

Alan M. Sandals
 Scott M. Lempert
 (A Member of the Bar of this Court)
SANDALS & ASSOCIATES, P.C.
 One South Broad Street
 Suite 1850
 Philadelphia, PA 19107
 (215) 825-4000

Howard Shapiro
 Robert W. Rachal
 Brian Neulander
PROSKAUER ROSE LLP
 650 Poydras Street
 Suite 1800
 New Orleans, LA 70130
 (504) 310-4088

David S. Preminger
KELLER ROHRBACK, L.L.P.
 770 Broadway
 Second Floor
 New York, NY 10003
 (646) 495-6198
 Counsel for Plaintiffs and
 the Proposed Class

Wanda L. Ellert
 (A Member of the Bar of this Court)
PROSKAUER ROSE LLP
 One Newark Center
 18th Floor
 Newark, NJ 07102
 (973) 274-3200
 Counsel for Defendants

**UNITED STATES DISTRICT COURT
 FOR THE DISTRICT OF NEW JERSEY**

PETER A. RAETSCH, GERALDINE RAETSCH, :
 CURTIS C. SHIFLETT, WILLIAM FOSTER, JR., :
 JOAN W. FOSTER, STANLEY THOMAS, and :
 LARRY F. THOMPSON, individually and on :
 behalf of all others similarly situated :

Plaintiffs,

v.

LUCENT TECHNOLOGIES INC., :
 ALCATEL-LUCENT USA INC., :
 LUCENT TECHNOLOGIES, INC. EMPLOYEE :
 BENEFITS COMMITTEE, and LUCENT :
 TECHNOLOGIES INC. MEDICAL EXPENSE :
 PLAN FOR RETIRED EMPLOYEES :

Defendants.

CIVIL ACTION NO. :
 2:05-cv-5134 (PGS) (ES)

CLASS ACTION

PARTIES' JOINT PROPOSED FINAL PRETRIAL ORDER

This matter having come before the Court for a Final Pretrial Conference pursuant to Fed. R. Civ. P. 16; Alan M. Sandals, Scott M. Lempert, and David S. Preminger having appeared for all plaintiffs, and Howard Shapiro, Robert Rachal, Brian Neulander, and Wanda Ellert having appeared for all defendants; the following Final Pretrial Order is hereby entered:

INTRODUCTION

This Pretrial Order is entered to prepare for trial based on and in light of the issues remaining in the case as defined by the Court's rulings to date. Motions related to class issues and renewed cross-motions for summary judgment are currently pending, and the parties therefore reserve their respective rights to modify, amend or supplement this Pretrial Order as needed in order to reflect or respond to any subsequent rulings.

1. JURISDICTION: (Set forth specifically)

This action arises under the Employee Retirement Income Security Act of 1974, as amended (ERISA), 29 U.S.C. § 1001 et seq. The Court has federal question subject matter jurisdiction action under 28 U.S.C. § 1331 and 29 U.S.C. §§ 1132(e) and (f).

2. PENDING/CONTEMPLATED MOTIONS: (Set forth all pending or contemplated motions, whether dispositive or addressed to discovery or the calendar. Also set forth the nature of the motion and the return date. If the Court indicated that it would rule on any matter at pretrial, summarize that matter and each party's position.)

A. Pending Motions. As of the date of filing of this Joint Final Pretrial Order, the following motions have been fully briefed and are pending and awaiting decision by the Court:

(a) Plaintiffs' Amended Motion for Class Action Certification. The parties' filings on this motion were filed on March 13, 2009 (plaintiffs' initial motion and supporting memorandum and affidavits, Doc. # 97); May 11, 2009 (plaintiffs' amended motion and

supporting memorandum reflecting addition of named plaintiffs, Doc. # 107); June 26, 2009 (defendants' memorandum in opposition, Doc. # 115); and July 10, 2009 (plaintiffs' reply memorandum, Doc. # 118). The return date on the motion had been set for June 15, 2009 but was not subsequently adjusted.

(b) Plaintiffs' Motion for Partial Summary Judgment. The parties' filings on this motion were filed on June 26, 2009 (plaintiffs' initial motion, supporting memorandum, Local Rule 56.1 Statement, and supporting declaration with exhibits, Doc. # 117); July 27, 2009 (defendants' memorandum in opposition, Local Rule 56.1 Statement, and declaration with exhibits, Doc. # 119); and August 6, 2009 (plaintiffs' reply memorandum and declaration with additional exhibit, Doc. # 124). The return date on the motion was August 17, 2009.

(c) Defendants' Renewed Motion for Summary Judgment. The parties' filings on this motion were filed on June 26, 2009 (defendants' initial motion, supporting memorandum, Local Rule 56.1 Statement, and supporting declaration with exhibits, Doc. # 116); July 27, 2009 (plaintiffs' memorandum in opposition, Local Rule 56.1 Statement, and declaration with exhibits, Doc. ## 120 and 121); and August 6, 2009 (defendants' reply memorandum and declaration with additional exhibits, Doc. ## 122 and 123). The return date on the motion was August 17, 2009.

(d) Defendants' Motion to Decide Before Trial Class Definition, Class Issues, and Trial Plan. Defendants filed their motion and supporting memorandum on August 14, 2009 (Doc. # 125). Due to the time demands associated with the preparation of this Final Pretrial Order, plaintiffs filed a letter under L. Civ. R. 7.1(d)(5) (Doc. # 127) electing to extend their date to file an opposition to on or before September 8, 2009, and that reset the return date, originally set for September 8, 2009, to September 21, 2009.

B. Contemplated Motions.

Plaintiffs: As of the date of filing of this Joint Final Pretrial Order, plaintiffs do not contemplate any other motions at this time.

Defendants: As of the date of filing of this Joint Final Pretrial Order, Defendants contemplate that they will address the following issues either through motion and/or through the Trial Brief. Defendants object to Plaintiffs' attempt to add in contribution and RECA issues to the Pretrial Order, and contemplate that they may file a motion or motions to exclude these issues from the trial and/or address through the Trial Brief. Defendants also object to Plaintiffs' attempt to seek bifurcation of trial, and contemplate that they may file a motion on this issue and/or address through the Trial Brief. Defendants also may file motion or motions in limine and/or address through the Trial Brief regarding excluding certain of Plaintiffs' proposed exhibits and proposed deposition testimony, including that the deposition testimony of the Aon witnesses, Steve Hoeffner and Tom Eckhard, is inadmissible hearsay.

3. STIPULATIONS OF FACTS: (Set forth in narrative form a comprehensive listing of all uncontested facts, including all answers to interrogatories and admissions, to which there is agreement among the parties.)

A. The Parties

1. Defendant Lucent Technologies Inc. ("Lucent") is a Delaware corporation with its principal place of business at 600 Mountain Avenue, Murray Hill, NJ. As of November 30, 2006, Lucent became wholly-owned by Alcatel Lucent SA. Effective November 1, 2008, Lucent's name became Alcatel-Lucent USA Inc. All references to "Lucent," including references in the caption and body of the Complaint, are deemed to also refer to defendant Alcatel-Lucent USA Inc.

2. Lucent was incorporated in 1995 and fully divested from AT&T Corporation on September 30, 1996.

3. Lucent established its own pension and medical plans, and certain participants and assets, along with obligations to pay certain benefits, were transferred from the plans of AT&T Corporation to Lucent's new plans.

4. The initial Lucent Technologies Inc. Management Pension Plan ("Pension Plan") was renamed the Lucent Retirement Income Plan effective January 1, 2000. Effective January 1, 2007, the Pension Plan was renamed the Alcatel-Lucent Retirement Income Plan.

5. Defendant Lucent Technologies Inc. Medical Expense Plan for Retired Employees ("Medical Plan") is a successor to certain retiree medical benefit plans sponsored by AT&T Corporation. Effective January 1, 2007, the Medical Plan was renamed the Alcatel-Lucent Medical Expense Plan for Retired Employees. Non-defendant Lucent Technologies Inc. Dental Expense Plan for Retired Employees is a successor to certain retiree dental benefit plans sponsored by AT&T Corporation. Effective January 1, 2007, the dental plan was renamed the Alcatel-Lucent Dental Expense Plan for Retired Employees. The Medical Plan and Dental Plan are referred to collectively hereinafter as "the Medical Plan."

6. The Medical Plan was established to provide post-retirement medical and dental benefits to eligible plan participants, spouses, and other dependents.

7. Defendant Lucent Technologies, Inc. Employee Benefits Committee is a body appointed by Lucent to serve designated plan administration functions for the Pension Plan.

8. Plaintiff Peter A. Raetsch ("Raetsch") was formerly employed by AT&T Corporation and Lucent. Raetsch retired from Lucent effective December 30, 1997. After Mr. Raetsch retired from Lucent, he became CEO of a consulting firm, Keystone Consultants but has

testified that he was not eligible for medical coverage for himself or his spouse as a result of this position. Plaintiff Geraldine Raetsch is the spouse of Raetsch. She is a current beneficiary of the Pension Plan and a former beneficiary of the Medical Plan. Peter Raetsch and Geraldine Raetsch participated in HMO medical options available under the Medical Plan.

9. Plaintiff Curtis C. Shiflett (“Shiflett”) was formerly employed by AT&T Corporation and Lucent. Shiflett retired from Lucent effective December 30, 1997. Shiflett and his spouse participated in HMO medical options available under the Medical Plan.

10. Plaintiff William Foster Jr. (“Foster”) was formerly employed by AT&T Corporation. Foster retired from AT&T effective December 1989. Plaintiff Joan W. Foster is the spouse of Foster and is a current beneficiary of the Pension Plan and the Medical Plan. Foster and his spouse participated in the Traditional Indemnity Plan medical option available under the Medical Plan. Due to Foster’s retirement from AT&T before March 1990, Medical Plan contribution requirements have not applied to the Fosters.

11. Plaintiff Stanley C. Thomas (“Thomas”) was formerly employed by AT&T Corporation. Thomas retired from AT&T effective May 1987. Thomas and his spouse participated in the Traditional Indemnity Plan medical option available under the Medical Plan. Due to Thomas’s retirement from AT&T before March 1990, Medical Plan contribution requirements have not applied to Thomas and his spouse, Cleo Thomas.

12. Plaintiff Larry F. Thompson, Ph.D. (“Thompson”) was formerly employed by AT&T Corporation. Thompson retired from AT&T effective during 1995. After Dr. Thompson retired from AT&T, he worked for several consulting firms, in which positions he has served from time to time as an expert witness in intellectual property disputes. Dr. Thompson declined active employee healthcare coverage from the consulting firms, in favor of his retiree healthcare

coverage from AT&T and Lucent. Thompson and his spouse participated in the High POS Plan medical option available under the Medical Plan.

13. Each of the plaintiffs is a participant or beneficiary in and receives benefits from the Pension Plan and receives, or is eligible to receive benefits from the Medical Plan.

B. Defendants' Transfers of Pension Assets Pursuant to Internal Revenue Code § 420

14. Pursuant to the authorization granted by Internal Revenue Code sections 401(h) and 420 and the provisions in the Pension Plan and Medical Plan, Lucent made the following four transfers of excess assets in the Pension Plan to the Pension Plan's Code § 401(h) account to fund retiree medical benefits:

(a) Lucent transferred \$182,993,000 on September 29, 1999, for the tax year ending September 30, 1999;

(b) Lucent transferred \$191,169,000 on December 22, 1999 for the tax year ending September 30, 2000;

(c) Lucent transferred \$214,000,000 on December 27, 2000 for the tax year ending September 30, 2001; and

(d) Lucent transferred \$300,000,000 on December 26, 2001 for the tax year ending September 30, 2002.

