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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

PETER A. RAETSCH, GERALDINE RAETSCH, and CURTIS C. SHIFLETT, individually and on behalf of all others similarly situated,	
Plaintiffs,	CIVIL ACTION NO.
v.	2:05-cv-5134 (PGS)
LUCENT TECHNOLOGIES, INC., LUCENT TECHNOLOGIES, INC. EMPLOYEE BENEFITS COMMITTEE, and LUCENT TECHNOLOGIES, INC. MEDICAL EXPENSE PLAN FOR RETIRED EMPLOYEES,	CLASS ACTION
Defendants.	MOTION DATE: July 23, 2007

PLAINTIFFS' MEMORANDUM IN SUPPORT OF MOTION FOR PARTIAL SUMMARY JUDGMENT

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Plaintiffs submit this Memorandum in support of their Motion for Partial Summary Judgment pursuant to Fed. R. Civ. P. 56(c) and (d).

For the reasons stated here and in the accompanying Plaintiffs' Statement Pursuant to Local Rule 56.1,[1] the law and the undisputed material facts of record establish that plaintiffs are entitled to partial summary judgment on the issues of (1) the standard of review applicable to the Court's consideration of the findings and conclusions stated in the Report of the Special Committee, dated December 28, 2006; and (2) defendants' liability for violating applicable plan provisions incorporating the "benefit maintenance" and "cost maintenance" requirements of Internal Revenue Code Section 420.

Plaintiffs therefore seek entry of an Order granting partial summary judgment to plaintiffs on the following issues:

(a) The Court's review of the factual findings set forth in the Report,

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[1] "PSF ¶ ____" refers to the numbered paragraphs of the accompanying Plaintiffs' Statement Pursuant to Local Rule 56.1. The Statement cites and quotes the source materials for each of the factual matters presented therein. In the interest of efficient presentation, plaintiffs ordinarily will not reproduce that detailed source information in this Memorandum. The documents referred to in the Statement are presented as exhibits to the accompanying Affidavit of Alan M. Sandals. Both the Statement and the Affidavit include a "Confidential Supplement" pertaining to facts and documents that currently are protected from public disclosure pursuant to the Stipulation and Protective Order Relating to Confidentiality of Discovery Materials, dated January 29, 2007. These two Confidential Supplements have been filed under seal, pending the required determination under Local Rule 5.3(c).

dated December 28, 2006, of the Special Committee that was empanelled pursuant to the Opinion and Order, dated October 26, 2006, should be a "highly penetrating" level of scrutiny, involving a "high degree of skepticism," and the Court should exercise de novo review of all questions of law presented by plaintiffs' claims, including questions of statutory interpretation and application.

(b) Defendants violated the "benefit maintenance" requirement of Internal Revenue Code Section 420, as incorporated in the Pension Plan and Medical Plan, during the period October 1, 1999 to September 30, 2003; and

(c) Defendants violated the "cost maintenance" requirement of Internal Revenue Code Section 420, as incorporated in the Pension Plan and Medical Plan, during the period October 1, 2003 to September 30, 2006.

The additional questions of defendants' liability on the ERISA statutory violations alleged, and appropriate monetary and other relief on the violations of plan provisions incorporating the requirements of Code Section 420, would be reserved for further proceedings pursuant to Fed. R. Civ. P. 56(c) and (d). Plaintiffs are not seeking summary judgment on the issue of monetary and other relief for the violations, inasmuch as additional document productions, testimony, and factual and actuarial investigation are required to fully quantify the financial effects of the violations.

STANDARD OF DECISION APPLICABLE TO THE MOTION

The standards governing the Court's review of this summary judgment motion are familiar ones. As the Court has written,

> Summary judgment is appropriate under Fed.R.Civ.P. 56(c) when the moving party demonstrates that there is no genuine issue of material fact and the evidence establishes the moving party's entitlement to judgment as a matter of law. *Celotex Corp. v. Catrett,* 477 U.S. 317, 322-23, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). A factual dispute is genuine if a reasonable jury could return a verdict for the non-movant, and it is material if, under the substantive law, it would affect the outcome of the suit. *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). "In considering a motion for summary judgment, a district court may not make credibility determinations or engage in any weighing of the evidence; instead, the non-moving party's evidence 'is to be believed and all justifiable inferences are to be drawn in his favor.'" *Marino v. Indus. Crating Co.,* 358 F.3d 241, 247 (3d Cir.2004) (quoting *Anderson,* 477 U.S. at 255).

Criss v. Cosgrove, Civ. No. 04-2244 (PGS), 2007 WL 542228 at * 2 (D.N.J. Feb. 16, 2007).

INTRODUCTION

Throughout this litigation, plaintiffs have maintained that their claims based on statutory requirements incorporated into Lucent's relevant benefit plans, as well as ERISA statutory provisions that are independently actionable and not subject to any administrative proceedings, are not appropriate for administrative review by plan fiduciaries, including the "Special Committee" that was appointed by defendants following the Court's October 26, 2006 ruling denying the motion to dismiss.

The very "administrative" proceedings that have been conducted since the Court's ruling have revealed additional reasons for rejecting defendants' argument that they are entitled to deferential review of their "interpretations" of the plan provisions which incorporate mandated statutory requirements that must be applied uniformly to all affected ERISA plans. Interpreting and applying federal statutes is reserved exclusively to the Court. It is not an activity that is consigned to the vagaries and self-serving preferences of high-ranking, conflicted executives of potentially liable defendants such as the members of the Special Committee here.

The record also shows that the members of the Special Committee do not have any relevant experience or expertise to bring to bear on the questions presented by plaintiffs' claims, either the statutory requirements incorporated in the plans or the application of these requirements to what are largely undisputed facts. Not surprisingly, the Special Committee's Report (Exhibit 3) and other parts of the record

do not reflect any experience or expertise on these issues which could warrant deference by the Court.

The record also establishes that the members of the Special Committee operated under an inherent and fatally disabling conflict of interest which rendered them incapable of rendering a fair and impartial decision on the claims. As will be seen, each Committee member is also a member of senior management of Lucent, and plaintiffs' claims expose their employer to very significant liability, in the hundreds of millions of dollars. In addition, Committee member George White, Jr. is a member of the defendant Employee Benefits Committee and is himself a potentially liable defendant in this case. A second Committee member, Stephen R. Rosen, is a working colleague of corporate counsel for benefits Steven R. Kronheim, who apparently guided the company in taking the challenged actions.

