TERMS YOU SHOULD KNOW

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

Acupuncturist: a provider carrying all recognized certifications applying to the practice of acupuncture who is licensed to practice acupuncture according to state laws.

Allowable amount: the portion of a provider's charge which is eligible for reimbursement either in full or in part. Any amount by which the provider's charge exceeds the allowable amount is not reimbursable under the Medical Plan.

Under **POS, Lucent Informed Choice** or the **Mental Health and Chemical Dependency Program in-network** benefits and **Indemnity** option **PPO** benefits, a **network** provider's charge always equals the allowable amount so that no charges above the allowable amount are payable by the participant.

When **non-network** providers are used under the **Indemnity** option (non-**PPO** providers), **Mental Health and Chemical Dependency Program**, or the Medical Plan's **out-of-network POS** or **Lucent Informed Choice** option provisions, the allowable amount for **medically necessary** services is based on **reasonable and customary** charges. Claims are paid based on the schedule in effect on the date on which a service was provided or based on the schedule in effect on the date the claim payment is made, in accordance with the practice of the **health care company** responsible for paying the claim. For claims incurred on or after January 1, 1996, each health care company uses the same industry-accepted pricing schedule to ensure that out-of-network reimbursement is consistent with what 9 out of 10 providers in a given area would charge.

The participant is responsible for the portion of the expense that is above the **reasonable and customary** amount. Amounts in excess of reasonable and customary do not apply toward the annual **deductible** or the **out-of-pocket maximum** as described in the Medical Plan. Any references in the **Indemnity** options (non-**PPO** provider), **POS** option **out-of-network** or out-of-area or **Lucent Informed Choice** out-of-network provisions of the Medical Plan to the amount or percentage of the amount that the Medical Plan covers or pays, refers to the reasonable and customary amount. *Note: Lucent offers a **Health Care Reimbursement Account** that allows you to set aside money, tax-free, to pay some of these expenses.*

Under the **Mental Health and Chemical Dependency Program network** benefits, the allowable amount for services from Masters degree level counselors will be 75% of what 9 out of 10 providers in a given area would charge.

Alternative care or alternative treatment: a type of care only available **in-network** under the **Mental Health and Chemical Dependency Program** that is more intensive than **out-patient** treatment and less intensive than hospitalization. Alternative treatment includes the following types of care: **partial hospitalization**, **residential treatment** and care from a **halfway house or group home**.

Ambulance: a vehicle licensed according to state laws, operated for the exclusive purpose of transporting patients with acute medical conditions and equipped to provide paramedic and stabilizing medical services.

Assigned option: the medical enrollment option that you will be automatically assigned to if you are eligible and do not enroll in one of the available options. Some employee classifications do not have an assigned option. These employees *must* enroll to be **covered** by the Medical Plan.

BDEC: the Benefit Directions Enrollment Center (BDEC) is the resource to call to enroll, to make changes in your coverage or to ask questions about your Medical Plan options. See “Important Contacts.”

Birthing center: a facility for prenatal, delivery and postpartum care that is (a) staffed by certified nurse-midwives; (b) has 24-hour access to consultation by an obstetrician/gynecologist with admitting privileges at a nearby **hospital**; (c) is accredited by the National Association of Child Bearing Centers or the Joint Commission on the Accreditation of Healthcare Organizations; and (d) is licensed by the state.

Brand name drug: one that has been patented and is produced by only one manufacturer.

Center of Excellence: a facility that is designated by the **health care company** as a preferable facility to handle selected services of a highly specialized nature, such as organ transplants.

Chemical dependency: both alcoholism and drug dependency as classified by the International Classification of Diseases of the U.S. Department of Health and Human Services.

Children: the biological and/or legally adopted children of you, your lawful spouse or your domestic partner. These include those who are in the formal legal adoption process, stepchildren living with you and children living with you for whom you, your lawful spouse or your domestic partner is the legal guardian (excluding "wards of the state" or "foster children.") See **Class I dependents, Class II dependents** and **domestic partnership dependents**.

Chiropractor: a Doctor of Chiropractic (D.C.) who is licensed to provide services in the state where the service is rendered.