C. The Section 420 Maintenance of Effort Requirements Applicable to Defendants

15. Section 420 of the Internal Revenue Code and provisions in the Pension Plan and Medical Plan impose two different Maintenance of Effort ("MOE") requirements: (i) maintenance of benefits ("MOB"), which required Lucent, and the Medical Plan, for the years and participants subject to this MOB requirement, to maintain "substantially the same" Applicable Health Benefits provided by the employer as were offered in the year prior to the

applicable Code § 420 transfer, and (ii) maintenance of costs (“MOC”), which required Lucent, and the Medical Plan, for the years and participants subject to MOC, to meet or exceed the per-capita expenses of the applicable baseline year.

16. The MOB standard in the Pension Plan states, inter alia, that the Medical Plan must “provide[] that the Applicable Health Benefits for each taxable year during the Benefit Maintenance Period are substantially the same as the Applicable Health Benefits provided by the employer during the taxable year immediately preceding the taxable year of the Qualified Transfer.” *See* Pension Plan, LAR 0483, 0518-0523.

17. As determined by the Court in its June 12, 2008 Opinion on the cross-motions for summary judgment, the applicable MOE standard for each tax year is as follows:

Fiscal Year		MOE Standard
1999	(10/1/1998-9/30/1999)	MOB
2000	(10/1/1999-9/30/2000)	MOB
2001	(10/1/2000-9/30/2001)	MOB
2002	(10/1/2001-9/30/2002)	MOB
2003	(10/1/2002-9/30/2003)	MOB
2004	(10/1/2003-9/30/2004)	MOC
2005	(10/1/2004-9/30/2005)	MOC
2006	(10/1/2005-9/30/2006)	MOC

D. Summary Data Regarding Changes in Medical Plan Benefits

18. The terms of the non-HMO medical, mental health, and prescription drug benefits provided to management participants in the Medical Plan during the benefit maintenance requirements baseline year of calendar year 1998 (other than terms relating to contributions and the RECA benefits) are accurately summarized in tabular form in the chart entitled “CY 1998 Benefits-at-a Glance (Baseline)” which is one of the charts attached hereto as Exhibit A.

19. The changes to the terms of the non-HMO medical, mental health, and

prescription drug benefits provided to management participants in the Medical Plan during the benefit maintenance period (January 1, 1999 to September 30, 2003) (other than changes, if any, relating to contributions and the RECA benefits), are accurately summarized in tabular form in the shaded cells in the charts entitled "CY [year] Benefits-at-a-Glance" for each of the calendar years 1999 through 2003, which are attached hereto as Exhibit A. The same changes are set out in narrative summary fashion in the accompanying sections of the Revised Buck Report, and are set out in narrative fashion below:

E. Benefits Changes During Tax Year 2001 (October 1, 2000 to September 30, 2001)

20. For covered participants, Defendants were governed by the benefit maintenance requirements during Lucent's tax year 2001, the period October 1, 2000 to September 30, 2001.

21. Effective January 1, 2001, defendants made the following changes in co-payment requirements, deductibles, out of pocket maximums, and similar coverage terms of the Medical Plan. Unless later changed, these changes continued to be effective during the remainder of the benefit maintenance period:

a. *Co-payments for Retail Prescription Drugs.* Effective January 1, 2001, the co-payment for in-network prescription drug transactions at retail pharmacies was increased from \$ 5 to \$ 6 per generic drug prescription, representing an increase of \$ 1 per generic drug prescription as compared to the benefit maintenance baseline year of 1998, and was increased from \$ 10 to \$ 15 per brand-name drug prescription, representing an increase of \$ 5 per brand name drug prescription as compared to the benefit maintenance baseline year of 1998.

b. *Co-payments for Mail Order Prescription Drugs.* Effective January 1, 2001, the co-payment for in-network prescription drug transactions filled through mail order was increased from \$ 8 to \$ 9 per generic drug prescription, representing an increase of \$ 1 per

prescription as compared to the benefit maintenance baseline year of 1998, and was increased from \$ 15 to \$ 25 per brand-name drug prescription, representing an increase of \$ 10 per prescription as compared to the benefit maintenance baseline year of 1998.

c. *Coinsurance for Out-of-Network Prescription Drug Claims.* Effective January 1, 2001, the coinsurance percentage (i.e., the percentage of the claim cost covered by the Plan) applicable to out-of-network prescription drug claims was decreased from 80% to 70% of the allowable claim amount above the applicable deductible.

d. *Deductibles for Out-of-Network Prescription Drug Claims.* Effective January 1, 2001, the deductible applicable to out-of-network prescription drug claims was increased from \$ 50 per individual and \$ 150 per family, to \$ 100 per individual / \$ 200 per two-person family / and \$ 300 per family of three or more persons.

e. *Out-of-Pocket Maximums for Pre-Medicare Members of Point of Service Option.* Effective January 1, 2001, the out-of-pocket maximum applicable to in-network services provided to members in the Point of Service (“POS”) Plan option who were not eligible for Medicare was increased from \$ 750 per individual to \$ 1,000 per individual, subject to a cap of \$ 2,000 per family.

f. *Office Visit Co-payments for Pre-Medicare Members of Point of Service Option.* Effective January 1, 2001, the physician office visit co-payment applicable to in-network services provided to members in the Point of Service (“POS”) Plan option who were not eligible for Medicare was increased from \$ 10 per office visit to \$ 15 per office visit.

g. *Coverages Added Effective January 1, 1999.* Effective January 1, 1999, (i) for the pre-65 POS plans changed the lifetime maximum to unlimited as applied to out-of-network services compared to the previous lifetime maximum of \$1,000,000; (ii) covered birth

control, including oral contraceptives, on the same basis as other medical expenses; (iii) covered smoking deterrents on the same basis as other medical expenses; and (iv) covered blood and blood derivatives.

F. Benefits Changes During Tax Year 2002 (October 1, 2001 to September 30, 2002)

22. For covered participants, Defendants were governed by the benefit maintenance requirements during Lucent's tax year 2002, the period October 1, 2001 to September 30, 2002.

23. Effective January 1, 2002, defendants made the following changes in co-payment requirements, deductibles, out of pocket maximums, and similar coverage terms of the Medical Plan. Unless later changed, these changes continued to be effective during the remainder of the benefit maintenance period:

i. *Co-payments for Retail Prescription Drugs – Non-Formulary Brand-Name Drugs.* Effective January 1, 2002, the co-payments for in-network prescription drug transactions at retail pharmacies were increased from \$ 15 per brand-name drug prescription to \$ 15 per formulary brand-name drug prescription and \$ 25 per non-formulary brand-name drug prescription, representing an increase of \$ 10 per prescription within the newly established non-formulary brand-name category. In other words, a three-tiered pricing system replaced a two-tiered system (the new categories were Generic/Brand Name Preferred/Brand Name Non-Preferred).

j. *Co-payments for Mail Order Prescription Drugs – Non-Formulary Brand-Name Drugs.* Effective January 1, 2002, the co-payments for in-network prescription drug transactions filled by mail order were increased from \$ 25 per brand-name drug prescription to \$ 25 per formulary brand-name drug prescription and \$ 40 per non-formulary brand-name drug prescription, representing an increase of \$ 15 per prescription within the newly established non-

formulary brand-name category. In other words, a three-tiered pricing system replaced a two-tiered system (the new categories were Generic/Brand Name Preferred/Brand Name Non-Preferred).

G. Benefits Changes During Tax Year 2003 (October 1, 2002 to September 30, 2003)

24. For covered participants, Defendants were governed by the benefit maintenance requirements during Lucent's tax year 2003, the period October 1, 2002 to September 30, 2003.

25. Effective January 1, 2003, defendants made the following changes in co-payment requirements, deductibles, out of pocket maximums, and similar coverage terms of the Medical Plan. These changes continued to be effective during the remainder of the benefit maintenance period:

k. *Co-payments for Retail Prescription Drugs.* Effective January 1, 2003, the co-payments for in-network prescription drug transactions at retail pharmacies were increased from \$ 6 to \$ 10 per generic drug prescription, representing an increase of \$ 4 per generic drug prescription; from \$ 15 to \$ 25 per formulary brand-name drug prescription, representing an increase of \$ 10 per formulary brand-name drug prescription; and from \$ 25 to \$ 40 per non-formulary brand-name drug prescription, representing an increase of \$ 15 per non-formulary brand-name drug prescription.

l. *Co-payments for Mail Order Prescription Drugs.* Effective January 1, 2003, the co-payments for in-network prescription drug transactions filled by mail order were increased from \$ 9 to \$ 20 per generic drug prescription, representing an increase of \$ 11 per filled generic drug prescription; from \$ 25 to \$ 50 per formulary brand-name drug prescription, representing an increase of \$ 25 per formulary brand-name drug prescription; and from \$ 40 to \$ 80 per non-formulary brand-name drug prescription, representing an increase of \$ 40 per non-

formulary brand-name drug prescription.

m. *Out-of-Pocket Maximum for In-Network Prescription Drugs.* Effective January 1, 2003, the annual out-of-pocket maximum applicable to in-network retail and mail order prescription drug claims was increased from \$ 750 per covered individual to \$ 1,000 per individual.

n. *Out-of-Network Annual Out-of-Pocket Maximums (POS Option).* Effective January 1, 2003, the annual out-of-pocket maximums applicable to out-of-network care under the POS option were increased from \$ 2,500 per individual to \$ 3,000 per individual, and from \$ 5,000 per family to \$ 6,000 per two person family and \$ 9,000 per family of three or more persons.

o. *Out-of-Network Annual Deductibles (POS Option).* Effective January 1, 2003, the annual out-of-network deductibles under the POS option were increased from \$ 400 per individual and \$ 800 per family, to \$ 500 per individual / \$ 1,000 per two-person family / and \$ 1,500 per family of three or more persons.

p. *Out-of-Network Hospital Admission Co-pays (POS Option).* Effective January 1, 2003, the out-of-network co-pay applicable to hospital admissions under the POS option was increased from \$ 150 per admission to \$ 200 per admission.

q. *Co-payments for In-Network Office Visits (Lucent Informed Choice Option).* Effective January 1, 2003, the co-payment for in-network office visits under the Informed Choice option was increased from \$ 15 to \$ 25 per visit, representing an increase of \$ 10 per office visit.

r. *In-Network Annual Deductibles (Lucent Informed Choice Option).* Effective January 1, 2003 new annual in-network deductibles were established for the Informed

Choice option. The amounts of the new deductibles were \$ 300 per individual / \$ 600 per two-person family / and \$ 900 per family of three or more persons.

s. *Out-of-Network Annual Deductibles (Lucent Informed Choice Option)*. Effective January 1, 2003, the out-of-network annual deductible under the Informed Choice option was increased from \$ 400 per individual to \$ 600 per individual, and from \$ 800 per family to \$ 1,200 per two person family and \$ 1,800 per family of three or more persons.

t. *In-Network Annual Out-of-Pocket Maximums (Lucent Informed Choice Option)*. Effective January 1, 2003, the annual out-of-pocket maximum applicable to in-network care under the Informed Choice option was increased from \$ 750 per individual to \$ 1,000 per individual, and from \$ 1,500 per family to \$ 2,000 per two person family and \$ 3,000 per family of three or more persons.