Finally, the proceedings by the Special Committee were marked by procedural unfairness and improprieties. Unlike the usual benefit claim under a plan, in which a participant has access to most of the sources of proof needed to prove his or her pension, medical or disability claim, fair resolution of these claims requires access to sources of proof (both documents and witnesses) which remain under the exclusive control of Lucent and its outside actuaries. While counsel for Lucent had full ability to review and select documents and interview knowledgeable personnel, plaintiffs' counsel were refused access to requested documents and received only those

documents which counsel for Lucent chose to selectively produce. Additional pertinent documents were produced by defense counsel only after the Committee issued its Report, beginning in February 2007. Plaintiffs did not receive, and so the Committee never saw or considered, these documents.

In addition, the internal work papers of the Committee and its counsel reveal that the Committee acted as an advocate for the interests of defendants and consciously avoided facts and conclusions that were warranted by the evidence and the law.

For these and additional reasons presented below, the customary basis for judicial deference to the ruling of an ERISA benefit plan administrative body is totally lacking in this case. Review of the Report shows that the Special Committee members repeatedly were attempting to define the law and serve as judges in their employer's case, not to decide disputed facts. The bulk of their analysis consisted of self-interested "interpretations" of the requirements of Internal Revenue Code Section 420 that happen to be incorporated in and actionable through the plans.

Under Third Circuit law, the record establishes at least five factors that militate against giving deference to the analysis by the Special Committee. Singly or in combination, these factors require that factual findings (if any) recited in the Report be viewed by this Court with a "high degree of skepticism" – to use the words of the leading Third Circuit decision. As to questions of statutory interpretation and application, the Court should apply the usual de novo standard of review.

When these proper standards of review are applied, it is apparent that the conclusion of the Special Committee members – that their employer did not violate plan requirements – should not be credited by the Court. In addition, the facts presented by plaintiffs to the Special Committee were not disputed by defendants or questioned by the Committee. These facts established that:

- Defendants made the four Section 420 pension asset transfers in the amounts and on the dates alleged.
- The first pension asset transfer triggered the "benefit maintenance" requirements of Section 420; these requirements applied to defendants through September 30, 2003.
- The three later pension asset transfers required defendants to comply with the "cost maintenance" requirements of Section 420 through September 30, 2006.
- Defendants made significant cutbacks in the retiree medical and dental benefits during the benefit maintenance period.
- Defendants did not expend and maintain the average per capita cost of the retiree medical and dental benefits during the cost maintenance period. No matter which measure is used to assess the financial severity of this violation, the benefit shortfalls during this period also are significant.

Accordingly, the questions presented to the Court involve interpretation of Section 420 statutory standards and their application to what are essentially undisputed facts about what happened to the benefits. Plaintiffs' motion for partial summary judgment therefore should be granted, with the Court reserving for further proceedings the question of relief for the plan violations and the claims of statutory violations.

MATERIAL FACTS
AS TO WHICH THERE IS NO GENUINE DISPUTE

The Court is familiar with the allegations and claims in this case from prior proceedings. To avoid repetition, plaintiffs respectfully refer the Court to the accompanying Plaintiffs' Statement Pursuant to Local Rule 56.1 (including its Confidential Supplement) for a complete statement of the facts that support their motion.

I. THE FACTUAL FINDINGS AND CONCLUSIONS OF THE SPECIAL COMMITTEE ARE NOT ENTITLED TO ANY DEFERENCE. THE LEGAL QUESTIONS PRESENTED BY PLAINTIFFS' CLAIMS ARE SUBJECT TO DE NOVO REVIEW BY THIS COURT.

Plaintiffs first seek summary judgment on the issue of the proper standard of judicial review of the action by the Special Committee in its review of plaintiffs' plan-based claims. The Court's ruling on defendants' motion to dismiss required plaintiffs to present these claims to the plan fiduciaries in the first instance, in the hope that these proceedings would narrow the issues. *See* Opinion, dated October 26, 2006, at 13-14. However, the Court made no ruling at that time as to the degree of deference, if any, that would be accorded to any decision by the plan fiduciaries. A record has been compiled which now permits the Court to rule on the appropriate standard of review.

The record now shows that the Report of the Special Committee is not entitled to any deference, but instead should be viewed with a high degree of skepticism. The Court accordingly should proceed in this case as it would in any other, giving little deference to the factual conclusions of the Committee and using the customary de novo standard of review for all questions of statutory interpretation and application.

The leading Third Circuit decision on the standard of review in ERISA benefits cases is *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377 (3d Cir. 2000). *Pinto* and its progeny identify a number of factors which warrant judicial adoption of a less deferential, and even skeptical standard of review. Any one factor may be sufficient to

warrant departure from deferential review. In combination, the factors may compel this. The decision on what standard of review to apply is based on the totality of the circumstances. *Pinto*, 214 F.2d at 392.

The record compiled in this case, after the Court's ruling denying the motion to dismiss, now establishes at least five actors that, either independently or in combination, warrant "penetrating" and "highly skeptical" review of the Committee's factual conclusions.

A. The Committee Members Were Fatally Conflicted Due to Their Status as Senior Members of Lucent Management and their Significant Financial Ties to the Company.

First, it is clear that the members of the Special Committee operated under a severe conflict of interest. All three were senior employees of Lucent at the time they were empanelled as a Special Committee in late November 2006 and while they reviewed the claims and finally issued the Report on December 28, 2006. PSF ¶ 3.[2] Member George A. White, Jr. also was a member of the *defendant* Employee Benefits Committee, which created the Special Committee as a "subcommittee." PSF ¶¶ 12, 22-24. White thus has potential personal liability on the claims as a fiduciary of the plans during the period of the benefit cutbacks. Member Janet Davidson was one of the

[2] "PSF ¶" refers to the sequentially numbered paragraphs of the accompanying Plaintiffs' Statement Pursuant to Local Rule 56.1. "CSPSF ¶" refers to the numbered paragraphs of the separately filed Confidential Supplement to the Statement.

highest ranking executives of Lucent. She held the title of President, Corporate Strategy. According to SEC filings, she was the member of senior management who had the fifth largest stake in Lucent stock, over 2.3 million shares including stock options. PSF ¶4.

Member Stephen A. Rosen, a member of Lucent's in-house legal staff, was a working colleague of in-house counsel Steven Kronheim, who advised the plans on compliance with Section 420; this advice is implicated by the claims. PSF ¶ 13. It is self-evident that a co-worker is unlikely to conclude that the Section 420 advice was faulty, or that a colleague permitted the plans to violate the law.[3]

As high executives of Lucent, each of the Committee members participates in "incentive" deferred compensation, bonus and stock option programs which confer significant monetary benefits on each of them, the value of which is dependent in part on the company's future financial performance. Each also holds significant stock options. Each is a party to special separation arrangements and financial protections relating to Lucent's recent merger with Alcatel. PSF ¶¶ 7-9; CSPSF ¶¶ 5-6, 10-11.

