Alcatel-Lucent
Flexible Spending Account Plans
Summary Plan Description
January 1, 2012

Disclaimer

This is a summary of the benefits offered to active management and represented employees under the Alcatel-Lucent Flexible Spending Account Plans ("Flexible Spending Accounts" or the "Plan"), with such Flexible Spending Accounts consisting of the Alcatel-Lucent Health Care Reimbursement Account Plan (the "Health Care Flexible Spending Account" or "HFSA") and the Alcatel-Lucent Child/Elder Care Reimbursement Account Plan (the "Dependent Care Flexible Spending Account" or "DFSA"). It is provided for informational purposes and is intended to comply with Department of Labor requirements for summary plan descriptions ("SPDs"). More detailed information is provided in the official Plan documents.

This summary is based on the provisions of the Flexible Spending Account Plans effective January 1, 2012 and replaces all previous SPDs and other descriptions of benefits provided under the Plans. If there is any conflict between the information in this SPD and either the HFSA or DFSA, as applicable, the HFSA or DFSA plan documents, as relevant, will govern.

Flexible Spending Account Plans May Be Amended or Terminated

The Company expects to continue the Flexible Spending Account Plans but reserves the right to amend or terminate the Plans, in whole or in part, at any time by the resolution of the Board of Directors or its properly authorized designee, subject to the terms of applicable collective bargaining agreements. In addition, the Company does not guarantee the continuation of any Flexible Spending Account benefits during employment or at or during retirement nor does it guarantee any specific level of benefits or contributions, subject to the terms of any applicable bargaining agreements.

Questions regarding your benefits should be addressed as indicated in this document (see "Important Contacts"). Because of the many detailed provisions of the Plan, no one is authorized to advise you as to your benefits, except as indicated in this SPD. The Company cannot be bound by statements made by unauthorized personnel. In the event of a conflict between any verbal information provided to you by an authorized resource and information in the official HFSA or DFSA plan document, the relevant plan document will govern.

> *Please Note:* Participation in the Flexible Spending Account Plans is neither an offer of nor a guarantee of continued benefits during retirement.

Alcatel-Lucent Flexible Spending Account Plans

January 1, 2012
This information is intended for eligible active management and represented employees in the Alcatel-Lucent Flexible Spending Account Plans. More detailed information is provided in the official Plan documents, which are controlling.

Introduction

The Flexible Spending Accounts allow you to set aside Pre-Tax dollars from your pay to cover certain healthcare or dependent care expenses. There are two separate Flexible Spending Accounts.

Terms to Know
There are several words and phrases that have specific meanings under the Flexible Spending Accounts. These words and phrases, which are printed in initial capital letters in this SPD, are defined in the Section N. "Terms to Know."

- The *Health Care Flexible Spending Account (HFSA)* may be used to pay for eligible healthcare expenses for yourself, your Lawful Spouse, and Eligible Healthcare Dependents.
- The *Dependent Care Flexible Spending Account (DFSA)* may be used to pay for eligible dependent care expenses that allow you to work, or if you are married, that allow both you and your Lawful Spouse to work, or your Lawful Spouse to attend school full time.

You may elect to participate in one account, both accounts or neither account.

Your salary reduction contribution elections do *not* automatically continue from one year to the next. If you want to continue participating after your initial enrollment, you *must re-enroll each Plan Year* during Annual Open Enrollment.

Section A. Flexible Spending Accounts At-a-Glance

Here's a summary of some key features of the Flexible Spending Accounts.

Plan Features	Summary
Eligibility	If you are a regular full-time or regular part-time employee who works for a Participating Company, you are eligible to enroll. Management employees are eligible to enroll on the first day of employment. Represented employees are eligible to enroll as of the first day of the month in which they complete six months of Net Credited Service.
Enrollment	You must actively enroll if you want to participate in the Flexible Spending Accounts. Enrollment is not automatic. Also, your salary reduction contribution elections do *not* automatically continue from one year to the next. To continue participation after your initial enrollment, you *must re-enroll for each calendar year* during Annual Open Enrollment.
About the Flexible Spending Accounts	The Flexible Spending Accounts allow you to set aside Pre-Tax dollars from your pay to cover certain healthcare or dependent care expenses. There are two Flexible Spending Accounts. The *HFSA* may be used to pay for eligible healthcare expenses (medical, dental, vision and hearing) for yourself, your Lawful Spouse, and your Eligible Healthcare Dependents. The *DFSA* may be used to pay for eligible dependent care expenses that allow you to work, or if you are married, that allow both you and your Lawful Spouse to work, or your Lawful Spouse to attend school full time. You may elect to participate in one account, both accounts or neither account. *Any amounts not used for expenses incurred during the Plan Year are forfeited. However, if you are participating in the HFSA on December 31 of a calendar year, any unused amounts as of December 31 can be applied to expenses incurred through March 15 of the following calendar year. The January 1 through March 15 period following a year of HFSA participation is often referred to as the "Grace Period." Note: the "Grace Period" does not apply to the DFSA.*

Plan Features	Summary
Your Salary Reduction Contributions	You fund your Flexible Spending Account(s) with Pre-Tax dollars that are deducted from your pay in installments based on the number of pay periods throughout the year. The minimum amount you may contribute to each account during any one Plan Year is $100. The maximum amount you may contribute each year is generally $5,000 for the HFSA and $5,000 for the DFSA**. However, these limits may vary based on nondiscrimination testing** if you are classified as a Highly Compensated Employee and, in the case of the DFSA, based upon your Lawful Spouse's income and your tax filing status. Effective for the 2013 Plan Year, pursuant to changes in the law, the maximum contribution to the HFSA will be $2,500. After 2013, the $2,500 limit for the HFSA will be adjusted annually for inflation. Any inflation adjustment that is not a multiple of $50 will be rounded down to the next lowest multiple of $50.
Flexible Spending Accounts Contact	Contact Ceridian at www.ceridian-benefits.com, or 1-877-799-8820 for information about the HFSA and the DFSA.

Section B. Joining the Plans

Who Is Eligible

Eligible Employees

If you are a full-time or part-time management employee, or a represented employee, you are eligible to enroll in the Flexible Spending Accounts. Management employees are eligible to enroll as of their first day of employment with the Company or a Participating Company. Represented employees are eligible to enroll as of the first day of the month in which they complete six months of Net Credited Service.

You are **not** eligible to participate if:

- You are not paid from the U.S. payroll of the Company or a Participating Company;
- You are a leased employee;
- You are employed by an independent company (such as an employment agency); or
- Your services are rendered pursuant to an agreement excluding participation in benefit plans.

Enrolling in the Plan

Newly Eligible Employees

When you commence employment or first become eligible to participate in the Flexible Spending Accounts, you will be provided with instructions on how to obtain enrollment information. The information provided will include details about both of the Flexible Spending Accounts, how to enroll and the date by which you must make your elections. To enroll, go to the Your Benefits Resources™ Web site at http://resources.hewitt.com/alcatel-lucent or call the Alcatel-Lucent Benefits Center.

Annual Open Enrollment

Annual Open Enrollment is held once a year, usually in the Fall. During Annual Open Enrollment you will have an opportunity to select the benefits that best meet your needs for the coming year.

Your salary reduction contribution elections do not automatically continue from one year to the next. If you want to continue participation in one or both of these accounts after your initial enrollment, you must re-enroll for each calendar year during Annual Open Enrollment. You will receive information about the Annual Open

Enrollment period and the enrollment procedures in advance of the Annual Open Enrollment period.

Elections made during Annual Open Enrollment are effective on the first day of the following calendar year.

You have several enrollment choices. You may:

- Enroll in the HFSA only;
- Enroll in the DFSA only;
- Enroll in both Flexible Spending Accounts; or
- Choose not to participate in either Flexible Spending Account.

You also must indicate the amount you want to contribute to your Flexible Spending Account(s).

Changing Your Coverage During the Year
Generally, once you enroll in the Plan, you cannot change your HFSA or DFSA contribution election during the calendar year. However, you may be able to change your contribution election during the year if you experience a "qualified status change," as described below.

Qualified Status Changes
A "qualified status change" is a change in eligibility for coverage under a Flexible Spending Account Plan or another employer's plan due to one of the events listed in the following tables.

Please note: Your election change under a Flexible Spending Account Plan during the year must correspond with the type of qualified status change that has occurred. For example, if you legally adopt a child, you may increase the amount you are contributing to one or both of the Flexible Spending Accounts. You may not, however, cancel your election to contribute to one or both of the Flexible Spending Accounts.

Qualified Status Changes for the HFSA Include:	**Description**
Change in Marital Status	Your marriage, divorce, legal separation, annulment or the death of your Lawful Spouse.
Change in the Number of Eligible Healthcare Dependents	The birth, death, legal adoption, or placement for legal adoption of one of your Eligible Healthcare Dependents.
Change in Employment Status, Work Schedule or Worksite That Affects Eligibility for Coverage Under an Employer-Sponsored	You, your Lawful Spouse, or other Eligible Healthcare Dependent becomes employed (and eligible for health insurance coverage through an employer) or loses employment (and health insurance coverage).

