Form 5500	Annual Return/Report of Employee Ben	efit Plan		OMB Nos. 12	10-0110 10-0089
Department of the Treasury Internal Revenue Service	This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).		2013		10-0089
Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	 Complete all entries in accordance with the instructions to the Form 5500. 	· / _	This I	Form is Open to Pu Inspection	blic
Part I Annual Report Iden	tification Information	I		inspection	
For calendar plan year 2013 or fiscal		ending 12/31/2013	3		
A This return/report is for:	a multiemployer plan; a multiple-employer	0	<u> </u>		
	a single-employer plan; a DFE (specify)	•			
B This return/report is:	the first return/report;				
	an amended return/report; a short plan year re	turn/report (less than	12 mc	onths).	
C If the plan is a collectively-bargaine	ed plan, check here			▶ X	
D Check box if filing under:	Form 5558; automatic extension	1;	the	e DFVC program;	
	special extension (enter description)				
Part II Basic Plan Inform	nation—enter all requested information				
1a Name of plan	Tation—enter an requested mormation		16	Thus a disit alon	
ALCATEL-LUCENT RETIREE WELF	ARE RENEFITS DI ANI			Three-digit plan number (PN) ▶	504
			1c	Effective date of pla	an
0			01-	10/01/1996	
2a Plan sponsor's name and address ALCATEL-LUCENT USA INC.	s; include room or suite number (employer, if for a single-employer p	lan)	2b	Employer Identification Number (EIN) 22-3408857	tion
			2c	Sponsor's telephon number 908-582-7140	
600 MOUNTAIN AVENUE, RM 2B-41 MURRAY HILL, NJ 07974	0		2d	Business code (see instructions) 334200	

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2014	INGRID ORAV	
	Signature of plan administrator	Date	Enter name of individu	al signing as plan administrator
SIGN HERE				
	Signature of employer/plan sponsor	Date	Enter name of individu	al signing as employer or plan sponsor
SIGN HERE				
TIERE	Signature of DFE	Date	Enter name of individu	al signing as DFE
Preparer's name (including firm name, if applicable) and address; include room or suite number. (optional) (o				Preparer's telephone number (optional)
For Pan	erwork Reduction Act Notice and OMB Control Numbers see	the instructions for	Form 5500	Form 5500 (2013)

	Form 5500 (2013) Page 2		
3a	Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address	3b Ad	ministrator's EIN
			ninistrator's telephone mber
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	4b Ell	N
а	Sponsor's name	4C PN	l
5	Total number of participants at the beginning of the plan year	5	99715
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
а	Active participants	. 6a	95929
b	Retired or separated participants receiving benefits	. 6b	0
C	Other retired or separated participants entitled to future benefits	. 6c	0
d	Subtotal. Add lines 6a, 6b, and 6c	. 6d	95929
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	. 6e	
f	Total. Add lines 6d and 6e.	. 6f	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	. 6g	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	. 6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	. 7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D

9a	Ja Plan funding arrangement (check all that apply)		arrangement (check all that apply)	9b	Plan ber	nefi	it arrangement (check all that apply)	
	(1)	X	Insurance		(1) X Insurance			
	(2)		Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts	
	(3)	X	Trust		(3)	X	Trust	
	(4)		General assets of the sponsor		(4)		General assets of the sponsor	
10	Check	all ap	plicable boxes in 10a and 10b to indicate which schedules are at	tache	ed, and, w	vhe	re indicated, enter the number attached. (See instructions)	
a Pension Schedules b G			b General Schedules					
	(1)		R (Retirement Plan Information)		(1)	X	H (Financial Information)	
	(2)	Π	MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	Γ	I (Financial Information – Small Plan)	
			Purchase Plan Actuarial Information) - signed by the plan		(3)	Х	A (Insurance Information)	
			actuary		(4)	X	C (Service Provider Information)	
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)	Х	D (DFE/Participating Plan Information)	
			Information) - signed by the plan actuary		(6)		G (Financial Transaction Schedules)	

SCHEDULE	A	Insuranc	e Information			
(Form 5500					0	MB No. 1210-0110
Department of the Treas Internal Revenue Serv	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2013
Department of Labo Employee Benefits Security Ad		File as an at	ttachment to Form 5500.			
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	re required to provide the RISA section 103(a)(2).	information	This Fo	orm is Open to Public Inspection
For calendar plan year 20	For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12					
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN B Three-digit plan number (PN)					er (PN)	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500	D	Employer Ide 22-3408857	entification Numbe	r (EIN)
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
UHC OF COLORADO HI	OM					
	(c) NAIC	(d) Contract or	(e) Approximate numb		Policy or	contract year
(b) EIN	code	identification number	persons covered at er policy or contract ye		(f) From	(g) To
84-1011378	95434	092027	128	01/0)1/2013	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. List i	n line 3 the age	ents, brokers, and	other persons in
(a) Total	amount of comr	nissions paid		(b) Total am	ount of fees paid	
		0				0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all per	sons).		
	(a) Name a	nd address of the agent, broker, o	or other person to whom c	ommissions or	fees were paid	
						_
(b) Amount of sales a	nd base	Fees	s and other commissions p	baid		
commissions pa	id	(c) Amount	(d)	Purpose		(e) Organization code
		I				
	(a) Name a	nd address of the agent, broker, o	or other person to whom c	ommissions or	fees were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Sched			dule A (Form 5500) 2013
			v. 130118

(b) Amount of sales and base commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base – commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pu	1 1 2				, , ,
		the entire group of such individual contracts v					cover individual employees,
8	Bene	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	c	Vision	(d Life insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term disability	у д 🗌	Supplemental unemp	oloyment I	h Prescription drug
	iΓ	Stop loss (large deductible)	j X HMO contract		PPO contract		I Indemnity contract
	m	Other (specify)	,				
	Г						
9	Expe	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	I	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies	F	9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These				9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide b	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2) .)	9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	748751
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	×	X No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuranc	ce Information			
(Form 5500)					OM	B No. 1210-0110
Department of the Treas Internal Revenue Serv	sury		to be filed under section 104 or come Security Act of 1974 (ERI		2013	
Department of Labo Employee Benefits Security Ad						
 Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). 			ation	This Form is Open to Public Inspection		
For calendar plan year 20	13 or fiscal plan	year beginning 01/01/2013	and	ending 12	2/31/2013	
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN B Three-digit plan number (PN) ↓ 504					504	
C Plan sponsor's name a ALCATEL-LUCENT USA Part I Informatio	INC.	e 2a of Form 5500 ing Insurance Contract C	22-3	408857	cation Number	
		Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
UNIVERA HEALTHCARE						
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	(f)	Policy or co From	ontract year (g) To
15-0329043	55107	*SEE BELOW	57	01/01/2	013	12/31/2013
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	I commissions paid. List in line	3 the agents	, brokers, and o	ther persons in
	amount of comn	nissions paid	(b)	Total amount	t of fees paid	
		0				0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all persons			
	(a) Name a	nd address of the agent, broker, o	or other person to whom comm	ssions or fee	s were paid	
(b) Amount of sales ar			s and other commissions paid			4
commissions pa	id	(c) Amount	(d) Purp	ose		(e) Organization code
	(a) Name a	nd address of the agent, broker, o	or other person to whom comm	ssions or fee	s were paid	

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
For Paperwork Reduction Act Notice	e and OMB Control Numbers,	see the instructions for Form 5500. Sched	lule A (Form 5500) 2013	

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid		(d) Purpose	(e) Organization code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
			<u> </u>		

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Page	4
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Pa	art II	Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same gr						
		information may be combined for reporting put the entire group of such individual contracts					s cover individual emplo	yees,
8	Bene	efit and contract type (check all applicable boxes)	,, , ,			r		
	a	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance	
	еľ	Temporary disability (accident and sickness)	f Long-term disabilit			nlovment	h Prescription drug	
				· • _		ployment		
		Stop loss (large deductible)	j X HMO contract	ĸ	PPO contract		I Indemnity contract	[
	m	Other (specify)						
_	_	· · · · · ·						
9	•	rience-rated contracts:	1	0-(1)			-	
		Premiums: (1) Amount received		9a(1)			4	
		(2) Increase (decrease) in amount due but unpaid(3) Increase (decrease) in unearned premium res					4	
		(4) Earned ((1) + (2) - (3))				. 9a(4)		
		Benefit charges (1) Claims paid	r			Ja(+)		
		(2) Increase (decrease) in claim reserves					4	
		(3) Incurred claims (add (1) and (2))						
		(4) Claims charged						
		Remainder of premium: (1) Retention charges (o						
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)]	
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were 🗌 paid in	cash, or	credited.)			
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement			
		(2) Claim reserves				. 9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	ot include amount entered	l in line 9c(2) .	.)	9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c				10a		236268
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b		

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE		Insurance Information					IB No. 1210-0110
(Form 5500	-	This schedule is required	to be filed under section	o 104 of th	0		2013
Department of the Treas Internal Revenue Serv		Employee Retirement Inc					2013
Department of Labo Employee Benefits Security Ad		File as an a	ttachment to Form 550	0.			
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	re required to provide the RISA section 103(a)(2).	e informat	ion		m is Open to Public Inspection
For calendar plan year 20	13 or fiscal plan	year beginning 01/01/2013		and en	ding 12	/31/2013	1
A Name of plan ALCATEL-LUCENT RETI	REE WELFARE	BENEFITS PLAN	-		e-digit number (Pl	N) 🕨	504
C Plan sponsor's name a	s shown on line	2a of Form 5500			vor Idoptific	ation Number	
ALCATEL-LUCENT USA				22-340	•		
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	ırrier						
HIP HEALTH PLAN OF N	NY	-					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nur persons covered at policy or contract	end of	(f)	Policy or co From	ontract year (g) To
13-1828429	55247	10093PD 000	6	1	01/01/20)13	12/31/2013
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. Lis	st in line 3	the agents,	brokers, and o	ther persons in
	amount of comr	nissions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all p	ersons).			
	(a) Name a	nd address of the agent, broker,	or other person to whom	n commiss	ions or fees	were paid	
(b) Amount of sales a			s and other commissions				
commissions pa	id	(c) Amount		d) Purpose	9		(e) Organization code
	(a) Name o	nd address of the agent, broker,	or other person to whom		ions or feor	were paid	

F				
(c) Amount	(d) Purpose	(e) Organization code		
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Sched				
	(c) Amount			

v. 130118

(b) Amount of sales and base	Fees and other commissions paid					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid				

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pa	art II	Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same gr						_
		information may be combined for reporting put the entire group of such individual contracts					s cover individual employee	5,
8	Bene	efit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance	
	еГ	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unem	plovment	h Prescription drug	
	i	Stop loss (large deductible)	j X HMO contract		PPO contract		I Indemnity contract	
	• L			ĸ	FFO contract			
	m	Other (specify)						
9	Expe	rience-rated contracts:						
-	•	Premiums: (1) Amount received		9a(1)			1	
		(2) Increase (decrease) in amount due but unpaid	1				1	
		(3) Increase (decrease) in unearned premium res					1	
		(4) Earned ((1) + (2) - (3))	······			. 9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (or	n an accrual basis)	<u>.</u>				
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)			1	
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)			_	
		(G) Other retention charges						
		(H) Total retention	_			. 9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	. 9d(1)		
		(2) Claim reserves				. 9d(2)		
		(3) Other reserves				. 9d(3)		
		Dividends or retroactive rate refunds due. (Do not	ot include amount entered	l in line 9c(2) .)	. 9e		
10		nexperience-rated contracts:						
		Total premiums or subscription charges paid to c				. 10a	447	295
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				. 10b		

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuranc	e Information	n			
(Form 5500				-		0	MB No. 1210-0110
Department of the Trea Internal Revenue Serv	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2013	
Department of Labo Employee Benefits Security Ac		File as an at	tachment to Form 55	00.			
Pension Benefit Guaranty Co	orporation	 Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). 			This Fo	rm is Open to Public Inspection	
For calendar plan year 20	13 or fiscal plar	n year beginning 01/01/2013		and end	ding 12/3	31/2013	-
A Name of plan ALCATEL-LUCENT RETI	REE WELFARE	BENEFITS PLAN		B Three plan	e-digit number (PN	I) ►	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		D Employ 22-340	•	ation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
	(-) NAIO	(II) Original an	(e) Approximate nu	umber of		Policy or o	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac	t end of	(f)	From	(g) To
14-1640868	95521	214424	6	60	01/01/201	13	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	l commissions paid. Li	ist in line 3 t	the agents, t	prokers, and	other persons in
(a) Total	amount of comr	missions paid		(b) To	tal amount c	of fees paid	
		0					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker, c	or other person to whor	m commissi	ons or fees	were paid	
(b) Amount of sales a			and other commission				
(b) Amount of sales an commissions pa		Fees (c) Amount		ns paid (d) Purpose)		(e) Organization code
					3		(e) Organization code

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Sched		
	v. 130118		

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(2) Na	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr					
		information may be combined for reporting put the entire group of such individual contracts	rposes if such contracts a	are experienc	e-rated as a unit. Whe	ere contracts	s cover individual employees,
8	René	efit and contract type (check all applicable boxes)				Teport.	
Ŭ	a [Health (other than dental or vision)	b Dental	c∏	Vision		d Life insurance
				님			
	е	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unemp	oloyment	h Prescription drug
	i [Stop loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
		_					
9	Expe	erience-rated contracts:	_				
	a F	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	I	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)		1	
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o					
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			_
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			4
		(E) Taxes		9c(1)(E)			4
		(F) Charges for risks or other contingencies		9c(1)(F)			4
		(G) Other retention charges		9c(1)(G)		a (1)(1)	
		(H) Total retention	_	_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These				9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide b	penefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2).)	9e	
10		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to c				10a	388841
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	×	X No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuranc	e Informatio	n				
(Form 5500)				OM	B No. 1210-0110		
Department of the Treas Internal Revenue Serv	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2013		
Department of Labor Employee Benefits Security Ad		File as an at	tachment to Form 55	600.				
Pension Benefit Guaranty Co	prporation	 Insurance companies ar pursuant to EF 	re required to provide t RISA section 103(a)(2)		ion	This For	m is Open to Public Inspection	
For calendar plan year 20	13 or fiscal pla	n year beginning 01/01/2013		and en	ding 12	/31/2013		
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN				B Three plan	e-digit number (Pl	N) 🕨	504	
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		D Emplo 22-340		ation Number	(EIN)	
		ning Insurance Contract C Individual contracts grouped as a						
1 Coverage Information:								
(a) Name of insurance ca	rrier							
KEYSTONE HEALTH PL	AN CENTRAL							
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	y or contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
23-2399845	95199	509964	30	62	01/01/20	13	12/31/2013	
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	l commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in	
(a) Total a	amount of com			(b) To	tal amount	of fees paid		
		0					0	
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all	persons).				
	(a) Name a	and address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fees	and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code	
	(a) Name a	and address of the agent, broker, c	or other person to who	m commiss	ions or fees	were paid	•	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Sched			dule A (Form 5500) 2013
			v. 1́30118