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[3] These and other facts bearing on the standard of review necessarily are found outside the "administrative record" of a benefit appeal. In "decid[ing] what standard of review to employ" a court must examine "evidence of potential biases and conflicts of interest" which is "not found in the administrative record." *Kosiba v. Merck & Co.*, 384 F.3d 58, 67 n. 5 (3d Cir. 2004).

B. Lucent Has Direct Financial Liability on Plaintiffs' Claims.

In *Pinto* the Third Circuit ruled that "heightened scrutiny is required when an insurance company is both plan administrator and funder [of plan benefits obligations]." 214 F.3d at 387. In this situation, the decision-maker's "fiduciary role is in perpetual conflict with its profit-making interest as a business." 214 F.3d at 384. This problem is referred to as "inherent conflict" or "structural bias." 214 F.3d at 389. "A court must take into account the existence of structural conflict of interest present when a financially interested entity also makes the benefit determinations." *Kosiba v. Merck & Co.*, 384 F.3d 58, 65-66, 67 (3d Cir. 2004). Heightened scrutiny therefore is appropriate when the circumstances suggest that the decision-maker is operating under such a conflict of financial interests. *Goldstein v. Johnson &* Johnson, 251 F.3d 433, 441 (3d Cir. 2001); *Orvosh v. Program of Group Ins. for Salaried Employees of Volkswagen of Am., Inc.*, 222 F.3d 123, 129 n. 7 (3d Cir. 2000). Defense counsel acknowledged the existence of this conflict at oral argument on the motion to dismiss. *See* Tr. of Hearing, Sept. 28, 2006 at 16.

The same principle requires this heightened scrutiny when an *employer* is acting as both the plan administrator which decides benefits entitlements and the funder of these benefits obligations. "[A]n employer-fiduciary may be subject to a conflict of interest requiring heightened scrutiny when its plan is 'unfunded,' that is, when it pays benefits out of operating funds rather than from a separate ERISA trust fund." *Vitale*

v. Latrobe Area Hospital, 420 F.3d 278, 282 (3d Cir. 2005), *citing Smathers v. Multi-Tool, Inc.*, 298 F.3d 191, 199 (3d Cir. 2002) ("A more penetrating review" and "heightened scrutiny is clearly appropriate in this case . . . because the employer is directly funding a portion of the plan and is benefited by denying the claims."). In this case, a determination that defendants violated either plan terms or the statute would require Lucent and the other defendants to bear financial liability, because the medical plan is "unfunded" (i.e., funded on a pay-as-you-go basis) and there is no trust corpus from which to satisfy the liability. PSF ¶ 14-15. The fact that the decision-maker was a committee consisting of members of senior management of Lucent – rather than the company – does not change this analysis. "When . . . an employer (*or a committee established by the employer*) both determines eligibility for benefits under a plan and pays benefits out of its own funds," the same heightened scrutiny is warranted. *Way v. Ohio Casualty Ins. Co.*, 2005 WL 3479729 (D.N.J. Dec. 16, 2005) (Simandle, J.) (emphasis added).

C. The Claims Are Asserted on Behalf of a Large Group of Retirees

Pinto expressly notes that "closer scrutiny" may be required "when more money was at stake – i.e., when a large class of beneficiaries requested and was denied benefits." 214 F.3d at 386, *citing Nazay v. Miller*, 949 F.2d 1323, 1335 (3d Cir. 1991); *see also Stratton v. duPont*, 363 F.3d 250, 255 n. 3 (3d Cir. 2004). In this case, of course, the claims are brought on behalf of a Class consisting of tens of thousands of

retired AT&T and Lucent management employees. PSF ¶ 18. Plaintiffs' preliminary analyses show that the admitted cutbacks in benefits involve hundreds of millions of dollars. PSF ¶¶ 16-17. Far from being an individual case with little impact on employer finances, this case presents a very large claim with enormous consequences for Lucent. The Special Committee knew this.

D. Lucent is Financially Distressed

Heightened scrutiny is also required when the employer-fiduciary is in financial distress. "Another factor to be considered is the current status of the fiduciary. When companies are breaking up, laying off a significant percentage of their employees, or moving all their operations, these incentives [to maintain employee satisfaction] diminish significantly." *Pinto*, 214 F.3d at 392. During 2006 and subsequently, in part during the time the Committee was deliberating, Lucent continued to be under significant financial pressure despite its merger with Alcatel. PSF ¶ 19. Lucent's inability to afford the legal and financial consequences of a Committee decision in favor of Plaintiffs was obvious to the Committee members. *Id*. This is another factor that negates deferential review.

E. The Claimants Are Not Part of Lucent's Active Workforce

The usual deferential review in simple benefits disputes is based on the assumption that benefits decision-makers have a natural incentive to resolve claims fairly, in order to maintain employee morale and good will. But, as the late Chief

Judge Becker observed in *Pinto*, "there are likely to be problems of imperfect information and information flow" in cases like this. When "claims for benefits are made after individuals have left active employment" it is unlikely that information about adverse benefits decisions will "seep into the collective knowledge of the still-active employees," so an employer will have "little motive" to consider workplace reaction to its decisions. 214 F.3d at 388. The desire to maintain good will among active employees is therefore absent and cannot counteract the financial conflict of interests. *See Kosiba v. Merck & Co.*, 384 F.3d 58, 65-66, 67 (3d Cir. 2004) ("When a *former* employee seeks benefits, this conflict-mitigating consideration is not present;" heightened level of review warranted if defendant "pays Plan benefits out of its general operating funds"), *citing Smathers v. Multi-Tool, Inc.*, 298 F.3d 191, 198 (3d Cir. 2002). In this case, all of the claimants are retired. Indeed, most retired before 1996 and never had any employment relationship at all with Lucent. PSF ¶ 20. Accordingly, their status as retirees is another factor weighing in favor of heightened scrutiny of the Special Committee's actions.

F. The Special Committee Proceedings Were Infected by Procedural Improprieties and Biased Conduct.

As a fifth and final factor warranting heightened scrutiny of the Special Committee's decision, a court must also consider "the process by which the result was achieved." *Pinto*, 214 F.3d at 393. Even in the absence of a financial conflict of

interests, another "cause for heightened review" is "demonstrated procedural irregularity, bias, or unfairness in the review of the [claim for benefits]." *Kosiba v. Merck & Co.*, 384 F.3d 58, 66, 68 (3d Cir. 2004). The combination of procedural bias and financial conflict of interests warrants "a significantly heightened arbitrary and capricious standard of review." 384 F.3d at 67-68.