Claims Administrator: the **health care company** authorized by Lucent Technologies Inc. to administer the Medical Plan.

Class I dependents: include your lawful spouse and each unmarried child through December 31 of the year in which the child reaches age 23.

To be eligible, a child must be:

- Your own child, including your legally adopted child, including any child in the formal legal process of adoption, regardless of residence,
- A stepchild living with you, or
- A child living with you for whom you or your lawful spouse is the legal guardian. This does not include "wards of the state" or "foster children."

Class I dependents also include each unmarried child of any age who is determined to be eligible by the applicable medical **Claims Administrator** and who meets all of the following:

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

To cover Class I dependents beyond age 23, they must be certified for coverage by the applicable medical **Claims Administrator**. You must complete an application form available from your applicable medical Claims Administrator and submit it to the address listed on the form for approval.

No coverage beyond age 23 is available for a child who is incapacitated for only a short time due to illness or accident (e.g., a broken leg).

Class II dependents: the following relatives who meet the eligibility requirements shown below:

- Your unmarried dependent **children** not included as **Class I dependents**,
- Your unmarried dependent stepchildren, not included as **Class I dependents**,
- Your unmarried grandchildren, your unmarried brothers and sisters, and your parents and grandparents, and
- Your lawful spouse's parents and grandparents.

To be eligible for coverage as Class II Dependents under the Medical Plan, those relatives must continue to meet the following requirements:

- They receive less than $12,000 per year in income from all sources (other than the Employee's support),
- They live with you or in a nearby household provided by you (note that unmarried dependent stepchildren must live with the employee throughout the period of coverage), and
- They either:

    Have been continuously reenrolled during each open enrollment since January 1, 1996 and continue to be reenrolled each year, or

    Were enrolled before June 1, 1986 (grandfathered dependents).

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

Coinsurance: the cost-sharing method by which the Medical Plan pays a percentage of the provider's **covered** charge (for example, 80%) and you pay a percentage (for example, 20%). Your coinsurance is your share of the cost.

Copayment: a flat dollar amount (such as $15) that the participant pays for a certain medical service (such as an office visit or supply) as his or her share of the cost.

Covered: eligible under the terms of the Medical Plan. “Covered” is often used to modify other terms. Covered expense means medical costs that satisfy all of the rules to be considered for payment under the Medical Plan. A covered person is one who has benefits available under the Medical Plan. A covered provider is one who is (or which is) eligible to provide services and receive payment under the Medical Plan.

Covered dependent: a **Class I dependent** or **domestic partnership dependent** who is **covered** as the dependent of an employee. Other people such as siblings, parents, and grandparents may be covered as **Class II dependents** if they are currently enrolled and if they continue to meet the eligibility criteria.

Custodial care: treatment or services generally prescribed by a medical professional, that could be rendered safely and reasonably by a person not medically skilled. Custodial care is treatment or services that do not directly treat illness or injury but that are designed mainly to help the patient with daily living activities or are provided primarily for the convenience or comfort of the patient. These activities include but are not limited to:

- Personal care such as help in walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing
- Homemaking, such as preparing meals or special diets
- Moving the patient
- Acting as a companion or sitter
- Supervising medication that can usually be self administered
- Treatment or services that any person may be able to perform with minimal instruction, including, but not limited to, recording temperature, pulse and respiration, or administration and monitoring of feeding systems

Custodial care is a type of care provided to a patient whose need for medical care has stabilized and whose current medical condition is not expected to significantly and objectively improve.

Deductible: the amount of eligible expenses you may be required to pay under the **POS** option, **Lucent Informed Choice** option, **MH/CD Program** or **Prescription Drug Program** (for **out-of-network** care) or **Indemnity** option each year before benefits for **covered** expenses can begin. Whether a deductible applies, and the amount of the deductible, depends upon the Medical

Plan option you choose, the type of service or supply you receive, and whether care is received **in-network** or out-of-network. There is usually no deductible under the **HMO** option.

Domestic partnership dependent: an individual who:

- Is a member of the same 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,

  Reside in a state under the law of which marriage or an attempted marriage between these two persons is not recognized as a valid marriage,

  In addition, the employee and domestic partner must be willing to 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, or

- The dependent is the birth or adopted child of a domestic partner meeting all of the criteria described above, a child whom the domestic partner is in the formal, legal process of adopting, or a child living with the employee for whom the domestic partner is the legal guardian.