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Ρ	ade	4

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employ the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. 8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) b Dental c Vision d Life insurance e Temporary disability (accident and sickness) f Long-term disability g Supplemental unemployment h Prescription drug i Stop loss (large deductible) j HMO contract k PPO contract I Indemnity contract m Other (specify) 9 Experience-rated contracts: 9a(1) 9a(2) 9a(3) (2) Increase (decrease) in amount due but unpaid. 9a(3) 9a(4) 9a(4) 9a(4) b Benefit charges (1) Claims paid. 9b(1) 9a(4) 9a(4) 9a(4)	ie
a Health (other than dental or vision) b Dental c Vision d Life insurance e Temporary disability (accident and sickness) f Long-term disability g Supplemental unemployment h Prescription drug i Stop loss (large deductible) j HMO contract k PPO contract I Indemnity contract m Other (specify) Image: Contracts: 9a(1) 9a(2) 9a(2) 9a(3) 9a(4) (4) Earned ((1) + (2) - (3))	
e Temporary disability (accident and sickness) f Long-term disability g Supplemental unemployment h Prescription drug i Stop loss (large deductible) j HMO contract k PPO contract I Indemnity contract m Other (specify) ▶ 9 Experience-rated contracts:	
i Stop loss (large deductible) j MHO contract k PPO contract I Indemnity contract m Other (specify) > I Indemnity contract I Indemnity contract 9 Experience-rated contracts:	
i Stop loss (large deductible) j MHO contract k PPO contract I Indemnity contract m Other (specify) > I Indemnity contract I Indemnity contract 9 Experience-rated contracts:	
m □ Other (specify) 9 Experience-rated contracts: a Premiums: (1) Amount received	
9 Experience-rated contracts: 9a(1) a Premiums: (1) Amount received	
a Premiums: (1) Amount received	
a Premiums: (1) Amount received	
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	
b Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	
(3) Incurred claims (add (1) and (2))	
(4) Claims charged	
C Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	
(B) Administrative service or other fees	
(C) Other specific acquisition costs	
(D) Other expenses	
(E) Taxes	
(F) Charges for risks or other contingencies	
(G) Other retention charges	
(H) Total retention	
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	
(2) Claim reserves	
(3) Other reserves	
Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	
10 Nonexperience-rated contracts:	
a Total premiums or subscription charges paid to carrier	13429
 b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did the	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the a	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuranc	e Information	n			
(Form 5500					ON	/IB No. 1210-0110	
Department of the Treas Internal Revenue Serv	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2013	
Department of Labo Employee Benefits Security Ad		File as an at	ttachment to Form 55	600.			
Pension Benefit Guaranty Co	orporation	 Insurance companies and pursuant to Elements 	re required to provide t RISA section 103(a)(2)		on	This Fo	rm is Open to Public Inspection
For calendar plan year 20	13 or fiscal plan	year beginning 01/01/2013		and end	ding 12	2/31/2013	-
A Name of plan ALCATEL-LUCENT RETII	REE WELFARE	BENEFITS PLAN		B Three plan	e-digit number (P	N)	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		D Employ 22-340		cation Number	(EIN)
on a separat		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
GHC PUGET SOUND							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a	H			contract year
(2) 2	code	identification number	policy or contrac		(f)	From	(g) To
91-0511770	95672	8800		74	01/01/20	013	12/31/2013
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	I commissions paid. L	ist in line 3 t	he agents,	brokers, and c	other persons in
(a) Total a	amount of comr			(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commissi	ons or fees	s were paid	
(b) Amount of sales ar	nd base	Fees	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	•		(e) Organization code
		nd address of the areat burling	or other percents when	m	000 0-6		
	(a) warne a	nd address of the agent, broker, o	or other person to Who	m commissi	UNS OF TEES	s were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Sched			dule A (Form 5500) 2013
			v. 130118

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization
	(c) Amount	(d) Purpose	code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Page	4
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Pa	art II	Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same gr						
		information may be combined for reporting put the entire group of such individual contracts					s cover individual employ	/ees,
8	Bene	efit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance	
	еГ	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unem	plovment	h Prescription drug	
	; F	Stop loss (large deductible)	j X HMO contract		PPO contract		I Indemnity contract	
	• L			ĸ	FFO contract			
	m	Other (specify)						
9	Expe	rience-rated contracts:						
-	•	Premiums: (1) Amount received		9a(1)			1	
		(2) Increase (decrease) in amount due but unpaid					1	
		(3) Increase (decrease) in unearned premium res					1	
		(4) Earned ((1) + (2) - (3))				. 9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				. 9b(3)		
		(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)			_	
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)			1	
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention	_			. 9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	. 9d(1)		
		(2) Claim reserves				. 9d(2)		
		(3) Other reserves				. 9d(3)		
		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	l in line 9c(2) .)	. 9e		
10		nexperience-rated contracts:						
		Total premiums or subscription charges paid to c				. 10a	3	330985
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				. 10b		

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	×	X No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insurand	e Informatio	n			
(Form 5500)					ON	/IB No. 1210-0110
Department of the Treas Internal Revenue Servi	ury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2013		
Department of Labor Employee Benefits Security Adr		File as an at	tachment to Form 55	600.			
Pension Benefit Guaranty Col	rporation	 Insurance companies ar pursuant to El 	re required to provide t RISA section 103(a)(2)		ion	This Fo	rm is Open to Public Inspection
For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and endin			ding 12	/31/2013	-		
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN				B Three plan	e-digit number (Pl	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA I		e 2a of Form 5500		D Emplo 22-340	-	ation Number	(EIN)
on a separate		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance car	rrier						
UHC OF ARIZONA HMO	1	T					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate ne persons covered a policy or contract	at end of	(f)	From	contract year (g) To
94-3267522	95617	060406	1	11	01/01/20)13	12/31/2013
2 Insurance fee and comr descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and c	other persons in
Ŭ	amount of comr	missions paid	(b) Total amount of fees paid				
		0					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales an			s and other commissio				4
commissions pai	d	(c) Amount		(d) Purpose	9		(e) Organization code
		nd address of the agent, broker, o	or other person to who	m commiss	ions or foor	were paid	
	(a) Name a	na address of the agent, bloker, t		001111135		more paid	

(b) Amount of sales and base	F	_	
commissions paid	(c) Amount	(e) Organization code	
For Paperwork Reduction Act Notice	e and OMB Control Numbers, see the instructions for Form 5500. Sched		dule A (Form 5500) 2013
		v. 130118	

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid		
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid		

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
			<u> </u>	

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Page	4
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Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr					
		information may be combined for reporting put the entire group of such individual contracts					s cover individual employees,
8	Bene	afit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	c	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unem	ployment	h Prescription drug
	iΓ	Stop loss (large deductible)	j X HMO contract		PPO contract		I Indemnity contract
	- L m [Other (specify)					
	m						
9	Expe	rience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	I	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges	L	9c(1)(G)			
		(H) Total retention		_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1	, i			9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	l in line 9c(2) .)	9e	
10		nexperience-rated contracts:					
		Total premiums or subscription charges paid to c				10a	69291
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				. 10b	

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE A Insurance Information			ON	IB No. 1210-0110				
(Form 5500 Department of the Treas	-	This schedule is required	to be filed under secti	on 101 of th	0		2013	
Internal Revenue Serv		Employee Retirement Inc					2013	
Department of Labo Employee Benefits Security Ad		File as an a	ttachment to Form 5	500.				
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This For	This Form is Open to Public Inspection				
For calendar plan year 20	13 or fiscal plar	year beginning 01/01/2013		and en	ding 12	2/31/2013	1	
A Name of plan ALCATEL-LUCENT RETII	REE WELFARE	BENEFITS PLAN		B Three plan	e-digit number (P	N) 🕨	504	
		0		Denut		Court Nieurolaum		
•	C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. D Employer Identification Number (EIN) 22-3408857							
		ing Insurance Contract (Individual contracts grouped as a						
1 Coverage Information:								
(a) Name of insurance ca	rrier							
BLUECROSS BLUESHIE	ELD							
		(d) Contract or	(e) Approximate n			Policy or contract year		
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
36-1236610	70670	H73523,B73523	1	89	01/01/20	013	12/31/2013	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	, brokers, and o	ther persons in	
	amount of comr	nissions paid		(b) To	otal amount	of fees paid		
		0					0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
	(a) Name a	nd address of the agent, broker,	or other person to who	om commiss	ions or fees	s were paid		
(b) Amount of sales ar			s and other commissio					
commissions pa	id	(c) Amount		(d) Purpose	9		(e) Organization code	
	(a) Nome -	nd addroop of the agent burlier	or other person to what	moommice	iono orfo	a woro poid		
	(a) Name a	nd address of the agent, broker,	or other person to Who	on commiss	IONS OF TEES	s were paid		

(b) Amount of sales and base	F				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
For Paperwork Reduction Act Notice	e and OMB Control Numbers,	see the instructions for Form 5500.	Schedule A (Form 5500) 2013		

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid			

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
			<u> </u>		

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Ρ	ade	4

Part III	Welfare Benefit Contract Informat If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the s urposes if such contracts	are experience	ce-rated as a unit. Wh	ere contracts	
8 Benef	fit and contract type (check all applicable boxes)					
a	Health (other than dental or vision)	b Dental	С	Vision		d 🗌 Life insurance
е 🗌	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unem	ployment	h Prescription drug
i 🗍	Stop loss (large deductible)	j 🛛 HMO contract	k	PPO contract		I Indemnity contract
m []	Other (specify)			-		
9 Exper	ience-rated contracts:					
-	remiums: (1) Amount received		9a(1)			
	2) Increase (decrease) in amount due but unpai					7
	3) Increase (decrease) in unearned premium res					1
	4) Earned ((1) + (2) - (3))		, , , , , , , , , , , , , , , , ,		9a(4)	
•	Benefit charges (1) Claims paid					
(2	2) Increase (decrease) in claim reserves		9b(2)			
(;	3) Incurred claims (add (1) and (2))				9b(3)	
(4	4) Claims charged				9b(4)	
	Remainder of premium: (1) Retention charges (
	(A) Commissions		9c(1)(A)]
	(B) Administrative service or other fees		9c(1)(B)]
	(C) Other specific acquisition costs		9c(1)(C)]
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies.					
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention				9c(1)(H)	
((2) Dividends or retroactive rate refunds. (These	e amounts were paid in	cash, or	credited.)	9c(2)	
d s	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement		
(2) Claim reserves				9d(2)	
((3) Other reserves				9d(3)	
e [Dividends or retroactive rate refunds due. (Do n	ot include amount entered	l in line 9c(2)	.)	. 9e	
10 Non	experience-rated contracts:					
a	Total premiums or subscription charges paid to o	carrier			. 10a	1878393
	f the carrier, service, or other organization incur retention of the contract or policy, other than rep				. 10b	

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did the	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the a	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	SCHEDULE A Insurance Information				OMB No. 1210-0110		
(Form 5500)						
Department of the Treas Internal Revenue Servi	ce	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2013		
Department of Labor Employee Benefits Security Adr		File as an a	ttachment to Form 55	500.			
Pension Benefit Guaranty Co	rporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		ion	This Form is Open to Public Inspection	
For calendar plan year 207	13 or fiscal pla	an year beginning 01/01/2013		and en	ding 12	/31/2013	
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN					e-digit number (Pl	N) 🕨	504
C Plan sponsor's name a	a ahawa an li	no 20 of Form FEOD		D Emplo	vor Idontific	ation Number (
ALCATEL-LUCENT USA I				22-340	•	allon Number (
		ning Insurance Contract C . Individual contracts grouped as a					
1 Coverage Information:						<u></u>	
(a) Name of insurance ca	rrier						
KAISER FOUNDATION H	IEALTH PLA	N OF SO. CA					
	(c) NAIC	(d) Contract or	(e) Approximate number of			Policy or contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
94-1340523	00000	122636	2	98	01/01/20)13	12/31/2013
2 Insurance fee and com descending order of the		nation. Enter the total fees and tota	al commissions paid. L	ist in line 3.	the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid			(b) Total amount of fees paid				
		0					0
3 Persons receiving com	missions and	fees. (Complete as many entries	as needed to report all	persons).			
	(a) Name	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales and base		Fees and other commissions p		ns paid			
commissions pai	d	(c) Amount	(d) Purpose		e		(e) Organization code
	(a) Name	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose		(e) Organization code
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Sche			Sched	ule A (Form 5500) 2013
				v. 130118

(b) Amount of sales and base commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	i, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base commissions paid		(e) Organization		
	(c) Amount	(d) Purpose	code	
Part I	Investment and Annuity Contract Information			
----------	--	-------------------------------------	-----------------------------	----------------
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Ρ	ade	4

Part	: 111	Welfare Benefit Contract Informat If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the s urposes if such contracts	are experience	ce-rated as a unit. Wh	ere contract	
8 B	enefi	t and contract type (check all applicable boxes))				
а	IП	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
е	$\overline{\Box}$	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unem	ployment	h Prescription drug
i	П	Stop loss (large deductible)	i X HMO contract	_	PPO contract		I Indemnity contract
n		Other (specify)	•	Ŀ	J		
	П						
9 E>	kperie	ence-rated contracts:					
а	Pre	emiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpai	d	9a(2)			7
	(3) Increase (decrease) in unearned premium res	serve	9a(3)			7
	(4	•) Earned ((1) + (2) - (3))	······			9a(4)	
k	э в	enefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))				9b(3)	
	(4) Claims charged				9b(4)	
C	R	emainder of premium: (1) Retention charges (c	on an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies.		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)		-	
		(H) Total retention				9c(1)(H)	
	(2	2) Dividends or retroactive rate refunds. (These	e amounts were 🗌 paid in	cash, or	credited.)	9c(2)	
c		tatus of policyholder reserves at end of year: (1					
	(2	2) Claim reserves	·			9d(2)	
	•	3) Other reserves				9d(3)	
e	Ð D	ividends or retroactive rate refunds due. (Do n	not include amount entered	l in line 9c(2)	.)	. 9e	
10	None	experience-rated contracts:					
a	а т	otal premiums or subscription charges paid to o	carrier			10a	1630679
k		the carrier, service, or other organization incur					
	re	etention of the contract or policy, other than rep	orted in Part I, line 2 above	e, report amo	ount	. 10b	

Part IV	Provision of Information			
11 Did the	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the a	answer to line 11 is "Yes," specify the information not provided.			

