LUCENT TECHNOLOGIES INC.

LONG-TERM CARE INSURANCE PLAN

SUMMARY PLAN DESCRIPTION
FOR RETIRED EMPLOYEES

Effective 01/01/2002
Last Updated 09/25/2002

This is a summary plan description (SPD) of the benefits available, effective January 1, 2002, to **eligible retirees** and eligible family members under the Lucent Technologies Inc. Long-Term Care Insurance Plan (Long-Term Care Plan). More detailed information is provided in the official Plan document, which is the final authority. In all instances, the Plan document will control and govern the operation of the Plan. In addition, if there is any conflict between the information in the summary plan description or plan documents and the applicable law, the law will govern. 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. Participants should make no assumptions about future changes unless any such change is formally announced by Lucent.

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. Participation in the Long-Term Care Plan is neither an offer nor a guarantee of continued benefits during retirement.

LONG-TERM CARE INSURANCE PLAN (RETIRED EMPLOYEES)

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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 retired 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 to elect 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 Retired Employees.

Long-Term Care Insurance Plan Features	Summary
Eligibility	Coverage under the Long-Term Care Plan is available to eligible retired employees of a **participating company** who are receiving a service or disability pension under the Lucent Technologies Inc. Pension Plan or Lucent Retirement Income Plan (LRIP). If you are eligible, coverage is also available to eligible family members. Former employees eligible for a deferred vested pension do not qualify for benefits under this Plan.
Enrolling	Generally, you and your eligible family members may request enrollment at any time during the year by completing an enrollment form. Employees who had long-term care coverage immediately before retirement do not need to re-enroll to continue coverage during retirement.
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, adult day care, an alternate plan of service, and respite care.
Costs	You pay the full cost of coverage under the Long-Term Care Plan. Payment is made directly to the Insurer.
Proof of Insurability	Proof of insurability is required to enroll. Proof is also required when requesting an increase in the **daily benefit** or when switching from Nursing Home to Comprehensive coverage.

Long-Term Care Insurance Plan Features	**Summary**
When Long-Term Care Coverage Begins	Generally, coverage is effective on the first day of the month that's on or after the date the Insurer approves the request for coverage.
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, when you reach the **total 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. Many of these terms are printed in boldface when they appear to let you know that they're defined here.

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

Domestic partner: an individual who:

- Is a member of the same or opposite sex as the employee,
- Complies with any state or local registration process for domestic partners, if applicable,
- Satisfies each of the specific criteria identified below and completes a Notarized Affidavit attesting that the employee and the domestic partner:

    Reside in the same household as a member of the household,

    Are each 18 years of age or older,

    Have mental capacity sufficient to enter into a valid contract,

    Are unrelated to each other by blood or marriage and are not legally married to another individual,

    Consider themselves 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 **children** of a domestic partner are the employee's dependents under Section 152 of the Internal Revenue Code.

Domestic partnership dependents include eligible **children** of your domestic partner.

Immediate family: the insured's spouse (legal husband or wife), **domestic partner**, child (natural, step or adopted), parent (including parent-in-law, step-parent, or step-parent-in-law), sibling, grandchild, or in-law. It also includes anyone else who normally resides in the insured's home.

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

Participating company/companies: a company or companies that participate in the Long Term Care Plan. As of June 1, 2002, these are:

- Ascend Communications Inc.
- Chromatis Networks Inc.
- Excel Switching Corporation
- Lucent Asset Management Corporation
- Lucent Technologies Inc.
- Lucent Technologies Construction Services, Inc.
- Lucent Technologies Fiber Guardian Corp.
- Lucent Technologies Guardian I Corp.
- Lucent Technologies GRL Corp.
- Lucent Technologies Management Services Inc.
- Lucent Technologies Optical Networking Guardian Corp.
- Lucent Technologies Sentinel I Inc.
- Lucent Technologies Wireless Guardian Corp.
- Lucent Technologies World Services Inc.
- Nassau Metals Corporation
- Nexabit Networks, Inc.
- SpecTran Corporation

- SpecTran Communications Fiber Technology
- SpecTran Specialty Optics Company
- SpringTide Networks, Inc.

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

OVERVIEW OF LONG-TERM CARE PLAN OPTIONS

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* Paid at 60% of **daily benefit**.

** **Daily benefits** are paid at 100% of actual 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.

Note: Certain benefits begin after a waiting period (see "Once Your Benefits Are Authorized").

A Nonforfeiture coverage option is also available to each participant (see "Nonforfeiture Coverage").

ELIGIBILITY AND PARTICIPATION

Who Is Eligible

If you are a retired employee of a **participating company** in the Lucent Technologies Inc. Pension Plan or Lucent Retirement Income Plan, you are eligible to apply for long-term care coverage.