Please note that states regulate the **HMO** options, and that some states do not offer domestic partner coverage or have special requirements about the time you must have been with your partner, coverage of your partner's children, and COBRA continuation coverage. If you are considering domestic partner coverage under an HMO option, please check with the HMO for any such requirements.

Effective date: the date upon which coverage under the Medical Plan starts or takes effect.

Elective care: care that can be postponed for ten days or more without undue risk to the patient.

Eligible dependents: The Medical Plan recognizes three dependent classes -- **Class I dependents**, **Class II dependents** and **domestic partnership dependents**. You may enroll your eligible Class I dependents and eligible domestic partnership dependents under the Medical Plan. However, no new Class II dependents may be enrolled. Only Class II dependents who still meet the eligibility requirements and who are currently enrolled are eligible to continue coverage.

Eligible employee: a regular full-time or part-time management employee or Lucent Business Assistant who works for a **participating company**.

Note that individuals who are not paid from the U.S. payroll of a **participating company**, who are employed by an independent company (such as an employment agency), or whose services are rendered pursuant to an agreement excluding participation in benefit plans are not eligible to participate in the Medical Plan.

Emergency: a life-threatening medical condition suddenly and unexpectedly manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could result in: (a) permanently placing the patient's health in jeopardy; (b) causing serious and/or permanent impairment of a bodily part or function; (c) causing serious and/or permanent dysfunction of any body organ or part; and (d) causing severe pain. See "Emergency Care" in the **Mental Health and Chemical Dependency Program** for the definition of emergency as it applies to a mental health condition rather than a physical condition.

The following examples are generally emergencies:

- Apparent poisoning
- Convulsions

- Excessive uncontrolled bleeding
- Severe chest pain
- Severe or multiple injuries, including fractures
- Shortness of breath or difficulty breathing
- Sudden loss of consciousness

The following examples are generally not considered to be emergencies:

- Childbirth (Childbirth is not normally considered an emergency. However, an unexpected complication such as premature birth would be considered an emergency.)
- Colds, sore throat, cough
- Diarrhea
- Earaches
- Minor cuts
- Moderate fever
- Rashes
- Sprains
- Vomiting

Experimental or investigative treatment, drug or device: medical, surgical and psychiatric procedures, treatments, devices, drugs and drug treatments not approved by government agencies such as the Food and Drug Administration (FDA), and not accepted as standard, tested and accepted effective practice by the medical community at large at the time the service is rendered, as determined by the **health care company**.

Extended care facility: an institution other than a **hospital** which is licensed according to state laws to provide **in-patient** medical services, and which is accredited by the Joint Commission on the Accreditation of Healthcare Organizations or approved by Medicare. An extended care facility provides

direct medical treatment, and must have a professional nursing staff and operate under the supervision of a **physician**. An extended care facility is not primarily a place for rest, for the aged, for **custodial care**, or for the treatment of **mental illness** or **chemical dependency**. The term extended care facility encompasses facilities that go by names such as skilled nursing facilities, convalescent facilities, intermediate care facilities, sub-acute care facilities and rehabilitation centers -- provided they meet all the conditions given here.

Generic drug: a drug which does not bear the trademark of the original manufacturer. It is chemically identical to and generally costs less than a **brand name drug**.

Group homes and halfway houses: settings for care that are **covered** under the **in-network** benefits of the **Mental Health and Chemical Dependency Program**. Group homes and halfway houses are residences that provide a structured living environment, deliver treatment from **mental health and chemical dependency professionals**, and afford the patient opportunities to transition into daily life activities for the purpose of recovery from mental health conditions or **chemical dependency**. Adult patients typically leave the group home or halfway house during the day to engage in outside activities such as work or school, and return at night.

Halfway houses: see **group homes and halfway houses**.

Health care company: any company authorized by Lucent to provide services under the Medical Plan, including Aetna U.S. HealthCare, CIGNA, United HealthCare, Prudential, **Mayo Management Services, Inc.,** Merck-Medco Managed Care, L.L.C. (Medco), and Magellan Behavioral Health (**Magellan**).