Qualified Status Changes for the HFSA Include:	**Description**
Group Health Plan	
Your Dependent Meets or No Longer Meets the Eligibility Requirements	An event that causes a dependent to meet or to no longer satisfy a Flexible Spending Account Plan's eligibility requirements — for example, a child reaches the maximum age for coverage.
Court-Ordered Coverage	A change in your responsibility to provide healthcare coverage for an Eligible Healthcare Dependent child as stipulated in a judgment, decree or court order resulting from a divorce, legal separation, annulment or change in legal custody (for example, a Qualified Medical Child Support Order). See "Qualified Medical Child Support Order Benefit Payments" in the "Other Important Information" section). If a dependent specified in the judgment, decree or court order does not meet the eligibility criteria of an Eligible Healthcare Dependent, the dependent's expenses are not eligible for reimbursement from your HFSA. The dependent may be eligible for COBRA coverage and you or your dependent(s) will be sent information about the cost of this coverage after you notify the Alcatel-Lucent Benefits Center.

Qualified Status Changes for the DFSA Include:	**Description**
Change in the Number of Qualifying Individuals	The birth, death, legal adoption, or placement for legal adoption with you of a Qualifying Individual.
Change in Employment Status for Your Lawful Spouse	Your Lawful Spouse's employment begins or ends or changes from part-time to full-time (or visa versa).
Your Qualifying Individual Meets or No Longer Meets the Eligibility Requirements	Your dependent ceases to satisfy the requirements to be a Qualifying Individual. For example, your child turns age 13.
Change of Dependent Care Providers	You decide to enroll your Qualifying Individual child in a different nursery school program.
Significant Cost or Coverage Changes	Applies only if a dependent care provider who is not a relative imposes the significant cost change, or if coverage is significantly curtailed or eliminated.

How to Make Changes to Your Coverage During the Year

If you experience one of the events described in this section and need to change your HFSA or DFSA election during the calendar year, you must report the event within **31 days** of its occurrence online through the Your Benefits Resources Web site at http://resources.hewitt.com/alcatel-lucent, or by calling the Alcatel-Lucent Benefits Center. If you do not report the event within the 31-day reporting period, you will not be able to make a contribution election coverage change until the next Annual Open Enrollment, unless you once again meet one of the conditions for a qualified status change during the year.

If you timely report the status-change event, any contribution election change due to the qualified status change takes effect as of the date of the qualified status change.

If You Don't Enroll

If you don't make any elections by the date specified in your enrollment information, you will not have an opportunity to enroll in either Flexible Spending Account until the next Annual Open Enrollment period. This means you will not be able to contribute to the HFSA or the DFSA for the current year. You must wait until the next Annual Open Enrollment period to enroll. However, if you have a qualified status change during the year, you may be eligible to enroll in the HFSA and/or the DFSA. Your enrollment must be consistent with your qualified status change.

If You and Your Spouse Work for Alcatel-Lucent

If you and your Lawful Spouse work for Alcatel-Lucent and are eligible to enroll in the Flexible Spending Accounts, here's what happens:

- Each of you may have your own HFSA. Each of you may contribute up to the Plan Year maximum to your HFSA.

- Each of you may have your own DFSA. However, your combined total annual contribution will be subject to IRS limitations (see "Special Rules for the DFSA").

About Participation

If you elect to participate in the Flexible Spending Accounts for a given Plan Year, your salary reduction contribution elections will remain in effect through December 31 of that Plan Year only.

Your contribution elections do not automatically continue from one year to the next. If you want to continue participation after your initial enrollment, you must re-enroll for each year during Annual Open Enrollment. You do not need to be enrolled for other benefits through Alcatel-Lucent in order to enroll for the HFSA or the DFSA.

When Participation Begins
You can participate in the Flexible Spending Accounts only if you enroll as follows:

- **For newly eligible employees:** If you enroll by the date specified in your enrollment information, your participation begins as of the first day of the following month. Your salary reduction contributions begin on the corresponding pay period. If you do not enroll within 31 days, you may not elect to participate until the next Annual Open Enrollment period, unless you have a qualified status change during the calendar year.

- **Following a qualified status change:** If you elect to increase, decrease or stop HFSA or DFSA salary reduction contributions within 31 days of a qualified status change, your change takes effect as of the first day of the following month. If you do not change your election within 31 days of the qualified status change, you must wait until the next Annual Open Enrollment period.

- **During Annual Open Enrollment:** If you enroll or re-enroll during the Annual Open Enrollment period, your participation for the next Plan Year begins on the first day of the following calendar year.

After your initial enrollment, you must re-enroll each year during Annual Open Enrollment if you want to continue your participation during the following year.

For more information, see "Qualified Status Change" and "Annual Open Enrollment."

Section C. How the Flexible Spending Accounts Work

Alcatel-Lucent's Flexible Spending Accounts allow you to set aside Pre-Tax dollars from your pay to cover certain healthcare or dependent care expenses. There are two Flexible Spending Accounts:

- The *HFSA* may be used to pay for eligible healthcare expenses for yourself, your Lawful Spouse, and your Eligible Healthcare Dependents.
- The *DFSA* may be used to pay for eligible dependent care expenses that allow you to work, or if you are married, that allow both you and your Lawful Spouse to work, or your Lawful Spouse to attend school full time.

You may elect to participate in one account, both accounts or neither account. The following chart provides some general guidelines about the Flexible Spending Accounts.

How the Flexible Spending Accounts Work		
	HFSA	**DFSA**
Each Year You Can Set Aside	$100 – $5,000* Effective for the 2013 Plan Year, the maximum contribution will be $2,500. After 2013, the $2,500 limit for the HFSA will be adjusted annually for inflation. Any inflation adjustment that is not a multiple of $50 will be rounded down to the next lowest multiple of $50.	$100 – $5,000*

How the Flexible Spending Accounts Work		
	HFSA	**DFSA**
To Be Eligible for Reimbursement, Expenses Must Be	Medically necessary Incurred by you, your Lawful Spouse, or your Eligible Healthcare Dependents Not reimbursed elsewhere Considered a tax deductible medical expense by the IRS	For care of your Qualifying Individuals (see Section N. Terms to Know) Fees for day care, babysitting and housekeepers whose duties include dependent care For payments to : (a) relatives (excluding your Lawful Spouse) who care for a Qualifying Individual and who are not claimed as a dependent on your or your Lawful Spouse's federal income tax return; or (b) your Children who provide care for a Qualifying Individual, as long as the Children are at least age 19 by the end of the calendar year Fees for before- and after-school care programs, provided the expenses are itemized separately from tuition expenses To allow you to work or if you are married, to allow you and your Lawful Spouse to work, or your Lawful Spouse to attend school full time
You Are Reimbursed This Way	Up to your annual election less any previous reimbursements	Up to your current account balance, less any previous reimbursements
These Special Rules Apply	Reimbursed expenses cannot also be claimed on your tax return If you and your Lawful Spouses both work for Alcatel-Lucent, each can contribute up to the maximum to separate accounts	Reimbursed expenses lower the amount you can claim as part of the Federal Dependent Care Tax Credit Contributions may be limited depending on the employment status and income of your Lawful Spouse, as well as whether you file your income tax return as "single," "married filing jointly," or "married filing separately."

*This amount may be limited by IRS rules if you are classified as a Highly Compensated Employee. For more information, see "Special Rules for the DFSA" and "Special Rules for the HFSA."

Balances Can Not Be Transferred Between HFSA and DFSA

If you participate in the HFSA and the DFSA, you cannot transfer balances from one Flexible Spending Account to another. Your HFSA balance may only be used for eligible healthcare expenses and your DFSA balance may only be used for eligible dependent care expenses.

HFSA Reimbursement Restrictions

The money contributed to your HFSA can only be used for eligible expenses incurred during the same Plan Year (and, if you were participating in the HFSA on December 31, during the immediately following Grace Period) in which you elected to contribute to the HFSA. However, you may submit claims for expenses incurred during a Plan Year (and, if you were participating in the HFSA on December 31, those expenses incurred during the immediately following Grace Period) up to the April 15 of the following Plan Year. Any money remaining in your HFSA after that date is forfeited.

How it Works

Claims submitted during the Grace Period are processed using a First In, First Out (FIFO) methodology, which means that eligible claims are paid in the order in which they are received.

For example: If you enrolled in an HFSA for 2011, and then re-enroll in an HFSA for 2012, claims that you incur during the Grace Period will be reimbursed first from your 2011 HFSA balance. Once your 2011 balance is exhausted, any new claims will be reimbursed from your 2012 HFSA balance. If you do not exhaust your entire 2011 HFSA balance during the Grace Period, any remaining 2011 balance will be forfeited (per the FSA "use it or lose it" rule).