u. *Out-of-Network Annual Out-of-Pocket Maximums (Lucent Informed Choice Option)*. Effective January 1, 2003, the annual out-of-pocket maximum applicable to out-of-network care under the Informed Choice option was increased from \$ 2,500 per individual to \$ 3,000 per individual, and from \$ 5,000 per family to \$ 6,000 per two person family and \$ 9,000 per family of three or more persons.

v. *Coinsurance (Traditional Indemnity Option)*. Effective January 1, 2003, the coinsurance for certain services covered under the Traditional Indemnity option was decreased from 100% to 80%.

w. *Annual Deductibles (Traditional Indemnity Option)*. Effective January 1, 2003, the annual deductibles under the Traditional Indemnity option for most participants were increased from \$ 50 plus 1% of pension (minimum deductible of \$ 75 and maximum deductible of \$ 200) per individual / two times individual deductible per two-person family / and three times

individual deductible per family of three or more persons), to \$ 150 plus 1% of pension (minimum deductible of \$ 175 and maximum deductible of \$ 300) per individual / two times individual deductible per two-person family / and three times individual deductible per family of three or more persons)

x. *Annual Deductibles for Medicare-Eligible Members in Traditional Indemnity Option whose Participation was Based on Account Balance Program.* Effective January 1, 2003, the annual deductibles applicable to members in the Traditional Indemnity Option whose participation was based on the Account Balance Program were increased from \$ 200 per individual / 400 per two-person family / 600 per family of three or more persons, to \$ 300 per individual / 600 per two-person family / 900 per family of three or more persons.

y. *Annual Out-of-Pocket Maximums (Traditional Indemnity Option).* Effective January 1, 2003, the annual out-of-pocket maximums applicable to coverage under the Traditional Indemnity option were increased from \$ 1,000 per individual to \$ 1,500 per individual, and from \$ 3,000 per family to \$ 3,000 per two person family and \$ 4,500 per family of three or more persons.

z. *Co-payments for First 10 In-Network Office Visits (Mental Health and Chemical Dependency Program).* Effective January 1, 2003, a \$ 25 co-payment requirement was established for the first ten in-network office visits under the Mental Health and Chemical Dependency (“MHCD”) Program applicable to retirees who were not Medicare-eligible.

aa. *Co-payments Following 10th Visit for In-Network Office Visits (Mental Health and Chemical Dependency Program).* Effective January 1, 2003, the co-payment amount following the 10th visit for in-network office visits under the Mental Health and Chemical Dependency Program applicable to retirees who were not Medicare-eligible was increased from

\$ 15 per visit to \$ 25 per visit.

bb. *Co-payments for Inpatient Daily Co-Pays (Mental Health and Chemical Dependency Program)*. Prior to January 1, 2003, there was no co-payment requirement for the first 10 days of inpatient stay, with a \$15 a day co-payment due thereafter for the Mental Health and Chemical Dependency Program. Effective January 1, 2003, a \$ 25 daily co-payment requirement was required for inpatient stays.

cc. *Annual Out-of-Pocket Maximums (Mental Health and Chemical Dependency Program)*. Effective January 1, 2003, the annual out-of-pocket maximum applicable to care under the Mental Health and Chemical Dependency Program for retirees who were not Medicare-eligible was increased from \$ 750 to none (i.e., unlimited out-of-pocket expenditures).

dd. *Coinsurance for Medicare-Eligible Inpatient Care (Mental Health and Chemical Dependency Program)*. Effective January 1, 2003, for inpatient treatment of retirees who were Medicare-eligible, the covered portion of charges was decreased from 100% to 80% for care under the Mental Health and Chemical Dependency Program

ee. *Outpatient Annual Visit Maximums (Mental Health and Chemical Dependency Program)*. Effective January 1, 2003, the annual maximum applicable to outpatient treatment under the Mental Health and Chemical Dependency Program applicable to retirees who were not Medicare-eligible was decreased from none in-network / 60 visits out-of-network, to 50 visits combined in and out-of-network.

ff. *Inpatient Annual Treatment Day Maximums (Mental Health and Chemical Dependency Program)*. Effective January 1, 2003, the annual maximum days applicable to inpatient treatment under the Mental Health and Chemical Dependency Program applicable to

Retirees who were not Medicare eligible was decreased from none in-network / 30 days out-of-network to 120 days combined in and out-of-network and 30 days out-of-network.

H. Contribution Refund During 2005

26. As of the summer of 2005, Defendants and their legal and actuarial advisors believed after careful study that the last § 420 transfer for FY 2002 controlled MOC, and thus that Lucent was legally obligated to exceed the FY 2001 per-capita spend amount (which Lucent then deemed to be \$3,165) for each of the three MOC years of FY 2004 to FY 2006. Therefore, Lucent made a contribution refund to participants of \$14.3 million in 2005. Had Defendants applied the per capita amount from FY 2000 to FY 2005, no contribution refund would have been due in FY 2005.

4. PLAINTIFFS' CONTESTED FACTS: (Stated separately for each defendant. Proof shall be limited at trial to the matters set forth below. Failure to set forth any matter shall be deemed a waiver thereof.)

A. Plaintiffs intend to prove the following contested facts with regard to liability:

1. Plaintiffs William Foster, Joan W. Foster, Stanley Thomas, and Larry F. Thompson have been directly affected and have been required to bear additional expenses as a result of the changes during the benefit maintenance period to the co-payment requirements, deductibles, out of pocket maximums, and similar coverage terms of the Medical Plan.

2. Plaintiffs Peter Raetsch, Geraldine Raetsch, Curtis Shiflett, and Larry F. Thompson have been directly affected and have been required to bear additional expenses as a result of the changes during the benefit maintenance period to the contribution amount requirements charged to retirees and their eligible dependents for coverage under the Medical Plan.

3. All Plaintiffs have been directly affected and have been required to bear additional expenses as a result of the changes made during the benefit maintenance period to discontinue and eliminate the Retired Employee Care Account (“RECA”) benefits under the Medical Plan effective January 1, 1999.

4. Plaintiffs Peter Raetsch, Curtis Shiflett, William Foster, Joan Foster, Stanley Thomas, and Larry F. Thompson were participants in the subsidized Medical Plan during tax year 2006 (i.e., October 1, 2005 to September 30, 2006). If the Court determines that defendants violated the cost maintenance requirements by failing to maintain the required level of per capita expenditures during tax year 2006, then these plaintiffs were directly affected by any such violation and were required to bear expenses that should have been paid by the Medical Plan and Lucent.

5. During the benefit maintenance period, the levels of retiree medical and dental benefits (including co-payment, deductible, out-of-pocket maximum, and similar provisions) provided to plaintiffs and other management retirees were not “substantially the same as” the level of benefits provided by Lucent during the tax year immediately preceding the tax year of the September 1999 transfer, *i.e.* the period October 1, 1997 to September 30, 1998.

6. Defendants are unwilling to stipulate to the amounts of financial impacts from these changes as calculated by their own expert, Buck Consultants.

7. The Buck calculations of the financial impacts on the retirees of the benefits changes other than contribution increases that were made by Lucent during tax years 2001, 2002 and 2003 (*i.e.*, during the period January 1, 2001 to September 30, 2003) are presented in Sections 4-10 of the Revised Buck Report. *See* Exhibit C at 9-23. Before considering defendants’ several proposed adjustments to these values, the financial impacts on the retirees

each tax year as calculated by defendants are as follows:

FINANCIAL IMPACTS AS CALCULATED BY BUCK/LUCENT

<u>TYPE OF BENEFITS</u>	1/1/01- 9/30/01	10/1/01- 9/30/02	10/1/02- 9/30/03
4. Prescription Drugs (Buck Report Table 4.2.3)	4,357,200	7,311,500	19,488,200
5. Office Visit Copays (Table 5.2)	272,600	631,300	1,817,500
6. Other POS Plan Changes (Table 6.2)	9,700	11,500	134,600
7. Mental Health Benefit Changes (Table 7.2)	-	-	119,800
8. Lucent Informed Choice Plan (Table 8.2)	-	-	248,300
9. Trad. Indem. Plan Deductible (Table 9.3)	-	-	2,548,600
10. Trad. Indem. Plan Coinsurance and OOP Max. (Table 10.2)	-	-	6,018,900
Totals by Year	4,639,600	7,954,300	30,375,900
GRAND TOTAL			42,969,800

The grand total of the financial impacts resulting from these benefit changes during the 2001-2003 benefit maintenance period, as calculated by defendants' own experts, is \$ 42,969,800.

8. When these types of benefit changes were adopted, defendants estimated their financial impact on the retirees. The "Cost Shift to Retirees" resulting from the changes first effective during 2002 was an average of \$ 800, increasing the average annual out-of-pocket expenses of pre-Medicare retirees from \$ 1,535 to \$ 2,315 (a 50.8% increase) and the out-of-pocket expenses of Medicare-eligible retirees from \$ 1,745 to \$ 2,580 (a 47.9% increase). *See* "Lucent Technologies Inc. U.S. Benefits Proposal 2002," at 7, 18, LR-E0003517, 3528.

9. In a 2004 presentation Lucent discussed the financial impact of benefit changes first effective during 2003 and reported the fact that its "per capita cost [for retiree medical coverage] for 2003 vs. 2002 was **flat**" (emphasis in original) and that "This is mainly attributable

to cost shifting under the medical plan. The average out-of-pocket expenses (excluding contributions [which also were increased]) have increased from: . . . \$ 777 [2002] to \$ 1,217 [2003] for pre-65 retirees [and] \$ 1,120 [2002] to \$ 2,195 [2003] for post-65 retirees.” See “U.S. Management Employees/Retirees Benefits Proposal for 2005 at LAR 0290.

10. At the time defendants made the 2001-2003 benefit changes, Lucent made contemporaneous projections of the cost savings the company would realize as a result of these benefit changes. For the 2001 changes, Lucent estimated a cost-shift of \$ 10 million (including increased contributions) from the company to the retirees. For the 2002 changes, Lucent estimated cost-shifting of an additional \$ 3 million from the company to the retirees. For the 2003 changes, Lucent estimated cost-shifting of an additional \$ 27 million from the company to the retirees. These annual values do not take into account the continuing impacts of the changes made during the previous years or concurrent increases in contributions (except as noted for 2001). See Transcript of Deposition, Thomas Eckhard, May 22, 2009, at 87:5-89:9, 92:5-97:22, and 101:16-103:18 and Exhibits PX 64, 66 and 67 thereto.

11. In its Annual Report Form 20-F dated March 31, 2009, defendant Alcatel-Lucent disclosed that, based on its analysis solely of the benefits changes first effective during fiscal year 2003, it has established a reserve in the amount of \$ 29.4 million due to the June 11, 2008 partial summary judgment entered against it. “Based upon a review of claims data, Lucent now believes that the impact of the 2003 benefit plan changes, during fiscal year ending September 30, 2003, is U.S. \$ 29.4 million.” Alcatel-Lucent Form 20-F, March 31, 2009.

12. In addition to the benefit changes itemized in the Stipulations of Fact, defendants made other changes during the benefit maintenance period (a) increasing the contributions charged to participants and (b) discontinuing and eliminating the valuable RECA benefits.

13. During the benefit maintenance period, defendants also did not maintain the baseline, tax year 1998 levels of contributions charged to retirees and their dependents but instead significantly increased the contributions for medical and dental plan coverage during the period 1999-2003. These levels of retiree contributions were not “substantially the same as” the levels of contributions required during the tax year immediately preceding the tax year of the September 1999 transfer, *i.e.* the period October 1, 1997 to September 30, 1998.