Health Care Reimbursement Account (HCRA): an account you may elect to establish, during open enrollment or upon hire, for a calendar year. This account allows you to set aside money from each paycheck, on a before-tax basis, to pay eligible health care expenses.

Health Connection[SM]: a 24 hour-a-day, seven day a week health information line participants in the **Lucent Informed Choice** option may call for information and answers to health-related questions. This line is staffed by Mayo Clinic registered nurses and supported by Mayo physicians.

HMO (Health Maintenance Organization)**:** a **network** of **hospitals**, doctors, and other medical providers who provide services through an HMO plan. When you follow your HMO's rules for care, you usually pay no **deductibles** and file no claim forms. See "HMO Option" for rules of care.

Home health care agency: an organization licensed according to state laws to provide skilled nursing and certain other health services on a visiting basis in the patient's home. The agency must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations or be Medicare approved in order to be **covered** under the Medical Plan.

Hospice: an organization licensed according to state laws to provide care to terminally ill patients. A hospice may be either an agency that performs its services in the patient's home, or a facility into which the patient is admitted.

Hospital: a facility providing **in-patient** and **out-patient** care for the diagnosis and treatment of acute illness and injury. Under the **Mental Health and Chemical Dependency Program**, hospital means an acute general hospital with a psychiatric and/or **chemical dependency** unit, an acute psychiatric facility or an acute chemical dependency facility. The facility must be licensed according to state law and be staffed by **physicians** (and qualified **mental health or chemical dependency professionals** under the Mental Health and Chemical Dependency Program) and maintain 24-hour nursing services. A hospital is not primarily a place for rest or **custodial care**, a nursing home, convalescent home, home for the aged or similar institution nor does it include confinement in a residential treatment facility under the Mental Health and Chemical Dependency Program.

Indemnity option**:** a Medical Plan option (Enhanced Indemnity). With the Indemnity option, an annual **deductible** generally applies to **covered** services other than covered preventive care. You pay the percentage of covered expenses that applies. Unless you use a **PPO** provider, you file claim forms to be reimbursed. See "How the Indemnity Option Works."

In-network: the benefit choice where you access the services of contracted **network** providers according to the rules of the option or program you are enrolled under. For the **POS** option, this means going through your **PCP**. For the **Lucent Informed Choice** option it means using **PHCS** providers. For the **Mental Health and Chemical Dependency Program**, it means going through **Magellan**. For the Prescription Drug Program, it means using a participating retail or the mail-order pharmacy.

In-patient: a patient who is confined in a **hospital** or other health care facility as a registered bed patient for at least 18 hours (out of 24) and incurs room and board charges. In-patient care refers to the care rendered to an in-patient. An in-patient facility is a facility which provides such care.

Lucent Informed Choice: a Medical Plan option available to **eligible employees** in Lucent Informed Choice areas. It provides comprehensive

coverage for the same range of medical care and services as other Lucent medical options. However, it also features a unique blend of quality, flexibility, expert resources and greater control over the management of your own health care. In addition, you can get answers to your health-related questions from Mayo Clinic registered nurses by simply calling a toll-free telephone number. With Lucent Informed Choice, you have direct access to a network of providers. Effective January 1, 2001, benefits are also available if you use **out-of-network** providers, but at a lesser level of reimbursement.

Mayo Management Services, Inc. (MMSI): is the **health care company** for the **Lucent Informed Choice** option. MMSI provides customer service and answers benefit questions for participants in the Lucent Informed Choice option. In addition, MMSI provides members with access to **Health Connection**, a 24 hour-a-day health information line.

Magellan Behavioral Health (Magellan): the company that administers the **Mental Health and Chemical Dependency Program**.

Medically necessary: (medical necessity). The determination of medical necessity is made by the applicable **health care company**. Care is considered medically necessary if:

- It is accepted by the health care profession in the U.S. as appropriate and effective for the condition being treated,

- It is based upon recognized standards of the health care specialty involved,

- It represents the most appropriate level of care: the frequency of services, the duration of services, and the site of services, depending on the seriousness of the condition being treated (such as in the **hospital** or in the **physician's** office), and

- It is not experimental or investigational.