	•	Incuren					
SCHEDULE (Form 5500)		Insurance Information			ON	IB No. 1210-0110	
Department of the Treasu Internal Revenue Service	ury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2013		
Department of Labor Employee Benefits Security Adn		▶ File as an attachment to Form 5500.					
Pension Benefit Guaranty Cor		 Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). 			This For	m is Open to Public Inspection	
For calendar plan year 2013 or fiscal plan year beginning 01/01/201				and en	ding 12	/31/2013	
A Name of plan ALCATEL-LUCENT RETIR	E BENEFITS PLAN		B Three plan	e-digit number (Pl	N) ►	504	
C Plan sponsor's name as ALCATEL-LUCENT USA II		e 2a of Form 5500		D Emplo 22-340		ation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance car KAISER FOUNDATION H		OF CO					
	(c) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
84-0591417	95669	07368	36	63	01/01/20	13	12/31/2013
2 Insurance fee and comm descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	mount of comr			(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving comr	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales an	d base	Fees	s and other commissio	ns paid			
commissions paid		(c) Amount		(d) Purpose	9		(e) Organization code

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	e and OMB Control Numbers,	edule A (Form 5500) 2013	
			v. 130118

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
			<u> </u>	

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Ρ	ade	4

Part	: 111	Welfare Benefit Contract Informat If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the s urposes if such contracts a	are experience	ce-rated as a unit. Wh	ere contract	
8 B	enefi	t and contract type (check all applicable boxes)					
а	ı 🗌	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
е	Π	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unem	ployment	h Prescription drug
i	Π	Stop loss (large deductible)	j 🛛 HMO contract	k [PPO contract		I Indemnity contract
n	n 🗌	Other (specify)			-		
9 E	merie	ence-rated contracts:					
	•	emiums: (1) Amount received	[9a(1)			-
) Increase (decrease) in amount due but unpai					
) Increase (decrease) in unearned premium res					-
) Earned ((1) + (2) - (3))	•			9a(4)	
k	•	enefit charges (1) Claims paid	T C C C C C C C C C C C C C C C C C C C				
) Increase (decrease) in claim reserves	•				
	•) Incurred claims (add (1) and (2))	L			9b(3)	
	(4) Claims charged				9b(4)	
c		temainder of premium: (1) Retention charges (c					
		(A) Commissions	Γ	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies.		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
	(2	2) Dividends or retroactive rate refunds. (These	e amounts were paid in	cash, or	credited.)	9c(2)	
C		tatus of policyholder reserves at end of year: (1					
	(2	2) Claim reserves	· · · · · · · · · · · · · · · · · · ·			9d(2)	
	(3	B) Other reserves				9d(3)	
e	• D	ividends or retroactive rate refunds due. (Do n	ot include amount entered	l in line 9c(2)	.)	. 9e	
10	None	experience-rated contracts:					
a	ат	otal premiums or subscription charges paid to o	carrier			10a	1882477
k		the carrier, service, or other organization incur etention of the contract or policy, other than rep				. 10b	
		control of the contract of policy, other than rep		c, report and	Junit	100	

Part IV	Provision of Information			
11 Did the	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the a	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	A	Insuranc	ce Informatio	n		OM	IB No. 1210-0110
(Form 5500))						
Department of the Treasury This schedule is required to be filed under section 104 of the Internal Revenue Service Employee Retirement Income Security Act of 1974 (ERISA).						2013	
Department of Labor Employee Benefits Security Adn		File as an at	ttachment to Form 55	500.			
Pension Benefit Guaranty Cor	poration	 Insurance companies and pursuant to El 	re required to provide t RISA section 103(a)(2		on	This For	m is Open to Public Inspection
For calendar plan year 201	3 or fiscal pla	an year beginning 01/01/2013		and en	ding 12	/31/2013	
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN B Three-digit plan number (PN) 504 504							504
C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. D Employer Identification Number (EIN) 22-3408857						(EIN)	
		ning Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:						0	
(a) Name of insurance car KAISER FOUNDATION H		N OF NORTHWEST	(e) Approximate n	umbor of		Deligy or o	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a		(f)	From	(g) To
	coue		policy or contrac	ct year	(1)	TIOM	(9) 10
93-0798039	95540	8384		60	01/01/20)13	12/31/2013
2 Insurance fee and comm descending order of the		nation. Enter the total fees and tota	I commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	mount of com	nmissions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving comr	nissions and	fees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name	and address of the agent, broker, o	or other person to who	m commissi	ons or fees	were paid	
(b) Amount of sales an			s and other commissio				4
commissions paid	d	(c) Amount		(d) Purpose)		(e) Organization code

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
For Paperwork Reduction Act Notice	e and OMB Control Numbers,	see the instructions for Form 5500. So	hedule A (Form 5500) 2013	

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid			

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
			<u> </u>	

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pa	art II	Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same gr						
		information may be combined for reporting put the entire group of such individual contracts					s cover individual employees	; ,
8	Bene	efit and contract type (check all applicable boxes)	,, , ,					
	a	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance	
	еĹ	Temporary disability (accident and sickness)	f Long-term disabilit			nlovment	h Prescription drug	
						ployment		
		Stop loss (large deductible)	j X HMO contract	ĸ	PPO contract		I Indemnity contract	
	m	Other (specify)						
_	_	· · · · · ·						
9	•	rience-rated contracts:	1	0-(1)			-	
		Premiums: (1) Amount received		9a(1)			4	
		(2) Increase (decrease) in amount due but unpaid(3) Increase (decrease) in unearned premium res					4	
		(4) Earned ((1) + (2) - (3))				. 9a(4)		
		Benefit charges (1) Claims paid	r			. 30(4)		_
		(2) Increase (decrease) in claim reserves					4	
		(3) Incurred claims (add (1) and (2))				. 9b(3)		
		(4) Claims charged				9b(4)		
		Remainder of premium: (1) Retention charges (o						
		(A) Commissions		9c(1)(A)			1	
		(B) Administrative service or other fees		9c(1)(B)			1	
		(C) Other specific acquisition costs		9c(1)(C)			1	
		(D) Other expenses		9c(1)(D)]	
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)		1		
		(H) Total retention	_			. 9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	. 9d(1)		
		(2) Claim reserves				. 9d(2)		
		(3) Other reserves				. 9d(3)		
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	l in line 9c(2) .)	. 9e		_
10		nexperience-rated contracts:						
		Total premiums or subscription charges paid to c				. 10a	3684	197
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				. 10b		

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuran	ce Informatio	n		OM	1B No. 1210-0110
(Form 5500							
Department of the Treas Internal Revenue Serv	ice	This schedule is required Employee Retirement In					2013
Department of Labo Employee Benefits Security Ad		File as an a	attachment to Form 5500.				
Pension Benefit Guaranty Co	orporation		ompanies are required to provide the information This irsuant to ERISA section 103(a)(2).			This For	m is Open to Public Inspection
For calendar plan year 20	13 or fiscal pla	n year beginning 01/01/2013		and en	iding 12	2/31/2013	
A Name of plan ALCATEL-LUCENT RETII	REE WELFARI	E BENEFITS PLAN			e-digit number (P	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		D Emplo		cation Number	(EIN)
Part I Information on a separat	on Concerr e Schedule A.	ing Insurance Contract	Coverage, Fees, a a unit in Parts II and III	and Com	missions	S Provide inform	nation for each contract
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION F		OF MIDATLANTIC STATES					
	(c) NAIC	(d) Contract or	(e) Approximate n	umber of		Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
52-0954463	95639	2204		62	01/01/20)13	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3-	the agents,	brokers, and o	ther persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount	of fees paid	
		0					0
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	and address of the agent, broker,	or other person to who	om commiss	ions or fees	s were paid	
(b) Amount of sales ar	nd hase	Fee	es and other commissio	ons paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(d) Purpose	(e) Organization	
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.				lule A (Form 5500) 2013
				v. 130118

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid			

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
			<u> </u>		

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Page	4
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Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pu	1 1 2		()		, , ,
		the entire group of such individual contracts v					,
8	Bene	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	c	Vision	(d 🗌 Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unemp	oloyment I	h Prescription drug
	iΓ	Stop loss (large deductible)	j 🛛 HMO contract	k∏	PPO contract		I Indemnity contract
	m	Other (specify)					
	L						
9	Expe	erience-rated contracts:	_				
	a F	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies	E Contraction of the second seco	9c(1)(F)			
		(G) Other retention charges		9c(1)(G)		1	
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1	Amount held to provide b	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not	ot include amount entered	in line 9c(2) .)	9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	264645
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	×	X No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

	•						
SCHEDULE A (Form 5500)	4	Insuran	ce Informatio	n		ON	1B No. 1210-0110
(FOTTI 5500) Department of the Treasury Internal Revenue Service		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2013
Department of Labor Employee Benefits Security Admin	nistration	File as an a	ttachment to Form 55	600.			
Pension Benefit Guaranty Corpo		 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		on	This For	m is Open to Public Inspection
For calendar plan year 2013	or fiscal plar	year beginning 01/01/2013	13 and ending 12/31/20				
A Name of plan ALCATEL-LUCENT RETIRE	EE WELFARE	BENEFITS PLAN		B Three plan	-digit number (Pl	N) ►	504
C Plan sponsor's name as a ALCATEL-LUCENT USA INC		e 2a of Form 5500		D Employ 22-340		ation Number	(EIN)
		ing Insurance Contract (Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance carrie KAISER FOUNDATION HE		OF GA					
	(c) NAIC	(d) Contract or	(e) Approximate n	umber of		Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
58-1592076 9	96237	2081		92	01/01/20	13	12/31/2013
2 Insurance fee and commis descending order of the ar		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3 t	he agents,	brokers, and c	ther persons in
(a) Total am	nount of comr	nissions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving commis	issions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to who	m commissi	ons or fees	were paid	
(b) Amount of sales and base		Fee	es and other commissions paid				
commissions paid		(c) Amount		(d) Purpose			(e) Organization code

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(c) Amount (d) Purpose		
For Paperwork Reduction Act Notice	see the instructions for Form 5500. Sc	hedule A (Form 5500) 2013		
	v. 130118			

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid		
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid		

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pu					, , ,
		the entire group of such individual contracts v					cover individual employees,
8	Bene	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	c	Vision	(d Life insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term disability	у д 🗌	Supplemental unemp	oloyment I	h Prescription drug
	iΓ	Stop loss (large deductible)	j X HMO contract		PPO contract		I Indemnity contract
	m	Other (specify)	,				
	Г						
9	Expe	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	l	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))	·····			9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These				9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide t	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2) .)	9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	836864
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	×	X No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE A		Insurance Information				0	MB No. 1210-0110
(Form 5500) Department of the Treasury		This schedule is required to be filed under section 104 of the					2013
Internal Revenue Service	_	Employee Retirement In					2010
Department of Labor Employee Benefits Security Administration		File as an a	attachment to Form 55	500.			
Pension Benefit Guaranty Corporation		 Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). 			This Fo	orm is Open to Public Inspection	
For calendar plan year 2013 or fise	al plar	year beginning 01/01/2013		and en	ding 12	/31/2013	
A Name of plan ALCATEL-LUCENT RETIREE WE	FARE	BENEFITS PLAN		B Three plan	e-digit number (Pl	N) 🕨	504
						-	
C Plan sponsor's name as showr ALCATEL-LUCENT USA INC.	on line	e 2a of Form 5500		D Emplo 22-340	•	ation Number	r (EIN)
		ing Insurance Contract					
1 Coverage Information:		individual contracto groupou do					
(a) Name of insurance carrier							
KAISER FOUNDATION HEALTH	PLAN	OF HI					
(c) (c)	AIC	(d) Contract or	(e) Approximate n			Policy or	contract year
(b) EIN co		identification number	persons covered a policy or contract		(f)	From	(g) To
94-1340523 60053		639		10	01/01/20	13	12/31/2013
2 Insurance fee and commission descending order of the amount		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3.	the agents,	brokers, and	other persons in
(a) Total amount of	f comr			(b) To	otal amount	of fees paid	
		0					0
3 Persons receiving commissions	and fe	ees. (Complete as many entries	as needed to report all	persons).			
(a) №	ame a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales and base		Fee	es and other commissio	ns paid			
commissions paid		(c) Amount		(d) Purpose	Э		(e) Organization code

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(d) Purpose		(e) Organization code
For Paperwork Reduction Act Notic	e and OMB Control Numbers,	see the instructions for Form 5500.	Sched	lule A (Form 5500) 2013
				v. 130118

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid		
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid		