Please note: Eligible claims incurred during the Grace Period will be *automatically* applied toward any 2011 plan year balance. **Be sure to submit all eligible 2011 expenses toward your remaining balance before submitting any 2012 plan year expenses; and no later than the April 15, 2012 filing deadline for 2011 claims**. Please see examples on the following page for Ceridian Benefits Card transactions and manual claims.

Manual Claims Using the Claim Reimbursement Form

Claims incurred in the 2011 plan year and submitted for reimbursement *by 12/31/11*	Will be reimbursed from the **2011** plan year account, assuming there is a remaining balance
Claims incurred in the 2011 plan year and submitted for reimbursement *by 4/15/12*	Will be reimbursed from the **2011** plan year account, assuming there is a remaining balance
Claims incurred in the 2012 plan year by **3/15/12** and submitted for reimbursement *by 4/15/12*	Will be reimbursed from the **2011** plan year account, assuming there is a remaining balance
Claims incurred in the 2012 plan year and submitted for reimbursement *after 4/15/12*	Will be reimbursed from the **2012** plan year account, even if you have a balance in your 2011 account (**Remember the "use it or lose it" rule**)

Benefits Card Purchases

Claims incurred in the 2011 plan year and paid with the Ceridian Benefits Card *by 3/15/12*	Will be paid from the **2011** plan year account, assuming there is a remaining balance
Claims incurred in the 2011 plan year and paid with the Ceridian Benefits Card *after 3/15/12*	Will be paid from the **2012** plan year account, even if you have a balance in your 2011 account
Claims incurred in the 2012 plan year and paid with the Ceridian Benefits Card *by 3/15/12*	Will be paid from the **2011** plan year account, assuming there is a remaining balance
Claims incurred in the 2012 plan year and paid with the Ceridian Benefits Card *after 3/15/12*	Will be paid from the **2012** plan year account, even if you have a balance in your 2011 account

DFSA Reimbursement Restrictions

The money contributed to your DFSA can only be used for eligible expenses incurred during the same Plan Year in which you elected to contribute to the DFSA. Unlike the HFSA, the DFSA does not offer a Grace Period. However, you may submit claims for expenses incurred during a Plan Year up to April 15 of the following Plan Year. Any money remaining in your DFSA after that date is forfeited.

When an Expense Is Incurred

Any healthcare or dependent care expense is considered "incurred" on the date the service or treatment is provided, not on the day you pay for it.

If a healthcare service or treatment extends beyond December 31, only expenses incurred during the Plan Year for which an HFSA election is made (or during the immediately following Grace Period, if you are participating in the HFSA on December 31 of the Plan Year) are eligible for reimbursement.

Account Statements

Online account statements are available for your Flexible Spending Accounts. You can check the balance of your HFSA and DFSA anytime by visiting the Ceridian Web site at http://www.ceridian-benefits.com, or calling 1-877-799-8820.

Section D. Your Contributions

You fund your Flexible Spending Account(s) with Pre-Tax dollars that are deducted from your pay in installments based on the number of pay periods throughout the year. If you elect to participate in the HFSA and the DFSA, your salary reduction contributions to each account are kept separately. Because of the special tax advantages offered by these accounts, IRS rules do not allow you to transfer money from one account to the other. This means you can only use your HFSA for eligible healthcare expenses and your DFSA for eligible dependent care expenses.

How Much You Can Contribute

The minimum amount you may contribute to each account during any one Plan Year is $100. The maximum amount you may contribute depends on the type of account. The following chart shows you how this works.

Minimum and Maximum Contribution Amounts for Any One Plan Year		
Account	**HFSA**	**DFSA**
Minimum	$100	$100
Maximum	$5,000* Beginning January 1, 2013, the maximum will be $2,500. After 2013, the $2,500 limit will be adjusted annually for inflation. Any inflation adjustment that is not a multiple of $50 will be rounded down to the next lowest multiple of $50.	$5,000*

*This amount may be limited by IRS rules if you are classified as a Highly Compensated Employee. For more information, see "Special Rules for the DFSA" and "Special Rules for the HFSA."

If your enrollment is effective after January 1 of a Plan Year, you can still set aside up to the maximum annual amount allowed for each account. Your contributions will be deducted from your pay in installments based on the number of pay periods remaining in that Plan Year.

Estimate Your Expenses to Determine Your Contributions

It is important to carefully estimate your expenses before you decide how much you want to contribute to the HFSA and/or the DFSA during the Plan Year. You should be able to get a good idea of what your expenses might be by looking at your expenses over the last couple of years. Also consider any healthcare expenses (medical, dental, vision or hearing) and/or changes to your dependent care needs that you expect may occur during the Plan Year.

You might want to be conservative in your estimate since any balance that is not used by the claim deadline is forfeited. For more information, see "Forfeiture of Unused Funds."

Changing Your Contributions

Each year during Annual Open Enrollment, you choose whether or not to participate in the HFSA and/or the DFSA. Generally, the choices you make during Annual Open Enrollment remain in effect for the full Plan Year. However, you may be permitted to change your contribution amount or stop contributions if you have a qualified status change. For more information, see "Qualified Status Changes."

Effect of Contributions on Other Benefits

Your contributions to the Flexible Spending Account(s) do not affect pay-related benefits, such as pension, disability and group life insurance.

Forfeiture of Unused Funds

IRS regulations require that any funds left in your account(s) after the deadline for filing claims must be forfeited. The deadline for filing claims is April 15 of the calendar plan year following the calendar year for which you made your election. Any amounts left in your account(s) after April 15 will be forfeited. (See "Flexible Spending Restrictions" for more information on when expenses may be incurred.)"

Section E. Your Health Care Flexible Spending Account

The HFSA allows you to use Pre-Tax dollars to pay for eligible healthcare expenses for yourself, your Lawful Spouse, or your Eligible Healthcare Dependents that:

- Are medically necessary;
- Are not reimbursed by an Alcatel-Lucent or another employer's medical, dental or vision plans (including your Lawful Spouse's or Eligible Healthcare Dependents' plans); and
- Are considered tax deductible medical expenses by the IRS.

Dependent Verification
From time to time, the Company will verify dependent eligibility. Verification will include documentation requirements.

Whom the HFSA Covers

For an expense to be eligible for reimbursement under the HFSA, it must be incurred by:

- You;
- Your Lawful Spouse; or
- Your Eligible Health Care Dependents, who are defined as:
  - Your Children through the end of the month in which they attain age 26, unless they are eligible to enroll in another employer-sponsored group health plan that is not a parent's employer-sponsored group health plan;
  - Your older Children who are certified (prior to the end of the month in which they attain age 26) by a medical claims administrator of the Alcatel-Lucent Medical Expense Plan for Management Employees or the Alcatel-Lucent Medical Expense Plan for Occupational Employees as meeting all of the following requirements:
    - Incapable of self-support;
    - Physically or mentally handicapped; and
    - Fully dependent on you for support; or
  - Anyone else you claim as a dependent on your federal income tax return.

For more information, see "When an Expense Is Incurred," "Eligible Healthcare Expenses," and "Ineligible Healthcare Expenses."

HFSA Debit Card

The HFSA debit card provides a convenient method to pay for out-of-pocket eligible health care expenses for you; your Lawful Spouse; and your Eligible Health Care Dependents. If you enroll in the HFSA, you will automatically be issued an HFSA debit card, free of charge. By signing or using the HFSA debit card, you agree to the terms of the "Benefits Card Cardholder Agreement" you received with the HFSA debit card. You can request additional cards, at no charge, from Ceridian.

A debit card will have a stored value equal to your HFSA election for the calendar year, less any previous reimbursements for that calendar year and the Grace Period following that calendar year. As you use your HFSA debit card, your eligible expenses are deducted automatically from your HFSA.

Each time you use your HFSA debit card, you are deemed to be making the following certifications: (1) that the expense is an eligible healthcare expense; (2) that the expense has not already been reimbursed; (3) that the expense will not be submitted for reimbursement from another source; and (4) that sufficient documentation for any expense paid using the HFSA debit card will be retained.

Where the HFSA Debit Card Can Be Used

The IRS has stringent regulations regarding appropriate use of the HFSA debit card, as far as where the card can be used and when follow-up documentation is required. **NOTE:** Use of the card **DOES NOT** necessarily eliminate all of the claim substantiation paperwork; you may be required to submit documentation to substantiate your charges. Per IRS regulations, the HFSA debit card can be used at the following locations:

- Health care providers (e.g., physicians, dentists, hospitals, vision care offices) that have a health care merchant category code ("MCC"). Every merchant that accepts credit cards has an MCC, which is a general category that is assigned when the merchant applies for the right to accept credit cards.

- Retail stores (e.g. pharmacies and drug stores) that have implemented the Inventory Information Approval System ("IIAS"). The IIAS restricts purchases with the HFSA debit card to eligible expenses. Stated simply, when you use the debit card, the payment card processor's or participating merchant's system collects information about the potential purchase, compares the information collected about the item with a list of eligible health care expenses, and generally approves the purchase through use of the card if the item is on the list. If the potential purchase is not on the list, you will not be able to use the HFSA debit card to make the purchase. You will have to pay with a separate form of payment and submit a claim for reimbursement.