Mental health and chemical dependency professionals: a psychiatrist (M.D.), a licensed psychologist (Ph.D.) or one of the following Master's degree-level providers: a clinical social worker; a marriage, family, and/or child counselor; a licensed professional counselor: a certified alcoholism counselor: a certified **chemical dependency** counselor; or a registered nurse with a specialty in psychiatric and mental health nursing. The provider must carry all recognized certifications appropriate to his or her specialty and, where state law requires, be licensed in the state in which he or she practices. The particular certification may differ in various areas of the country.

Conditions of service:

- The provider may treat only those conditions, either mental health or **chemical dependency**, appropriate to his/her certification and licensing status.

Covered services:

- Diagnosis and treatment of mental health or **chemical dependency** conditions
- Psychological testing
- Psychotherapy
- **Chemical dependency** counseling

Mental Health and Chemical Dependency Program: the program that provides benefits for treatment of mental health and **chemical dependency** conditions to individuals **covered** under the **POS**, **Indemnity** and **Lucent Informed Choice** options. The Mental Health and Chemical Dependency Program is administered by **Magellan Behavioral Health** (**Magellan**) and is separate from the coverage available under your medical option and the Prescription Drug Program.

Mental health emergency: a mental health condition that appears or increases suddenly and is accompanied by severe symptoms. Without immediate treatment, a mental health emergency condition would result in: (a) the person harming him- or herself, or others; (b) severe diminishment or long-term damage to the state of the person's mental health; or (c) permanent physical impairment of bodily parts or functions as a consequence of the mental health emergency.

Mental illness: for the purpose of determining benefits under the Medical Plan, means a condition that meets either of the following two conditions: (a) it is classified as a mental illness in the latest edition of the International Classification of Diseases of the U.S. Department of Health and Human Services; or (b) it is a condition generally accepted by health care professionals in the U.S. as one that requires psychiatric treatment and will respond to such treatment.

Morbid obesity: obesity that has become a direct and immediate threat to a person's life.

Negotiated fee: under the **Lucent Informed Choice** option, **PHCS** providers are paid "negotiated fees" for covered services and supplies. The negotiated

fees are less than the doctors' and hospitals' normal charges. When you visit a PHCS **hospital**, you pay 15% of the negotiated fee (the lower fee the provider has agreed to charge). You won't be balance billed -- that is, billed for charges above the negotiated rate.

Network: the providers in a given area who participate with the **health care company** (or PHCS under the **Lucent Informed Choice** option). Network providers offer services to members enrolled with that health care company at a **prenegotiated rate** (or for the **negotiated fee** under the **Lucent Informed Choice** option).

Non-network: refers to a **physician**, **hospital** or other health care provider that has not signed a **network** provider agreement with the **health care company** (or PHCS under the **Lucent Informed Choice** option).

Occupational therapy: treatment to increase a patient's use of fine motor skills to enable him or her to apply them to the tasks required in daily living, after those skills have been impaired by illness or injury.

Open enrollment: the period of time each year when employees can change their coverage options. Open enrollment generally takes place in the fall. Elections made during annual open enrollment are effective on the first day of the following calendar year.

Other Covered Charges: the benefits provided under the Medical Expense Plan based on the applicable Coninsurance percentage rate under which the Participant has elected coverage, for purposes of Class II dependents including extended hospital confinements, nursing services, physician visits, physical therapy, blood, protheses, rental of durable medical equipment, replacement of durable medical equipment, local professional ambulance services, air ambulance services, mammography, chiropractic care, podiatric care, orthotic care, physiotheraphy and hemodialysis/peritoneal dialysis for chronic renal disease.

Out-of-network: the benefit choice where you access services without following the rules of the program for accessing contracted (**network**) providers. For the **POS** option, this means obtaining services without a referral from your **PCP**, or obtaining services from a **non-network** provider. For the **Lucent Informed Choice** option, this means not using **PHCS** providers or hospitals (other than in the case of **emergency** or **urgent** care). For the **Mental Health and Chemical Dependency program**, it means obtaining services without a referral or authorization from **Magellan**. For the Prescription Drug Program, it means using a pharmacy not identified as a **participating pharmacy**.