14. The Revised Buck Report and Segal Report present calculations which solely concern the changes made to benefits other than contributions during 2001-2003. Lucent and Medstat were not able to produce information regarding the monthly contributions charged to retirees during the period 1998-2003. *See, e.g.*, Revised Buck Report at 43 (“The Employee Contribution Amount (field #9) was only available for CY2004-2006. We tested these data thoroughly and concluded that they were not sufficient to include premium contributions in the scope of our financial impact analysis.”) (Exhibit C).

15. With two narrow exceptions (discussed below), during the baseline tax year 1998 retirees and dependents were not required to contribute for their medical and dental coverage from Lucent. During 1998, “If you are under age 65 or if you retired before 3/1/90, you will not be required to contribute toward the cost of your medical coverage.” *See* Lucent 1998 Benefit Elections booklet, at LAR 004995. Also during 1998, for those who retired on or after March 1, 1990 and were age 65 or over, there was a modest contribution requirement, but it was paid for by the “Retired Employee Care Account” (“RECA”) benefits that defendants discontinued effective January 1, 1999. *See* Lucent 1998 Benefit Elections booklet, at LAR 004995, 4999-5000. *See also* FAS Disclosure Letter for Fiscal Year 1999, dated October 26, 1999, LR-E0004555 et seq., at Attachment B-3 (LR-E0004576) (“no management retiree contributions will

be required for 1998”).

16. During tax year 1998, the Medical Plan required retirees and dependents to contribute for their medical coverage in only two limited situations. First, if the cost of an HMO option selected by a retiree exceeded the cost to Lucent of providing the Traditional Indemnity and POS options, then the retiree was responsible to pay the incremental difference. *See* Lucent Technologies Inc. Medical Expense Plan for Retired Employees, effective as of October 1, 1996 at § 6.1(2), page 43. Second, “for calendar years 1995 through 1998,” modest monthly contributions ranging between \$ 5 (for single coverage of a 1997 retiree who was Medicare-eligible) and \$ 40 (under age 65 family coverage of a 1998 retiree) were required of employees who retired in 1997 and 1998 and who participated in the High POS Option. *Id.* at § 10.2(b), page 55.

17. Plaintiffs Peter Raetsch, Geraldine Raetsch, and Curtis Shiflett (and his spouse) participated in HMO options through the Lucent plan. During tax year 1998 they were not required to pay any premiums for their coverage. Contributions were later imposed on them, and increased dramatically, during the benefit maintenance period however. *See* Deposition of Geraldine Raetsch, June 3, 2009, at 35:13-36:20, 46:24-49:4; Deposition of Curtis Shiflett, June 3, 2009, at 18:5-22, 31:9-27. Plaintiff Thompson and his spouse also had not been required to contribute for their medical coverage under the POS option during tax year 1998 and contributions first began to be required of them in about 2000. *See* Deposition of Larry F. Thompson, Ph.D., June 2, 2009, at 18:8-12.

18. For the bulk of the retirees, Lucent first began charging contributions during the benefit maintenance period, in calendar year 2001:

2001

- Some post-3/1/90 retirees began paying for healthcare on a monthly basis

See Booklet used at December 18, 2002 Board Committee meeting at LAR 00231.

19. Lucent required more retirees to pay contributions, at increased levels, during calendar year 2002, and made further increases requiring all retirees who retired after March 1, 1990 to pay contributions, during calendar year 2003:

2003

- All post-3/1/1990 retirees will beg[i]n paying for healthcare on a monthly basis

See LAR 00231.

20. In December 2006, Lucent and its benefits consultant, Aon Consulting, prepared a compilation of various headcount, cost and expense data for fiscal years 1998 to 2006. The original data compilation is dated December 13, 2006 (LAR 001396). In May 2009, Lucent produced a revised data compilation which made minor revisions in the data listed for fiscal years 2004-2006. The revised data compilation is dated May 11, 2009 (AON 0025547). (Plaintiffs have disputed and continue to dispute certain aspects of the data tabulation but use it for the limited purposes stated here.)

21. Lucent's data compilation records the increases in contributions charged to and paid by the retirees as follows:

Fiscal Year 1998	\$ 5,332,036
Fiscal Year 1999	\$ 6,338,381
Fiscal Year 2000	\$ 7,529,357
Fiscal Year 2001	\$ 10,752,079
Fiscal Year 2002	\$ 20,617,382
Fiscal Year 2003	\$ 45,216,826

See Revised Data Compilation, row entitled “Retiree Contributions”.

22. Using the headcount data presented in the same data compilation, the average per capita contribution amounts can be calculated by dividing the “Retiree Contributions” amount for each fiscal year by the “# of Members” amount for the fiscal year. The average per capita contributions paid by the retirees are as follows:

Fiscal Year 1998	\$ 75.03
Fiscal Year 1999	\$ 88.46
Fiscal Year 2000	\$ 100.90
Fiscal Year 2001	\$ 136.05
Fiscal Year 2002	\$ 220.76
Fiscal Year 2003	\$ 495.63

See Revised Data Compilation, rows entitled “Retiree Contributions” and “# of Members”.

23. The 2003 value of the average per capita contributions, \$ 495.63, is 660% of the 1998 value, \$ 75.03. This increase in the average per capita contributions was noted by Anne Moran, counsel to the Lucent Special Committee. On the cover page of one copy of Plaintiffs’ Submission to the Committee, dated December 15, 2006, Ms. Moran wrote the following note: “To Ds: How can you argue [that] an increase from [\$] 75/yr to 500/yr is not signif[icant].” See Annotated copy of Plaintiffs’ Submission to Special Committee, dated December 15, 2006, at LR 000730.

24. Defendants also reduced benefits during the benefit maintenance period by eliminating and discontinuing the RECA benefits. Effective January 1, 1999, defendants discontinued and terminated the Lucent Retired Employee Care Account (“RECA”) benefits which previously had been provided to all participants and beneficiaries in the Medical Plan.

These benefits were formally designated as the “Lucent Technologies Inc. Care Accounts” in Section 9.1 of the Medical Plan document effective October 1, 1996. The RECA benefits constituted an annual payment which could be used by the participants to defray any applicable contribution requirements or to reimburse co-payments, deductibles, or other eligible medical-related out of pocket expenses which had been incurred by the participants but which were not covered or paid by the Medical Plan.

25. During the baseline year 1998, the RECA benefits were paid by the Medical Plan in the following amounts:

<u>Under Age 65</u>	<u>Age 65 and Over</u>
Family: \$ 250.00	Family: \$ 130.00
Single: \$ 130.00	Single: \$ 70.00

(1996 Medical Plan at § 9.1, LR-E0000190-91).

26. During the cost maintenance period, defendants did not maintain the required per capita level of expenditures, at least during tax year 2006. The required expenditures for that tax year are derived from the baseline year of tax year 2001.

27. The only per capita expenditure value for tax year 2001 that was ever certified by Aon Consulting, Lucent’s outside actuarial consultant, appears in a letter dated March 5, 2004, from Aon Actuary Jonathan Nemeth to Lucent in-house counsel Steven Kronheim. The FY 2001 value certified by Aon was \$ 3,255. This calculation was based on claims data compiled by Medstat. Medstat is the same vendor that Lucent has used to compile data to compute damages.

28. During the summer of 2004, Lucent became concerned that it would not fulfill its Maintenance of Cost obligations for tax year 2004 if the value of \$ 3,255 were used. It began to

suggest to Aon that in lieu of the Medstat data, certain inconsistent internal data at Lucent be used, resulting in a lower per capita value of \$ 3,165 for tax year 2001.

29. The validity of the internal data was the subject of an investigation by Lucent and Aon which continued into at least March 2005, but the investigation never reached a conclusion confirming that the data underlying the lower \$ 3,165 value was correct. The \$ 3,255 value for per capita expenditures is the only such value that Aon ever certified for tax year 2001.

30. The per capita expenditure value for tax year 2001 serves as the benchmark for defendants' Maintenance of Cost obligation during tax year 2006. *See* June 11, 2008 Opinion at 27-28. Using the correct per capita value of \$ 3,255 for tax year 2001 certified by Aon in March 2004, adjusted (increased) to include the value of the benefits reductions for tax year 2001, yields the following calculation:

Calculation Item	FY 2001	FY 2006
Per Capita Medical Spend Per Aon Compilation	2,699	3,315
Headcount Per Aon Compilation	79,032	63,241
Historic Medical Spend Amount per Aon	213,307,169	
ADD Benefit Reductions from Segal Report (Ex. B)	4,827,602	
ADD Contribution Increases (Paragraph B(4) below)	4,822,025	
Adjusted FY 2001 Medical Spend Amount	222,956,790	
Adjusted FY 2001 Medical Per Capita Amount	2,821	
Medical Per Capita Increase Adjustment	122	

Total FY 2001 Per Capita Certified by Aon in April 2004	3,255	
Adjusted Total FY 2001 Per Capita	3,377	
Comparison FY 2006 vs. FY 2001		(62)
Shortfall During FY 2006 (63,241 times \$ 62)		3,920,942

31. The per capita level of expenditures required of Lucent under the cost maintenance requirement during tax year 2006 was not less than \$ 3,377 after adjusting the baseline tax year 2001 level of expenditures to reflect the impact of the benefit maintenance violations in that year's expenditures.

32. Top executives of the company were informed and aware that the provisions of Internal Revenue Code Sections 401(h) and 420, as incorporated in both the Pension Plan and the Medical Plan, required Lucent to observe a five-year "benefit maintenance period" for retiree medical benefits through September 30, 2003. The five-year benefit maintenance requirement was pointed out to top management and Directors of the company at the December 18, 2002 meeting of the Corporate Governance and Compensation Committee Meeting. The agenda and minutes for the meeting were produced in the death benefit litigation at production numbers D-002451 through D-002466.

33. The December 18, 2002 meeting was attended by, *inter alia*, CEO and Director Patricia Russo; Director Henry Shacht; CFO Frank D'Amelio; General Counsel Richard Rawson; VP William Carapezzi; Chief Investment Officer Collette Chilton; Sr. VP Human Resources Pamela Kimmet; and Managing Corporate Counsel Steven Kronheim. D-002455. Page 3 of the minutes recites that Ms. Kimmet provided background on pension and healthcare

issues and “distributed a binder entitled ‘U.S. Healthcare and Retirement Plans Discussion’” to which she referred during her presentation. The minutes also state that Ms. Kimmet “addressed the requirements of Section 420 of the Internal Revenue Code regarding prior transfers of excess pension assets to fund retiree healthcare and cost maintenance requirements.” D-002457.

34. The information binder used at the December 18, 2002 Board Committee meeting includes materials discussing the requirements of Section 420. Page 49 sets forth a chart entitled “Section 420 - Maintenance of ‘Benefit/Cost’ Expirations.” This page has the following note:

Note: It appears that, under a Section 420 transition rule, the Maintenance of “Benefit” requirement applies for all years through FYE 2003. This interpretation is reflected in our chart.

LAR 0234 (emphasis added). The preceding page warned that “Penalties for violating [section 420] requirements include Pension Plan disqualification, excise and income taxes, and possible damages. The risk of challenges and penalties rises with the magnitude of change.” LAR 00233.