A few examples of procedural irregularity illustrate application of this standard. In *Pinto*, the Third Circuit reviewed a number of "procedural anomalies" in the claims decision process by a disability insurer and concluded that "whenever it was at a crossroads, [the insurer] chose the decision disfavorable to [the claimant]." 214 F.3d at 394. These procedural anomalies caused the Court to heighten its standard of review all the way to "the far end of the arbitrary and capricious 'range,' and [to] examine the facts before the administrator with a high degree of skepticism." *Id.* There was "sufficient evidence at this stage to merit a penetrating review of the decision under the heightened standard." *Id.* at 395.

In *O'Sullivan v. Metropolitan Life Ins. Co.*, 114 F. Supp. 2d 203 (D.N.J. 2000), Judge Brotman denied summary judgment due to procedural irregularities, including the fact that the decision maker made self-serving use of evidence, did not thoroughly consider competing evidence, and did not seek additional information (as requested by plaintiffs here, *see* PSF ¶¶ 25-26, 41, 45-46). In *Morley v. Avaya Inc. Long Term Disability Plan*, 2006 WL 2226336 (D.N.J. August 3, 2006), Judge Cooper ruled that

the decision on which *Pinto* standard to employ depended on disputed issues of fact regarding procedural irregularities and bias by a benefit committee. These issues were to be resolved at trial. In *Small v. First Reliance Std. Life Ins. Co.*, 2005 WL 486614 *4 (E.D. Pa. Feb. 28, 2005), Judge Sánchez found after trial that procedural irregularities, including "selective use of information for self-serving reasons" raised the court's "suspicion" and required application of the "'high degree of skepticism' standard."

The record establishes procedural irregularities, bias and unfairness in the review and decision-making process. A lengthy account of the deficiencies of the Special Committee's process is set forth in Plaintiffs' Statement Pursuant to Local Rule 56.1. PSF ¶¶ 21-41. In summary, the Committee and its counsel:

(1) ignored and suppressed its counsel's own previously published article on Section 420, stating that under the "maintenance of benefits" requirement, "it is the level of *benefits*, and not their *costs*, which count." PSF ¶ 29 (emphasis in the original article). Although this article was circulated to the Committee, there is no mention of it in the Report.

(2) ignored and suppressed its counsel's own observations that the benefit cutbacks during the benefit maintenance period were dramatic. PSF ¶¶ 33-35 ("To Ds: How can you argue [that] an increase from [$] 75/yr to 500/yr is not signif[icant]" and "See fn. 29 [of plaintiffs' submission] – Avg OOP [out-of-pocket expenses to retirees]

increased [$] 777 – 1217 [;] 1120 to – 2195."). These observations were not acknowledged in the Report, and the Report omitted any reference to the underlying evidence from which they were drawn.

(3) repeatedly referred to the text of the Report as setting forth "arguments." PSF ¶¶ 37-39 ("Attached below in email form is a substitute for the argument on whether the amounts changed in the [Medical Plan] were substantial.")

(4) acted to tailor the language of the Report to cast defendants' points in the best light and plaintiffs' in the worst light. PSF ¶ 39 ("Another thing I need you [the Committee members] to consider is whether we should keep the Plaintiffs' chart in our response. It emphasizes plaintiffs' point of view and their numbers . . .")

(5) advised the Committee members that the 10%/20% guideline in the Treasury Department regulation on cost maintenance was not applicable, PSF ¶ 39 ("I don't think that's correct legally, and plaintiffs could redo the numbers and get them to flunk the specific rule."), but then proceeded to use the inapposite 10%/20% guideline anyway.

(6) in last-minute revisions to the Report made on December 27, 2006, after the Committee had approved the Report, counsel and the Committee realized that plaintiffs' numbers, as stated in the Report, showed that the company had reduced benefits by at least 10.2% during the benefit maintenance period. In order to obscure this fact, counsel revised the report to re-calculate the numbers as a percentage of

expected costs, so that the percentage stated in the Report would come in below 10%. PSF ¶ 40.

(7) under the claim of privilege, counsel for defendants had withheld from plaintiffs' counsel and the administrative record several documents revealing Lucent's contemporaneous understanding of the benefit maintenance requirement. The existence of these purportedly privileged documents was not even disclosed until after the Report was issued. PSF ¶ 41 and exhibits cited therein. After plaintiffs invoked the "fiduciary exception" recognized in ERISA cases, and Magistrate Judge Hedges made a preliminary review of these documents on March 1, 2007, the bulk of them were produced on March 30, 2007. *See* Exhibit 41 (March 30, 2007 cover letter from defense counsel). One such Lucent document, dating from October 2002, revealed this assessment of Section 420's constraints on benefits changes:

> The Maintenance of Effort requirement associated with Section 420 transfers and Lucent's Labor Contract impact its ability to make changes for 1/1/2003 – particularly for health benefits for Retirees and Occupational Actives.
>
> ***
>
> - Transfers made in FY 1999 or before are subject to "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.

PSF ¶ 31. Since defendants withheld this document, it did not become part of the

administrative record and plaintiffs could not use it to present argument.

In short, "whenever it was at a crossroads, [the Special Committee] chose the decision disfavorable to [plaintiffs]." *Pinto*, 214 F.3d at 394. The Committee and its counsel crafted the Report as though it were a piece of advocacy and "argument" in favor of Lucent, rather than an impartial and balanced review of the facts and the law. This "was not consistent with an exercise of discretion by a fiduciary acting free of the interests that conflict with those of the beneficiaries." *Pinto*, 214 F.3d at 391.

Defendants and their hand-picked "Special Committee" of top executives thus failed to deliver on the promise made to the Court at oral argument, that "it is our intent to offer the plaintiffs a fair and unbiased administrative review." Tr., September 28, 2006, at 19.[4] Not only did the Special Committee fail to conduct an independent, dispassionate investigation and synthesis of the facts, it also acted with patent bias in reviewing the facts and legal arguments presented by the parties.

Under Third Circuit law, each one of these five factors standing alone is a sufficient basis to warrant "heightened" and "penetrating" review of the claims. In combination, these five factors compel the conclusion that any basis for deference is

[4] Defense counsel also led the Court to believe that the reviewing fiduciaries would be "independent" – not the fifth largest executive shareholder, a member of the defendant Committee, and a working colleague of in-house defense counsel. Tr. of Hearing, September 28, 2006, at 16 ("THE COURT: . . . It goes to the independent fiduciaries, and who are they? MR. SHAPIRO: They will be persons who will be appointed by Lucent.").

lacking, and that the customary de novo standard of judicial review when claims present questions of statutory interpretation and application to disputed facts is required here.