If you were employed by Lucent during any applicable transition period, the Long-Term Care Plan will count benefits provided under the corresponding AT&T Corp. plan toward the **total 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** or surviving spouse,
- Your **domestic partner**, and
- Your parents, parents-in-law, step-parents, step-parents-in-law, grandparents, and grandparents-in-law.

When You Enroll

You and your eligible family members can enroll for long-term care coverage at any time during the year by completing an enrollment form and providing proof of insurability. You can obtain an enrollment form by contacting the Insurer (see "Important Contacts").

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

If You Had Long-Term Coverage When Actively Employed

You do not need to re-enroll for coverage when you retire if you had long-term care coverage under the Lucent Technologies Inc. Long-Term Care Plan (or the corresponding plan offered by AT&T) while actively employed.

However, as a retired employee, payment for long-term care is made directly to the Insurer. (See "Costs" for information on payment options.)

Proof of Insurability

Proof of insurability that is satisfactory to the Insurer is required to enroll. 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 also 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 Plan Features").

When Coverage Begins

Coverage becomes effective on the first day of the month on or after the date the Insurer approves your 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.

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 level of coverage chosen,
- The **daily benefit** chosen, and
- Whether you elect the optional Nonforfeiture feature.

Payment is made directly to the Insurer. You have the option of paying monthly, quarterly, semiannually or annually. Monthly payments must be automatically deducted from your checking account.

For all other payment options, there is a 31-day grace period. 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 April 1, 1995, under the corresponding plan offered by AT&T Corp., the cost for your initial coverage is based on your age on March 31, 1993. 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 coverage levels and **daily benefits** for long-term care services. When you enroll:

- You first select the level 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 health care services are reimbursed up to 60% of the daily benefit.
- You may also elect the Nonforfeiture coverage option, which provides reduced **total lifetime benefits** to covered individuals who have paid premiums for at least three years and elect to stop making payments.

The level 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. 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 at 1-800-984-8651. 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 that is licensed as a nursing facility. For benefits to be paid, the facility must satisfy the Insurer's criteria of 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 by 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 require 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. This feature may vary by state; contact the Insurer for details.

- *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 as 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 if you are receiving the Nonforfeiture coverage.

Comprehensive Coverage

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

- *Home health care:* You may receive care in the comfort of your home from a nurse, home health aide, homemaker and/or a physical, occupational, speech or respiratory 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 that 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 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 Total Lifetime Benefit

Once you choose the level 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 level of coverage determine the daily and lifetime maximums you can receive for covered services. The **total 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 **total 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 level 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 level 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 Requested	When You Can Request the Change	Proof of Insurability	When Your Change is Effective
Nursing Home to Comprehensive coverage or increase **daily benefit**	Any time	Required*	If approved, on the first day 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 day 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").

*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's how your cost is affected:

- If you are changing the level 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 increasing the **daily benefit** within your current level of coverage (for example, if you have Nursing Home and you increase from $80 to $120), the cost for this incremental increase is 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 Plan Features").

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

- If you are adding the Nonforfeiture feature, your premium for the Nonforfeiture coverage will be based on your age when you entered the plan, i.e., your original bill age. Please note that the required three-year vesting period and the total premiums available for the reduced lifetime benefit begin on the date that the Nonforfeiture option is added.

How Changes Affect Your Total Lifetime Benefit

When you change your level of coverage, your **total lifetime benefit** also changes. Any long-term care benefits you previously received under the Long-Term Care Plan will count toward your revised total 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, in-patient hospice, or assisted living facility, the Long-Term Care Plan will continue to pay to hold your bed in the nursing home for up to 10 days per hospital stay.

- *Opportunity for increase:* At least once every five years, you and your participating eligible 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 **total lifetime benefit**. The cost for this incremental increase will be based on your or your participating eligible family member's age on the effective date of the change. This feature may vary by state; contact the Insurer for details.

- *Cost waiver:* If you are authorized for or are 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 return is:

Number of Complete Years Covered Under the Comprehensive Option	**Percentage Available for Return (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:

- *Eating:* feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- *Dressing:* putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- *Bathing:* washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.
- *Transferring:* moving into or out of a bed, chair or wheelchair.
- *Toileting:* getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- *Continence:* ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

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 and 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:

- 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 ("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 covered 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 covered services*
Home Care Services: • Home Health Care • Adult Day Care • Ongoing Care Advisory Services • Out-patient or At-home Hospice Care • Alternate Plan of Service	30 days of receiving covered services*
Respite Care	30 days of receiving covered services*

Covered 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.

* Under the Nursing Home Plan, the waiting period is 60 days of covered services. Under the Comprehensive Plan, the waiting period is 30 days of covered services. Only days on which a covered service is received count toward the waiting period. For example, if you receive home care services three days per week, only those three days are counted toward the 30-day waiting period, not all seven days of the week.

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 covered 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 end before the date of notification.