- Retail stores with the MCC for drugstores and pharmacies if, on a store location-by-location basis, 90% of the store's gross receipts during the prior taxable year consisted of items that qualify as eligible health care expenses.

You need to keep your receipts from your services or purchases to provide documentation that may be required after you have used your HFSA debit card to verify it was used for eligible health care expenses.

When the HFSA Debit Card Will Be Deactivated
Your HFSA debit card will be deactivated upon the occurrence of one of the following events:

- Your employment with the Company or a Participating Company is terminated;
- You use, or attempt to use, the HFSA debit card to purchase an ineligible healthcare expense;
- When Ceridian is notified that your HFSA debit card has been lost or stolen;
- Subject to the termination or suspension conditions described in the "Benefits Card Cardholder Agreement;" or
- When card transactions remain unsubstantiated, after reasonable written notice to you.

While the HFSA debit card is deactivated, you will have to submit any claims for reimbursement as described under Section I. Claims for Reimbursement.

To notify Ceridian of a lost or stolen debit card, or if you need more information regarding the HFSA debit card, contact Ceridian at www.ceridian-benefits.com, or 1-877-799-8820**.**

Eligible Healthcare Expenses

This section lists examples of the most common expenses that you pay for out-of-pocket and that may qualify for reimbursement under the HFSA. A complete list of eligible expenses may be obtained from Ceridian, at www.ceridian-benefits.com, or 1-877-799-8820**.**

- Prescription and physician office visit copayments under your medical, dental and vision plans;
- Deductibles and co-insurance under medical, dental and vision plans;
- Prescribed medications, including prescribed over-the-counter medications; and

■ Insulin (whether or not prescribed).

Ineligible Healthcare Expenses

Not all healthcare expenses are eligible for reimbursement under the HFSA. Some examples of healthcare expenses that are not eligible for reimbursement under your HFSA include:

■ Cosmetic surgery or procedures to improve appearance;

■ Cosmetics, toothpaste, and other toiletries;

■ Custodial care in an institution;

■ Dependent care expenses (these may be eligible for reimbursement under the DFSA);

■ Fees for an exercise, athletic or health club membership unless there is a special medical reason for the membership;

■ Insurance premiums paid for any health coverage (including Medicare Part B premiums);

■ Marriage and family counseling;

■ Vitamins taken for general health improvement; and

■ Certain non-prescribed over-the-counter medicines.

Special Rules for the HFSA

The following special rules apply to the HFSA:

■ If you are participating in the HFSA on December 31 of a calendar year, any unused amounts as of December 31 can be applied to expenses incurred through March 15 of the following calendar year. Previous and current calendar year balances will be maintained separately.

■ For expenses incurred from January 1 through March 15 of a calendar year, funds are generally drawn down from the unused balance of the prior calendar year (if any), until depleted, before funds are taken from the current year's account.

■ You cannot claim expenses reimbursed through your HFSA as a deduction on your federal income tax return.

■ If you and your Lawful Spouse both work for Alcatel-Lucent, you can each set aside up to the maximum amount in separate HFSA accounts each year.

- The HFSA must meet certain nondiscrimination standards. If these requirements are not satisfied, Highly Compensated Employees may not be able to make the maximum contribution. You will be notified if this applies to you.

Section F. Your Dependent Care Flexible Spending Account

The DFSA allows you to use Pre-Tax dollars to cover eligible dependent care expenses that allow you to work. If you're married, you and your Lawful Spouse must be working, or your Lawful Spouse must be a full-time student (i.e., enrolled for 5 or more months during the calendar year in the number of course hours required to be a full-time student at an education organization that has a regular faculty curriculum and enrolled student body at a place where its educational activities are regularly carried on) or incapable of self-care.

Also see "Federal Dependent Care Tax Credit" for important information.

Whom the DFSA Covers

For an expense to be eligible under the DFSA, it must be for the care of a "Qualifying Individual," which is defined as:

- Your Children, brothers, sisters, stepbrothers, stepsisters, or any of their descendants under age 13 who:
  - Live with you for more than half of the calendar year; and
  - Have not been able to provide over one-half of their own support for the calendar year.
- Your older Children, Lawful Spouse and/or dependent of any age who:
  - Is mentally or physically incapable of self-care;
  - Lives with you for more than half of the calendar year; and
  - Has not been able to provide over one-half of his or her own support for the calendar year.

Eligible Dependent Care Expenses

This section lists some of the most common expenses that may qualify for reimbursement under the DFSA. If you want to determine if a particular expense is covered, call Ceridian at www.ceridian-benefits.com, or 1-877-799-8820.

Some examples of dependent care expenses that may be eligible for reimbursement under your DFSA include:

- Fees for preschool, nursery school, or similar programs for children below the level of kindergarten;

- Fees for Dependent Care Centers (i.e., child care or adult care centers that comply with any state and local laws or regulations), including those Dependent Care Centers which provide day camp or similar programs (day camps can include those camps which specialize in a particular activity, such as soccer day camp);

- What you pay baby-sitters inside or outside your home;

- Costs of housekeepers whose duties include child or elder care;

- The amount you pay relatives who care for your Qualifying Individuals, as long as you do not claim the caregivers as dependents on your income tax return (payments to your Children who provide such care may be made only if that child is at least age 19 by the end of the calendar year);

- Fees for people who care for an elderly or incapacitated Qualifying Individual; and

- Fees for before-school and after-school day care programs, for children in kindergarten or higher grades, provided the fees are itemized separately from any tuition expenses.

Ineligible Dependent Care Expenses

Not all dependent care expenses are eligible for reimbursement under the DFSA. Some examples of dependent care expenses that are not eligible for reimbursement under your DFSA include:

- Expenses for food, clothing, diapers, education, or lodging of a Qualifying Individual (unless the expenses are incidental to and cannot be easily separated from the cost of the dependent care);

- Fees for schooling in kindergarten or higher grades (including summer school or tutoring programs);

- Expenses for transportation between your house and the Dependent Care Center or to pick up a baby-sitter, unless the transportation is provided by the Dependent Care Center;

- Expenses for which you use the Federal Dependent Care Tax Credit;

- Nursing home expenses;

- Amounts you pay to the Qualifying Individual's parent for care provided to the Qualifying Individual;

- Expenses for overnight summer camps; and

- Healthcare expenses (these may be eligible for reimbursement under the HFSA).

Federal Dependent Care Tax Credit

The IRS makes available a Federal Dependent Care Tax Credit for dependent care expenses. You file for the tax credit on your annual tax return. However, you cannot claim the same expenses under the Federal Dependent Care Tax Credit as you do under the DFSA. In addition, the amount you elect to contribute to a DFSA for a calendar year will reduce the amount of the dependent care tax credit available to you for that year. Eligibility for the Federal Dependent Care Tax Credit, which depends on your income, could impact whether the DFSA or the Federal Dependent Care Tax Credit is more beneficial to you. **You will need to decide whether participation in a DFSA or the Federal Dependent Care Tax Credit is more beneficial, and you may want to consult a financial or tax advisor to help with this determination.**

Special Rules for the DFSA

The following special rules apply to the DFSA.

- If you're married, you and your Lawful Spouse may both participate in a Dependent Care Flexible Spending Account. However, the following limits apply:

  - If you file a joint federal income tax return your combined total annual contribution cannot exceed $5,000.

  - If you file separate returns, each of you may contribute up to $2,500.

  - The annual amount you contribute to your DFSA cannot be more than your income or your Lawful Spouse's income, whichever is lower. For instance, if you earn $30,000 a year and your Lawful Spouse earns $4,500, the maximum your family can set aside for eligible dependent care expenses is $4,500.

  - If your Lawful Spouse is a full-time student (i.e., enrolled for 5 or more months during the calendar year in the number of course hours required to be a full-time at an education organization that has a regular faculty curriculum, and enrolled student body at a place where its educational activities are regularly carried on), or if he or she is disabled and has no income, the IRS assumes your Lawful Spouse's income is $250 a month ($3,000 a year) if you claim expenses for one Qualifying Individual, and $500 a month ($6,000 a year) if you claim expenses for two or more Qualifying Individuals.

- If you're single or divorced, you may contribute the full $5,000 each year.

- The DFSA must meet certain nondiscrimination standards. If these requirements are not satisfied, Highly Compensated Employees may not be able to make the maximum contribution. You will be notified if this applies to you.

Filing a Claim for Reimbursement

There is no minimum claim amount. You must file a claim to request reimbursement for eligible dependent care expenses. For more information, see "DFSA Claims."

Section G. Your Costs

There is no premium cost associated with the Flexible Spending Account(s).

However, if you elect to participate in the HFSA and/or DFSA, you fund your account(s) with Pre-Tax dollars that are deducted from your pay in installments based on the number of pay periods throughout the year. If you enroll during the year, your contributions are deducted from your pay in installments based on the number of pay periods throughout the remaining months of that Plan Year.

For more information, see "Your Contributions."