35. All senior executives of the company, including CEO Patricia Russo, CFO Frank D’Amelio, and General Counsel Richard Rawson, were aware that Section 420 required maintenance of benefits through the end of fiscal year 2003. But “because of adverse conditions, the company had to look hard at what the – what the maintenance of effort obligations really meant on a going – going forward basis.” *See* Deposition of Steven Kronheim, May 8, 2009, at 31:11-34:8, 45:7-46:21, 131:10-137:6.

36. A second document presented to the Executive Committee of Lucent in October 2002 likewise stated that “an explicit legal condition for implementing a Section 420 Transfer is that the employer commit itself to satisfying certain ‘maintenance of effort’ requirements with respect to postretirement health coverage during the taxable year of the transfer and the

following four taxable years.” The next page of the booklet included the following statement describing the Section 420 benefit maintenance requirements applicable to Lucent during the benefit maintenance period:

Postretirement Health Considerations

For Lucent’s Section 420 Transfers that occurred in FYE 1999, the applicable “maintenance of effort” requirement until the end of FY 2003 is “Maintenance of Benefit.”

- In Lucent’s particular circumstances, “Maintenance of Benefit” essentially means that **the types and levels of health benefits that were being provided for retirees at the time of the Section 420 Transfers must be maintained** until the end of FY 2003.
- **The Maintenance of Benefit requirement would probably also preclude Lucent from requiring additional employee contributions toward postretirement health benefits** (although this is not expressly addressed in the statute.)

See Additional portions, “Benefits Analysis, Lucent Technologies Executive Committee, October 2002,” at 17-18.

B. Plaintiffs intend to prove the following contested facts with regard to damages: (This must include each item of damages, the amount of each item, the factual basis for each item and, if punitive damages are claimed, the facts upon which plaintiffs will rely to establish punitive damages.)

1. As calculated by plaintiffs’ actuarial experts at The Segal Company, the financial impacts on the retirees of the benefit changes relating to co-payment, deductible, out-of-pocket maximum, and similar plan provisions was \$ 45,144,131 during the period January 1, 2001 to September 30, 2003, and \$ 7,629,776 during the fourth quarter of 2003 as the prior benefit changes in violation of the benefit maintenance requirement continued to be effective. These amounts are exclusive of prejudgment interest.

2. The details of these damage calculations are set forth in the Report of The Segal Company, dated April 20, 2009, as amended June 24, 2009 (attached as Exhibit B). The

following table summarizes these damage calculations:

NATURE OF BENEFIT CHANGES	1/1/01- 9/30/01	10/1/01- 12/31/01	1/1/02- 9/30/02	10/1/02- 12/31/02	1/1/03- 9/30/03	10/1/03- 12/31/03
CHANGES FIRST EFFECTIVE DURING TAX YEAR 2001						
b. - i. - p. Copayments for Retail Prescription Drugs						
(i) Retail In-Network Generic Drugs	253,853	77,807	302,708	89,787	1,448,612	385,196
(ii) Retail In-Network Brand-Name Drugs	2,505,247	768,507	3,232,593	803,168	6,957,149	1,666,240
c. - j. - q. Copayments for Mail Order Prescription Drugs						
(i) Mail Order In-Network Generic Drugs	83,483	31,805	101,705	35,425	1,051,622	277,295
(ii) Mail Order In-Network Brand-Name Drugs	1,480,747	556,093	2,098,660	696,649	6,500,772	1,778,964
d. - n. - r. Coinsurance Percentage for Out-of-Network Prescription Drugs	28,567	13,221	40,414	11,084	25,939	7,813
e. - o. - s. Deductibles for Out-of-Network Prescription Drugs	8,489	3,922	9,482	4,380	9,615	4,442
g. - k. - v. Out-of-Pocket Maximums for Pre-Medicare Members of POS	35,516	11,839	35,721	11,921	30,971	10,324
h. - l. - u. Office Visit Co-Payments for Pre-Medicare Members of POS	431,700	215,115	722,670	242,145	1,808,976	584,034
CHANGES FIRST EFFECTIVE DURING TAX YEAR 2002						
i. Copayment for Non-Formulary Retail Drugs						

– (b.-i.-p.)

j. Copayment for Non-Formulary Mail Order
Drugs – (c.-j.-q.)

**CHANGES FIRST EFFECTIVE DURING
TAX YEAR 2003**

t. Annual Out-of-Pocket Maximum for In-
Network Prescription Drugs

2,554,283 654,141

w. Out-of-Network Annual Out-of-Pocket
Maximums (POS)

39,353 14,835

x. Out-of-Network Annual Deductibles (POS)

128,808 30,977

y. Out-of-Network Hospital Admission
Deductibles (POS)

10,206 3,756

z. Copayments for In-Network Office Visits
(Informed Choice)

91,726 29,614

aa. In-Network Annual Deductibles (Informed
Choice)

214,424 42,222

bb. Out-of-Network Annual Deductibles
(Informed Choice)

34,369 9,305

cc. In-Network Annual Out-of-Pocket
Maximums (Informed Choice)

19,561 6,253

dd. Out-of-Network Annual Out-of-Pocket
Maximums (Informed Choice)

3,540 1,471

ee. Coinsurance Percentage (Traditional Indemnity)					5,767,080	1,714,003
ff. Annual Deductibles (Traditional Indemnity)					2,548,600	190,619
hh. Annual Out-of-Pocket Maximums (Traditional Indemnity)					251,820	26,062
ii. Copayments for In-Network Office Visits (MHCD)					285,860	78,179
jj. Copayments for Inpatient Daily Stays (MHCD)					261,688	76,269
kk. Annual Out-of-Pocket Maximums (MHCD)					31,367	8,798
ll. Coinsurance for Medicare-Eligible In-Patient Care (MHCD)					75,007	16,874
mm. Outpatient Annual Visit Maximums (MHCD)					48,360	12,090
TOTAL FOR PERIOD	4,827,602	1,678,309	6,543,953	1,894,559	30,199,708	7,629,776
TOTAL FOR TAX YEAR	4,827,602		8,222,262		32,094,267	7,629,776
GRAND TOTAL				1/01 - 9/03	45,144,131	52,773,907

3. The financial impacts on the retirees of the benefit changes relating to defendants' imposition and collection of increased contributions are reasonably estimated to total \$ 59,695,586 during the period January 1, 2001 to September 30, 2003, and \$ 9,592,860 during the fourth quarter of 2003 as the contribution changes in violation of the benefit maintenance requirement continued to be effective.

4. This calculation is based on the following analysis. If Lucent had maintained the baseline tax year 1998 level of average per capita contributions equal to \$ 75.03 during the ensuing benefit maintenance period, then the retirees would not have been required to absorb increases in the contribution amounts. The following table compares the actual contributions Lucent charged to the expected contributions using the 1998 per capita level and the actual headcount each tax year as recorded in Lucent's data tabulation, and tabulates the difference in these amounts for each tax year:

<u>Tax Year</u>	<u>Actual Contrib.</u>	<u>Expected Contrib.</u>	<u>Excess Contrib.</u>
1999	\$ 6,338,381	\$ 5,376,306	\$ 962,075
2000	\$ 7,529,357	\$ 5,599,080	\$ 1,930,277
2001	\$ 10,752,079	\$ 5,930,054	\$ 4,822,025
2002	\$ 20,617,382	\$ 7,007,611	\$ 13,609,771
2003	\$ 45,216,826	\$ 6,845,388	<u>\$ 38,371,438</u>
TOTAL			\$ 59,695,586

5. The amount calculated for tax year 2003 does not include the excess contributions which continued to be collected during the remaining fourth quarter of 2003. Using 25% of the tax year 2003 amount, the amount of excess contributions for the fourth quarter of 2003 equals \$ 9,592,860. Accordingly, the financial impact to the retirees from defendants' violations of the

benefit maintenance requirement applicable to contribution levels is \$ 69,288,446 exclusive of prejudgment interest.

6. During tax year 2006, Lucent's per capita expenditure level for Maintenance of Cost purposes was \$ 3,315. After adjustment to reflect the financial impact of the benefit maintenance violations set forth above, the baseline tax year 2001 per capita expenditure level is \$ 3,377 per person. The resulting shortfall during tax year 2006 of \$ 62 per person for 63,241 participants and beneficiaries results in an aggregate Maintenance of Cost shortfall of \$ 3,920,942, exclusive of prejudgment interest.

5. DEFENDANTS' CONTESTED FACTS: (Stated separately for each plaintiff. See instructions above.)

A. Defendants intend to prove the following contested facts with regard to liability:

1. Defendants substantially maintained benefits during MOB. The approximately 2% in cost sharing in FY 2001 and FY 2002 was not a substantial change in benefits, and the approximately 9% cumulative cost-sharing in FY 2003 was also not a substantial change in benefits.

2. Defendants met the MOC requirements for FY 2006: \$3,315 per-capita expense for FY 2006 exceeded the baseline per-capita expenses of \$3,165 for FY 2001.

3. The correct per-capita baseline for FY 2001 was \$3,165. Code § 420 required use of the cash basis to monitor compliance. The initial calculation of the FY 2001 per capita amount of \$3,255 was based on Medstat data, which collects data that does not depend on when Lucent paid the vendor. Aon recalculated the amount using the data (Lucent HR Finance data) that reflects Lucent's actual cash payments. Aon agrees that the recalculated per-capita amount of \$3,165 based on the Lucent HR Finance data accurately reflects the cash approach, and once

this amount was recalculated, Aon and Lucent used this \$3,165 amount to monitor compliance with the maintenance of cost requirements.

4. Pursuant to the analysis of Defendants' designated expert, Buck, the plan changes in FY 2001 and FY 2002 shifted approximately 2% of plan costs to participants for FY 2001 and FY 2002. See Revised Buck Report at § 2.2 (Exhibit C).

5. Pursuant to Buck's analysis, the cumulative plan changes through FY 2003 shifted a gross total of 8.8% of the plan's costs to participants. See Revised Buck Report at § 2.2 (Exhibit C). This gross total percentage includes the cumulative effect of changes implemented in CY 2001, CY 2002 and CY 2003; valuing only changes implemented in CY 2003 would lower this percentage.

6. On Lucent's employer-provided funding and per-capita costs:

- a. For 1998, Lucent provided \$189.4 million in employer provided funding with \$2,683 per capita costs. See Revised Buck Report at § 12.2 (Exhibit C).
- b. For 1999, Lucent provided \$200.9 million in employer provided funding with \$2,835 per capita costs. See Revised Buck Report at § 12.2 (Exhibit C).
- c. For 2000, Lucent provided \$211.1 million in employer provided funding with \$2,857 per capita costs. See Revised Buck Report at § 12.2 (Exhibit C).
- d. For 2001, Lucent provided \$247.4 million in employer provided funding with \$3,165 per capita costs. See Revised Buck Report at § 12.2 (Exhibit C).

- e. For 2002, Lucent provided \$342.1 million in employer provided funding with \$3,689 per capita costs. See Revised Buck Report at § 12.2 (Exhibit C).
- f. For 2003, Lucent provided \$340.6 million in employer provided funding with \$3,768 per capita costs. See Revised Buck Report at § 12.2 (Exhibit C).
- g. For 2004, Lucent provided \$255 million in employer provided funding with \$3,350 per capita costs. See Revised Buck Report at § 12.2 (Exhibit C).
- h. For 2005, Lucent provided \$216.1 million in employer provided funding with \$3,232 per capita costs. See Revised Buck Report at § 12.2 (Exhibit C).
- i. For 2006, Lucent provided \$207.3 million in employer provided funding with \$3,315 per capita costs. See Revised Buck Report at § 12.2 (Exhibit C).

