part, or if you or your dependents believe that benefits under the Long-Term Care Plan to which you are entitled have not been provided, an appeal process is available to you. You, your dependents, or your authorized representative may appeal in writing within 60 days after the earlier of the date the denial is received or the 90- (or 180-) day period has expired.

**Appeal Procedures**

A claimant can appeal a denied claim if:

- No reply at all is received from the Insurer after 90 days,
- The Insurer has extended the response time by an additional 90 days, and no reply is received within that time, or

- Written denial of the claim is received within the appropriate time frame and the claimant wants to appeal it.

If you wish to file an appeal, you must do so in writing within 60 days of receiving notification of the Insurer's decision. You're entitled to request a copy of and review the Long-Term Care Plan "Plan Document" when you prepare your appeal. If you believe an error has occurred, you can support your request by giving the reason you think there is an error. Also, whenever possible, send copies of any documents or records that support your appeal. Whether or not you can provide such additional information, your claim will be reconsidered after your request is received. Send a written request for review of any denied claim directly to the Insurer (see "Important Contacts").

The Insurer will conduct a review and make a final decision within 60 days after receiving the written request for review.

If special circumstances cause the Insurer to need more than 60 days to make a decision, a representative will notify you in writing within the initial 60-day period and explain why more time is required. An additional 60 days (for a total of 120 days) may be taken if the Insurer sends this notice.

The decision will be in writing and will specify the pertinent plan provisions on which the decision is based.

If you submit your request for a written review according to the procedures described in this section and you do not hear from the Insurer within the time limits given here, your appeal is considered denied.

Although this decision is final and is not subject to further review, you or your beneficiary may have additional rights under ERISA. However, applicable law and the Long-Term Care Plan's provisions require you to pursue all your claim and appeal rights on a timely basis *before* seeking any other legal recourse regarding claims for benefits.

### *Your Rights Under ERISA*

It's Lucent's policy to provide meaningful benefits -- above and beyond your paycheck. Part of this additional protection is provided through the Lucent Long-Term Care Plan. You're entitled to certain rights and protection under ERISA. These rights are described in this section.

It's your right to know about your benefits. Therefore, in addition to this summary plan description of your benefits under the Lucent Long-Term Care Plan, you

automatically receive a summary of the Plan's annual financial report. You also may examine the Plan documents. These documents are available for you to examine without charge in the Plan Administrator's office.

You can receive a copy of any of these documents, for a reasonable charge, by making a written request to the Plan Administrator. If you don't receive the requested documents within 30 days (unless the delay is beyond the control of the Plan Administrator), you have a right to file suit in a federal court. The Plan Administrator may be required to pay a fine -- as much as $110 per day -- for each day's delay, in addition to furnishing the requested documents to you.

You also have the right to expect the fiduciaries -- the people responsible for the operation of the Long-Term Care Plan -- to act prudently and in the best interest of those who participate as a whole. The Plan's fiduciaries must act in the best interest of all Plan participants.

If a fiduciary misused funds, if you're improperly denied a benefit or if you're discriminated against for asserting your rights under ERISA, you have the right to ask the U.S. Department of Labor for help or to file suit in a federal or state court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay the costs and fees. If you lose, the court may order you to pay the costs and fees -- for example, if the court finds your claim is frivolous.

The company will not (and cannot) dismiss you or discriminate against you to prevent you from obtaining benefits or exercising any of your rights under ERISA.

For answers to questions about the Long-Term Care Plan, contact the Insurer or the Plan Administrator (see "Important Contacts"). If you have any questions about this statement of your rights, or about your rights under ERISA, contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory; or contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C.  20210.

### *Family and Medical Leave Act of 1993*

Under the Family and Medical Leave Act of 1993 (FMLA), Lucent Technologies Inc. provides **eligible employees** with unpaid leave for up to a total of 12 work weeks within a 12-month period for any of the following reasons:

- Birth of the employee's newborn child and to care for the employee's child,
- To care for the employee's **lawful spouse**, child or parent, who has a serious health condition,
- For a serious health condition that makes the employee unable to perform the essential functions of his or her own job, or
- Placement with the employee of a child for adoption or foster care and to care for the newly placed child.

Employees are eligible if they worked for the company for at least one year and had at least 1,250 hours of service over the previous 12 months.

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

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

The FMLA makes it unlawful for any employer to:

- Interfere with, restrain or deny the exercise of any right provided under the FMLA, or

- Discharge or discriminate against any person for opposing any practice made unlawful by the FMLA or for involvement in any proceeding under or relating to the FMLA.

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

## *Administrative Information*

| | |
|---|---|
| **Plan Name** | The official Plan Name is the Lucent Technologies Inc. Long-Term Care Insurance Plan. |
| **Plan Sponsor** | Lucent Technologies Inc. |
| **Plan Administration** | The Plan is underwritten under an insured contract by the Metropolitan Life Insurance Company (the Insurer). The official Plan documents and the contract between Lucent Technologies Inc. and the Insurer govern the operation of the Long-Term Care Plan at all times. |
| **Plan Administrator** | The Plan Administrator for the Lucent Technologies Inc. Long-Term Care Plan is:<br>Lucent Technologies Inc.<br>c/o Lucent Technologies Inc. Long-Term Care Insurance Plan<br>475 South Street, 3rd Floor<br>Morristown, NJ 07960 |
| **Insurer** | To submit or appeal a claim, write the Insurer at:<br>Metropolitan Life Insurance Company<br>Long-Term Care Group<br>PO Box 937<br>Westport, CT 06881-0937 |
| **Agent for Service of Legal Process** | The Insurer is the agent for service of legal process regarding a claim for benefits. All other processes concerning the Long-Term Care Plan should be directed to either the Insurer or Lucent Technologies Inc. (see addresses above). |
| **Plan Records, Plan Year and Type of Plan** | The Lucent Technologies Inc. Long-Term Care Insurance Plan is considered a welfare plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA). This Long-Term Care Plan and all of its records are kept on a calendar year basis, beginning January 1 and ending December 31. |
| **Plan Identification Number** | The Plan Identification Number is 524. |
| **Employer Identification Number** | The Employer Identification Number is 22-3408857. |