G. The Special Committee Had No Experience or Expertise to Apply to the Claims. Its Views on the Issues, Principally Questions of Statutory Construction, Are Not Accorded Deference by the Courts.

Even if these five factors did not compel de novo review, the record also confirms that the basic factual premise for deferential review is absent in this atypical case. There simply is nothing – no expertise, no experience, and no institutional memory – for the Court to defer to. No member of the Special Committee has had any experience with plan compliance issues involving the requirements of Code § 420. PSF ¶ 43. Indeed, even the permanent Employee Benefits Committee had never considered any question of this type, even under the guise of "interpreting" any of the plans while the benefit maintenance and cost maintenance requirements were in force. PSF ¶ 42. In addition, no Committee member has had any experience with actuarial issues, nor did the Committee members seek the advice or assistance of an actuary (although *defense* counsel, at the eleventh hour, finally called on Lucent's own outside actuary at Aon to compile and produce plan expenditure and participant headcount data *one day* before the parties' submissions were due to the Committee). PSF ¶¶ 43-46. The Committee thus did not engage in any fact-finding on actuarial issues, or even examine the actuarial information submitted by defendants and the factual disputes

presented by the parties – despite defense counsel's assurance and the Court's resulting expectation that this would be a principal benefit of requiring special administrative proceedings in this case.

The law of the Third Circuit also makes clear that courts defer to benefits rulings only when a claim presents questions that are within the special expertise and experience of the plan administrator or other decision-maker. In the absence of such questions, there is no room for administrative "interpretation" or "discretion" and a court will decide the matter for itself. *See Epright v. Environmental Resources Mgmt., Inc.*, 81 F.3d 335, 339-40 (3d Cir. 1996).

The Committee thus had no experience or expertise to bring to bear on the claims, which essentially call for a judicial determination of the uniform federal statutory requirements embodied in Code § 420 and incorporated verbatim in the plans, and application of these statutory standards to what are largely undisputed facts. The Report shows this. The Committee repeatedly engages in statutory construction, not interpretation of plan terms or application of standards of decision that are specific to Lucent and its plans. PSF ¶¶ 47-48 (e.g., Report at 12: "The Special Committee believes that the statute contemplates . . ."). Now that the review proceedings have run their course, it is clear that there is no basis for this Court to give any deference to the Committee's "interpretation" of federal statutes or to surrender its judicial power to determine what Code § 420 and ERISA obligated defendants to do. Even as to the

Committee's discussion of the facts, the five factors identified in Third Circuit law, including especially the procedural bias shown by the Committee's repeated actions to assume a role championing the interests of their employer, warrant, at best for defendants, "a high degree of skepticism."

II. DEFENDANTS' ANSWER AND LUCENT DOCUMENTS ESTABLISH THAT THERE IS NO DISPUTE AS TO THE BASIC FACTS PERTINENT TO DEFENDANTS' LIABILITY ON PLAINTIFFS' PLAN-BASED CLAIMS.

Plaintiffs also move for partial summary judgment on the issues of defendants' liability for violating the plan terms that incorporate the "benefit maintenance" and "cost maintenance" requirements of Section 420 of the Internal Revenue Code. Defendants' Answer, filed April 20, 2007, as well as contemporaneous Lucent documents, establish the following key facts and thereby prove the violations.

A. The Dates and Amounts of the Section 420 Transfers Are Admitted.

First, defendants admit the dates and amounts of the transfers of pension assets that Lucent made pursuant to Section 420. Lucent made four such transfers of pension assets from the Pension Plan to fund retiree medical benefits for plaintiffs and other management retirees and their dependents as follows:

(a) in the amount of $182,993.00 on or about September 29, 1999;

(b) in the amount of $191,169.00 on or about December 31, 1999;

(c) in the amount of $214 million on or about December 27, 2000; and

(d) in the amount of $300 million on or about December 26, 2001.

The total amount of these four transfers was $888,162,000. Answer, ¶ 37 (Exhibit 2); Complaint ¶ 37 (Exhibit 1). *See* PSF 62.

B. The Existence and Duration of the Benefit Maintenance and Cost Maintenance Requirements of Section 420 Are Admitted.

Second, defendants admit that the first pension asset transfer in September 1999 subjected them to the Section 420 "benefit maintenance" requirement until September 30, 2003, and the later transfers subjected them to the "cost maintenance" requirement from October 1, 2003 to September 30, 2006:

> [U]nder the terms of the Lucent Technologies Inc. Management Pension Plan, later renamed the Lucent Technologies Inc. Retirement Income Plan, the transfers of excess Pension Plan assets to find health benefits for management retirees and their dependents caused Lucent to be subject to certain maintenance of effort obligations, consisting of a "benefits maintenance" obligation for tax years 1999 through 2003 [ending September 30, 2003] and a "cost maintenance" obligation for tax years 2004 through 2006 [ending September 30, 2006].

Answer ¶ 5 (Exhibit 2). *See* PSF ¶ 63.

There also can be no dispute that the Pension Plan and Medical Plan incorporate the relevant requirements of Internal Revenue Code Section 420. In conformity with its mandates, the Pension Plan includes provisions that, *inter alia*, a separate account "Health Care Fund" was established within the pension trust to fund a portion of the retiree medical benefits; the Health Care Fund "shall meet the requirements of Code §

401(h)" and any transfers of pension assets would be limited to transfers that were qualified under the Code; and a transfer of pension assets would be permitted only if each Medical Plan "provides 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 (Exhibit 35). PSF ¶ 64.

Lucent also amended the Medical Plan to recite that:

> **17.11 Pension Asset Transfers**
>
> Pursuant to Sections 401(h) and 420 of the Code, Lucent Technologies Inc. shall comply with all cost maintenance period requirements and benefit maintenance period requirements that may be applicable to this Plan for any Code Section 420 pension asset transfer by or on behalf of Lucent Technologies Inc. for qualified current retiree health liabilities (as defined under Code Section 420). With respect to any prior asset transfer by AT&T under Code Section 420, Lucent Technologies Inc. agrees to comply with the provisions of Code Section 420 for the applicable cost maintenance or benefit maintenance periods to which this Plan is subject.

See Lucent Technologies Medical Expense Plan for Retired Employees, § 17.11 at 129 (amended and restated effective January 1, 2001; executed September 30, 2002), LAR 0621, 0760 (Exhibit 36); PSF ¶ 65. Contemporaneous Lucent documents also reflect the recognition that defendants were governed by the "benefit maintenance" requirement through September 30, 2003. PSF ¶¶ 31, 67-69; CSPSF ¶ 32.