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid		(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Page	4
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Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pu					y o (<i>y</i>)
		the entire group of such individual contracts v					······································
8	Bene	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	c	Vision	C	d Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unemp	oloyment I	h Prescription drug
	iΓ	Stop loss (large deductible)	j 🛛 HMO contract	k∏	PPO contract		I Indemnity contract
	m	Other (specify)	•				
	··· L						
9	Expe	erience-rated contracts:					
	a F	Premiums: (1) Amount received		9a(1)]
		(2) Increase (decrease) in amount due but unpaid	l	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))	·····			9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide t	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2) .)	9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	67955
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	×	X No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

	•						
SCHEDULE		Insurance Information			OM	B No. 1210-0110	
(Form 5500 Department of the Treas	-	This schedule is required to be filed under section 104 of the				2013	
Internal Revenue Servi	ce	Employee Retirement Inc					2010
Department of Labor Employee Benefits Security Adr		File as an at	tachment to Form 55	600.		This Fam	m is Onen te Public
Pension Benefit Guaranty Co	rporation	 Insurance companies ar pursuant to EF 	e required to provide t RISA section 103(a)(2)		ion		m is Open to Public Inspection
For calendar plan year 207	13 or fiscal pla	n year beginning 01/01/2013	01/2013 and ending 12/31			/31/2013	I
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN B Three-digit plan number			-	N) 🕨	504		
							(- 1)
C Plan sponsor's name a ALCATEL-LUCENT USA I		e 2a of Form 5500		D Emplo		ation Number (EIN)
		ning Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca							
KAISER FOUNDATION H	IEALTH PLAN	I OF NO. CA					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate no persons covered a policy or contract	at end of	(f)	From	ontract year (g) To
94-1340523	00000	35147	5	35	01/01/20	13	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	l commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of com	missions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving com	missions and f	ees. (Complete as many entries a	is needed to report all	persons).			
	(a) Name a	and address of the agent, broker, c	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	d base	Fees	and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code
	(a) Name a	and address of the agent, broker, c	or other person to who	m commiss	ions or fees	were paid	•

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose		(e) Organization code
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Schedu				lule A (Form 5500) 2013
				v. 130118

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid		(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pa	rt II						
		If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees,					
		the entire group of such individual contracts					s cover individual employees,
8	Bene	fit and contract type (check all applicable boxes)	,				
•	a [Health (other than dental or vision)	b Dental	сГ	Vision		d Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	ployment	h Prescription drug
	i	Stop loss (large deductible)	j 🕺 HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Expe	rience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpai					
		(3) Increase (decrease) in unearned premium rea	serve	9a(3)		I	
	-	(4) Earned ((1) + (2) - (3))				9a(4)	
		Benefit charges (1) Claims paid					4
		(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	on an accrual basis)				4
		(A) Commissions					
		(B) Administrative service or other fees					4
		(C) Other specific acquisition costs					4
		(D) Other expenses					1
		(E) Taxes					4
		(F) Charges for risks or other contingencies.					4
		(G) Other retention charges					
		(H) Total retention	_			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These				9c(2)	
	d	Status of policyholder reserves at end of year: (7	1) Amount held to provide	benefits after	r retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n	not include amount entered	d in line 9c(2)	.)	. 9e	
10	Nor	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to o	carrier			10a	3644629
		If the carrier, service, or other organization incur retention of the contract or policy, other than rep				. 10b	

Part IV	Provision of Information			
11 Did	he insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
12 If the	e answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuranc	e Information	า			
(Form 5500)			•			OMB No. 1210-0110	
Department of the Treasury Internal Revenue ServiceThis schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2013				
Department of Labo Employee Benefits Security Ad		File as an at	tachment to Form 55	00.			
Pension Benefit Guaranty Co	prporation	 Insurance companies are pursuant to EF 	e required to provide to RISA section 103(a)(2)		ion	This F	orm is Open to Public Inspection
For calendar plan year 20	13 or fiscal pla	n year beginning 01/01/2013		and en	ding 12/	/31/2013	
A Name of plan ALCATEL-LUCENT RETI	REE WELFAR	E BENEFITS PLAN		B Three plan	e-digit number (PN	<u>1)</u>	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		D Emplo 22-340	-	ation Numbe	er (EIN)
		ning Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca HORIZON BCBS OF NJ	rrier						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or	contract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
22-2651245	95529	77087	23	33	01/01/20	13	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	l commissions paid. Li	ist in line 3	the agents,	brokers, and	l other persons in
(a) Total	amount of com			(b) To	otal amount	of fees paid	
		0					0
3 Persons receiving com		ees. (Complete as many entries a		•			
	(a) Name a	and address of the agent, broker, o	or other person to whor	m commissi	ions or fees	were paid	
(b) Amount of sales and base		Fees	and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	9		(e) Organization code
	(a) Name a	and address of the agent, broker, o	or other person to whor	m commissi	ions or fees	were paid	

(b) Amount of sales and base	F	ees and other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Sched			hedule A (Form 5500) 2013
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(b) Amount of sales and base	Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base	Fees and other commissions paid		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Page	4
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Pa	art II	I Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts	oup of employees of the supposes if such contracts	are experienc	e-rated as a unit. Whe	ere contrac	
8	Ben	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	oloyment	h Prescription drug
	ίĪ	Stop loss (large deductible)	j 🛛 HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)		E			
9	Expe	erience-rated contracts:					
	a	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	l	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			_
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			_
		(E) Taxes		9c(1)(E)			_
		(F) Charges for risks or other contingencies		9c(1)(F)			_
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	_	_		9c(1)(H))
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not	ot include amount entered	d in line 9c(2) .	.)	9e	
10) No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	1704003
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Δ	Insuranc	ce Information	n				
(Form 5500		insulanc				ON	/IB No. 1210-0110	
Department of the Treas Internal Revenue Servi	sury	This schedule is required Employee Retirement Inc					2013	
Department of Labor Employee Benefits Security Ad		File as an at	ttachment to Form 55	600.				
Pension Benefit Guaranty Co	rporation	 Insurance companies and pursuant to E 	re required to provide t RISA section 103(a)(2)		on	This Fo	This Form is Open to Public Inspection	
For calendar plan year 20	13 or fiscal plar	year beginning 01/01/2013		and end	ding 12	2/31/2013		
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN						504		
C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN) ALCATEL-LUCENT USA INC. 22-3408857								
on a separat		ing Insurance Contract C Individual contracts grouped as a						
1 Coverage Information:								
(a) Name of insurance ca	rrier							
UHC OF CALIFORNIA H	MO							
(c) NAIO		(d) Contract or	(e) Approximate nu	umber of		Policy or c	contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
95-2931460	00000	142111	2	12	01/01/20	013	12/31/2013	
2 Insurance fee and comp descending order of the		ation. Enter the total fees and tota	I commissions paid. L	ist in line 3 t	he agents,	brokers, and o	other persons in	
(a) Total a	amount of comr	nissions paid		(b) To	tal amount	of fees paid		
		0					0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).				
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commissi	ons or fees	s were paid		
(b) Amount of sales ar	nd base	Fees	s and other commissio	ns paid				
commissions pai		(c) Amount		(d) Purpose			(e) Organization code	
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commissi	ons or fees	s were paid		

(b) Amount of sales and base	F				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
For Paperwork Reduction Act Notice	e and OMB Control Numbers,	see the instructions for Form 5500. Sche	chedule A (Form 5500) 2013		
	v. 130118				

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid			

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pu					
		the entire group of such individual contracts v	with each carrier may be tr	eated as a u	nit for purposes of this	report.	
8	Bene	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision	(d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unemp	oloyment I	h Prescription drug
	i [Stop loss (large deductible)	j 🛛 HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Expe	rience-rated contracts:					
	a F	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	l	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)		1	
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)		1	
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	· · · · ·				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			ļ
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)		1	
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide b	penefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not	ot include amount entered	in line 9c(2).)	9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	1194641
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insurance Information					
(Form 5500)				OMB No. 1210-0110		
Department of the Treas Internal Revenue Serv	ice	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2013		
Department of Labor Employee Benefits Security Ad		File as an at	tachment to Form 55	600.			
Pension Benefit Guaranty Co	orporation	 Insurance companies ar pursuant to EF 	e required to provide t RISA section 103(a)(2)		ion	This Form is Open to Public Inspection	
For calendar plan year 20	13 or fiscal pla	n year beginning 01/01/2013		and en	ding 12	/31/2013	-
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN				B Three plan	e-digit number (Pl	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		D Emplo 22-340		ation Number	(EIN)
		ning Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:		- ·		·		-	
(a) Name of insurance ca	rrier						
PARTNERS NATL. HEAL	TH PLANS O	F NC INC.	1				
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a policy or contract	at end of	(f)	Policy or co From	ontract year (g) To
56-0894904	95300	011453		33	01/01/20	13	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	l commissions paid. L	ist in line 3.	the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		0					0
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	and address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fees and other commissions paid					
commissions paid		(c) Amount	(d) Purpose			(e) Organization code	
		and address of the agent, broker, c	at other person to who		iona or food	wore paid	L

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Sche			edule A (Form 5500) 2013	
			v. 130118	

(b) Amount of sales and base commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	i, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base commissions paid		(e) Organization		
	(c) Amount	(d) Purpose	code	
Part I	Investment and Annuity Contract Information			
----------	--	-------------------------------------	-----------------------------	----------------
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pa	art II	Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same gr information may be combined for reporting pu						
		the entire group of such individual contracts v						<i>y</i> cco,
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unem	ployment	h Prescription drug	
	iΓ	Stop loss (large deductible)	j 🛛 HMO contract	k 🗌	PPO contract		I Indemnity contract	:t
	m	Other (specify)	, []					
	Г							
9	Expe	rience-rated contracts:						
	a F	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	I	9a(2)				
		(3) Increase (decrease) in unearned premium res	erve	9a(3)				
		(4) Earned ((1) + (2) - (3))				. 9a(4)		
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				. 9b(3)		
		(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention	_			9c(1)(H))	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	. 9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				. 9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	ot include amount entered	d in line 9c(2) .	.)	. 9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			. 10a		3163503
	b	If the carrier, service, or other organization incurr						
		retention of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	ount	. 10b		

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	•	Incuron	ce Informatio	<u> </u>			
(Form 5500)		Insuland				ON	//B No. 1210-0110
Department of the Treasury Internal Revenue Service This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2013				
Department of Labo Employee Benefits Security Ad		File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		on	This Fo	rm is Open to Public Inspection
For calendar plan year 20	13 or fiscal plan	vear beginning 01/01/2013		and end	ling 12	2/31/2013	-
A Name of plan ALCATEL-LUCENT RETI	REE WELFARE	BENEFITS PLAN		B Three plan r	-digit number (P	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		D Employ 22-3408		cation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
UHC OF OKLAHOMA H	NO						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or c	contract year
	code	identification number	policy or contrac		(f)	From	(g) To
33-0115166	96903	008102	14	48	01/01/20	013	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3 tl	he agents,	, brokers, and o	other persons in
	amount of comr	nissions paid		(b) Tot	al amount	of fees paid	
		0					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to who	m commissio	ons or fees	s were paid	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			4
commissions paid		(c) Amount		(d) Purpose			(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to who	m commissio	ons or fees	s were paid	

(b) Amount of sales and base	F	Fees and other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Sched			dule A (Form 5500) 2013
	v. 130118		

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		Fees and other commissions paid	(e) Organization code
commissions paid	(c) Amount	(d) Purpose	
			<u> </u>

(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pa	art II	Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same gr						
		information may be combined for reporting put the entire group of such individual contracts					s cover individual employee	es,
8	Bene	efit and contract type (check all applicable boxes)	,			<u> </u>		
	a	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance	
	еГ	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unen	nnlovment	h Prescription drug	
	: [Stop loss (large deductible)	j X HMO contract	· • _	PPO contract	npioymone		
	' L			ĸ	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Evec	rience-rated contracts:						
3	•	Premiums: (1) Amount received		9a(1)			4	
		(2) Increase (decrease) in amount due but unpaid					4	
		(3) Increase (decrease) in amount due but unpaid (3) Increase (decrease) in unearned premium res					4	
		(4) Earned ((1) + (2) - (3))				9a(4)		
		Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves					1	
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged						
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)]	
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)			_	
		(F) Charges for risks or other contingencies					_	
		(G) Other retention charges						
		(H) Total retention	_					
	_	(2) Dividends or retroactive rate refunds. (These						
	d	Status of policyholder reserves at end of year: (1	, ,					
		(2) Claim reserves						
		(3) Other reserves				9d(3)		
4.0	e	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	t in line 9c(2) .	.)	9e		
10		nexperience-rated contracts:				40-		
		Total premiums or subscription charges paid to o				<u>10a</u>	676	6356
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b		

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE A (Form 5500) Department of the Treasury		Insuranc	ce Information	n		ON	IB No. 1210-0110
		This schedule is required to be filed under section 104 of the					2013
Internal Revenue Serv	ice	Employee Retirement Inc					2013
Department of Labo Employee Benefits Security Ad	Employee Benefits Security Administration File as an attachment to Form 5500.				This Fer	m is Onen te Rublic	
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		on	Inis For	m is Open to Public Inspection
For calendar plan year 20	13 or fiscal plar	n year beginning 01/01/2013		and end	ding 12	2/31/2013	1
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN B Three-digit plan number (PN) 504					504		
C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. D Employer Identification Number (EIN) 22-3408857							
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
HUMANA HEALTH PLAN	NS, INC						
(c) NAIC		(d) Contract or	(e) Approximate n			Policy or contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
61-1013183	95885	B2941	1	15	01/01/20	013	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3 t	he agents,	brokers, and o	ther persons in
v	amount of comr	missions paid		(b) To	tal amount	of fees paid	
		0				·	0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to who	m commissi	ons or fees	s were paid	
(b) Amount of sales ar	nd base	Fee	s and other commissio	ns paid			_
commissions pa	id	(c) Amount		(d) Purpose	!		(e) Organization code
	(a) Nome a	nd addrose of the agent, broker	or other person to who	m commissi	one or foor	woro poid	
	(a) Name a	nd address of the agent, broker,	or other person to Who	m commissi	UNS OF TEES	s were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	e and OMB Control Numbers,	see the instructions for Form 5500. Sche	dule A (Form 5500) 2013
			v. 130118