7. Pursuant to the Court's order, the actuarial experts for defendants, Buck, also analyzed the Named Plaintiffs' claims data to determine the financial impact of the plan changes during FY 2001 to FY 2003 on the Named Plaintiffs and their dependents. Buck computed the impacts as stated immediately below. Per the Court's order, Plaintiffs' expert, Segal, was supposed to provide its analysis; however, no analysis was provided, instead Plaintiffs informed Defendants that Segal's analysis revealed materially similar, although not identical, results to Buck's analysis.

- a. Named Plaintiffs Peter Raetsch, Geraldine Raetsch, and Curtis Shiflett and his spouse, Betty Shiflett, were not impacted by these types of plan changes because each elected coverage by HMOs, which set their own benefit structure.
- b. Named plaintiffs William Foster, Joan Foster, and Stanley Thomas and his spouse, Cleo Thomas, were affected by the prescription drug changes and the deductible and coinsurance changes effective January 1, 2001, January 1, 2002 and January 1, 2003. The following table details the overall impact of the changes for these participants during MOB:

	FY2001	FY2002	FY2003
William Foster	\$70 (\$6/month)	\$118 (\$10/month)	\$359 (\$30/month)
Joan Foster	\$40 (\$3.33/month)	\$33 (\$2.75/month)	\$495 (\$41/month)
Stanley Thomas	\$77 (\$6.50/month)	\$87 (\$7.25/month)	\$545 (\$45.50/month)
Cleo Thomas	\$34 (\$3/month)	\$93 (\$8/month)	\$722 (\$60/month)

- c. Named plaintiff Larry Thompson and his spouse, Frances Thompson were affected by the prescription drug changes and the office visit copayment changes effective January 1, 2001, January 1, 2002 and January 1, 2003. The following table details the overall impact of the changes for these participants during MOB:

	FY2001	FY2002	FY2003
Larry Thompson	\$120	\$169	\$440

	(\$10/month)	(\$14/month)	(\$37/month)
Frances Thompson	\$29 (\$2.50/month)	\$103 (\$9/month)	\$158 (\$13/month)

8. The plan terms limit MOB coverage to those “retired employees who, immediately before the Qualified Transfer, are entitled to receive such benefits upon retirement.”

9. Excluding those who were not retired as of the date of the Qualified Transfer triggering MOB coverage reduces the financial impact for FY 2003 by an estimated \$7.4 million. See Revised Buck Report at § 11.4 & 2.2.5 (Exhibit C).

10. Excluding window retirees who were not eligible to retire as of the date of the Qualified Transfer triggering MOB coverage reduces the financial impact for FY 2003 by an estimated \$854 thousand. See Revised Buck Report at § 11.4 & 2.2.5 (Exhibit C).

11. Defendants exceeded the per-capita expense requirement in FY 2004 and FY 2005: (i) \$3,350 per-capita expense for FY 2004 as against the baseline of \$2,835 for FY 1999; and (ii) \$3,232 per-capita expense for FY 2005 as against the baseline of \$2,857 for FY 2000.

12. Segal’s estimates of financial impact are overstated for four reasons: (i) Segal was instructed to and did exclude the value of benefit improvements during MOB, which caused an approximate \$1,000,000 overstatement for FY 2001 to FY 2003; (ii) Segal appears to have double-counted increased mental health co-pays, which caused an approximate \$285,000 overstatement for FY 2003; (iii) Segal appears to have overestimated the impact of an increase in the drug out-of-pocket maximum, which caused an approximate \$800,000 overstatement for FY 2003; and (iv) Segal interpreted “noise” in the data against Lucent, which caused the bulk of the remaining differences between Segal and Buck’s numbers for FY 2001 to FY 2003. Segal

also uses the wrong standard and makes an irrelevant calculation of plan changes for the period October 1, 2003 to December 31, 2003, which period is subject to MOC, not MOB, standards.

13. Defendants submit that contributions should not be part of this trial. As noted in Defendants' class issues motion (Doc. # 125) Defendants submit that contributions are not a proper class issue, as the actual amounts paid turn on a host of individualized issues and elections made by each participant. As noted in Defendants' summary judgment opposition (Doc #119) Plaintiffs' calculation of claimed "excess" contributions suffers from numerous proof defects, including that (i) the claim ignores that the class became weighted to a more contributory group as time passed; and (ii) it includes contributions from those paying for "access only" coverage through COBRA and the Family Security Plan. Defendants also note that Plaintiffs' calculation of claimed excess contributions for October 1, 2003 to December 31, 2003 is irrelevant and contrary to this Court's ruling that this period was subject to MOC requirements. If the Court nonetheless allows contributions to be part of this Pretrial order and trial, Defendants intend to prove the foregoing, and also that Lucent improved its benefits by raising the caps to be funded by Lucent during MOB.

14. Defendants submit that any attempt to measure whether a change was substantial based on the change in a retiree's out-of-pocket costs, including in relation to his or her income and financial circumstances, should not be part of this trial. As noted in Defendants' class issues motion (Doc. # 125) Defendants submit that this is not a proper class issue because it depends on the individualized circumstances of each participant. As noted in Defendants' summary judgment opposition (Doc #119), Defendants submit that Plaintiffs are precluded from pursuing this issue because they barred discovery into the individual financial circumstances of the Named Plaintiffs, claiming these circumstances were irrelevant to whether benefits had been

substantially maintained. As also noted in Defendants' summary judgment opposition (Doc #119), such an approach is also wrong on the merits, as what had to be substantially maintained was not a particular retiree's relative out-of-pocket expenses, it was the "Applicable Health Benefits provided by the employer." Rec Doc. No. 116-12, Pension Plan § 5.9(b), Ex. J to Def. Mot Sum. Judg. If the Court nonetheless allows Plaintiffs to pursue this approach in this Pretrial Order and trial, Defendants intend to prove the foregoing.

15. Defendants submit that the RECA issue sought to be asserted by Plaintiffs in this Pretrial Order should not be part of this trial. This issue was not included in the original or amended complaint, and no discovery or expert work has been done on this issue. If the Court nonetheless allows the RECA issue to be part of this Pretrial order and trial, Defendants intend to prove that there was no cutback in any RECA benefit which, pursuant to the plan terms, was an additional benefit that was provided for, by its terms, only for CY 1997 and 1998.

16. Steve Kronheim, former in-house counsel for Lucent, advised Lucent on compliance with its MOE requirements, and Lucent sought to comply with its MOE requirements.

B. Defendants intend to prove the following contested facts with regard to damages: (This statement must include the factual basis for each defense against plaintiffs' claims for damages.)

1. Segal overstated the financial impacts from the benefits changes for the reasons noted above.

2. Any asserted claim for alleged damages for contributions is unsupported and unwarranted for the reasons noted above.

3. Any asserted claim for alleged RECA damages is unsupported and unwarranted for the reasons noted above.

4. The damages for any violation for FY 2003 should be limited to only those caused by the changes that went into effect in CY 2003.

5. Any recovery for FY 2003 should be reduced by \$7.4 million to exclude participants who were not retired at the time of the MOB transfer.

6. Any recovery for FY 2003 should be reduced by \$854 thousand to exclude participants who only became eligible for retiree health benefits from electing CY 2001 window plans.

7. Any recovery should be offset by the mistaken overpayment of \$14.3 million.

8. The period of October 1, 2003 to December 31, 2003 is subject to MOC standards, and is not part of any MOB recovery.

6. PLAINTIFFS' WITNESSES: (Aside from those called for impeachment purposes, only the witnesses whose names and addresses are listed below will be permitted to testify at trial.)

A. On liability plaintiffs intend to call the following witnesses who will testify in accordance with the following summaries:

Stuart I. Wohl and **Cheryl A. Findlay**, The Segal Company, Washington, DC: Actuarial Consultants Stuart I. Wohl and Cheryl A. Findlay will testify regarding their evaluation of claims-related data under the Lucent Medical Expense Plan for Retired Employees and their calculations of the financial impacts of the various changes in co-pays, deductibles and similar terms during the benefit maintenance period and continuing in the fourth quarter of 2003. They will testify as expert witnesses on the matters set forth in their Report (as amended), attached hereto as Exhibit B. The information set forth in response to item 8(a) below is incorporated by reference.

Plaintiffs may call **Steven Hoeffner** and **Thomas P. Eckhard**, both of Aon Consulting,

to testify regarding the matters covered in the portions of their depositions designated by plaintiffs.

Plaintiffs reserve the right to call witnesses who are designated or offered by defendants, and also reserve the right to call additional witnesses who are not currently named by any party to rebut evidence offered by defendants.

B. On damages plaintiffs intend to call the following witnesses who will testify in accordance with the following summaries:

Stuart I. Wohl and **Cheryl A. Findlay**, The Segal Company, Washington, DC: *See* description above.

Plaintiffs may call **Steven Hoeffner** and **Thomas P. Eckhard**, both of Aon Consulting, to testify regarding the matters covered in the portions of their depositions designated by plaintiffs.

Plaintiffs reserve the right to call witnesses who are designated or offered by defendants, and also reserve the right to call additional witnesses who are not currently named by any party to rebut evidence offered by defendants.

C. Defendants object to the following witnesses for the reasons stated:

See response to Section 8(B). Defendants also object to the descriptions of the proposed testimony of **Steven Hoeffner** and **Thomas P. Eckhard** as being unduly vague (most of their depositions have been designated and they cover numerous topics) and object as much of this testimony is on irrelevant matters on which there is not proper foundation.

7. DEFENDANTS' WITNESSES: (See instructions above)

A. On liability defendants intend to call the following witnesses who will testify in accordance with the following summaries:

Steve Kronheim, former Lucent in-house counsel, specializing in employee benefit

matters, will testify about (i) Lucent's efforts to comply with the maintenance of effort requirements imposed by the plan terms and by Code § 420; and (ii) the \$14.3 million contribution refund.

Jonathan Nemeth, actuarial consultant at Aon, to testify on the calculation of the per-capita amount for FY 2001.

Steve Ferruggia, Buck Consultants. See part 8 (C) below.

May call **Mary Harrison**, Buck Consultants. See part 8 (C) below.

Defendants reserve the right to call witnesses who are designated or offered by Plaintiffs, and also reserve the right to call additional witnesses who are not currently named by any party to rebut evidence offered by Plaintiffs.

B. On damages defendants intend to call the following witnesses who will testify in accordance with the following summaries:

Steve Ferruggia, Buck Consultants. See part 8(C) below.

May call **Mary Harrison**, Buck Consultants. See part 8 (C) below.

Steve Kronheim, former Lucent in-house counsel, specializing in employee benefit matters, will testify about the \$14.3 million contribution refund.

Defendants reserve the right to call witnesses who are designated or offered by Plaintiffs, and also reserve the right to call additional witnesses who are not currently named by any party to rebut evidence offered by Plaintiffs.