Section H. When Participation Ends

Your eligibility to make Pre-Tax contributions to the HFSA and/or the DFSA ends if any of the following events occur:

- Your employment with a Participating Company is terminated for any reason;
- You become eligible for long-term disability benefits under the Alcatel-Lucent Long Term Disability Plan or the Alcatel-Lucent Long Term Disability Plan for Occupational Employees (see "If You Become Disabled" in Section M. Events Affecting Participation;
- You take a leave of absence (other than a Family and Medical Leave Act (FMLA) leave) of more than 30 days (see "If You Take a Leave of Absence" in Section M. Events Affecting Participation);
- The company for which you work ceases to be a Participating Company; or
- The Flexible Spending Account Plan(s) is terminated.

Although you are no longer eligible to make Pre-Tax contributions to your Flexible Spending Account(s), your participation may not end at that time. For more information, see "What Happens When Participation Ends."

What Happens When Participation Ends

If your participation ends during the Plan Year, you cannot withdraw the cash remaining in your Flexible Spending Account(s). (An exception is available for qualified military service. Contact the Plan Administrator if you think that this might apply to you.) However, you have until the annual claim filing deadline (April 15 of the year following the year for which you made your election) to submit claims for the reimbursement of eligible expenses incurred prior to the date your participation terminated. After the April 15th annual claim filing deadline, you forfeit any balance remaining in your Flexible Spending Account(s). If you die, your dependents, estate or representative also has until the April 15 annual claim filing deadline to submit claims for the reimbursement of eligible expenses incurred prior to the date of your death.

When HFSA Participation Ends

You may be eligible to continue your participation in your HFSA for a limited period of time. However, your future contributions will be in after-tax dollars. In addition, your HFSA debit cards are automatically cancelled when you cease to participate in the HFSA. If you elect to continue your participation, you may submit claims for eligible expenses incurred for as long as you participate in the HFSA. For more information, see "Continuing Your HFSA Coverage Through COBRA."

When DFSA Participation Ends

Participation in a DFSA for a given Plan Year ends on the earlier of:

- December 31 of that Plan Year; or

- When there is no more money in your account.

However, you can continue to submit claims for eligible dependent care expenses incurred at any time during that calendar year until April 15 of the following calendar year.

You cannot continue to make DFSA contributions after you leave the payroll.

Section I. Claims for Reimbursement

Filing a Claim for Reimbursement

HFSA Claims

You can be reimbursed for eligible healthcare expenses (see "Eligible Healthcare Expenses"), up to the amount you choose to contribute to your HFSA, incurred during the calendar year (and, if you were participating in the HFSA on December 31 of a calendar year, through March 15 of the following calendar year), less any reimbursements already made.

To request reimbursement from your HFSA:

Step 1: When you have an eligible healthcare purchase. (If you have an HFSA debit card, you may be able to skip steps 2 and 3.) Keep your original itemized receipt or invoice from the provider and/or Explanation of Benefits ("EOB"). You may be asked to substantiate your claim at a later date.

Step 2: Submit your claim online via www.ceridian-benefits.com (see "Important Contacts") and print your confirmation page. (Note that you may also submit a claim by mail. Call Ceridian at 1-877-799-8820 to get started.)

Step 3: E-mail, fax or mail your receipt (or EOB, invoice, or other statement verifying that you incurred an eligible healthcare expense) and confirmation page.

- *E-mail:* consumerservices@ceridian.com
- *Fax:* 1-866-717-3820
- *Mail:*
  Ceridian Benefits Services
  P.O. Box 534451
  St. Petersburg, FL 33747

Also:

- If expenses were partially covered by a medical, dental or vision care plan, log onto the Ceridian Web site at http://www.ceridian-benefits.com, or call 1-877-799-8820 to request a Flexible Spending Account claim form if you do not have one.

- Attach a copy of the invoice or statement from the provider or an EOB you received from the insurance company to your claim form, to serve as proof that you have

incurred the eligible healthcare expense. (A cancelled check is not acceptable proof.) The invoice, statement, or EOB must contain the following information:

— Type of service or product provided;

— Date expense was incurred;

— Name of employee or Dependent for whom the service/product was provided;

— Person or organization providing the service or product; and

— Amount of expense.

- Attach a copy of the prescription (or another item showing that a prescription was issued) if you are submitting a claim for reimbursement of a prescribed over-the-counter medication.

- Submit the completed form with the required documentation to the address printed on the form.

If your claim is denied, you may file a claim to appeal the decision.

DFSA Claims

You can be reimbursed for eligible dependent care expenses (see "Eligible Dependent Care Expenses") only up to the amount available in your DFSA. Claims over that amount are reimbursed as the money accumulates in your account.

To request reimbursement from your DFSA:

Step 1: When you have an eligible expense. Keep your original itemized receipt or invoice from the provider and/or EOB. You may be asked to substantiate your claim at a later date.

Step 2: Submit your claim online via www.ceridian-benefits.com and print your confirmation page. (Note that you may also submit a claim by mail. Call Ceridian at 1-877-799-8820 to get started.)

Step 3: E-mail, fax or mail your receipt (or EOB, invoice, or other statement verifying that you incurred an eligible healthcare expense) and confirmation page.

E-mail: consumerservices@ceridian.com

Fax: 1-866-717-3820

Mail:
Ceridian Benefits Services

P.O. Box 534451
St. Petersburg, FL 33747

Note: Your itemized bill or receipt from the provider should show:

- Name(s) of the Qualifying Individual(s) who received the service;
- Type of service provided;
- Date the expense was incurred;
- Name of the person or organization providing the service and their Social Security number or federal tax identification number or the nonprofit equivalent (special rules apply if you cannot obtain these numbers);
- Amount of the expense; and
- Provider's signature.

If your claim is denied, you may appeal the decision.

Filing Deadline

You must submit claims for eligible expenses by April 15 of the calendar year following the calendar year for which you made your election. For example, if you make an election effective January 1, 2012, you must submit all claims for money in your account(s) no later than April 15, 2013. Any money remaining in your account(s) after April 15 is forfeited. For more information, see "When an Expense Is Incurred" and "Forfeiture of Unused Funds."

Payment of Claims

If your claim is approved and you have elected direct deposit, payment/ reimbursement will be made by direct deposit to the bank account of your choice. If you have not elected direct deposit, you will receive a check in the amount of any payment/reimbursement due.

Section J. Continuing Coverage

Continuing Your HFSA Coverage Through COBRA

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to offer "qualified beneficiaries" (enrolled Eligible Employees, their Lawful Spouses, and their Eligible Healthcare Dependents) the opportunity to continue their group health coverage (including participation in the HFSA) *at their own expense* for a limited period of time if they lose coverage due to a qualifying event.

You may, under certain circumstances, be eligible to continue your participation in the HFSA by making after-tax payments. HFSA continuation is available only if you have unclaimed money remaining in your account when the qualifying event occurs which exceeds the cost of HFSA continuation coverage for the remainder of the calendar year. So, if you already claimed all the money you had contributed to your account, you would not be eligible to continue participation under COBRA.

Coverage may be extended until December 31 of the calendar year in which the qualifying event occurs. If you have COBRA continuation coverage as of December 31, your coverage will be extended to March 15 of the following calendar year. If you, your Lawful Spouse, or Eligible Healthcare Dependents are eligible for any other continuing health care coverage, that coverage also counts toward your COBRA continuation period.

Event	COBRA continuation coverage
• Termination of your employment for any reason other than gross misconduct, or • A reduction in your work hours.	You and/or your Lawful Spouse or Eligible Healthcare Dependents (or a dependent newly acquired by marriage, birth or adoption during the **COBRA** coverage period) may continue coverage through December 31 of that calendar year (March 15th of the following calendar year if covered under COBRA as of December 31).
• Disability of you, your Lawful Spouse, or an Eligible Healthcare Dependent as	The disabled person and other qualified beneficiaries (or a dependent newly

Event	COBRA continuation coverage
defined under the Social Security Act at the time of the qualifying event.	acquired by marriage, birth, or adoption during the **COBRA** coverage period) may extend continued coverage through December 31 of that calendar year (March 15th of the following calendar year if covered under COBRA as of December 31).
• Your divorce or legal separation, • Your death, • You (the Alcatel-Lucent employee's) entitlement to Medicare, or • Your Lawful Spouse's or Eligible Healthcare Dependent's loss of eligibility under the Plan (see "Who Is Eligible").	Your Lawful Spouse or Eligible Healthcare Dependents may continue coverage through December 31 of that calendar year (March 15th of the following calendar year if covered under COBRA as of December 31).

COBRA Coverage Cost
You pay the full cost for COBRA continuation coverage (for the HFSA, this would be the amount of the after-tax contributions you elect to make to your HFSA), plus an administrative fee.