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
			<u> </u>		

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pu	1 1 2				, , ,
		the entire group of such individual contracts v					cover individual employees,
8	Bene	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	c	Vision	(d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unemp	ployment I	h Prescription drug
	iΓ	Stop loss (large deductible)	j 🛛 HMO contract	k∏	PPO contract		I Indemnity contract
	m	Other (specify)	- 🗆				
	L						
9	Expe	erience-rated contracts:	_				
	a F	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	l	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))	······			9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)]
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)]
		(A) Commissions		9c(1)(A)			J
		(B) Administrative service or other fees		9c(1)(B)]
		(C) Other specific acquisition costs		9c(1)(C)			J
		(D) Other expenses		9c(1)(D)]
		(E) Taxes		9c(1)(E)]
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1				9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no				9e	
10		nexperience-rated contracts:				-	
	а	Total premiums or subscription charges paid to c	arrier			10a	413223
	-	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo	ed any specific costs in co	onnection with	n the acquisition or	10b	

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	×	X No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insurance Information				C	MB No. 1210-0110	
(Form 5500)							
Department of the Treas Internal Revenue Serv	ice		ed to be filed under section 104 of the ncome Security Act of 1974 (ERISA).				2013	
Department of Labor Employee Benefits Security Ad		File as an a	attachment to Form 5500.					
Pension Benefit Guaranty Co	Insurance companies a pursuant to E	are required to provide t ERISA section 103(a)(2)		on	This Fo	orm is Open to Public Inspection		
For calendar plan year 20	13 or fiscal plar	n year beginning 01/01/2013		and en	ding 12	/31/2013		
A Name of plan ALCATEL-LUCENT RETII	REE WELFARE	E BENEFITS PLAN		B Three plan	e-digit number (PI	N) 🕨	504	
C Plan sponsor's name a ALCATEL-LUCENT USA	INC.			22-340	8857	ation Numbe		
		Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca								
METROPOLITAN LIFE IN	NSURANCE CO	JMPANY				Dellassa		
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a policy or contract	it end of	(f) From		contract year (g) To	
13-5581829	65978	95083-G	9592	29	01/01/20	13	12/31/2013	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in	
(a) Total a	amount of comr	missions paid		(b) To	tal amount	of fees paid		
		181666					566412	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
	(a) Name a	nd address of the agent, broker,		m commissi	ons or fees	were paid		
AON CONSULTING INC			OX 905494 RLOTTE, NC 28290-549	94				
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			_	
commissions pa	(d) Purpose (e) Organization 3 SUPPLEMENTAL COMPENSATION 3				(e) Organization code 3			
	(a) Name a	nd address of the agent, broker,	or other person to who	m commissi	ons or fees	were paid		
AON CONSULTING INC		PO B	OX 905494 RLOTTE, NC 28290-549					
		Fee	es and other commissio	ns paid				
(b) Amount of sales an commissions pa		(c) Amount		(d) Purpose	;		(e) Organization code	
		262161 AI	DMIN FEES				3	
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	e the instructions for I	Form 5500.		Sch	edule A (Form 5500) 2013 v. 130118	

Schedule A (Form 5500) 2013

Page **2 -** 1

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

AON CONSULTING INC

PO BOX 905494 CHARLOTTE, NC 28290-5494

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
181666 68		NON-MONETARY COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Part	III Welfare Benefit Contract Informa	tion			
	If more than one contract covers the same g information may be combined for reporting p				
	the entire group of such individual contracts				
8 Be	nefit and contract type (check all applicable boxes))			
а	Health (other than dental or vision)	b Dental	с	Vision	d 🛛 Life insurance
е	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemployme	nt h Prescription drug
i	Stop loss (large deductible)	j 🗍 HMO contract		PPO contract	I Indemnity contract
m					
m					
9 Ex	perience-rated contracts:				
	Premiums: (1) Amount received		9a(1)	856	6441
	(2) Increase (decrease) in amount due but unpai	d			
	(3) Increase (decrease) in unearned premium re-	serve	9a(3)		
	(4) Earned ((1) + (2) - (3))				4) 856441
b	Benefit charges (1) Claims paid		9b(1)	82457	774
	(2) Increase (decrease) in claim reserves		9b(2)	2186	5710
	(3) Incurred claims (add (1) and (2))				3) 84644484
	(4) Claims charged				4) 84644484
С	Remainder of premium: (1) Retention charges (on an accrual basis)			
	(A) Commissions		9c(1)(A)	181	1666
	(B) Administrative service or other fees		9c(1)(B)		0
	(C) Other specific acquisition costs		9c(1)(C)		0
	(D) Other expenses		9c(1)(D)	1912	
	(E) Taxes		9c(1)(E)	1458	3662
	(F) Charges for risks or other contingencies.				9016
	(G) Other retention charges		9c(1)(G)		9675
	(H) Total retention	_		<u></u>	
	(2) Dividends or retroactive rate refunds. (These				2) 569103
d	Status of policyholder reserves at end of year: (7	1) Amount held to provide	benefits after	r retirement 9d	1) 410493540
	(2) Claim reserves				2) 22828546
	(3) Other reserves				(3) 0
е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2)	9.)	e
10 N	Ionexperience-rated contracts:				
a					а
b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep				b

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuranc	e Information			ID No. 4040.0440	
(Form 5500)				ON	/IB No. 1210-0110	
Department of the Treas Internal Revenue Serv	ice	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2013	
Department of Labo Employee Benefits Security Ad		File as an at	ttachment to Form 5500.				
Pension Benefit Guaranty Co	orporation		re required to provide the in RISA section 103(a)(2).	formation	This Fo	rm is Open to Public Inspection	
For calendar plan year 20	13 or fiscal plan	vear beginning 01/01/2013		and ending	12/31/2013	-	
A Name of plan ALCATEL-LUCENT RETI	REE WELFARE	BENEFITS PLAN	В	Three-digit plan number (PN)	504	
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		Employer Identi 22-3408857	fication Number	(EIN)	
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
AETNA HEALTH INC.							
	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or c	Policy or contract year	
(b) EIN	code	identification number	persons covered at enc policy or contract yea		(f) From	(g) To	
52-1270921	95287	US28740	136	01/01/2	2013	12/31/2013	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. List in	line 3 the agent	s, brokers, and o	other persons in	
	amount of comr	nissions paid	(b) Total amount of fees paid				
		0				0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all perso	ons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whom co	mmissions or fe	es were paid		
(b) Amount of sales ar	nd base	Fees	s and other commissions pa	id		4	
commissions paid		(c) Amount	(d) P	urpose		(e) Organization code	
	(a) Nome a	nd address of the agent, broker, o	or other person to whom ea				

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Schere		
			v. 130118

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid		

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Ρ	ade	4

Pa	rt III	Welfare Benefit Contract Informat If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of e urposes	if such contracts a	are experien	ce-rated as a unit. WI	here contrac		
8	Bene	fit and contract type (check all applicable boxes)							
	a	Health (other than dental or vision)	b 🗌 🛙	Dental	С	Vision		d Life insur	ance
	e	Temporary disability (accident and sickness)	f∏l	ong-term disabilit	y g	Supplemental unem	nployment	h Prescript	ion drug
	i 🗍	Stop loss (large deductible)	j 🛛 ⊦	IMO contract	k	PPO contract			y contract
	m [Other (specify)			-	-			
	•	ience-rated contracts:		ſ	• (1)			_	
i		remiums: (1) Amount received			9a(1)			_	
		2) Increase (decrease) in amount due but unpai						_	
		3) Increase (decrease) in unearned premium res					0.(1)		
		4) Earned ((1) + (2) - (3))		r		 I	9a(4)	_	
		Benefit charges (1) Claims paid						_	
	``	2) Increase (decrease) in claim reserves		1	· · ·		01-(2)		
		3) Incurred claims (add (1) and (2))							
		4) Claims charged					9b(4)		
	C	Remainder of premium: (1) Retention charges (I	0-(4)(4)			_	
		(A) Commissions			9c(1)(A)			_	
		(B) Administrative service or other fees			9c(1)(B)			_	
		(C) Other specific acquisition costs		ľ	9c(1)(C)			_	
		(D) Other expenses			9c(1)(D)			_	
		(E) Taxes		ľ	9c(1)(E)			_	
		(F) Charges for risks or other contingencies.			9c(1)(F)			_	
		(G) Other retention charges					0-(4)(1)		
		(H) Total retention		_				1	
		(2) Dividends or retroactive rate refunds. (These							
		Status of policyholder reserves at end of year: (1	,						
		(2) Claim reserves							
		(3) Other reserves					9d(3)		
		Dividends or retroactive rate refunds due. (Do n	ot includ	e amount entered	l in line 9c(2] .)	9e		
10		experience-rated contracts:							
	-	Total premiums or subscription charges paid to o					10a		696271
		If the carrier, service, or other organization incur retention of the contract or policy, other than rep					10b		

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did the	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the a	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	A	Insuranc	ce Information	า			1B No. 1210-0110
(Form 5500))						
Department of the Trea Internal Revenue Serv		This schedule is required Employee Retirement Inc					2013
Department of Labo Employee Benefits Security Ac		File as an a	ttachment to Form 550	00.			
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	re required to provide th RISA section 103(a)(2).		ion	This For	m is Open to Public Inspection
For calendar plan year 20	13 or fiscal plar	vear beginning 01/01/2013		and en	ding 12	2/31/2013	-
A Name of plan ALCATEL-LUCENT RETI	REE WELFARE	BENEFITS PLAN		B Three plan	e-digit number (P	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		D Emplo 22-340	•	cation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	arrier						
BLUE ADVANTAGE HM	0						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
36-1236610	70670	H73525,B73524	17	2	01/01/20	013	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. Li	st in line 3	the agents,	brokers, and c	other persons in
(a) Total	amount of comr	nissions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving corr	nmissions and fe	ees. (Complete as many entries	as needed to report all p	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to whon	n commiss	ions or fees	s were paid	
(b) Amount of sales a			s and other commission				4
commissions pa	aid	(c) Amount	((d) Purpose	9		(e) Organization code
	1						
		nd address of the agent, broker,	or other percentents where	n none-te-	ana arta -		

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Sche			edule A (Form 5500) 2013
	v. 130118		

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid		

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Ρ	ade	4

Part I	Welfare Benefit Contract Informa If more than one contract covers the same g		same employ	ver(s) or members of th	ne same emp	ployee organizations(s), the
	information may be combined for reporting p the entire group of such individual contracts	urposes if such contracts	are experience	ce-rated as a unit. Wh	ere contract	
8 Ben	efit and contract type (check all applicable boxes)				
а	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance
е	Temporary disability (accident and sickness)	f 🗌 Long-term disabili	ty g	Supplemental unem	ployment	h Prescription drug
i [Stop loss (large deductible)	j 🛛 HMO contract		PPO contract		I Indemnity contract
m						
m	Other (specify)					
9 Exp	erience-rated contracts:					
•	Premiums: (1) Amount received		9a(1)			1
	(2) Increase (decrease) in amount due but unpai					1
	(3) Increase (decrease) in unearned premium re					1
	(4) Earned ((1) + (2) - (3))				9a(4)	
b	Benefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves		9b(2)			1
	(3) Incurred claims (add (1) and (2))				9b(3)	
	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (on an accrual basis)				
	(A) Commissions		9c(1)(A)]
	(B) Administrative service or other fees		9c(1)(B)]
	(C) Other specific acquisition costs		9c(1)(C)]
	(D) Other expenses		9c(1)(D)]
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies.					
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention				9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	e amounts were 🗌 paid ir	n cash, or	credited.)	9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	r retirement	. 9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
е	Dividends or retroactive rate refunds due. (Do r	not include amount entered	d in line 9c(2)).) <u>.</u>	. 9e	
10 No	onexperience-rated contracts:					
а	Total premiums or subscription charges paid to	carrier			. 10a	1784812
b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep				10b	
	retention of the contract of policy, other than rep	oneu in Fait I, inte Z abov	e, report and	Juni		

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did the	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the a	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE		Insurance Information				OM	B No. 1210-0110
(Form 5500 Department of the Treas Internal Revenue Serv	sury	This schedule is required					2013
Department of Labor		Employee Retirement Inc	2).		
Employee Benefits Security Ad Pension Benefit Guaranty Co			ttachment to Form 55			This For	m is Open to Public
	Ipolation	 Insurance companies a pursuant to E 	RISA section 103(a)(2		ion		Inspection
For calendar plan year 20	13 or fiscal plar	year beginning 01/01/2013		and en	ding 12	2/31/2013	I
A Name of plan ALCATEL-LUCENT RETII	REE WELFARE	BENEFITS PLAN		B Three plan	e-digit number (P	'N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA	INC.			22-340	8857	cation Number (
		ing Insurance Contract (Individual contracts grouped as a	• • •				
1 Coverage Information:							
(a) Name of insurance ca	rrier						
AETNA LIFE INSURANC	E CO.						
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate n persons covered a policy or contract	at end of	(f)	Policy or co From	ontract year (g) To
06-6033492	60054	700140-RET	349	60	01/01/20	013	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents	, brokers, and o	ther persons in
(a) Total a	amount of comr	nissions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales ar			s and other commissio				
commissions par	id	(c) Amount		(d) Purpose	9		(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to who	m commise	ions or fee	s were paid	
		nu autress or the agent, broker,				s were paiu	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	e and OMB Control Numbers,	see the instructions for Form 5500. Sch	edule A (Form 5500) 2013
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(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid		
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid		

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base	d base Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Ρ	ad	e	4

