Lucent Supplemental Healthcare Benefits Plan for Formerly Represented Retirees

Plan Document and
Summary Plan Description

As Amended and Restated
Effective December 15, 2012

Introduction

This Lucent Supplemental Healthcare Benefits Plan for Formerly Represented Retirees (frequently referred to hereinafter as the "Plan") provides supplemental medical and dental benefits for claims incurred on or after January 1, 2006 (the "Effective Date") for formerly represented retirees and their eligible dependents who are Participants in the Alcatel-Lucent Medical Expense Plan for Retired Employees, the Alcatel-Lucent Dental Expense Plan for Retired Employees or their successor plans (hereafter referred to collectively as the "Retiree Health Plans"). This Plan is designed to cover a portion of the cost of co-payments, co-insurance or premiums that are, or may be, required from those Participants who qualify for benefits under the Retiree Health Plans pursuant to the collective bargaining agreement effective November 1, 2004, designated the Memorandum of Understanding ("MOU"), between Lucent Technologies Inc., now known as Alcatel-Lucent USA Inc. ("Alcatel-Lucent" or "Employer") and the Communications Workers of America ("CWA") and the International Brotherhood of Electrical Workers ("IBEW") and any successor agreement(s) entered into by the bargaining parties that expressly requires the Employer to make contributions to this Plan for retiree healthcare benefits. The Plan provides payment directly to the Retiree Health Plans or, where medical or dental benefits are advanced by the Employer, reimbursement to the Employer for a portion of the Participants' medical and/or dental expenses. The Plan does not provide payment directly to Formerly Represented Retirees or their medical service providers.

This document contains definitions and general administrative procedures that govern the Plan. The Plan is intended to qualify as a "welfare benefit plan" within the meaning of Section 419(e) of the Internal Revenue Code of 1986, as amended, and to meet the requirements of any other applicable provisions of law including the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The MOU requires certain periodic contributions to be made for, or by, Participants in the Retiree Health Plans to receive coverage under those plans but also provides that certain Employer contributions be made to a trust fund for the purpose of funding the benefits provided for in this Plan. Pursuant to the MOU and the Trust Agreement for the Lucent Supplemental Healthcare Benefits Trust for Formerly Represented Retirees (the "Trust"), the Trustees shall determine the payments to the Retiree Health Plan, or the reimbursements to the Employer for retiree health benefits paid by the Employer, that shall be provided by this Plan. The Plan cannot provide more healthcare benefits than the Accumulated Contributions (defined below) allow. If the Accumulated Contributions are insufficient, benefits will have to be modified or the Plan will be terminated by the Trustees, in which case the Participants will have to bear the full cost of co-payments, co-insurance, premiums, contributions or medical expenses not paid by the Employer, the Retiree Health Plans, or the Plan.

The Board of Trustees intends the terms of this Plan Document and Summary Plan Description ("SPD") to be the official text governing the operation of the Plan. For additional information about the Retiree Health Plans, refer to the SPDs and plan documents of the Retiree Health Plans. For further information on the terms of the CBA, MOU or the Accumulated Contributions in this Plan, you should contact your union representative.

Definitions

The following terms will have the meanings set forth below, unless a contrary meaning is clearly intended by the context in which they are written.

"Accumulated Contributions" means the amount of Employer contributions paid to, or transferred to, the Lucent Supplemental Healthcare Benefits Trust for Formerly Represented Retirees, increased (or decreased) by investment earnings (for losses) and reduced by healthcare benefit payments or administrative costs paid by the Trust.

"Board of Trustees" or **"Trustees"** means the Trustees of the Lucent Supplemental Healthcare Benefits Trust for Formerly Represented Retirees.

"Code" means the Internal Revenue Code of 1986, as amended from time to time, and regulations issued thereunder.

"Collective Bargaining Agreement," "CBA," "Memorandum of Understanding" or **"MOU"** means the labor agreement(s) between the Employer, the CWA and the IBEW, known as the 2004 CWA/IBEW/Lucent National Memorandum of Understanding, as well as any successor or future agreements that expressly require the Employer to make contributions to this Plan for retiree healthcare benefits.

"CWA" means the Communications Workers of America, AFL-CIO.

"Effective Date" means January 1, 2006.

"Employer" or **"Alcatel-Lucent"** means Alcatel-Lucent USA Inc.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Formerly Represented Retiree" means a former employee of the Employer formerly represented by the CWA or the IBEW who qualifies for coverage under the Retiree Health Plans.

"IBEW" means the International Brotherhood of Electrical Workers, AFL-CIO.

"Participant" means a Formerly Represented Retiree who is eligible for benefits in the Retiree Health Plans, or such retiree's eligible dependents who qualify for coverage under the Retiree Health Plans.

"Plan" means this Lucent Supplemental Healthcare Benefits Plan for Formerly Represented Retirees.