C. Plaintiffs object to the following witnesses for the reasons stated:

Plaintiffs do not challenge the qualifications of Mr. Ferruggia or Ms. Harrison to provide expert testimony regarding the specific calculations set forth in their Reports and the basis for those calculations. However, plaintiffs object to any testimony by Mr. Ferruggia or Ms. Harrison which purports to state any opinions or conclusions on (a) the significance or substantiality of the

benefit changes made by defendants during the benefit maintenance period; (b) the nature and terms of the contribution requirements under the Medical Plan; (c) historic facts about the Medical Plan including levels of expenditures and contributions; (d) ultimate facts; (e) questions of law; or (f) mixed questions of fact and law. Mr. Ferruggia and Ms. Harrison are not qualified to provide expert testimony on these subjects, and these subjects are outside the permissible scope of expert testimony in any event. In addition, to the extent that Mr. Ferruggia or Ms. Harrison attempts to present testimony regarding historic facts about the Medical Plan, that testimony would be incompetent and lack foundation. Plaintiffs also object to certain of Ferruggia's and Ms. Harrison's calculations as being inaccurate, incomplete or irrelevant for the reasons noted above.

8. EXPERT WITNESSES: (No expert shall be permitted to testify at Trial unless listed below and unless a summary of his qualifications and a copy of his report are attached hereto. Said summary shall be read into the record at the time he/she takes the stand, and no opposing counsel shall be permitted to question his/her expert qualifications unless the basis of objection is set forth herein.)

A. Plaintiffs' expert witnesses are:

Stuart I. Wohl and **Cheryl A. Findlay**, The Segal Company, Washington, DC: Actuarial Consultants Stuart I. Wohl and Cheryl A. Findlay will testify as expert witnesses regarding their evaluation of claims-related data under the Lucent Medical Expense Plan for Retired Employees and their calculations of the financial impacts of the various changes in co-pays, deductibles and similar terms during the benefit maintenance period and continuing in the fourth quarter of 2003.

Copies of the Report of The Segal Company, dated April 20, 2009, and the Amendment to the Report, dated June 24, 2009, are attached hereto as Exhibit B. Mr. Wohl is a Senior Vice

President of The Segal Company, having joined that national actuarial and benefits consulting firm in 1988. He specializes in active and retiree health care and life insurance benefits and their valuation. He is serving as a Consultant to numerous trust funds which provide health care benefits to retirees, including retirees of Pan American Airways and Lone Star Industries. Ms. Findlay has over 20 years of experience in the field of data management and analysis as well as senior underwriter experience in health and life insurance. Summaries of the expert qualifications of Mr. Wohl and Ms. Findlay appear in Exhibits A and B to their Report (attached hereto as Exhibit B), which are incorporated by reference.

B. Defendants' objections to the qualifications of plaintiffs' experts are:

Defendants do not challenge the qualifications of Stuart I. Wohl and Cheryl A. Findlay to provide expert testimony regarding the specific calculations set forth in their Report and the basis for those calculations. Defendants object to certain of Wohl and Findlay's calculations as being inaccurate or irrelevant for the reasons noted above.

C. Defendants' expert witnesses are:

Steve Ferruggia, Buck Consultants. Mr. Ferruggia is a principal and consulting health actuary for Buck Consultants LLC, an ACS company. Mr. Ferruggia is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and a Fellow of the Conference of Consulting Actuaries. Mr. Ferruggia has more than 30 years experience in the strategy, design, financing and administration of health and welfare benefit programs for large plan sponsors. Mr. Ferruggia served on the Subcommittee of Retiree Health Benefit Plans of the American Academy of Actuaries, working closely with the Financial Accounting Standards Board (FASB) throughout the drafting and exposure process of Financial Accounting Standard No. 106 (FAS 106). Mr. Ferruggia also served on the Retiree Health Care Committee of the

Actuarial Standards Board, and was a contributing author of the Actuarial Compliance Guide for FAS 106.

Copies of the Revised Buck Report, dated June 25, 2009 (Rec # 116-4), are attached hereto as Exhibit C. Summaries of the expert qualifications of Mr. Ferruggia are included in § 1.2 of the Revised Buck Report, which are incorporated by reference. Mr. Ferruggia will testify as an expert witness on the topics covered in the Revised Buck Report, including (i) the financial impact of the benefit changes during FY 2001 to FY 2003; (ii) whether those changes were substantial from his perspective as an actuary and benefits consultant; (iii) the total and per-capita expenses of Lucent from FY 1998 to FY 2006; (iv) whether exceeded per-capita expense requirements for FY 2004 to FY 2006; (v) the class cohort exclusions; and (vi) the mistaken contribution refund of \$14.3 million in 2005. If the contribution issue is not excluded, then Mr. Ferruggia will also testify regarding the premium contribution strategy during MOB, including the premium caps in place and improvements during this period, and the variables that determined the contributions actually paid by an applicable participant.

May call **Mary Harrison**, Buck Consultants, to testify regarding the analysis of the financial impacts of plan changes on Named Plaintiffs and their dependents as set forth in the May 12, 2009 Harrison letter. Ms. Harrison has extensive experience in healthcare data, including in data analysis of healthcare data.

D. Plaintiffs' objections to the qualifications of defendants' experts are:

Plaintiffs do not challenge the qualifications of Mr. Ferruggia or Ms. Harrison to provide expert testimony regarding the specific calculations set forth in their Reports and the basis for those calculations. However, plaintiffs object to any testimony by Mr. Ferruggia or Ms. Harrison which purports to state any opinions or conclusions on (a) the significance or substantiality of the

benefit changes made by defendants during the benefit maintenance period; (b) the nature and terms of the contribution requirements under the Medical Plan; (c) historic facts about the Medical Plan including levels of expenditures and contributions; (d) ultimate facts; (e) questions of law; or (f) mixed questions of fact and law. Mr. Ferruggia and Ms. Harrison are not qualified to provide expert testimony on these subjects, and these subjects are outside the permissible scope of expert testimony in any event. In addition, to the extent that Mr. Ferruggia or Ms. Harrison attempts to present testimony regarding historic facts about the Medical Plan, that testimony would be incompetent and lack foundation. Plaintiffs also object to certain of Ferruggia's and Ms. Harrison's calculations as being inaccurate, incomplete or irrelevant for the reasons noted above.

9. PLAINTIFFS' DEPOSITIONS: (List by page and line, all deposition testimony to be offered into evidence. All irrelevant and redundant matters and all colloquy between counsel must be eliminated, unless ruled relevant. Deposition testimony to be used solely for impeachment purposes need not be listed.)

Plaintiffs' designations, and any objections by Defendants, are attached as Exhibit D to this Final Pretrial Order.

The parties have agreed to allow the depositions of Named Plaintiffs to be used in lieu of live testimony, and accordingly waive hearsay objections based on the witness being available for trial. The parties otherwise preserve their right to object to this deposition testimony.

10. DEFENDANTS' DEPOSITIONS: (See instructions above.)

Defendants' designations, and any objections by Plaintiffs, are attached as Exhibit E to this Final Pretrial Order.

The parties have agreed to allow the depositions of Named Plaintiffs to be used in lieu of

live testimony, and accordingly waive hearsay objections based on the witness being available for trial. The parties otherwise preserve their right to object to this deposition testimony.

11. PLAINTIFFS' EXHIBITS (Except for exhibits, the need for which could not reasonably have been foreseen or which are used solely for impeachment purposes, only the exhibits set forth on the exhibit list attached hereto may be Introduced at the Trial. Any objection to an exhibit, and the reason for said objection, must be set forth below or it shall be deemed waived. All parties hereby agree that it will not be necessary to bring in the custodian of any exhibit as to which no such objection is made.)

A. Plaintiffs intend to introduce into evidence the exhibits listed on **Plaintiffs' Exhibit List** attached hereto as Exhibit F (list by number with a description of each exhibit).

Plaintiffs reserve the right to offer into evidence the exhibits which are listed in Defendants' Exhibit List or which are otherwise offered or marked by defendants. Plaintiffs also reserve the right to offer into evidence documents which are not listed for purposes of cross-examination or impeachment of defendants' witnesses, or to rebut evidence presented by defendants.

B. Defendants object to the introduction of plaintiffs' exhibits (set forth number of exhibit and grounds for objection):

Defendants' objections are noted on **Defendants' Annotated Copy of Plaintiffs' Exhibit List**, attached as Exhibit G. Defendants generally reserve their right to object to each of Plaintiffs' exhibits at the time of trial based on (a) lack of relevance and/or (b) lack of foundation.

12. DEFENDANTS' EXHIBITS (See instructions above.)

A. Defendants intend to introduce into evidence the exhibits listed on **Defendants' Exhibit List** attached hereto as Exhibit H (list by number with a description of each exhibit).

Defendants reserve the right to offer into evidence the exhibits which are listed in

Plaintiffs' Exhibit List or which are otherwise offered or marked by Plaintiffs. Defendants also reserve the right to offer into evidence documents which are not listed for purposes of cross-examination or impeachment of Plaintiffs' witnesses, or to rebut evidence presented by Plaintiffs.

B. Plaintiffs object to the introduction of defendants' exhibits (set forth number of exhibit and grounds for objection):

Plaintiffs generally reserve their right to object to each of defendants' exhibits at the time of trial based on (a) lack of relevance and/or (b) lack of foundation. Assertion of these objections will depend upon the specific use of the exhibits as proposed by defendants at time of trial. In addition, plaintiffs object to certain portions of defendants' exhibits 21, 22, 24 and 25 as inaccurate, incomplete, lacking in proper foundation, and/or misleading due to the manner in which data are presented. With respect to defendants' exhibits 21 and 22, the reports prepared by Buck Consultants, plaintiffs also incorporate by reference their objections to the testimony of defense expert Steven Ferruggia set forth above in response to Item 8(D). The same objections apply to the written work product of Buck Consultants which appears in defendants' exhibits 21 and 22.

(COPIES OF EXHIBITS ARE TO BE MADE FOR OPPOSING COUNSEL, AND A BENCH BOOK OF EXHIBITS IS TO BE DELIVERED TO THE JUDGE AT THE START OF TRIAL. IF COUNSEL DESIRES TO DISPLAY EXHIBITS TO THE JURY, SUFFICIENT COPIES SHOULD BE AVAILABLE TO PROVIDE EACH JUROR WITH A COPY. ALTERNATIVELY, ENLARGED PHOTOGRAPHIC OR PROJECTED COPIES MAY BE USED.)

13. PLAINTIFFS' LEGAL ISSUES:

The parties' cross-motions for summary judgment remain pending before the Court. This Final Pretrial Order has been prepared by the parties in advance of the Court's rulings on the summary judgment motions. Plaintiffs therefore reserve the right to modify, amend and

supplement this statement up to and including the time of trial in order to reflect subsequent rulings and developments.

A. Whether the changes made by defendants to the co-payment requirements, deductibles, out of pocket maximums, and similar coverage terms of the Medical Plan during the benefit maintenance period (*i.e.*, October 1, 2002 to September 30, 2003) constitute a violation of the benefit maintenance requirements of Internal Revenue Code § 420 as incorporated in the Medical Plan? **Answered in the affirmative by the Court in its June 11, 2008 Opinion and Order granting partial summary judgment to plaintiffs.**

B. Whether the changes made by defendants to the co-payment requirements, deductibles, out of pocket maximums, and similar coverage terms of the Medical Plan during the earlier portion of the benefit maintenance period (*i.e.*, January 1, 2001 to September 30, 2002) also constitute a part of the violation of the benefit maintenance requirements of Internal Revenue Code § 420 as incorporated in the Medical Plan?

C. Whether the changes made by defendants to the contribution requirements imposed on and charged to retirees and their eligible dependents for coverage under the Medical Plan during the benefit maintenance period (*i.e.*, January 1, 1999 to September 30, 2003) also constitute a part of the violation of the benefit maintenance requirements of Internal Revenue Code § 420 as incorporated in the Medical Plan?