Part						
	If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees,					
	the entire group of such individual contracts	with each carrier may be to	reated as a u	nit for purposes of this	report.	
8 Be	nefit and contract type (check all applicable boxes)					
а	Health (other than dental or vision)	b 🛛 Dental	c	Vision		d Life insurance
е	Temporary disability (accident and sickness)	f 🗌 Long-term disabilit	у д	Supplemental unemp	oloyment	h Prescription drug
i	Stop loss (large deductible)	j 🗌 HMO contract	k	PPO contract		I Indemnity contract
m	Other (specify)					
9 Exp	perience-rated contracts:					
а	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpai	d	9a(2)			
	(3) Increase (decrease) in unearned premium rea	serve	9a(3)		-	
	(4) Earned ((1) + (2) - (3))				9a(4)	
b	Benefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))				9b(3)	
	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (on an accrual basis)				
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies.		9c(1)(F)			
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention				9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	e amounts were 🗌 paid in	cash, or	credited.)	9c(2)	
d	Status of policyholder reserves at end of year: (7				9d(1)	
	(2) Claim reserves	·			9d(2)	
	(3) Other reserves				9d(3)	
е	Dividends or retroactive rate refunds due. (Do r	ot include amount entered	l in line 9c(2)	.)	9e	
10 N	onexperience-rated contracts:					
а	Total premiums or subscription charges paid to	carrier			10a	11456500
b	If the carrier, service, or other organization incur					
	retention of the contract or policy, other than rep	orted in Part I, line 2 abov	e, report amo	ount	10b	

Specify nature of costs 🕨

Part IV Provision of Information

11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12	If the answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE		Insuranc	ce Information		O	MB No. 1210-0110
(Form 5500 Department of the Treas Internal Revenue Serv	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2013
Department of Labor Employee Benefits Security Ad			ttachment to Form 5500.			
Pension Benefit Guaranty Co		Insurance companies ar	re required to provide the inform RISA section 103(a)(2).	ation	This Fo	rm is Open to Public Inspection
For calendar plan year 20	13 or fiscal plan	year beginning 01/01/2013	and	ending 12	/31/2013	
A Name of plan ALCATEL-LUCENT RETII	REE WELFARE	BENEFITS PLAN		ee-digit n number (Pl	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		loyer Identific 408857	ation Number	(EIN)
on a separat		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca HUMANA HEALTH PLAN						
	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or o	contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f)	From	(g) To
61-1103898	95270	* SEE BELOW	67	01/01/20	13	12/31/2013
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	I commissions paid. List in line	3 the agents,	brokers, and	other persons in
(a) Total a	amount of comn	nissions paid	(b)	Fotal amount	of fees paid	
		0				0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all persons)			
	(a) Name a	nd address of the agent, broker, o	or other person to whom commi	sions or fees	were paid	
						1
(b) Amount of sales ar			s and other commissions paid			
commissions pai		(c) Amount	(d) Purpo	se		(e) Organization code
	(a) Name a	nd address of the agent, broker, o	or other person to whom commi	sions or fees	were paid	1

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	e and OMB Control Numbers,	see the instructions for Form 5500. See Section Se	chedule A (Form 5500) 2013
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(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid (c) Amount (d) Purpose		- (e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
			<u> </u>

(b) Amount of sales and base	d base Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pu					
		the entire group of such individual contracts v	with each carrier may be tr	eated as a u	nit for purposes of this	report.	
8	Bene	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	С	Vision	(d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unem	ployment I	h Prescription drug
	i [Stop loss (large deductible)	j 🛛 HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Expe	rience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	I	9a(2)			
		(3) Increase (decrease) in unearned premium res		9a(3)			
		(4) Earned ((1) + (2) - (3))	-			9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)		1	
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide b	penefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2).)	9e	
10	No	nexperience-rated contracts:				r	
	а	Total premiums or subscription charges paid to c	arrier			10a	110408
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	×	X No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insurance	ce Information				
(Form 5500		insurance information				OMB No. 1210-0110	
Department of the Treas Internal Revenue Serv	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2013		
Department of Labo Employee Benefits Security Ad		File as an attachment to Form 5500.					
Pension Benefit Guaranty Co	orporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				This Form is Open to Public Inspection	
For calendar plan year 20	13 or fiscal plar	year beginning 01/01/2013		and end	ding 12	/31/2013	1
A Name of plan ALCATEL-LUCENT RETI	BENEFITS PLAN	E		e-digit number (Pl	N) 🕨	504	
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500	C	D Employ 22-340		ation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
HUMANA HEALTH PLAN	NS, INC.						
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate numl persons covered at en policy or contract ye	nd of	(f)	Policy or c From	ontract year (g) To
65-1137990 95885		H9248,D7825	121 01/01/20		01/01/20	13	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. List	in line 3 t	he agents,	brokers, and c	other persons in
(a) Total	amount of comr	nissions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all per	rsons).			
	(a) Name a	nd address of the agent, broker,	or other person to whom o	commissi	ons or fees	were paid	
(b) Amount of sales an			ees and other commissions paid			4	
commissions pa	id	(c) Amount	(d)	Purpose			(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to whom o	commissi	ons or fees	were paid	

(b) Amount of sales and base	F	Fees and other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	e and OMB Control Numbers,	see the instructions for Form 5500. Sc	hedule A (Form 5500) 2013
			v. 130118

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contract enter group of such individual contracts with each carrier may be treated as a unit for purposes of this report 8 Benefit and contract type (check all applicable boxes)	tracts cover individual employees,
the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report	d Life insurance
8 Benefit and contract type (check all applicable boxes)	
a Health (other than dental or vision) b Dental c Vision	
e Temporary disability (accident and sickness) f Long-term disability g Supplemental unemployme	nt h Prescription drug
$i \square$ Stop loss (large deductible) $j \blacksquare$ HMO contract $k \square$ PPO contract	I Indemnity contract
m ☐ Other (specify) ►	
9 Experience-rated contracts:	
a Premiums: (1) Amount received	
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	(4)
b Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	
(3) Incurred claims (add (1) and (2))	(3)
(4) Claims charged9k	(4)
C Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	
(B) Administrative service or other fees	
(C) Other specific acquisition costs	
(D) Other expenses	
(E) Taxes	
(F) Charges for risks or other contingencies	
(G) Other retention charges	
(H) Total retention	
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	
(2) Claim reserves	
(3) Other reserves	
	9
10 Nonexperience-rated contracts:	
a Total premiums or subscription charges paid to carrier	a 299850
 b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	b

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE A		Insuranc	ce Information)		01	/B No. 1210-0110
(Form 5500)							
Department of the Treasu Internal Revenue Servic				2013			
Department of Labor Employee Benefits Security Adm	ninistration	File as an at	ttachment to Form 550	00.			
Pension Benefit Guaranty Cor	poration	 Insurance companies an pursuant to El 	re required to provide th RISA section 103(a)(2).	ie informati	on	This Form is Open to Public Inspection	
For calendar plan year 201	3 or fiscal plan	year beginning 01/01/2013		and end	ding 12	/31/2013	-
A Name of plan ALCATEL-LUCENT RETIR	BENEFITS PLAN	-	B Three plan	-digit number (P	N) 🕨	504	
C Plan sponsor's name as ALCATEL-LUCENT USA II		e 2a of Form 5500		D Employ 22-340		cation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance car	rier						
AETNA HEALTH INC.							
	(c) NAIC (d) Contract or identification number	(d) Contract or	(e) Approximate number of persons covered at end of policy or contract year		Policy or contract year		
(b) EIN		.,			(f)	From	(g) To
23-2169745	95109	US28740	109	9	01/01/20)13	12/31/2013
2 Insurance fee and comm descending order of the		tion. Enter the total fees and tota	I commissions paid. Lis	st in line 3 t	he agents,	brokers, and o	other persons in
	nissions paid	(b) Total amount of fees paid					
		0					0
3 Persons receiving comm	nissions and fe	es. (Complete as many entries a	as needed to report all p	persons).			
	(a) Name ar	nd address of the agent, broker, o	or other person to whom	n commissi	ons or fees	s were paid	
(b) Amount of sales and base Fees and other commissions paid							
commissions paid		(c) Amount	(1	d) Purpose	1		(e) Organization code
	(a) Name ar	nd address of the agent, broker, o	or other person to whom	n commissi	ons or fees	were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.			hedule A (Form 5500) 2013
	v. 130118		

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
Schedule A (Form 5500) 2013

Page 3

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier	6b		
С	Premiums due but unpaid at the end of the year	6c		
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	. 7e(4)		
	•			
	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Schedule A (Form 5500) 2013

Pa	art II	I Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts w	oup of employees of the s rposes if such contracts	are experienc	e-rated as a unit. Wh	ere contrac		
8	Ben	efit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	e	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unem	ployment	h Prescription drug	
	i [Stop loss (large deductible)	j 🕺 HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Expe	erience-rated contracts:						
	a	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium res	erve	9a(3)				
		(4) Earned ((1) + (2) - (3))		<u></u>		9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies						
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1	Amount held to provide	benefits after	retirement	. 9d(1)		
		(2) Claim reserves				. 9d(2)		
		(3) Other reserves				. 9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	d in line 9c(2) .	.)	. 9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			. 10a	75555	51
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				. 10b		

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the	answer to line 11 is "Yes," specify the information not provided.			

(Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation For calendar plan year 2013 or fiscal plan year beginning 01 A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. Part I Service Provider Information (see inst or more in total compensation (i.e., money or anything else plan during the plan year. If a person received only eligible answer line 1 but are not required to include that person when 1 Information on Persons Receiving Only Elig a Check "Yes" or "No" to indicate whether you are excluding a indirect compensation for which the plan received the require b If you answered line 1a "Yes," enter the name and EIN or received only eligible indirect compensation. Complete as r (b) Enter name and EIN or address THE DREYFUS CORPORATION	ructions) tions, to report the information requir of monetary value) in connection with indirect compensation for which the en completing the remainder of this I ible Indirect Compensation person from the remainder of this P ed disclosures (see instructions for c address of each person providing the	e of the Employee RISA). D0. and ending <u>12/31</u> Three-digit plan number (PN) Employer Identification 22-3408857 red for each person which services rendered to plan received the requipant. Part. Part because they received definitions and condition e required disclosures for	o received, the plan or the ired disclosu ved only elig	directly or indirectly, \$5,000 he person's position with the ures, you are required to ible X Yes No
Internal Revenue Service Retirer Department of Labor Imployee Benefits Security Administration Pension Benefit Guaranty Corporation 1 For calendar plan year 2013 or fiscal plan year beginning 01 01 A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. Part I Service Provider Information (see insi You must complete this Part, in accordance with the instruc or more in total compensation (i.e., money or anything else plan during the plan year. If a person received only eligible answer line 1 but are not required to include that person where the plan year indirect compensation for which the plan received the require bird for which the plan received the require bird indirect compensation for which the plan received the require bird indirect compensation for which the plan received the require bird plan bird indirect compensation. Complete as received only eligible indirect compen	The initial information requires the information requires the information requires indicating the remainder of this is a disclosures (see instructions for chaddress of each person providing the remainder of the information requires the instructions for chaddress of each person providing the remainder of the information in the remainder of the instructions for chaddress of each person providing the remainder of the information in the remainder of the information in the remainder of the instructions for chaddress of each person providing the remainder of the information in the remainder of th	RISA). 20. and ending <u>12/31</u> , Three-digit plan number (PN) Employer Identification 22-3408857 red for each person which h services rendered to the plan received the required	o received, the plan or the ired disclosu ved only elig	Inspection. 504 EIN) directly or indirectly, \$5,000 he person's position with the ures, you are required to ible
Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation For calendar plan year 2013 or fiscal plan year beginning 01 A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. Part 1 Service Provider Information (see inst You must complete this Part, in accordance with the instruc or more in total compensation (i.e., money or anything else plan during the plan year. If a person received only eligible answer line 1 but are not required to include that person wh 1 Information on Persons Receiving Only Elig a Check "Yes" or "No" to indicate whether you are excluding a indirect compensation for which the plan received the requir b If you answered line 1a "Yes," enter the name and EIN or a received only eligible indirect compensation. Complete as r (b) Enter name and EIN or address THE DREYFUS CORPORATION 13-5673135	File as an attachment to Form 550 (01/2013 B (01/2013 B (01/2013 B (01/2013 B (01/2013 B (01/2013 B (01/2013 (01/2013 (01/2013 (01/2013 (01/2013 (01/2013 (01/2013) (01/2013 (01/2013) (01/2013 (01/2013) (01/2	and ending 12/31/ Three-digit plan number (PN) Employer Identification 22-3408857 red for each person when his services rendered to plan received the requipant. Part. Part because they received the requipant. Part because they received the requipant.	o received, the plan or the ired disclosu ved only elig	Inspection. 504 EIN) directly or indirectly, \$5,000 he person's position with the ures, you are required to ible
For calendar plan year 2013 or fiscal plan year beginning 01 A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. Part I Service Provider Information (see inst You must complete this Part, in accordance with the instruct or more in total compensation (i.e., money or anything else plan during the plan year. If a person received only eligible answer line 1 but are not required to include that person whether you are excluding a Check "Yes" or "No" to indicate whether you are excluding a indirect compensation for which the plan received the require b If you answered line 1a "Yes," enter the name and EIN or a received only eligible indirect compensation. Complete as r (b) Enter name and EIN or address THE DREYFUS CORPORATION	B ructions) tions, to report the information requir of monetary value) in connection with indirect compensation for which the en completing the remainder of this I ible Indirect Compensation a person from the remainder of this P ed disclosures (see instructions for c address of each person providing the	Three-digit plan number (PN) Employer Identification 22-3408857 red for each person which h services rendered to plan received the requiper Part. Part because they received definitions and condition e required disclosures for	on Number (I	EIN) directly or indirectly, \$5,000 he person's position with the ires, you are required to ible
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. Part I Service Provider Information (see insi You must complete this Part, in accordance with the instruct or more in total compensation (i.e., money or anything else plan during the plan year. If a person received only eligible answer line 1 but are not required to include that person whether you are excluding a Check "Yes" or "No" to indicate whether you are excluding a indirect compensation for which the plan received the required b If you answered line 1a "Yes," enter the name and EIN or a received only eligible indirect compensation. Complete as received only eligible indirect compensation. The DREYFUS CORPORATION 13-5673135	B ructions) tions, to report the information requir of monetary value) in connection with indirect compensation for which the en completing the remainder of this I ible Indirect Compensation a person from the remainder of this P ed disclosures (see instructions for c address of each person providing the	Three-digit plan number (PN) Employer Identification 22-3408857 red for each person which h services rendered to plan received the requiper Part. Part because they received definitions and condition e required disclosures for	on Number (I	EIN) directly or indirectly, \$5,000 he person's position with the ires, you are required to ible
ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. Part I Service Provider Information (see inst You must complete this Part, in accordance with the instruc or more in total compensation (i.e., money or anything else plan during the plan year. If a person received only eligible answer line 1 but are not required to include that person wh 1 Information on Persons Receiving Only Elig a Check "Yes" or "No" to indicate whether you are excluding a indirect compensation for which the plan received the requir b If you answered line 1a "Yes," enter the name and EIN or received only eligible indirect compensation. Complete as r (b) Enter name and EIN or address THE DREYFUS CORPORATION 13-5673135	ructions) tions, to report the information requir of monetary value) in connection with indirect compensation for which the en completing the remainder of this I ible Indirect Compensation person from the remainder of this P ed disclosures (see instructions for c address of each person providing the	plan number (PN) Employer Identification 22-3408857 red for each person which services rendered to the plan received the requirement Part. Part because they received definitions and condition e required disclosures for	o received, the plan or tl ired disclosu ved only elig is)	EIN) directly or indirectly, \$5,000 he person's position with the ires, you are required to ible
ALCATEL-LUCENT USA INC. Part I Service Provider Information (see inst or more in total compensation (i.e., money or anything else plan during the plan year. If a person received only eligible answer line 1 but are not required to include that person whether 1 Information on Persons Receiving Only Elig a Check "Yes" or "No" to indicate whether you are excluding a indirect compensation for which the plan received the require b If you answered line 1a "Yes," enter the name and EIN or a received only eligible indirect compensation. Complete as r (b) Enter name and EIN or address THE DREYFUS CORPORATION 13-5673135	tions, to report the information requir of monetary value) in connection with indirect compensation for which the en completing the remainder of this I ible Indirect Compensation a person from the remainder of this P ed disclosures (see instructions for c address of each person providing the	22-3408857 red for each person wh h services rendered to plan received the requipant. Part. Part because they received definitions and condition e required disclosures for	o received, the plan or tl ired disclosu ved only elig is)	directly or indirectly, \$5,000 he person's position with the ures, you are required to ible X Yes No
ALCATEL-LUCENT USA INC. Part I Service Provider Information (see inst or more in total compensation (i.e., money or anything else plan during the plan year. If a person received only eligible answer line 1 but are not required to include that person whether 1 Information on Persons Receiving Only Elig a Check "Yes" or "No" to indicate whether you are excluding a indirect compensation for which the plan received the require b If you answered line 1a "Yes," enter the name and EIN or received only eligible indirect compensation. Complete as r (b) Enter name and EIN or address THE DREYFUS CORPORATION 13-5673135	tions, to report the information requir of monetary value) in connection with indirect compensation for which the en completing the remainder of this I ible Indirect Compensation person from the remainder of this P ed disclosures (see instructions for c address of each person providing the	22-3408857 red for each person wh h services rendered to plan received the requipant. Part. Part because they received definitions and condition e required disclosures for	o received, the plan or tl ired disclosu ved only elig	directly or indirectly, \$5,000 he person's position with the ures, you are required to ible X Yes No
You must complete this Part, in accordance with the instruct or more in total compensation (i.e., money or anything else plan during the plan year. If a person received only eligible answer line 1 but are not required to include that person wh 1 Information on Persons Receiving Only Elig a Check "Yes" or "No" to indicate whether you are excluding a indirect compensation for which the plan received the requir b If you answered line 1a "Yes," enter the name and EIN or received only eligible indirect compensation. Complete as r (b) Enter name and EIN or address THE DREYFUS CORPORATION 13-5673135	tions, to report the information requir of monetary value) in connection with indirect compensation for which the en completing the remainder of this I ible Indirect Compensation person from the remainder of this P ed disclosures (see instructions for c address of each person providing the	h services rendered to plan received the requ Part. Part because they receiv definitions and condition e required disclosures for	the plan or til ired disclosu ved only elig	he person's position with the ares, you are required to ible X Yes No
or more in total compensation (i.e., money or anything else plan during the plan year. If a person received only eligible answer line 1 but are not required to include that person wh 1 Information on Persons Receiving Only Elig a Check "Yes" or "No" to indicate whether you are excluding a indirect compensation for which the plan received the requir b If you answered line 1a "Yes," enter the name and EIN or received only eligible indirect compensation. Complete as r (b) Enter name and EIN or address THE DREYFUS CORPORATION 13-5673135	of monetary value) in connection with indirect compensation for which the en completing the remainder of this I ible Indirect Compensation person from the remainder of this P ed disclosures (see instructions for c address of each person providing the	h services rendered to plan received the requ Part. Part because they receiv definitions and condition e required disclosures for	the plan or til ired disclosu ved only elig	he person's position with the ares, you are required to ible X Yes No
 a Check "Yes" or "No" to indicate whether you are excluding a indirect compensation for which the plan received the require b If you answered line 1a "Yes," enter the name and EIN or a received only eligible indirect compensation. Complete as r (b) Enter name and EIN or address THE DREYFUS CORPORATION 13-5673135 	person from the remainder of this P ed disclosures (see instructions for c address of each person providing the	Part because they received definitions and condition and condition are required disclosures for the second se	ıs)	XYes No
THE DREYFUS CORPORATION 13-5673135				
	s of person who provided you disclos	sures on eligible indirec	t compensat	lion
(b) Enter name and EIN or addres				
	s of person who provided you disclos	sure on eligible indirect	compensati	on
METLIFE				
13-5881829				
(b) Enter name and EIN or address	of person who provided you disclos	ures on eligible indirect	compensat	ion
(b) Enter name and EIN or address			compensat	ion
	of person who provided you disclos	ures on eligible indirect	·	

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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HEWITT ASSOCIATES LLC

36-2235791

(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest		(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
13 50	NONE	10435797	Yes 🗌 No 🛛	Yes 🗌 No 🗌		Yes 🗌 No 🗍
(a) Enter name and EIN or address (see instructions)						

UNITED HEALTHCARE

36-2739571

(b)	(c)	(d)	(e)	(f)	(g)	(h)			
Service	Relationship to	Enter direct	Did service provider	Did indirect compensation	Enter total indirect	Did the service			
Code(s)	employer, employee	compensation paid	receive indirect	include eligible indirect	compensation received by	provider give you a			
	U 7	by the plan. If none,		compensation, for which the	service provider excluding	formula instead of			
	person known to be	enter -0	other than plan or plan	plan received the required disclosures?	eligible indirect	an amount or			
	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element				
					(f). If none, enter -0				
13 50	NONE	5944463							
			Yes No 🗙	Yes No		Yes No			
		1	a) Enter name and EIN or	address (see instructions)					
	(a) Enter name and EIN or address (see instructions)								

MEDCO CONTAINMENT LIFE INSURANCE CO

(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest		(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
13 50	NONE	1836381	Yes 🗌 No 🛛	Yes 🗌 No 🗌		Yes 📔 No 🗌

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EXPRESS SCRIPTS, INC.

22-3461740

(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest		(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?	
13 50	NONE	902264	Yes 🗌 No 🛛	Yes No		Yes No	
(a) Enter name and EIN or address (see instructions)							

AETNA

06-6033492

(b)	(c)	(d)	(e)	(f)	(g)	(h)	
Service	Relationship to	Enter direct	Did service provider	Did indirect compensation	Enter total indirect	Did the service	
Code(s)	employer, employee	compensation paid	receive indirect	include eligible indirect	compensation received by	provider give you a	
	U 7	by the plan. If none, enter -0		compensation, for which the plan received the required	service provider excluding	formula instead of	
	person known to be a party-in-interest	enter -0	other than plan or plan sponsor)	disclosures?	eligible indirect compensation for which you	an amount or	
	a party-in-interest		sponsor)		answered "Yes" to element		
					(f). If none, enter -0		
40.50							
13 50	NONE	621623					
			Yes No 🗙	Yes No		Yes No	
		(a) Enter name and EIN or	address (see instructions)			

AON CONSULTING, INC.

(b) Service	(c) Relationship to	(d) Enter direct	(e) Did service provider	(f) Did indirect compensation	(g) Enter total indirect	(h) Did the service
Code(s)	employer, employee	compensation paid	receive indirect	include eligible indirect	compensation received by	provider give you a
	person known to be	enter -0	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or
	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element	estimated amount?
					(f). If none, enter -0	
11 16 38 50	NONE	386970				
			Yes No 🗙	Yes No		Yes No

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ING

04-3516284

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	Did the service provider give you a formula instead of an amount or estimated amount?
13 50	NONE	341565	Yes 🗌 No 🛛	Yes 🗌 No 🗌		Yes 🗌 No 🗌
		(a) Enter name and EIN or	address (see instructions)		
TRUVEN H	EALTH ANALYTICS					
06-1467923	3					
(h)	(-)	(1)	(-)	(f)	(~)	(6)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0		(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?	
15 50	NONE	305647	Yes 🗌 No 🗙	Yes No		Yes No	
(a) Enter name and EIN or address (see instructions)							

ERNST & YOUNG LLP

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest		(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
10 50	NONE	198900	Yes 🗌 No 🔀	Yes 🗌 No 🗌		Yes 📔 No 🗌

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MAX-IT MAILING & FULFILLMENT

22-3788849

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?	
38 50	NONE	79242	Yes 🗌 No 🛛	Yes 🗌 No 🗌		Yes 🗌 No 🗍	
(a) Enter name and EIN or address (see instructions)							

CANDID LITHO

13-3574319

(b)	(c)	(d)	(e)	(f)	(g)	(h)		
Service	Relationship to	Enter direct	Did service provider	Did indirect compensation	Enter total indirect	Did the service		
Code(s)	employer, employee	compensation paid	receive indirect	include eligible indirect		provider give you a		
	•	by the plan. If none,		compensation, for which the	service provider excluding	formula instead of		
	person known to be	enter -0	other than plan or plan	plan received the required	eligible indirect	an amount or		
	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element	estimated amount?		
					(f). If none, enter -0			
					(I). II Hone, enter -0			
36 50	NONE	52351						
		02001	Yes No 🗙	Yes No		Yes 🗌 No 🗍		
			a) Enter name and EIN or	address (see instructions)				

ALCATEL-LUCENT INVEST MGMT CORP

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service	Relationship to	Enter direct	Did service provider	Did indirect compensation	Enter total indirect	Did the service
Code(s)	employer, employee	compensation paid	receive indirect	include eligible indirect	compensation received by	provider give you a
	organization, or	by the plan. If none,	compensation? (sources	compensation, for which the	service provider excluding	formula instead of
	person known to be	enter -0	other than plan or plan	plan received the required	eligible indirect	an amount or
	a party-in-interest		sponsor)		compensation for which you answered "Yes" to element (f). If none, enter -0	
31 50	AFFILIATE	36675	Yes 🗌 No 🔀	Yes 🗌 No 🗌		Yes 🗌 No 🗌

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UNIVERSAL MAILING SERVICE

22-2381663

(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
38 50	NONE	29144	Yes 🗌 No 🗙	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		

TAX SAVER

75-1761182

(b)	(c)	(d)	(e)	(f)	(g)	(h)	
Service	Relationship to	Enter direct	Did service provider	Did indirect compensation	Enter total indirect	Did the service	
Code(s)	employer, employee	compensation paid		include eligible indirect	compensation received by	provider give you a	
		by the plan. If none,		compensation, for which the	service provider excluding	formula instead of	
	person known to be	enter -0	other than plan or plan	plan received the required disclosures?	eligible indirect	an amount or	
	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element	estimated amount?	
					(f). If none, enter -0		
13 50	NONE	24900					
		2.000	Yes No 🗙	Yes No		Yes 🗌 No 🗍	
		1	a) Enter name and EIN or	address (see instructions)			
		(a Enter name and EIN or	address (see instructions)			

BLACKROCK INSTITUTIONAL TRUST CO NA

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest		(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
28 49 50 51	NONE	20954	Yes 🗙 No 🗌	Yes 🗴 No 🗌	0	Yes 🗌 No 🗙

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BANK OF NEW YORK MELLON

13-5160382

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
19 21 25 49 50 62	NONE	20000	Yes 🛛 No 🗌	Yes 🛛 No 🗌	0	Yes 🛛 No 🗌
(a) Enter name and EIN or address (see instructions)						

HEWITT ENNISKNUPP, INC.

36-3109431

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect	Did the service provider give you a formula instead of an amount or
16 50	NONE	15000	Yes 🗌 No 🗙	Yes 🗌 No 🗌		Yes 🗌 No 🗌
			a) Enter name and EIN or	address (see instructions)		

RICHARD CASH

PO BOX 733 PISCATAWAY, NJ 08855-0733

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest		Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect	Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	6875	Yes 🗌 No 🕅	Yes 🗌 No 🗌		Yes 🗌 No 🗌

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
		compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect c	ompensation, including any
	formula used to determine t	the service provider's eligibility le indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect c	ompensation, including any the service provider's eligibility
	for or the amount of th	ie indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect conformula used to determine to	he service provider's eligibility
	for or the amount of th	e indirect compensation.