Out-of-pocket maximum: the limit on the amount you spend for **covered** medical expenses in **copayments** or **coinsurance**. Some charges do not count toward this maximum.

Out-patient: a patient who is treated in a **hospital** or other health care facility for less than 18 hours, and who does not incur a room and board charge. Out-patient care refers to the care rendered to an out-patient. An out-patient facility is one which provides such care.

Out-patient medical facilities: any medical diagnosis or treatment facility which doesn't offer overnight care, has a staff of medical professionals (including nurses), is operated under the direction of a **physician** and is licensed according to state law. **Covered** facilities include medical laboratories, **out-patient** surgical centers, **birthing centers**, **urgent** care facilities and out-patient rehabilitation facilities. It does not include a physician's office.

PCP: see **primary care physician**.

PPO: see **Preferred Provider Organization**.

Partial hospitalization: a type of care **covered** under the **in-network** benefits of the **Mental Health and Chemical Dependency Program**. Partial hospitalization means **out-patient** care delivered on a daily basis in a **hospital** or other facility. The facility must have both **physicians** and nurses on staff and be authorized to administer medications. Partial hospitalization is typically a less intense level of care than **in-patient** care, but more intense than intensive out-patient care.

Participating company/companies: a company or companies that participate in the Medical Plan. As of May 1, 2001, these are:

- Agere Systems Inc. through July 31, 2001
- Ascend Communications, Inc.
- Chromatis Networks Inc.
- Excel Switching Corporation
- Herrmann Technology, Inc.
- 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.
- Agere Systems Guardian Corp.
- Lucent Technologies Optical Fiber Solutions Inc.
- Lucent Technologies Optical Networking Guardian Corp.
- Lucent Technologies Optical Specialty Fibers Inc.
- Agere Systems Optoelectronics Guardian Corp.
- Lucent Technologies Wireless Guardian Corp.
- Lucent Technologies World Services Inc.
- Lucent Technologies Caribbean and Latin America Sales Inc.
- Lucent Technologies Sentinel I Inc. (effective 7/1/2001)
- Nassau Metals Corporation
- Nexabit Networks, Inc.
- Ortel Corporation
- SpecTran Corporation
- SpecTran Communications Fiber Technology Inc.
- SpecTran Specialty Optics Company
- Spring Tide Networks, Inc.
- Xedia Corporation

Participating pharmacy: a pharmacy that is a PAID Prescriptions participating retail pharmacy under the Prescription Drug Program.

Physical therapy: treatment to increase the patient's use of large-muscle motor skills, such as those needed for walking, after those skills have been impaired by illness or injury.

Physician: a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy in the state where the care is provided and is **covered** under the Medical Plan. Under the **Mental Health and Chemical Dependency Program**, care should be sought from a provider who is a psychiatrist or another provider who is certified in the treatment of mental health and/or **chemical dependency**.

Point-of-Service (POS): a medical option that provides a higher level of coverage when you coordinate care through your **primary care physician (PCP).** However, you may go **out-of-network** and use any health care provider you wish. Your cost usually is higher for out-of-network care.

Precertification: the process by which a **health care company** or precertification company reviews requested treatment in advance and advises you as to how benefits would be paid. In most instances, precertified care is paid at full Medical Plan benefits and **medically necessary** care that is not precertified is paid at a reduced level, or not **covered** at all. The need for precertification applies only to certain procedures.

Preferred Provider Organization (PPO): a **network** of providers offered in many areas of the country. When you are **covered** under the Indemnity option and you elect to receive medical care from providers in an available PPO network through your health care company, charges are generally lower and guaranteed to be within the **allowable amount**. The Lucent Informed Choice option also offers a PPO network, as provided through Private Healthcare Systems.

Prenegotiated rate: a rate for medical services to which a **network** provider has contractually agreed. Network providers agree to accept the prenegotiated rate as payment in full. This rate is usually less than their normal charge for that service.

Primary care physician (PCP): a **network physician** under the **HMO** or **POS** option who:

- Qualifies as a participating provider in general practice, internal medicine, family practice or pediatrics, and
- Has been selected by you as authorized by your **health care company** to provide your primary health care and authorize all your other **in-network** care.