Electing COBRA Continuation Coverage
Complete details about COBRA continuation coverage, including information about election and cost, is automatically sent to your home if you (the Alcatel-Lucent employee) lose coverage due to a COBRA qualifying event. If your Lawful Spouse or Eligible Healthcare Dependent loses coverage due to a COBRA qualifying event other than your termination or reduction in hours, information isn't sent automatically. If your Lawful Spouse or Eligible Healthcare Dependent wants to continue coverage under COBRA, you, your Lawful Spouse, or your Eligible Healthcare Dependent must notify the Alcatel-Lucent Benefits Center within 60 days of the date the event occurs.

Continuing Your DFSA Coverage

You cannot continue to make contributions to the DFSA after you leave the payroll. However, you may submit claims for eligible dependent care expenses incurred during the Plan Year in which your contributions end. For more information, see "When DFSA Participation Ends."

Section K. Claims and Appeals

Types of Claims

The Plan contemplates two types of claims:

- Eligibility claims; and
- Benefits claims.

Eligibility Claims

An eligibility claim is a claim concerning your right to participate in the Plan. For example, you may believe an error was made during an Annual Open Enrollment that resulted in you being incorrectly excluded from participation in the Plan.

Benefits Claims

A benefits claim is exactly what it sounds like — it is a claim for benefits (i.e., reimbursement) under the HFSA or the DFSA.

Eligibility Claims

Filing Deadlines

If you have an eligibility claim, contact the Alcatel-Lucent Benefits Center. If appropriate, a representative will provide you with an eligibility claim form, called a Claim Initiation Form ("CIF").

On the CIF, you will be asked to set forth the nature of the claim (for example, failure to permit a mid-year change in elections), all pertinent facts and the reasons why you believe you are entitled to the relief you are requesting. Also, include with your CIF any documentation supporting your claim.

Where to Send Your Claim Form

Mail your completed CIF and any enclosures to the following address:

Alcatel-Lucent Benefits Review Team
P.O. Box 1407
Lincolnshire, IL 60069-1407

If your eligibility claim is coupled with a claim for benefits, send the benefits claim form to Ceridian, but also include a **copy** of it with your eligibility claim submitted to

the Benefits Review Team. Be sure to note in your eligibility claim submitted to the Benefits Review Team that you are also submitting a benefits claim to Ceridian.

When You Can Expect To Receive a Decision

When you file an eligibility claim, the Benefits Review Team reviews the claim and makes a decision to either approve or deny the claim. Generally, you will be notified of the Benefits Review Team's decision within 30 days after its receipt of your claim. The Benefits Review Team may extend the period for making the claim decision by 15 days if it determines that an extension is necessary and notifies you, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision.

If you do not provide sufficient information to allow the Benefits Review Team to make a decision with respect to your eligibility claim, you will be notified of the need for the information. You will have at least 45 days from receipt of the notice to provide the specified information. In such an instance, the Benefit Review Team's deadline for rendering a decision is suspended from the date on which it sends notice of the need for necessary information until the date on which you provide the information. For example, if the Benefits Review Team notifies you on Day 10 of the initial 30-day review period that additional information is required, you will have 45 days from your receipt of the notice to provide the necessary information. If the Benefits Review Team then receives that information on, for example, Day 30 of your 45-day response time, the time within which the Benefits Review Team is required to decide your claim picks up as if it were Day 11 of its initial 30-day review period.

What You Will Be Told If Your Eligibility Claim Is Denied

If your eligibility claim is denied, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial;
- The specific Plan provisions on which the denial is based;
- A description of any additional material or information needed and an explanation of why it is necessary;
- If an internal rule, guideline or protocol was relied upon in connection with the denial of your benefits claim on appeal, a copy of the actual rule, guideline or protocol, or a statement that the rule, guideline or protocol was used and that you can request a copy free of charge; and
- An explanation of the Plan's claim review procedures, applicable time limits and your rights. If your claim is denied and your appeal is also denied, you have the right to bring a civil action in federal court under ERISA Section 502(a).

Appeal Procedures and Deadline
If your initial eligibility claim is denied by the Benefits Review Team, you or your authorized representative may appeal the denial under the Plan's administrative review procedures. The Plan contemplates a single, mandatory appeals process with respect to eligibility claims.

Your appeal must be in writing and should be addressed to:

Alcatel-Lucent
Employee Benefits Committee
600-700 Mountain Avenue
Room 2B-410
Murray Hill, New Jersey 07974

You should include a copy of your initial claim denial notification, the reason(s) for the appeal and relevant documentation with your appeal request.

You must file your appeal within 180 days from the date on the claim denial letter. During the 180-day period, you or your authorized representative will be given reasonable access to all documents and information relevant to the claim and you may request copies free of charge. You can also submit written comments, documents, records and other information relating to the appeal to the Employee Benefits Committee.

Review of your appeal will take into account all comments, documents, records and other information relating to the appeal, without regard to whether the information was submitted to or considered by the Benefits Review Team in connection with the initial claim decision. Your appeal will be reviewed "de novo," which means you get to "start fresh" with your claim on appeal. In reviewing your appeal, the Employee Benefits Committee will not place deference upon the original decision. Your appeal will be reviewed by an appropriate named fiduciary who is not the individual who made the initial decision, who is not subordinate to the initial reviewer and who will give a full and fair review of the claim and the denial.

When You Can Expect To Receive a Decision on Appeal
The Employee Benefits Committee will review your appeal and you will be notified of the decision on appeal within 60 days after receipt of your appeal.

What You Will Be Told If Your Eligibility Claim Is Denied on Appeal
If your eligibility claim is denied on appeal, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial;
- The specific Plan provisions on which the denial is based;

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the benefits claim;

- If an internal rule, guideline or protocol was relied upon in connection with the denial of your benefits claim on appeal, a copy of the actual rule, guideline or protocol, or a statement that the rule, guideline or protocol was used and that you can request a copy free of charge; and

- A statement about the claimant's right to bring an action under section 502(a) of ERISA.

Other Voluntary Options
There is no independent, voluntary third-party appeal review process for eligibility claims. If the Employee Benefits Committee denies your eligibility claim on appeal, you have the right to bring a civil action in federal court under Section 502(a) of ERISA. This option is available to you only after you have exhausted all of the administrative remedies available to you through the Plan's claims and appeals process as described in this section.

Benefits Claims

One of the advantages of using the HFSA debit card is that in many instances, your HFSA debit card purchases are deemed automatically substantiated at the point-of-sale and you don't need to submit any claim forms.

However, you do need to submit a claim form to receive benefits if the HFSA debit card purchase is not automatically deemed substantiated at the point-of-sale or you do not use the HFSA debit card.

Claim Deadlines

In instances where you are required to file a claim form in connection with a benefits claim, you must submit a claim no later than April 15 of the year following the year for which you made your election. Any money remaining in your account(s) after that date is forfeited. No benefits will be paid for claims submitted after this April 15th annual claim filing deadline.

To file a benefits claim, see Section I. Claims for Reimbursement.

Your claim will be evaluated to determine if any benefits will be paid. If benefits are payable, a check will be sent to you or, if you elected direct deposit, will be made directly to your designated bank account**.** If your claim is denied, you will be advised of the reasons for the denial and may appeal the decision (see, respectively, "What You Will Be Told If Your Benefits Claim Is Denied" and "Appeal Procedures and Deadline" later in this section).

When You Can Expect To Receive a Decision

When you file a benefits claim, Ceridian reviews the claim and makes a decision to either approve or deny the claim. The time frames within which you can expect to be advised of that decision are described below.

Generally, you will be notified of Ceridian's decision within 30 days after Ceridian's receipt of your claim. Ceridian may extend the period for making the claim decision by 15 days, if it determines that an extension is necessary and notifies you, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision.

If you do not provide sufficient information to allow Ceridian to determine whether, or to what extent, the claim is payable under the Plan, you will be notified of the need for the information. You will have at least 45 days from receipt of the notice to provide the specified information. In such an instance, Ceridian's deadline for rendering a decision is suspended from the date on which it sends notice of the need for necessary information until the date on which you provide the information. For example, if Ceridian notifies you on Day 10 of the initial 30-day review period that additional information is required, you will have 45 days from your receipt of the notice to provide the necessary information. If Ceridian then receives that information on, for example, Day 30 of your 45-day response time, the time within which Ceridian is required to decide your claim picks up as if it were Day 11 of its initial 30-day review period.

What You Will Be Told If Your Claim Is Denied

If your benefits claim is denied, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial;
- The specific Plan provisions on which the denial is based;
- A description of any additional material or information needed and an explanation of why it is necessary;
- If an internal rule, guideline or protocol was relied upon to determine a claim, a copy of the actual rule, guideline or protocol, or a statement that the rule, guideline or protocol was used and that explains that you can request a copy free of charge; and
- An explanation of the Plan's claim review procedures, applicable time limits and your rights. If your claim is denied and your appeal is also denied, you have the right to bring a civil action in federal court under ERISA Section 502(a).

Appeal Procedures and Deadline
If your initial claim for benefits is denied, you or your authorized representative may appeal that denial under the Plan's administrative review procedures. Responsibility for conducting the review of a denied benefits claim is with Ceridian and the Employee Benefits Committee, although the Employee Benefits Committee's determination is final and binding.