"Plan Administrator" means the Board of Trustees or any agent(s) to whom it has designated authority to act in such capacity.

"Retiree Health Plans" means the medical and dental benefits available to Formerly Represented Retirees and their eligible dependents under the Alcatel-Lucent Medical Expense Plan for Retired Employees, the Alcatel-Lucent Dental Expense Plan for Retired Employees, or their successor plans.

"Trust" means the Lucent Supplemental Healthcare Benefits Trust for Formerly Represented Retirees.

Participation and Eligibility

Participation / Eligibility

You are a Participant and automatically eligible for coverage under this Plan if you are a Formerly Represented Retiree who is eligible and enrolled for benefits in the Retiree Health Plans. You became a Participant on the Effective Date or, if later, at the time you first enrolled in the Retiree Health Plans.

Termination of Participation

Your participation in this Plan will terminate if your coverage terminates under the Retiree Healthcare Plans or the Plan terminates.

Loss of Eligibility for Coverage

The following events could cause you to lose your coverage under the Plan:

(a) You lose eligibility for benefits under the Retiree Health Plans.

(b) The Retiree Health Plans are terminated.

(c) The Trustees, in the exercise of their discretion, determine that the amount of the Accumulated Contributions in this Plan is not adequate to provide healthcare benefits under the Plan, and the Plan is terminated by the Board of Trustees.

(d) This Plan is terminated by the Trustees in accordance with the MOU.

(e) The MOU is amended to terminate this Plan.

Qualified Medical Child Support Orders

To the extent that healthcare benefit coverage is provided by the Retiree Health Plans in accordance with the provisions of any court judgment, decree or order that:

(a) requires group health coverage for a Participant's child, and

(b) meets the requirements of Section 609(a) of ERISA as a qualified medical child support order,

healthcare benefits will be provided by the Plan for as long as the child satisfies the definition of dependent for the applicable Retiree Health Plan benefits and the qualified medical child support order is effective.

Funding and Benefits

Funding

The sole responsibility and liability of the Employer is to make the contributions required under the MOU on a timely basis. The Plan is funded by Employer contributions to the Trust made pursuant to the MOU.

Description of Benefits

The Plan provides for payment to the Retiree Health Plans or reimbursements to the Employer for health benefits paid by the Employer for actual healthcare benefits for Participants under those plans. The amount of such payment will be determined by the Trustees annually. Unless otherwise determined by the Trustees, the benefits provided under this Plan each calendar year shall be as follows: $25,000,000 of Trust assets, less a reasonable allowance for administrative expenses necessary, in the sole discretion of the Trustees, for the administration of the Plan and Trust. For the calendar year 2013, the benefits provided under this Plan shall be $47,301,125.

Benefit payment(s) shall be utilized for the purpose of enabling a reduction in premiums payable by Formerly Represented Retirees or to avoid or reduce an increase in premiums. Benefits are to be applied so that each such Formerly Represented Retiree who pays contributions or premiums for coverage or other healthcare payments under the Alcatel-Lucent Medical Expense Plan for Retired Employees will benefit in a substantially equal amount.

A detailed description of the healthcare benefits provided through the Retiree Health Plans is contained in the Plan documents and SPDs of those plans.

Limits on Benefits

Healthcare benefits will not be paid beyond the amount of Accumulated Contributions determined by the Trustees to be available for this purpose.

General Provisions

Authority

The Board of Trustees has the exclusive authority to control and manage the administration of this Plan and to interpret the Plan, subject to the Agreement and Declaration of Trust establishing the Lucent Supplemental Healthcare Benefits Trust for Formerly Represented Retirees, the Collective Bargaining Agreement(s), and ERISA.

Benefits under this Plan are automatic. Participants need not submit claims on their own behalf. Claims for reimbursement of healthcare benefits under the Plan are submitted to it by the plan administrators of the Retiree Health Plans on behalf of eligible Participants. Participants in the Retiree Health Plans need not submit a claim for benefits to this Plan unless they believe that they are eligible for healthcare benefits from the Plan that have not been applied and would effectively reduce the amount of premiums being sought from them. To file a claim, contact the Plan Administrator or your IBEW or CWA representative. Before submitting a claim for healthcare benefits under the Plan, you may wish to consult with your IBEW or CWA representative.

Appeals Procedure When a Claim for Benefits is Denied

Claims must be filed no later than 12 months following the date on which the benefit, in the normal course, would have been paid. To file a claim, contact the Plan Administrator or your IBEW or CWA representative. In the event that you make a claim for healthcare benefits under this Plan and that claim is denied in whole or in part, you will be notified by the claims administrator within 30 days of receipt of your claim. This period may be extended by the claims administrator by 15 days if the claims administrator determines that an extension is due to matters beyond the control of the Plan and if he/she notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which he/she expects to render a decision. The written denial will state:

(a) the specific reasons;

(b) a reference to the specific Plan provision(s) on which the denial is based;

(c) a description of any additional material or information necessary to correct the claim and the reason why such material or information is needed; and

(d) an explanation of the Plan's claim review procedures.