Payment of Benefits

The Long-Term Care Plan pays for the actual charge for covered services up to your **daily benefit**. 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, if there is not a designated professional care advisor in your area.

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 levels, 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 *no 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.

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

Benefit Limits

Maximum **daily benefits** and **total 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 level of coverage and **daily benefit** you or your eligible family members elect. 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 actual charge, 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 for Retired Employees, Short Term Disability Plan, or Long Term Disability Plan,
- Any motor vehicle no-fault law, and
- Any benefits paid or payable by Workers' Compensation or similar law.

What Is Not Covered

The Plan does not cover the cost of:

- Care specifically provided for detoxification of or rehabilitation for alcohol or drug abuse (chemical dependency), except drug abuse sustained at the hands of or while being treated by a physician for an injury or sickness.
- Any service or supply received outside the United States or its territories.
- 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).
- Treatment provided in a government facility, unless otherwise required by law.
- Any care provided while in a hospital, except for confinement in a distinct part of a hospital that is licensed as a nursing home or hospice.
- Any service provided by your **immediate family,** unless the service is a covered service from an informal caregiver.
- Expenses for any service or supply reimbursable under Medicare, or that would be reimbursable but for the application of a deductible, coinsurance or copayment. This exclusion will not apply in those instances where Medicare is determined to be secondary payor under applicable law.

- Services for which no charge is normally made in the absence of insurance.

Terminating Your Coverage

You and your eligible family members can cancel your Long-Term Care Plan coverage at any time. Your 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 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	On the last day of the month for which a required payment is made to the Insurer
You reach your **total 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 and your eligible family members are no longer eligible under the Long-Term Care Plan.

IMPORTANT CONTACTS

Contact/Service Provided	Address/Telephone Number
Insurer: Approves or denies claims and interprets the Long-Term Care Plan.	MetLife Long-Term Care Group P.O. Box 937 Westport, CT 06881-0937 1-800-984-8651 • 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 • Saturday, 9:00 a.m. to 4:30 p.m., Eastern time TDD available at 1-800-638-1004

IMPORTANT INFORMATION ABOUT YOUR BENEFITS

This section contains important information about the Long-Term Care Plan for retired employees that is covered in the summary plan description. The information and other details provided in this section are required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Because this section includes important information for several Lucent retiree plans, each of which has its own definitions section, defined terms do not appear in bold.

Your Rights Under ERISA

It's our policy to provide meaningful benefits -- above and beyond your paycheck. Part of this additional protection is provided through the Long-Term Care Plan. The Company isn't required to provide this Long-Term Care Plan. Because it does, however, you're entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as amended (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 describing your benefits under the Long-Term Care Plan, you automatically receive a summary of the Long-Term Care Plan's annual financial report. You also may examine all Long-Term Care 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 Long-Term Care Plan participants.

If a fiduciary misuses 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 (see "Important Contacts"). If you have any questions about this statement 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 NW, Washington, D.C. 20210.

Plan Funding and Payment of Benefits

The Long-Term Care Plan is insured by MetLife. You and your eligible family members pay your costs directly to MetLife. The expenses of administering the Long-Term Care Plan and benefit payments are the responsibility of MetLife. You may wish to consult your financial advisor about the taxability of your Long-Term Care Plan benefits.

For a list of participating companies by plan, please refer to the definition of participating company in the "Terms You Should Know" section.

Plan Documents Govern

This retiree summary plan description is designed to describe Lucent Technologies Inc. post-retirement benefits in easy-to-understand terms. It is shorter and less technical than the legal plan document. However, the individual plan document determines your rights and the rights of your eligible dependents under the plan covered in the summary plan description. In all instances, the plan document will govern.

Plan May Be Amended or Terminated

The company expects to continue this plan, but reserves the right to amend or terminate the plan at any time by the resolution of the Board of Directors or its properly authorized designee. In addition, the company doesn't guarantee the continuation of any benefits during retirement nor does it guarantee any specific level of benefits or contributions.

Plan Administrator and Claims Administrator

The plan administrator and the designated party for administering claims as designated for in the retiree summary plan description have the full discretionary authority and power to control and manage all aspects of the plan for which they are responsible, to determine eligibility for plan benefits, to interpret and construe the terms and provisions of the plans, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the plans as they may deem appropriate in accordance with the terms of the plans and all applicable laws. See "Plan Identification" for a list of the plan and claims administrators.

Plan Sponsors

The plan sponsor may allocate or delegate its responsibilities for the administration of the plan for which it is responsible to others and employ others to carry out or render advice with respect to its responsibilities under each of the plans. This includes the discretionary authority to interpret and construe the terms of the plan, to direct disbursements, and to determine eligibility for plan benefits.