C. The Existence and Nature of the Reductions in the Medical Benefits Provided to Plaintiffs and the Class Are Either Admitted or Not Subject to Dispute.

Third, there is no dispute that Lucent changed and reduced the level of benefits provided to the retirees under the Medical Plan during the benefit maintenance period and later the cost maintenance period. The existence and nature of the benefits reductions are either admitted by Lucent in its Answer, or are indisputable from Lucent's own documents. The benefits reductions are as follows:

> (a) Effective January 1, 2001, Lucent acted to (1) impose contribution requirements for participation in the Medical Plan by certain retirees (and their spouses) who retired on or after March 1, 1990; (2) increase office visit co-payment amounts and out of pocket individual and family maximums for medical services covered under the Medical Plan; and (3) increase co-pays for retail and mail order prescription drugs covered under the Medical Plan. *See* LAR 00231 (Exhibit 38); LAR 04976 (Exhibit 39).
>
> (b) Effective January 1, 2002, Lucent acted to further increase co-pays for retail and mail order prescription drugs covered under the Medical Plan by adding a "third tier" of coverage, for "non-preferred" branded prescription drugs with higher co-pay requirements. *See* LAR 0231 (Exhibit 38).
>
> (c) Effective January 1, 2003, Lucent acted to (1) impose contribution requirements for participation in the Medical Plan by all retirees who retired on or after March 1, 1990; (2) increase co-pays, individual and family annual deductibles, and individual and family out of pocket maximums for medical services covered under the Medical Plan for all retirees and dependents; (3) increase co-pays and annual out-of-pocket maximums for retail and mail order prescription drugs covered under the Medical Plan for all retirees and dependents; and (4) impose

co-insurance and co-pays for retail and mail order prescription drugs prescribed for outpatient chemotherapy covered under the Medical Plan for all retirees and dependents. *See* LAR 00231 (Exhibit 38); LAR 4948-56 (Exhibit 40).

(d) Effective October 1, 2003, Lucent acted to (1) eliminate company reimbursements of Medicare Part B premiums paid by all Medicare-eligible management retirees and dependents. *See* LAR 5013, 5021 (Exhibit 41).

(e) Effective January 1, 2004, after the cost maintenance requirement took effect, Lucent acted to (1) eliminate company-paid coverage for dependents of all management retirees who retired on or after March 1, 1990 and whose base salary at retirement was $ 87,000 or more; (2) eliminate company-paid dental coverage for all management retirees and their dependents and reduce healthcare contribution caps by a commensurate amount; (3) increase co-pays for hospitalization and emergency room visits, reduce the quantity of medication covered by the retail prescription drug program, and increase the annual out-of-pocket maximum for prescription drugs. *See* LAR 05014, 05022-5023, 05055 (Exhibit 41).

(f) Effective January 1, 2005, Lucent acted to (1) eliminate company-paid coverage for dependents of management retirees who retired on or after March 1, 1990 and whose base salary at retirement was $ 65,000 or more; (2) reduce allowable "reasonable and customary" charges under the POS out-of-network, traditional indemnity, and mental health coverages; and (3) change the "coordination of benefit" provision where another plan also covers a charge, so that Lucent would pay only the incremental difference between what its plan would have paid and what the other plan would pay. *See* LAR 00158-160 (Exhibit 42).

(g) Effective January 1, 2006, Lucent acted to (1) impose new contribution requirements for participation in the Medical Plan for retirees who retired on or after March 1, 1990 and their spouses. *See* LAR 3011 (Exhibit 43).

See also, Answer ¶ 41 (Exhibit 2); PSF ¶ 74.

D. The Benefits Reductions During the Benefit Maintenance Period Violated the Section 420 Benefit Maintenance Requirement Incorporated in the Plans.

Fourth, the question whether the benefit reductions that occurred during the benefit maintenance period violated the Section 420 benefit maintenance requirement incorporated into the plans is a question of law. As a matter of the undisputed facts and the law, the benefit maintenance requirement was violated.

Despite the Special Committee's self-interested attempt to interpret Section 420, the statute on its face required defendants to provide "substantially the same" benefits throughout the benefit maintenance period. This benefit maintenance requirement is set forth in Code section 420(c), entitled "Requirements of Plans Transferring Assets." The language of this provision in effect in September 1999 mandated that "each group health plan or arrangement under which applicable health benefits are provided provides that *the applicable health benefits provided by the employer during each taxable year during the benefit maintenance period are substantially the same as the benefits provided by the employer during the taxable year immediately preceding* the taxable year of the qualified transfer." Code § 420(c)(3)(A) (as in effect from December 9, 1994 to December 17, 1999) (emphasis added).

The statute on its face requires maintenance of "benefits" not "costs." This was clear to Committee counsel Anne E. Moran when, soon after the passage of the 1994 amendment adopting the benefit maintenance rule, she authored an article stating that,

"Thus under the new test, it is the level of *benefits*, and not their *costs*, which count." (emphasis in original). *See* Article, Anne E. Moran, "Use of Excess Pension Assets to Pay Retiree Medical Costs – Section 420 at Midlife," 8 *Benefits Law Journal* 91, 102-03 (Summer 1995), LR 000167, 000178-79 (Exhibit 20). PSF ¶ 30.

Ms. Moran seemed to have the same understanding on December 15, 2006 – before she received and read the parties' submissions to the Special Committee. On that day, she circulated to the Committee members an "outline of the chronological history" of Section 420 that she had prepared. Under the heading "General Rule for Section 420," she stated that "This maintenance of cost rule was enacted in 1990. It was changed to a maintenance of effort rule (*focusing on benefits, not costs*), in late 1994, and changed back to a maintenance of cost rule in 2000." (emphasis added). Under the heading "Specific Rules Applying as Law Changes" and the subheading "Minimum Benefits – 1994 Change," the outline states, "Rule: Maintain 'substantially the same level' of employer-provided retiree health coverage as provided in the taxable year immediately preceding the transfer for each 5-year benefit maintenance period." *See* Outline, "Section 420" at LR 000164 (Exhibit 20). PSF ¶ 29.

Even Lucent had this understanding while the benefit maintenance period was in force and applicable to it. In a portion of a presentation to the Lucent Benefits Committee dated October 2002, Lucent management set forth its contemporaneous understanding of the benefit maintenance requirement as follows:

> The Maintenance of Effort requirement associated with Section 420 transfers and Lucent's Labor Contract impact its ability to make changes for 1/1/2003 – particularly for health benefits for Retirees and Occupational Actives.
>
> ***
>
> - Transfers made in FY 1999 or before are subject to "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.
>
> - Transfers made in FY 2000 or after are subject to "Maintenance of Cost."
>
>   The average per capita postretirement health costs for of [sic] the group of individuals that was receiving postretirement health benefits at the time of the Section 420 Transfer must be maintained during the taxable year of the Section 420 Transfer and the following four years.