If healthcare benefits are denied in whole or in part; if you disagree with a Plan policy, determination, or action in whole or in part; if you have a question concerning your claim; or if you have been adversely affected by an action or decision of the Board of Trustees, you can file a written appeal to the Board of Trustees in care of Alcatel-Lucent Investment Management Corporation, 600 Mountain Avenue, Murray Hill, NJ, 07974.

Your written appeal should state the reason for your appeal and must be filed within 180 days of the date you receive notice of the denied claim. The Trustees or a designated committee of the Trustees will review your appeal at their next regularly scheduled meeting immediately following the receipt of your appeal, or, if it is earlier, within 60 days of the filing of the appeal. If special circumstances require an extension of the time for review by the Trustees, you will be notified in writing. The review of your claim denial will not defer to the initial determination made by the claims administrator and the individual or individuals who review your appeal will be independent from the individual or individuals who reviewed your claim.

You will receive written notice of the decision of the Trustees promptly following the review. The notice will explain the reason for the decision, will include references to Plan provisions on which the

decision is based, and may indicate if additional information might help your claim. If your appeal is denied, you have the right to bring a civil action in federal court under section 502(a) of ERISA. This option is only available to you after you have exhausted all of the administrative remedies available to you through this claims and appeals process.

In connection with an appeal or renewed appeal, you may review documents after making arrangements with the Plan Administrator or you may request that documents be provided to you. The Plan may charge $0.25 per page to provide documents to you, and this amount must be paid in advance.

Termination of the Plan

The Board of Trustees has reserved the authority to terminate the Plan. Should the Plan terminate, the Board of Trustees shall, in its exclusive discretion, after the payment or provision for the payment of healthcare benefits payable prior to the date of termination, use any remaining Accumulated Contributions until they are exhausted to provide health and welfare benefits for Participants at the time of termination or to transfer remaining Accumulated Contributions to an appropriate successor plan.

Controlling Law

This Plan and all rights thereunder will be governed by and construed in accordance with ERISA.

Liability of Plan

The use of services of any healthcare provider is the voluntary act of the Participant even in cases where the Retiree Health Plans limit coverage to certain providers. The healthcare providers rendering service in connection with this Plan are independent contractors, and, as such, the Plan makes no representation regarding the quality of service or treatment of any provider and is not responsible for the negligence of any provider rendering services or supplies in connection with this Plan.

General Information

Plan Name

The Lucent Supplemental Healthcare Benefits Plan for Formerly Represented Retirees

Type of Plan

Employee Welfare Benefit Plan

Trust Employer Identification Number

20-6673883

Type of Administration

The Plan is administered by the Board of Trustees of the Lucent Supplemental Healthcare Benefits Trust for Formerly Represented Retirees.

Plan Number

501

Sponsor's Name and Address

The Board of Trustees of the Lucent Supplemental Healthcare Benefits Trust for Formerly Represented Retirees, c/o Alcatel-Lucent Investment Management Corporation,
600 Mountain Avenue, Murray Hill, N.J. 07974.

Plan Administrator

The Board of Trustees of the Lucent Supplemental Healthcare Benefits Trust for Formerly Represented Retirees, c/o Alcatel-Lucent Investment Management Corporation,
600 Mountain Avenue, Murray Hill, N.J. 07974.

Service of Legal Process

Service of legal process may be made on any one of the Trustees at his or her address listed below.

Plan Trustees

Jeanmarie Grisi
Alcatel-Lucent
600 Mountain Avenue
Murray Hill, NJ 07974

Kathy-Ann Reissman
Alcatel-Lucent
24 Federal Street
Suite 600
Boston, MA 02110

Mary Jo Reilly
Communications Workers of America
80 Cottontail Lane
Suite 320
Somerset, NJ 08873

Randal Middleton
International Brotherhood of Electrical Workers
900 7th Street, NW
Room 344
Washington, DC 20001

Collective Bargaining Agreement

The Plan is maintained pursuant to a Collective Bargaining Agreement as described above. Copies of the Collective Bargaining Agreement may be obtained by Participants upon request to your IBEW or CWA representative or to the Plan Administrator.

Your ERISA Rights Under the Plan

As a participant in The Lucent Supplemental Healthcare Benefits Trust for Formerly Represented Retirees, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at the offices of your local unions, all documents governing the Plan, including collective bargaining agreements, and 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.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including any 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 a summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain limits.

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 materials, 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, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. 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 any questions about your Plan, you should contact the Plan Administrator. 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, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. 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.