Your appeal must be in writing and should be addressed to Ceridian. You should include a copy of your initial claim denial notification, the reason(s) for the appeal and relevant documentation with your appeal request.

You must file your appeal within 180 days of the date you receive notice of the denied claim. During the 180-day period, you or your authorized representative will be given reasonable access to all documents and information relevant to the claim and you may request copies free of charge. You can also submit written comments, documents, records and other information relating to the appeal.

Review of your appeal will take into account all comments, documents, records and other information relating to the appeal, without regard to whether the information was submitted or considered in the initial claim decision. Your appeal will be reviewed "de novo." That means you get to "start fresh," and an independent Plan fiduciary will review your appeal. In reviewing your appeal, he or she will not place deference upon the original decision. Your appeal will be reviewed by an appropriate named fiduciary who is not the individual who made the initial decision, who is not subordinate to the initial reviewer and who will give a full and fair review of the claim and the denial.

When You Can Expect To Receive a Decision on Appeal
Ceridian will review your appeal, and it determines that your claim was denied in error, it will approve your claim. If Ceridian believes that your appeal should be denied, it will forward your appeal to the Employee Benefits Committee for review. The Employee Benefits Committee's determination on the appeal shall be final and binding. You will be notified of the appeal decision within 60 days after receipt of your appeal.

What You Will Be Told If Your Benefits Claim Is Denied on Appeal
If your benefits claim is denied on appeal, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial;

- The specific Plan provisions on which the denial is based;

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the benefits claim;

- If an internal rule, guideline or protocol was relied upon in connection with the denial of your benefits claim on appeal, a copy of the actual rule, guideline or protocol, or a statement that the rule, guideline or protocol was used and that you can request a copy free of charge; and

- A statement about the claimant's right to bring an action under section 502(a) of ERISA.

Other Voluntary Options

There is no independent, voluntary third-party appeal review process for benefits claims. If the Employee Benefits Committee denies your benefits claim on appeal, you have the right to bring a civil action in federal court under Section 502(a) of ERISA. This option is available to you only after you have exhausted all of the administrative remedies available to you through the Plan's claims and appeals process as described in this section.

Section L. Improper Payments and Overpayments

In General

In general, if an HFSA or DFSA is used to reimburse ineligible expenses (improper payments), or if all or some of the payments made exceed the benefits payable under your account(s) (excess payments), then those improper or excess payments must be refunded. If you do not refund the improper or excess payment, you are responsible for paying any state or federal income taxes or employment taxes which would have been withheld by the Company had such amounts been paid to you as taxable cash compensation, as well as interest and penalties on such amounts. You may also be responsible for any penalties or interest payable by the Company or a Participating Company due to your receipt of the improper or excess payment.

The HFSA Debit Card

If the improper or excess payment involved the use of the HFSA debit card, your HFSA debit card shall be deactivated until the amount of the improper or excess payment is recovered. While the HFSA debit card is deactivated, you will have to make claims for reimbursement as described under Section I. Claims for Reimbursement.

The Plan Administrator will ask you to refund the improper or excess payment. If you do not refund the improper or excess payment, the Company or a Participating Company reserves the right to withhold that amount from your pay. The Plan Administrator may also attempt to recoup the improper or excess payment by applying a claims substitution or offset to a later claim you submit for reimbursement within the same Plan Year (or the immediately following Grace Period) of the improper or excess payment. (So, for example, if you received an improper payment of $200 and you later submit a claim for $250 during the Plan Year (or immediately following Grace Period), you would receive reimbursement of only $50.) As a last resort, the Company or a Participating Company will treat the improper or excess payment as business indebtedness. As a result, you might have to include in income up to the entire amount of your HFSA election for the year of the improper or excess payment. You would have to pay taxes, and possibly interest and penalties, on that amount.

Section M. Events Affecting Participation

If You Terminate Your Employment

Your eligibility to make Pre-Tax contributions to the Health Care Flexible Spending Account (HFSA) and/or the Dependent Care Flexible Spending Account (DFSA) ends if your employment with a Participating Company ends for any reason.

However, your participation may not end at that time. For more information, see "What Happens When Participation Ends."

If You Become Disabled

Your participation in the HFSA and DFSA may be affected if you become disabled. The duration of your disability and the disability benefit plan under which you are receiving benefits determines the effect it will have on your participation.

Alcatel-Lucent Sickness and Accident Disability Benefit Plan

If you become totally disabled as determined under the Alcatel-Lucent Sickness and Accident Disability Benefit Plan, your participation in the HFSA and the DFSA may continue for the remainder of that Plan Year, provided your disability continues. Different rules apply after you have been totally disabled for one year.

Alcatel-Lucent Short Term Disability Plan ("STD Plan")

If you become disabled and receive benefits under the STD Plan, your participation in the HFSA and/or the DFSA may continue for as long as you continue to receive disability benefits the STD Plan.

Alcatel-Lucent Long Term Disability Plan ("LTD Plan")

If you receive benefits under the LTD Plan your eligibility to make Pre-Tax contributions to HFSA and/or the DFSA will cease and your eligibility to participate will be governed by the rules contained in Section H "When Participation Ends."

If You Take an Approved Leave of Absence

If you're participating in the HFSA and/or the DFSA during an approved leave of absence (other than a Family and Medical Leave Act (FMLA) leave) that begins and ends during the same Plan Year, your contributions will stop during your leave. When you return to work, your contributions will automatically resume. You cannot make up the missed contributions.

If you're on an approved leave of absence (other than an FMLA leave) during the next Annual Open Enrollment, you cannot enroll at that time. However, if you return to active employment during the next Plan Year, you can enroll within 31 days of your return to work. Your enrollment will be effective no later than the first day of the second month after the enrollment.

Section N. Terms To Know

There are several words and phrases that have specific meanings under one or both of the Flexible Spending Account Plans. This section explains those terms so you can better understand your benefits. These terms are printed in initial capital letters when they appear to let you know they are defined here.

Alcatel-Lucent Benefits Center: the resource to call to enroll, to make changes to your coverage or to ask questions about your Flexible Spending Account Plan(s). Call 1-888-232-4111 (domestic) or 1-212-444-0994 (outside of the United States, Puerto Rico or Canada). If you are hearing or speech impaired, please use a Relay Service when calling a representative. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET). You can also obtain information by visiting the Your Benefits Resources™ Web site at http://resources.hewitt.com/alcatel-lucent.

Annual Open Enrollment: the period of time each year designated by the Company during which you can generally make changes to your benefits. Elections made during the Annual Open Enrollment period are effective as of the first day of the subsequent calendar year. If you want to continue participating in the HFSA and/or the DFSA for any year after the year of your initial enrollment, you *must re-enroll each calendar year* during Annual Open Enrollment. Your elections do *not* automatically continue from one year to the next.

Children: your biological children, stepchildren, legally adopted children, children lawfully placed with you for adoption, and foster children placed with you by an authorized placement agency or by judgment, decree, or other order of any court or competent jurisdiction.

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

Company: Alcatel-Lucent USA Inc.

Dependent Care Center: A facility which provides adult or child care for more than six individuals (other than individuals who reside at the facility) and receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether the facility is operated for a profit).

DFSA: Dependent Care Flexible Spending Account. Money in this account may be used to pay for eligible dependent care expenses that allow you to work, or if you are married, that allow both you and your Lawful Spouse to work, or your Lawful Spouse to attend school full time.

Eligible Employee: a regular, active full-time or part-time management or represented employee who works for Alcatel-Lucent or a Participating Company.

*Please note***:** Individuals who are not paid from the U.S. payroll of the Company or a Participating Company, who are employed by an independent company (such as an employment agency) or whose services are rendered pursuant to an agreement excluding participation in benefit plans are not eligible to participate in the Flexible Spending Account Plans.

Eligible Healthcare Dependents:

- Your Children through the end of the month in which they attain age 26, unless they are eligible to enroll in another employer-sponsored group health plan which is not a parent's employer-sponsored group health plan;

- Your older Children who are certified (prior to the end of the month in which they attain age 26) by a medical claims administrator of the Alcatel-Lucent Medical Expense Plan for Management Employees or the Alcatel-Lucent Medical Expense Plan for Occupational Employees, as meeting all of the following requirements:

  — Incapable of self-support;

  — Physically or mentally handicapped; and

  — Fully dependent on you for support; or

- Anyone else you claim as a dependent on your federal income tax return.

Grace Period: If you are a participant in the HFSA as of the last day of the Plan Year (December 31), you may continue to incur expenses through March 15th immediately following the end of the Plan Year to access funds remaining in the previous Plan Year.

HFSA: Health Care Flexible Spending Account. Money in this account may be used to pay for eligible healthcare expenses for yourself, your Lawful Spouse, and Eligible Healthcare Dependents.