See Executive Summary – Key Findings, LR 001412 (Exhibit 21) (emphasis added); *see also* Benefits Analysis, Benefit Committee, October 2002, LR 001576-84 (Exhibit 22). PSF ¶ 31.

Finally, as a matter of law, these were changes in "benefits." Under longstanding Third Circuit precedent, when retirees challenge employer cutbacks taking the form of increased premiums or other financial terms incorporated in a medical plan, their claims may proceed as claims for "benefits" under 29 U.S.C. § 1132(a)(1)(B). *See, e.g., In re Unisys Corp. Retiree Medical Benefits ERISA*

Litigation, 58 F.3d 896 (3d Cir. 1995) (challenge to elimination of company subsidy for retiree medical plan and replacement with new, unsubsidized plan, was claim for benefits); *Alexander v. Primerica Holdings, Inc.*, 967 F.2d 90 (3d Cir. 1992) (challenge to increase in retiree monthly premiums from $ 5 to $ 50 per month as violation of plan terms). The same point was the basis for defendants' argument to the Court that plaintiffs' claims should be subject to administrative exhaustion as claims for benefits under the plans.

The Special Committee adopted a contrary position, essentially espousing its "view" that the benefit maintenance requirement focuses on costs, not benefits. *See, e.g*, Report at 11 ("It is the Special Committee's view that because Lucent supported the MEPRE with the same or greater amount of dollars on a per capita basis as the benchmark period, . . ."") (Exhibit 3). This turns on its head Ms. Moran's own repeated admonitions to "focus[ ] on benefits, not costs" as well as Lucent's own understanding.

The Special Committee's "view" also happens to be contrary to the plain terms of Section 420. A mere recital of the benefits changes (as set forth above), which had the intended effect of shifting a greater share of the cost of medical care on to the retirees, shows that Lucent did not provide "health benefits . . . during each taxable year during the benefit maintenance period [that were] *substantially the same as the benefits provided by the employer during the taxable year immediately preceding the taxable year of the qualified transfer*." Code § 420(c)(3)(A) (emphasis added).

There also can be no dispute that these benefit reductions were substantial and significant. Committee counsel Moran herself noted this significance. On one copy of Plaintiffs' Submission to the Committee, dated December 15, 2006, she wrote the following note on the cover page: "To Ds: How can you argue [that] an increase from [$] 75/yr to 500/yr is not signif[icant]." PSF ¶ 33. Unfortunately, the Committee never acknowledged this dramatic increase in the contributions Lucent charged to retirees during the *benefit maintenance* period. PSF ¶ 33. On another copy of Plaintiffs' Submission, Ms. Moran wrote the following note on the cover page: "See fn. 29 – Avg OOP [out-of-pocket expenses to retirees] increased [$] 777 – 1217 [;] 1120 to – 2195." PSF ¶ 34. The cited footnote in Plaintiffs' Submission, in turn, quoted from a 2004 company document reporting 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." PSF ¶ 76.

The Committee's counsel was correct in specially noting these facts. Under any sensible view of the term "substantial," a 660% increase in retiree contributions (PSF ¶ 33) and an increase in retiree out-of-pocket costs from 2002 to 2003 equal to $ 1,075 for a retiree eligible for Medicare (PSF ¶ 34), a 95% increase, is substantial, especially

to a retiree living on a fixed income. For a retiree not yet eligible for Medicare, an increase of $ 450, or 57% year over year, also is substantial.

Despite the lack of full data to make a complete projection, plaintiffs also were able to present to the Committee calculations showing that, after factoring in growth in Lucent's management retiree population and reported medical inflation trends, maintaining the same level of benefits that was provided during fiscal year 1999 should have caused Lucent to expend almost $ 138 million more than it actually did spend during the years 2000-2003. The Committee acknowledged this information (after considering the option of keeping it out of the Report, PSF ¶ 39) but then belittled the figure as being less than 10% of the expected expenditures by Lucent. Report at 16 (Exhibit 3). As noted, this percentage was re-engineered at the last minute by Committee counsel to come out to less than 10%; an earlier draft showing the shortfall as 10.2% was changed at the last minute. PSF ¶ 40. Plaintiffs' analysis showing an aggregate shortfall during the benefit maintenance period of $ 138 million (before interest) actually contained an arithmetic error. The correct value is $ 165 million. PSF ¶¶ 95-97 & n. 3. The straightforward calculations leading to this result, based on documents and data presented to the Committee by Lucent, are set forth in PSF ¶¶ 75-97. Compared to Lucent's actual expenditures during the benefit maintenance period, the correct shortfall is 12.3%.

Whether the value of the benefit maintenance shortfall without interest is $ 138 million, or $ 165 million, or some other number in the tens of millions, it is still indisputable that the benefits reductions are substantial and significant and were not "substantially the same."[5] Certainly, Lucent would sue for payment if a supplier or customer shortchanged it by a like amount. It also would sue if a supplier shorted it 9, 10 or 12% of a contractual quantity. There is no reason why the same is not also true when the issue is complying with a contractual, plan-based commitment to maintain medical benefits for tens of thousands of retirees.

Considering Lucent's own documents establishing the significant cost-shifting and contribution increases imposed on retirees during the benefit maintenance period, and the above estimates of their aggregate dollar impact based on simple arithmetic, the record is clear that the changes in benefits were significant. The Court therefore can declare on this record that the benefit maintenance requirement was violated by defendants. It is not necessary for the Court at this time to quantify the losses to the Class and determine relief. These issues should be reserved for further proceedings.

[5] It should not surprise defendants to learn that, "'Substantially the same' has been interpreted to mean that it is the same in all important particulars." *Young v. Byrne*, 144 N.J. Super. 10, 17, 364 A.2d 47, 51 (N.J. Super. 1976).

E. Lucent Made Significant Reductions in Its Average Per Capita Expenditures for the Retirees' Benefits During the Cost Maintenance Period. This Violated the Section 420 Cost Maintenance Requirement Incorporated in the Plans.

The parties agree that Lucent was governed by the "cost maintenance" requirement of Section 420 during the period October 1, 2003 to September 30, 2006. Under this requirement, Lucent was obligated to continue to spend during each year of the cost maintenance period the same "applicable employer cost," which is defined in the statute as the higher of the average per capita costs spent during each of the "2 taxable years immediately preceding the taxable year of the qualified transfer." IRC § 420(c)(3)(A)-(B).