D. Whether defendants' failure to maintain the Retired Employee Care Account ("RECA") subsidy benefits applicable to all retirees and their eligible dependents for coverage under the Medical Plan during the benefit maintenance period (*i.e.*, January 1, 1999 to September 30, 2003) also constitutes a part of the violation of the benefit maintenance requirements of Internal Revenue Code § 420 as incorporated in the Medical Plan?

E. Whether the changes defendants made during the benefit maintenance period (1) to the co-payment requirements, deductibles, out of pocket maximums, and similar coverage terms of the Medical Plan, (2) to the contribution requirements imposed on and charged to retirees and their eligible dependents for coverage under the Medical Plan, and (3) eliminating the Retired Employee Care Account (“RECA”) subsidy benefits applicable to all retirees and their eligible dependents for coverage under the Medical Plan, which continued to be effective during the fourth quarter of 2003 (*i.e.*, October 1, 2003 to December 31, 2003) also constitute a part of the violation of the benefit maintenance requirements of Internal Revenue Code § 420 as incorporated in the Medical Plan?

F. Whether defendants failed to maintain the level of per capita medical and dental plan expenditures during the cost maintenance period (*i.e.*, October 1, 2005 to September 30, 2006) that was required under the cost maintenance requirements of Internal Revenue Code § 420 as incorporated in the Medical Plan?

G. Whether defendants violated their strict ERISA fiduciary duties of prudence and loyalty to the participants as set forth in ERISA Section 404(a), 29 U.S.C. § 1104(a), by implementing the benefit changes in issue in this litigation?

H. Whether plaintiffs and the members of the class are entitled to prejudgment interest on the amounts determined to constitute the financial impact of defendants’ violations, and whether such prejudgment interest should be calculated using the rates set forth in N.J. Ct. Rule 4:42-11(a) or some other appropriate standard to adequately compensate the class members for the value of these funds?

I. Whether plaintiffs and the members of the class are entitled to recover attorneys’ fees, costs and expenses under ERISA Section 502(g)(1), 29 U.S.C. § 1132(g)(1)?

14. DEFENDANTS' LEGAL ISSUES:

The parties' cross-motions for summary judgment remain pending before the Court. This Final Pretrial Order has been prepared by the parties in advance of the Court's rulings on the summary judgment motions. Defendants therefore reserve the right to modify, amend and supplement this statement up to and including the time of trial in order to reflect subsequent rulings and developments. Based on the Court's earlier rulings, below are Defendants' legal issues left for trial:

- A. Whether the claim remaining in this case arises under the terms of the Pension Plan and Medical Plans?
- B. Under the terms of the plan, and/or Code § 420, is the proper measure for evaluating compliance with MOB whether the percentage of plan costs shifted to retirees during each year of MOB because of plan changes constitutes a substantial change in the "Applicable Health Benefits provided by the employer"?
- C. Whether the shifting of plan costs by Lucent constituted a substantial change in benefits during MOB?
- D. Under the terms of the plan, and/or Code § 420, in evaluating whether the changes in benefits are substantial, are increases that are caused not by changes in plan terms, but by medical inflation, excluded from this calculation? More specifically, are claims for "excess" contributions actionable as a matter of law when Lucent increased the caps funded by Lucent during MOB, i.e., Lucent improved benefits from the perspective of the retirees?
- E. Is the 2001 per capita baseline figure of \$3,165, based on Lucent's cash payments as required by the plan (and Code § 420), the proper standard for measuring MOC in 2006?
- F. Are the actual cash expenses required to be used to determine compliance with MOC, or is this amount adjusted for any claimed MOB violation?
- G. Since the fourth quarter of 2003 (October 1, 2003 – December 31, 2003), is subject to MOC, does this mean MOC, not MOB, requirements apply to determine compliance for FY 2004, which FY runs from October 1, 2003 to September 30, 2004?
- H. Is the Court required to address and define the class and the class claims and issues prior to trial of a purported class action?

- I. Should the Court require development of a class trial plan prior to trial of a purported class action?
- J. Does Plaintiffs' continued pursuit of the claim that Defendants did not comply with Code § 420 create a conflict with the class that Plaintiffs seek to represent?
- K. Is an analysis that evaluates plan changes based on the impact on individual retiree's out-of-pocket expenses proved by class-wide or individualized proof?
- L. Since, for those participants to whom is it applicable, the amounts paid in contributions depend on numerous elections and choices made by each participant, are claims for alleged increased contributions proved by class-wide or individualized proof?
- M. Should participants that were not retired at the time of the "Qualified Transfer," *i.e.*, September 29, 1999, be excluded from any class?
- N. Should participants who only became eligible for retiree health benefits because of the 2001 window plans be excluded from any class?
- O. If liability for FY 2003 is established, should the remedy be only for the changes for CY 2003, or does the remedy include the impact of earlier, lawful changes that were still in effect in FY 2003?
- P. If liability for FY 2003 is established, should this matter be remanded to the Employee Benefits Committee for a determination of the remedy due under the terms of the plan? (*See Frommert v. Conkright*, 535 F.3d 111 (2d Cir. 2008), *cert. granted*, 2009 WL 1835177 (U.S. June 29, 2009)?)
- Q. If liability for FY 2003 is established, should the mistaken contribution refund of \$14.3 million in 2005 be offset against any damages awarded to Plaintiffs?
- R. If liability is established and any damages are due, whether Plaintiffs are entitled to prejudgment interest and, if so, whether the Court should use the federal rate set forth in 28 U.S.C. § 1961 or a similar rate?
- S. Whether Plaintiffs are entitled to attorney's fees under ERISA § 502(g)(1), 29 U.S.C. § 1132(g)(1)?

Based on Plaintiffs' insertions in the Pretrial Order, Defendants add the following legal issues:

- T. Whether the Court has already excluded any fiduciary breach claim from this case based on its prior ruling that the remaining claim in this case is a claim for benefits arising under the plan terms, and if not, whether such should be excluded?
- U. Whether the RECA issue should be excluded because it was not pled in the

complaint or amended complaint, and was not part of fact or expert discovery? If the Court nonetheless allows the RECA issue to be part of this Pretrial order and trial, whether there was any cutback in any RECA benefit which, pursuant to the plan terms, was an additional benefit that was only provided for CY 1997 and CY 1998.

- V. Whether the Plaintiffs can circumvent the scheduling orders in this case by attempting to use bifurcation for an improper purpose, i.e., to continue the case after trial on RECA and contribution issues for which Plaintiffs are not prepared for trial.

15. MISCELLANEOUS:

Set forth any other matters which require action by, or should be brought to the attention of, the Court.

16. JURY TRIALS:

NOT APPLICABLE

17. NON-JURY TRIALS:

Not later than September 28, 2009:

A. Each party shall submit to the District Judge and to opposing counsel, a Trial Brief or memorandum in accordance with General Rule 27, with citations to authorities cited and arguments in support of its position on all disputed issues of law. In the event a brief is not filed, the delinquent party's complaint or defense may be stricken.

B. Each side shall submit to the Judge and other counsel proposed written findings of fact and conclusions of law. There is reserved to counsel the right to submit additional proposed findings of fact [and conclusions of law at any time prior to submission of the case for decision].

C. If any hypothetical questions are to be put to an expert witness on direct examination, these shall be submitted to the Judge and opposing counsel.

18. TRIAL COUNSEL: (List names of trial counsel for all parties)

- A. Trial Counsel for Plaintiffs:

Alan M. Sandals
Scott M. Lempert
(A Member of the Bar of this Court)
SANDALS & ASSOCIATES, P.C.

One South Broad Street
Suite 1850
Philadelphia, PA 19107
(215) 825-4000

David S. Preminger
KELLER ROHRBACK, L.L.P.
770 Broadway
Second Floor
New York, NY 10003
(646) 495-6198

B. Trial Counsel for Defendants:

Howard Shapiro
Robert W. Rachal
Brian Neulander
PROSKAUER ROSE LLP
650 Poydras Street
Suite 1800
New Orleans, LA 70130
(504) 310-4088

Wanda L. Ellert
(A Member of the Bar of this Court)
PROSKAUER ROSE LLP
One Newark Center
18th Floor
Newark, NJ 07102
(973) 274-3200

19. BIFURCATION: Where appropriate, the issues relating to liability shall be severed and tried to verdict. Thereafter, all issues relating to damages issues will be tried.

Plaintiffs: Bifurcation of damages issues is not necessary with respect to the damages relating to any benefit maintenance violation by defendants based upon the changes in co-pays, deductibles, and similar terms of plan coverage. The Medstat data produced by defendants was sufficient to enable the parties' actuarial experts to compute the financial impacts of defendants' benefit changes.

If the Court determines that defendants also are liable for a benefit maintenance violation

based upon defendants' imposition of and increases in the contributions charged to retirees and their dependents for medical and/or dental coverage under the Lucent Plans and/or based upon defendants' elimination of the RECA benefits during the benefit maintenance period between October 1, 1998 and September 30, 2003 (or December 31, 2003), the Court may order defendants to reimburse those excess contribution amounts to the retirees. Defendants' expert agreed that the Medstat data previously produced by defendants was insufficient to quantify the amounts of contributions paid by the retirees before 2004. The quantification of the amounts of such excess contribution charges and lost RECA benefits which are the subject of the order to reimburse therefore would be the subject of additional factual examination and calculation by the parties. If the parties are not able to stipulate to these amounts, the Court may need to conduct further remedial proceedings to determine these amounts.

Defendants: Defendants object to any attempt by Plaintiffs to seek bifurcation in this case. Defendants do not seek bifurcation because there is no prejudice from trying liability and damages issues together in this case, and bifurcation would not facilitate the prompt resolution of this case. Rather, the parties have been aware since December 2008 that this case was going to trial in the September-October 2009 period, and Plaintiffs seek to use bifurcation for an improper purpose. Specifically, Plaintiffs seek to use bifurcation to circumvent the scheduling orders in this case by attempting to continue the case after trial on RECA and contribution issues for which Plaintiffs are not prepared to prove their asserted claims at trial. Defendants also note that these issues are unfounded for the reasons noted above.

20. ESTIMATED LENGTH OF TRIAL:

The parties estimate that, to the extent that live testimony is necessary on issues of liability or damages, the trial can be completed in one to two days.

AMENDMENTS TO THIS PRETRIAL ORDER SHALL NOT BE PERMITTED UNLESS THE COURT DETERMINES THAT MANIFEST INJUSTICE WOULD RESULT IF THE AMENDMENT IS DISALLOWED. THE COURT MAY, FROM TIME TO TIME, SCHEDULE CONFERENCES AS MAY BE REQUIRED EITHER ON ITS OWN MOTION OR AT THE REQUEST OF COUNSEL.

Dated: August 31, 2009

Respectfully submitted,

SANDALS & ASSOCIATES, P.C.

By: s/ Alan M. Sandals
s/ Scott M. Lempert

Alan M. Sandals
Scott M. Lempert
One South Broad Street, Suite 1850
Philadelphia, PA 19107
(215) 825-4000

David S. Preminger
KELLER ROHRBACK, L.L.P.
770 Broadway, Second Floor
New York, NY 10003
(646) 495-6198

Counsel for Plaintiffs and
the Proposed Class

PROSKAUER ROSE LLP

By: s/ Howard Shapiro
s/ Robert W. Rachal

Howard Shapiro
Robert W. Rachal
Yolanda D. Montgomery
Brian Neulander
650 Poydras Street, Suite 1800
New Orleans, LA 70130
(504) 310-4088