Plan Identification

Plan Name	The official plan name is the Lucent Technologies Inc. Long-Term Care Insurance Plan.
Plan Sponsor	Lucent Technologies Inc. is the plan sponsor.
Plan Administrator	The Plan Administrator is: Lucent Technologies Inc. c/o Lucent Technologies Inc. Long-Term Care Insurance Plan 600 Mountain Ave. Room 3A226 Murray Hill, NJ 07974
Plan Administration	The plan is underwritten under an insured contract by the Metropolitan Life Insurance Company (MetLife). The official plan documents and the contract between Lucent and MetLife govern the operation of the Long-Term

	Care Plan at all times.
Designated Party Responsible for Claim and Claim Appeals and Agent for Service of Legal Process	Claims and claim appeals should be sent to MetLife (see the "Claim Denial and Appeal Procedures" section of the summary plan description). MetLife 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 MetLife or Lucent Technologies Inc.
Plan Records and Plan Year	The Long-Term Care Plan and all of its records are kept on a calendar year basis, beginning on January 1 and ending December 31 of each year.
Type of Plan	The Long-Term Care Plan is considered a "long-term care welfare plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Plan Number	The plan number is 524.
Employer Identification Number	The employer identification number is 22-3408857.

FILING LONG-TERM CARE CLAIMS

All claim forms needed to file for benefits for long-term care insurance will be given to you by the Insurer (see "Important Contacts") once there has been a determination that you are eligible for benefits. The Insurer will be ready to answer questions about your long-term care insurance and to assist you in filing claims.

The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully and any required medical statements and bills are submitted with the claim form. The completed claim form should be returned to the Insurer.

Please refer to the "eligibility for benefits" provisions of your long-term care insurance certificate for procedures for requesting a determination as to eligibility for benefits and the claims provisions of your certificate for claim procedures that apply to the long-term care insurance coverage provided under the Plan.

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries, including the Insurer as claim fiduciary, shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

CLAIM DENIAL AND APPEAL PROCEDURES

This section outlines the procedures for filing a written claim for benefits for all of the plans covered in the retiree summary plan descriptions. It also details procedures for appealing a denied claim. For related information (e.g., determining the agent for service of legal process), please refer to the "Important Information About Your Benefits" section of each plan's summary plan description.

Claim Denial Procedures

Participants, their beneficiaries (if applicable) or any individual duly authorized by them have the right under the Employee Retirement Income Security Act of 1974, as amended (ERISA) and any of the plans covered in the retiree summary plan descriptions to file a written claim for benefits.

Written claims for benefits should be sent to the designated party for claims and claim appeals as outlined in the following chart.

Plan	Designated Party for Claims/Claim Appeals
Long-Term Care Plan	Metropolitan Life Insurance Company Long-Term Care Group P.O. Box 937 Westport, CT 06881-0937

If a claim is denied in whole or in part, the claimant will receive a written notice from the designated party as to the decision, within 90 days after receipt of the claim. The written notice will include:

- The specific reason(s) for the denial,
- Reference to the specific 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
- Information about the steps to be taken if you, your dependent, or an authorized representative wishes to submit the claim for review, and

- A statement regarding your right to obtain, upon request and free of charge, a copy of documents, records and other information relevant to your denied claim.

If the designated party responsible for reviewing your claim 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 this notice is sent. The extension notice will show the date by which the decision will be sent.

If you submit your claim according to the procedures described in this section and you do not hear from the designated party responsible for processing your claim 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 plan for which the claim is being submitted 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 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 designated party responsible for processing your claim within 90 days,

- The designated party responsible for reviewing your claim 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 designated party's decision. Send a written request for review of any denied claim directly to the Insurer (see "Important Contacts"). If you do not receive notification, you may appeal within 60 days after the 90-day period has lapsed. You're entitled to request a copy of and review the "plan document" for the plan under which you are submitting a claim when you prepare your appeal. You may submit with your appeal any written comments, documents, records and any other information relating to your claim, even if they were not submitted with the original claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge. If you believe an error has occurred, you can support your request by giving the reason you think there is an error. Whether or not you can provide such additional information, your claim will be reconsidered after your request is received.

The designated party for the plan for which you are submitting an appeal will conduct a review and make a final decision within 60 days after receiving the written request for review.

If special circumstances cause the designated party responsible for processing your appeal 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 this notice is sent.

The decision will be in writing and will include:

- The specific reasons for the adverse determination,
- References to the specific Plan provision(s) on which the decision is based,
- A description of the Plan's review procedures and time limits, and
- A statement that you are entitled to receive, upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim.

If you submit your request for a written review according to the procedures described in this section and you do not hear from the designated party responsible for processing your appeal 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. Under the Medical Plan, you may also have a Third Party Appeal Review Process available. For more information, see "Third Party Appeal Review Process (Medical Plan Only)." However, applicable law and the provisions of the plans included in this book require you to pursue all of your claim and appeal rights on a timely basis before seeking any other legal recourse regarding claims for benefits.