Private duty nursing: nursing services provided in the home by a private duty nurse who holds a valid, recognized nursing certificate and is licensed according to state law in the state where services are received.

Private Healthcare Systems (PHCS): a national **network** of doctors and **hospitals** used under the **Lucent Informed Choice** option.

Qualified Medical Child Support Order (QMCSO): a judgment, decree, or order issued by a court that requires medical plan coverage for a participant's child and that has been determined by the Plan Administrator to be qualified under the Internal Revenue Code of 1986. See "Other Contacts" for whom you should contact with questions regarding QMCSO. Lucent Technologies Inc. has a policy to comply with the requirements of a QMCSO.

Reasonable and customary charge (or **R&C**)**:** the fee determined by the Claims Administrator on the basis of:

- The fees usually charged most patients for a similar service, and

- The range of fees charged by providers with similar training and experience for the same or similar services within the geographic region.

For the Prescription Drug Program, the R&C is consistent with the cost of prescriptions obtained from **participating pharmacies**.

Rehabilitation therapy: services provided by a physical therapist, speech therapist or occupational therapist. Rehabilitation services may be provided in a **hospital**, **extended care facility** or through a **home health care agency**. However, the need for rehabilitation can't be the primary reason for hospital confinement. Rehabilitation therapists may work independently or be on the staff of a hospital, extended care facility or home health care agency.

Residential treatment: a type of care **covered** under the **in-network** benefits of the **Mental Health and Chemical Dependency Program**. Residential treatment means 24-hour-a-day **in-patient** care in a facility that provides sub-acute care (sub-acute care is less intense than the treatment typically offered by a **hospital**). The facility must provide regular treatment activities under the supervision of licensed and certified mental health professionals, with both **physician**/psychiatrist and nursing services available on either a staff or contracted basis. A residential treatment facility is not solely or principally an alternate residence or a place of rest. On the contrary, measurable improvement, the reasonable likelihood of future improvement, and active family or guardian participation in the treatment are important criteria for authorization of continued treatment.

Skilled nursing facility: a facility that provides continuous skilled nursing care on an **in-patient** basis. It must be licensed in accordance with state and local law and be accredited by the Joint Commission on the Accreditation of Healthcare Organizations or approved by Medicare. A skilled nursing facility is not primarily a place for rest, for the aged, for **custodial care**, or for the treatment of **mental illness** or **chemical dependency**.

Speech therapy: therapy services that assist in the restoration of communication abilities that have been acutely impaired by illness, injury or birth defect.

Status change: as permitted under federal regulations, qualified status changes include the following:

Qualified Status Change	**Description**
Marital Status	A change in your legal marital status, including marriage, death of your spouse, divorce, legal separation, or annulment.
Number of Family Members	Events that change the number of eligible family members, including birth, adoption, placement for adoption, or death.
Employment Status	A termination or commencement of employment by you, your spouse, or child.
Work Schedule	A reduction or increase in hours of employment by you, your spouse, or a child, including a switch between part-time and full-time, or the start of or return from an unpaid leave of absence.
Family Member Meets or No Longer Meets the Eligibility Requirements	An event that causes a member of your family to meet or to no longer meet the plan's eligibility requirements for coverage. This may include a child reaching the maximum age for coverage, etc.
Residence or Worksite	A change in the place of residence or worksite of you, your spouse, or a child.

Lucent also considers corresponding changes in **domestic partnership dependents** as status changes.

The Internal Revenue Service (IRS) states you can change your level of coverage during the year if you have a qualified change in status. (You may also be eligible to change your Medical Plan option if you move outside the area where your current option is available.) Status changes must be reported within 31 days of the event.

Urgent: a medical condition that manifests itself by acute symptoms of sufficient severity that postponing treatment for more than 48 hours would:

- Place the patient's life in jeopardy,
- Cause serious, permanent impairment of a bodily part or function, or
- Cause severe pain.

Care that is needed to treat such a condition is called urgent care. Care rendered after the urgent situation has passed is not urgent care.

An urgent care facility is freestanding and not connected to a **hospital**. An urgent care facility is designed to respond to urgent medical conditions and perform minor surgical procedures