As demonstrated by the record and explained in the previous section, defendants committed antecedent violations of the benefit maintenance requirement during the period ending September 30, 2003. However, because defendants denied liability and the Committee agreed, neither of them made any attempt to adjust the historic company expenditure data to reflect the levels of per capita expenditures that would have existed if the benefit maintenance requirement had been complied with. It is fundamental that a defendant may not gain any advantage from its violation, yet that is the clear result of the Committee's use of historic expenditure data which, by definition, reflect what actually happened rather than what the law required.

There are several alternative means to perform the appropriate cost maintenance

analysis. These are set out in detail in Plaintiffs' Statement at ¶¶ 99-108. Although it is not necessary at this juncture for the Court to quantify the shortfall in the company's expenditures, the analyses demonstrate that defendants' violation of the average per capita cost maintenance requirement is significant. The amounts that the retirees were deprived of are by no means trivial or *de minimis*.

The simple calculations relating to the benefit maintenance requirement and expected costs show that if defendants had maintained substantially the same level of retiree medical and dental benefits that was in force in fiscal year 1999 through the end of fiscal year 2003, then company expenditures during fiscal year 2003 would have been approximately $ 416.9 million. This level of expenditure also serves as the baseline for purposes of implementing the per capita cost maintenance requirement that applied during fiscal years 2004-2006.

Even if Lucent had made a permissible 10% reduction of headcount in fiscal year 2004, and a second 10% reduction in headcount in that reduced population in fiscal year 2005,[6] it should have expended the following expected costs in order to

[6] These calculations apply the 10% reduction factor to the cost in each immediately preceding year, i.e., 2003 expected costs times 0.9 equals 2004 expected costs, and 2004 expected costs times 0.9 equals 2005 expected costs.

These calculations also assume that a 10% reduction in headcount actually resulted in a full 10% reduction in plan cost. This is a conservative assumption working in defendants' favor, because it is not necessarily true that a 10% headcount reduction would result in a 10% cost reduction.

maintain the average per capita cost during fiscal years 2004-2006:

FISCAL YEAR	EXPECTED COSTS	ACTUAL COSTS	SHORTFALL
2003	$ 416,935,469	$ 340,645,758	$ -
2004	$ 375,241,922	$ 255,637,571	$ 119,604,351
2005	$ 337,717,729	$ 217,067,000	$ 120,650,729
2006	$ 337,717,729	$ 209,322,185	$ 128,395,544
		Total Shortfall	**$ 368,650,624**

PSF ¶¶ 99-101.

Using the appropriate *corrected* level of benefits and costs for fiscal year 2003, and factoring in the maximum headcount reductions and resulting cost reductions that would be permitted under the Section 420 cost maintenance regulations issued by the Treasury Department, Treas. Reg. § 1.420-1, this analysis shows that there was a cumulative shortfall in the per capita benefit expenditures by the company, having an estimated value of $ 368,650,624 exclusive of interest.

Even though defendants will dispute this precise number, the magnitude of the number establishes that the violation of the cost maintenance requirement is substantial. The same conclusion of significance emerges if the estimates are expressed on a per capita basis rather than as an aggregate amount. As stated, the expected total costs for fiscal year 2003, assuming compliance with the benefit maintenance requirement, equal $ 416,935,469. When that value is divided by the actual number of fiscal year 2003 plan participants reported by the company in the December 13, 2006 data compilation (91,231 participants), the result is an average per

capita cost of $ 4,570 per participant. The differences between the expected annual per capita company expenditures of $ 4,570 for fiscal year 2003 and the actual per capita expenditures reported in defendants' December 13, 2006 data compilation, i.e., $ 3,358 in fiscal year 2004, $ 3,246 in 2005, and $ 3,389 in 2006, are also significant. PSF ¶¶ 103-104. These shortfall amounts are consistent with the Lucent documents noting the cost-shifting of $ 1,000 to the Medicare-eligible retirees. PSF ¶ 76.

An alternative analysis of compliance with the cost maintenance requirement, which does not take into account the pre-existing benefit maintenance requirement and instead uses the actual, reported level of company costs in fiscal year 2003, also can be performed. Fiscal year 2004 was the first year in which the cost maintenance requirement was applicable to Lucent and is treated as the start of a distinct cost maintenance period. The two taxable years immediately preceding fiscal year 2004 were fiscal years 2003 and 2002.

According to the December 13, 2006 data compilation provided by the company (Exhibit 13), the average per capita cost in fiscal 2003 was $ 3,768, and that was the higher per capita value of the two fiscal years, 2002 and 2003. The same data compilation shows that, using the average per capita cost figure from fiscal year 2003 and not taking into account any other issues, in each succeeding year the company provided benefits that had a per capita average cost considerably less than $ 3,768. The per capita difference was $ 410 ($ 3,768 – 3,358) in fiscal year 2004, equal to a

total shortfall of $ 32,353,920 for the listed 78,912 participants. The difference was $ 522 ($ 3,768 – 3,246) in fiscal year 2005, equal to a total shortfall of $ 35,280,936 for the listed 67,588 participants. The difference was $ 379 ($ 3,768 – 3,389) in fiscal year 2006, equal to a total shortfall of $ 23,632,166 for the listed 62,354 participants. The combined total of these differences during fiscal years 2004-2006 is $ 91,267,022. PSF ¶¶ 105-07. These annual per capita and combined total amounts are significant. (Again, these calculations do not utilize the higher expected amount of 2003 per capita costs estimated in ¶¶ 95-96 above, which takes into account the benefit maintenance shortfalls through September 30, 2003).

These headcount and per capita expenditure numbers are taken from defendants' own data compilation (Exhibit 13). They are not subject to dispute by defendants. They establish that defendants did not expend and maintain the average per capita cost of the medical benefits during the cost maintenance period. No matter which benchmark is used, the benefit shortfalls during this period also are significant.

For these reasons, based on the law and the admitted and undisputed (or indisputable) facts of record, defendants did not maintain the appropriate average per capita expenditure during the period October 1, 2003 to September 30, 2006. The Court therefore can declare on this record that the cost maintenance requirement was violated by defendants. It is not necessary for the Court at this time to quantify the

losses to the Class and determine relief. These issues should be reserved for further proceedings.

CONCLUSION

For the reasons stated here and in Plaintiffs' Statement Pursuant to Local Rule 56.1, plaintiffs request that their Motion for Partial Summary Judgment be granted.

Dated: June 28, 2007

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CERTIFICATE OF SERVICE

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