Highly Compensated Employee: For purposes of the DFSA, you are considered by the Plan to be highly compensated if: (a) you are a 5% owner of the Company during the Plan Year or the preceding Plan Year; or (b) your total annual pay exceeds a certain annual threshold ($115,000 for 2012) and you are among the top 20% of paid

employees. For purposes of the HFSA, you are considered by the Plan to be highly compensated if: (i) you are one of the 5 highest paid officers of the Company; (ii) you are a shareholder owning more than 10% in value of the stock of the Company; or (iii) you are among the top 25% of paid employees .The income threshold is adjusted annually. Please contact the Alcatel-Lucent Benefits Center to obtain more information if you believe that you may be a Highly Compensated Employee.

IRS: Internal Revenue Service

Lawful Spouse: a person of the opposite sex who is recognized as the lawful husband or wife of an Eligible Employee under the federal Defense of Marriage Act.

Net Credited Service: the continuous number of years, months and days you have worked for a company participating in the Alcatel-Lucent pension plans, beginning with your most recent date of hire and ending with your retirement or other termination of employment. (Your Net Credited Service also includes any service credited under applicable service bridging rules or acquisition agreements.

Participating Company/Companies: a company or companies that participates in the Flexible Spending Account Plans. As of January 1, 2012, these are:

Alcatel-Lucent Investment Management Corporation;

Alcatel-Lucent Managed Solutions LLC

Alcatel-Lucent USA Inc.

Alcatel-Lucent Management Services Inc.

LGS Innovations International Inc.

LGS Innovations LLC

Lucent Technologies GRL LLC

Plan Year: a 12-month period beginning on January 1 and ending on December 31.

Pre-Tax: contributions you make to your HFSA and/or your DFSA on a before-tax basis — before federal, Social Security (FICA) and most state and local taxes are withheld.

Qualifying Individual:

- Your Children, brothers, sisters, stepbrothers, stepsisters, or any of their descendants under age 13 who:

  — Live with you for more than half of the calendar year; and

- Have not been able to provide over one-half of their own support for the calendar year.

■ Your older Children, Lawful Spouse and/or dependent of any age who:

- Is mentally or physically incapable of self-care;
- Lives with you for more than half of the calendar year; and
- Has not been able to provide over one-half of his or her own support for the calendar year.

Your Benefits Resources Web site™: a Web-based resource located online at http://resources.hewitt.com/alcatel-lucent where you can learn more about all of the healthcare benefits and where you can enroll for your benefits. Your Benefits Resources™ is a trademark of Hewitt Management Company LLC.

Section O. Important Contacts

The following is a list of resources for the Plan.

Resource	For What Kinds of Information	Contact Online or by Phone
The Your Benefits Resources (YBR) Web site	View your current coverage During the annual enrollment period, waive your coverage for the next Plan Year Understand how a life event may affect your benefits	http://resources.hewitt.com/alcatel-lucent
Alcatel-Lucent Benefits Center	Enroll or make changes to your coverage during your enrollment period Resolve an issue that you have not been able to solve first on your own Notify Alcatel-Lucent when you have a COBRA qualifying event	1-888-232-4111 (1-212-444-0994 from outside of the United States, Puerto Rico or Canada) Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET). Alcatel-Lucent Benefits Center 2300 Discovery Drive P.O. Box 785029 Orlando, FL 32878-5029
Ceridian	Administers plans on Alcatel-Lucent's behalf, answers questions about eligible and ineligible healthcare and dependent care expenses, provides claim forms, processes claims and decides appeals of denied claims	http://www.ceridian-benefits.com 1-877-799-8820 Ceridian Benefits Services P.O. Box 534451 St. Petersburg, FL 33747
The Alcatel-Lucent BenefitAnswers Plus Web Site	Obtain electronic copies of your enrollment materials during Annual Open Enrollment	www.benefitanswersplus.com
Alcatel-Lucent Payroll Office	Handles contribution problems	http://payroll.web.alcatel-lucent.com/default2.htm 1-877-331-5692

Resource	For What Kinds of Information	Contact Online or by Phone
Domestic Relations Matters Group *(contact for matters relating to a Qualified Medical Child Support Order [QMCSO])*	Handles matters relating to Qualified Child Support Orders (QMCSO)	Alcatel-Lucent QDRO Administration P.O. Box 56887 Jacksonville, FL 32241-6887
Plan Administrator	Contact for all legal actions, except for legal actions regarding a claim for benefits; legal actions regarding a claim for benefits should be directed to Ceridian	Alcatel-Lucent Room 2B-410 600 Mountain Ave. Murray Hill, NJ 07974

Section P. Other Important Information

This section contains administrative information about the Flexible Spending Account Plans and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Please note: The Employee Retirement Income Security Act of 1974, as amended (ERISA) governs only the HFSA.

Your Legal Rights

Your Rights Under ERISA

You are entitled to certain rights and protections under ERISA. These rights are described in this section.

ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. A Form 5500 is only required to be filed for Plan Number 518, which governs the HFSA.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue HFSA coverage for yourself, your Lawful Spouse or your Eligible Healthcare Dependents if there is a loss of coverage under the Plan as a result of a "qualifying event." You, your Lawful Spouse, or your Eligible Healthcare Dependents will have to pay for this coverage. Review this SPD and the Plan document to learn about the rules governing your COBRA continuation coverage rights.

In addition to establishing rights for Plan participants, ERISA imposes certain duties on the people responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries," have a duty to do so prudently and in the interest of all participants and beneficiaries.

No one, including the Company or a Participating Company, may fire you or otherwise discriminate against you in any way to keep you from obtaining a welfare benefit or exercising your ERISA rights.

If your claim for a welfare benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, you may also file suit in federal court if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have questions about the Plan, you should contact the Plan Administrator or the Alcatel-Lucent Benefits Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), United States Department of Labor, listed in your telephone directory, or write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration

United States Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272 or by logging on to the Internet at www.dol.gov/ebsa.

Qualified Medical Child Support Order Benefit Payments

Benefit payments under your HFSA will be made according to the terms of a Qualified Medical Child Support Order (QMCSO). If the Plan Administrator determines that a medical child support order qualifies, benefit payments from your HFSA may be made for eligible healthcare expenses incurred by the Eligible Healthcare Dependent named in the order.

Benefits Cannot Be Assigned

You cannot assign or transfer any amount in your HFSA or your DFSA to anyone, nor can your creditors claim amounts in these accounts.

HFSA and DFSA Plan Funding and Payment of Benefits

The source of funds for the HFSA and the DFSA is your elected payroll deductions. The general operating assets of Alcatel-Lucent pay the cost of administering the Plan. Any amounts left in the Flexible Spending Accounts after all claims are paid out (through April 15 of the next year) are considered forfeited balances.

Plan Documents

This SPD was designed to describe the Plan in easy-to-understand terms. However, it is the Plan documents, and any applicable collective bargaining agreements, that determine your rights and the rights of your Lawful Spouse, and Eligible Healthcare Dependents under the Plan. In all instances, even if the SPD and the Plan are in conflict, the terms of the Plan document will govern.

Plan May Be Amended or Terminated

The Company expects to continue the HFSA and the DFSA indefinitely, but reserves the right to amend or terminate the Plan at any time by the resolution of its Board of Directors or a properly authorized designee, subject to the terms of applicable collective bargaining agreements. In addition, the Company does not guarantee the continuation of any healthcare or dependent care reimbursement benefits during employment or at or during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administration

The Plan Administrator has the full discretionary authority and power to control and manage all aspects of the Plans, to determine eligibility for Plan benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Plan as they may deem appropriate in accordance with the terms of the Plan, applicable collective bargaining agreements and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Plan, including discretionary authority to interpret and construe the terms of the Plan, to direct disbursements, and to determine eligibility for Plan benefits.

The Plan Administrator has delegated to Ceridian the discretionary authority and power to administer the Plan, including claims for benefits. The Plan Administrator has delegated to the Employee Benefits Committee the full discretionary authority to review and determine appeals of denied claims under the Plan.

Section Q. Administrative Information

Plan Names	The official Plan Names of the Flexible Spending Account Plans are the: ■ Alcatel-Lucent Health Care Reimbursement Account Plan ("HFSA") ■ Alcatel-Lucent Dependent Care Reimbursement Account Plan ("DFSA")
Plan Sponsor	Alcatel-Lucent USA Inc.
Type of Administration	The HFSA Plan and the DFSA Plan are administered on behalf of Alcatel-Lucent by Ceridian.
Plan Administrator	Alcatel-Lucent Room 2B-410 600 Mountain Avenue Murray Hill, New Jersey 07974 Attn.: Flexible Spending Account Plans Administrator 1-908-582-7140
Agent for Service of Legal Process	Legal process regarding a claim should be sent to Ceridian. All other legal actions should be sent to the Plan Administrator.
Plan Records and Plan Year	The HFSA and the DFSA and all their records are maintained on a calendar-year basis, beginning on January 1 and ending on December 31 of each year.
Type of Plans	The HFSA and DFSA are considered welfare benefit plans under ERISA.
Plan Number	The Plan Numbers are: HFSA ..... 518 DFSA ..... N/A

Employer Identification Number	22-3408857