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P	Part II Service Providers Who Fail or Refuse to Provide Information								
4	4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.								
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide						
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide						
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide						
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide						
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide						
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide						

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)			structions)
а	Name		b EIN:
С	Positio	on:	
d Addr		SS:	e Telephone:
Ex	planatio	n:	

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:	
С	Position:		
d	Address:	e Telephone:	

Explanation:

SCHEDULE D (Form 5500)	DFE/Participating Plan Information			OMB No. 1210-0110
Department of the Treasury Internal Revenue Service	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2013
Department of Labor Employee Benefits Security Administration		File as an attachment to Form 5500.		This Form is Open to Public Inspection.
For calendar plan year 2013 or fiscal p	olan year beginning	01/01/2013 an	d ending 12/3	31/2013
A Name of plan ALCATEL-LUCENT RETIREE WELFA	RE BENEFITS PLAN		B Three-digit plan numb	er (PN) 504
C Plan or DFE sponsor's name as she ALCATEL-LUCENT USA INC.	own on line 2a of Form	n 5500	D Employer lo 22-340885	dentification Number (EIN) 7
	entries as needed	Ts, PSAs, and 103-12 IEs (to be co to report all interests in DFEs)	mpleted by pla	ans and DFEs)
b Name of sponsor of entity listed in		INSTITUTIONAL TRUST CO. N.A.		
C EIN-PN 94-3167617-001	d Entity C code	e Dollar value of interest in MTIA, CCT, F 103-12 IE at end of year (see instruction		60746862
a Name of MTIA, CCT, PSA, or 103-	12 IE: BLACKROCK	EAFE EQUITY INDEX FUND		
b Name of sponsor of entity listed in	(a): BLACKROCK	INSTITUTIONAL TRUST CO. N.A.		
C EIN-PN 94-6581674-001	d Entity C code	e Dollar value of interest in MTIA, CCT, F 103-12 IE at end of year (see instruction		20322173
a Name of MTIA, CCT, PSA, or 103-	12 IE: BLACKROCK	U.S. DEBT INDEX FUND		
b Name of sponsor of entity listed in	(a): BLACKROCK	INSTITUTIONAL TRUST CO. N.A.		
C EIN-PN 94-3138366-001	d Entity C code	e Dollar value of interest in MTIA, CCT, F 103-12 IE at end of year (see instruction		25637592
a Name of MTIA, CCT, PSA, or 103-	12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, F 103-12 IE at end of year (see instruction)		
a Name of MTIA, CCT, PSA, or 103-	12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, F 103-12 IE at end of year (see instruction)		
a Name of MTIA, CCT, PSA, or 103-	12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, F 103-12 IE at end of year (see instruction		
a Name of MTIA, CCT, PSA, or 103-	12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, F 103-12 IE at end of year (see instruction		

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Schedule D (Form 5500) 2	013	Page 2 - 1		
a Name of MTIA, CCT, PSA, or 103-	-12 IE:			
b Name of sponsor of entity listed in (a):				
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)		
a Name of MTIA, CCT, PSA, or 103-	-12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)		
a Name of MTIA, CCT, PSA, or 103-	-12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)		
a Name of MTIA, CCT, PSA, or 103-	-12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)		
a Name of MTIA, CCT, PSA, or 103-	-12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)		
a Name of MTIA, CCT, PSA, or 103-	-12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)		
a Name of MTIA, CCT, PSA, or 103-	-12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)		
a Name of MTIA, CCT, PSA, or 103	·12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)		
a Name of MTIA, CCT, PSA, or 103-	-12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)		
a Name of MTIA, CCT, PSA, or 103-	-12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)		

Page **3 -** 1

Ρ	Part II	Information on Participating Plans (to be completed by DFEs) (Complete as many entries as needed to report all participating plans)	
а	Plan na		
b	Name o plan spo		C EIN-PN
а	Plan na	ne	
b	Name o plan spo		C EIN-PN
а	Plan na	ne	
b	Name o plan spo		C EIN-PN
а	Plan na	ie	
b	Name o plan spo		C EIN-PN
а	Plan na	ie	
b	Name o plan spo		C EIN-PN
а	Plan na	ie	
b	Name o plan spo		C EIN-PN
а	Plan na	le	
b	Name o plan spo		c ein-pn
а	Plan na	le	
b	Name o plan spo		c ein-pn
а	Plan na	ne	
b	Name o plan spo		C EIN-PN
	Plan na		
b	Name o plan spo		C EIN-PN
	Plan na		
b	Name o plan spo		C EIN-PN
	Plan na		
b	Name o plan spo		C EIN-PN

SCHEDULE H	Financial Infor	mation			(OMB No. 1210	-0110	
	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the				2013			
Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	 File as an attachment to Form 5500. 					This Form is Open to Public Inspection		
For calendar plan year 2013 or fiscal plan year beginning	01/01/2013	and	endir	ng 12/31/	2013		I	
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLA	N		В	Three-dig plan num		•	504	
C Plan sponsor's name as shown on line 2a of Form 550 ALCATEL-LUCENT USA INC.	0		D	Employer I 22-340885		n Number (E	EIN)	
Part I Asset and Liability Statement								
1 Current value of plan assets and liabilities at the begin the value of the plan's interest in a commingled fund c lines 1c(9) through 1c(14). Do not enter the value of th benefit at a future date. Round off amounts to the ne and 1i. CCTs, PSAs, and 103-12 IEs also do not comp	ontaining the assets of more t at portion of an insurance cor earest dollar. MTIAs, CCTs,	han one plan on a htract which guara PSAs, and 103-12 ructions.	a line- intees 2 IEs	by-line basis , during this do not comp	s unless the plan year, plete lines 1	e value is rep to pay a spe lb(1), 1b(2),	portable on ecific dollar 1c(8), 1g, 1h,	
Assets		(a) (Begin	ning of Year		(b) End	of Year	
a Total noninterest-bearing cash		1a						
b Receivables (less allowance for doubtful accounts):								
(1) Employer contributions	1	b(1)						
(2) Participant contributions		b(2)						
(3) Other	1	b(3)		67092	2000		64542000	
C General investments: (1) Interest-bearing cash (include money market acc of deposit)		c(1)		1160	0000		10367000	
(2) U.S. Government securities		c(2)						
(3) Corporate debt instruments (other than employer	securities):							
(A) Preferred		(3)(A)						
(B) All other		(3)(B)						
(4) Corporate stocks (other than employer securities								
(A) Preferred	, 	(4)(A)						
(B) Common		(4)(B)						
(5) Partnership/joint venture interests		c(5)						
(6) Real estate (other than employer real property)	4	c(6)						
(7) Loans (other than to participants)		c(7)						
	1	c(8)						
(8) Participant loans(9) Value of interest in common/collective trusts		c(9)		9221	6000		106707000	
		:(10)					100707000	
(10) Value of interest in pooled separate accounts		:(11)						
(11) Value of interest in master trust investment accou								
 (12) Value of interest in 103-12 investment entities (13) Value of interest in registered investment compar funds) 	nies (e.g., mutual	:(12) :(13)		1043	5000		22226000	
(14) Value of funds held in insurance company genera contracts)	al account (unallocated 10	:(14)		375624	4000		410493000	
(15) Other		:(15)						

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500

Schedule H (Form 5500	2013
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1d	Employer-related investments:		(a) Beginning of Year	(b) End of Year
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
е	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	556967000	614335000
	Liabilities			
g	Benefit claims payable	1g	35600000	25100000
h	Operating payables	1h	3227000	1909000
i	Acquisition indebtedness	1i		
j	Other liabilities	1j	9575000	11422000
k	Total liabilities (add all amounts in lines 1g through1j)	1k	48402000	38431000
	Net Assets			
I	Net assets (subtract line 1k from line 1f)	11	508565000	575904000

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

	Income		(a) Amount	(b) Total
а	Contributions:			
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	38554000	
	(B) Participants	2a(1)(B)	144463000	
	(C) Others (including rollovers)	2a(1)(C)		
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		183017000
b	Earnings on investments:			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	(F) Other	2b(1)(F)	257000	
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		257000
	(2) Dividends: (A) Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)		
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		0
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)		
	 (C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B) 	2b(5)(C)		0

			(a) Amount		(b)	Total
	(6) Net investment gain (loss) from common/collective trusts	2b(6)				19378000
	(7) Net investment gain (loss) from pooled separate accounts	2b(7)				
	(8) Net investment gain (loss) from master trust investment accounts	2b(8)				
	(9) Net investment gain (loss) from 103-12 investment entities	2b(9)				
	(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)				
С	Other income	2c				62966000
d	Total income. Add all income amounts in column (b) and enter total	2d				265618000
	Expenses					
е	Benefit payment and payments to provide benefits:					
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	1267	69000		
	(2) To insurance carriers for the provision of benefits	2e(2)	570	59000		
	(3) Other	2e(3)				
	(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)				183828000
f	Corrective distributions (see instructions)	2f				
g	Certain deemed distributions of participant loans (see instructions)	2g				
h	Interest expense	2h				
i	Administrative expenses: (1) Professional fees	2i(1)	144	51000		
	(2) Contract administrator fees	0:(0)				
	(3) Investment advisory and management fees	0:(0)				
	(4) Other	0:(4)				
	(5) Total administrative expenses. Add lines 2i(1) through (4)	0:(5)				14451000
i	Total expenses. Add all expense amounts in column (b) and enter total			-		198279000
,	Net Income and Reconciliation					
k	Net income (loss). Subtract line 2j from line 2d	2k				67339000
I	Transfers of assets:					
	(1) To this plan	21(1)				
	(2) From this plan	21(2)				
_						
-	art III Accountant's Opinion					
	Complete lines 3a through 3c if the opinion of an independent qualified public attached.	accountant is attach	ned to this Form 5	500. Compl	lete line 3d if a	n opinion is not
a	The attached opinion of an independent qualified public accountant for this pla	in is (see instruction	is):			
	(1) Unqualified (2) Qualified (3) Disclaimer (4)	Adverse				_
b	Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.10	3-8 and/or 103-12(d	1)?		Yes	X No
С	Enter the name and EIN of the accountant (or accounting firm) below:					
	(1) Name: ERNST & YOUNG LLP) EIN: 34-656559	6		
ď	The opinion of an independent qualified public accountant is not attached be (1) This form is filed for a CCT, PSA, or MTIA. (2) It will be atta		rm 5500 pursuant	to 29 CFR	2520.104-50.	
Ра	rt IV Compliance Questions					
4	CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete		1a, 4e, 4f, 4g, 4h,	4k, 4m, 4n,	or 5.	
	During the plan year:		Yes	No	Am	ount
а	Was there a failure to transmit to the plan any participant contributions withi					
	period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correct		40	X		
b	Were any loans by the plan or fixed income obligations due the plan in defa	- ,	4a	^		
U	close of the plan year or classified during the year as uncollectible? Disrega					
	secured by participant's account balance. (Attach Schedule G (Form 5500)	Part I if "Yes" is		х		
	checked.)		4b	~		

			Yes	No	Amount
С	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		Х	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions				
	reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		х	
е	Was this plan covered by a fidelity bond?	4e	Х		1000000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		х	
g	Did the plan hold any assets whose current value was neither readily determinable on an				
	established market nor set by an independent third party appraiser?	4g		Х	
h	Did the plan receive any noncash contributions whose value was neither readily				
	determinable on an established market nor set by an independent third party appraiser?	4h		Х	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	Х		
i	Were any plan transactions or series of transactions in excess of 5% of the current				
,	value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j	X		
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another	,			
	plan, or brought under the control of the PBGC?	4k		Х	
Т	Has the plan failed to provide any benefit when due under the plan?	41		Х	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR				
	2520.101-3.)	4m			
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n			
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If "Yes," enter the amount of any plan assets that reverted to the employer this year			Amou	nt:
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s),				

If, during this plan year, any as transferred. (See instructions.)

5b((1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)
5c If t	the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERIS)	A section 4021)? Yes No No	ot determined
Part V	Trust Information (optional)		
6a Name	of trust	6b Trust's EIN	

FINANCIAL STATEMENTS AND SUPPLEMENTAL SCHEDULES

Alcatel-Lucent Retiree Welfare Benefits Plan Years Ended December 31, 2013 and 2012 With Report of Independent Auditors

Ernst & Young LLP





Financial Statements and Supplemental Schedules

December 31, 2013 and 2012

Contents

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Schedule H, Line 4i – Schedule of Assets (Held at End of Year) Schedule H, Line 4j – Schedule of Reportable Transactions	



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Report of Independent Auditors

The Employee Benefits Committee Alcatel-Lucent Retiree Welfare Benefits Plan

We have audited the accompanying financial statements of Alcatel-Lucent Retiree Welfare Benefits Plan, which comprise the statements of benefit obligations and net assets available for benefits as of December 31, 2013 and 2012, and the related statement of changes in benefit obligations and net assets available for benefits for the year ended December 31, 2013, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.



We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of Alcatel-Lucent Retiree Welfare Benefits Plan at December 31, 2013 and 2012, and the changes in its financial status for the year ended December 31, 2013, in conformity with U.S. generally accepted accounting principles.

Supplemental Schedules

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying supplemental schedules of assets (held at end of year) as of December 31, 2013, and reportable transactions for the year then ended, are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements information directly to the underlying accounting and other records used to prepare the financial statements as a certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Ernet + Young LLP

October 14, 2014

Statements of Benefit Obligations and Net Assets Available for Benefits (In Thousands)

		December 31		
		2013	2012	
Benefit obligations				
Accumulated postretirement benefit obligation: Current retirees	\$	2 (02 000 0	4 2 4 1 200	
Medical claims payable and liability for claims incurred	Φ	3,682,800 \$	4,341,300	
but not reported		25,100	35,600	
Other participants fully eligible for benefits		15,400	25,900	
Other participants not yet fully eligible for benefits		98,900	132,200	
Total benefit obligations	·	3,822,200	4,535,000	
Total benefit obligations		3,022,200	4,555,000	
Net assets				
Cash		_	1	
Refund receivable		13,782	16,817	
Rebates receivable		50,760	50,275	
Group life insurance policies		410,493	375,624	
Assets held in Lucent Technologies Inc. Master Pension Trust		,	,	
Restricted for 401(h) account		232,865	213,929	
Restricted for applicable life insurance account		1	1	
Common/collective trusts		106,707	92,216	
Guaranteed interest rate contract		10,367	11,599	
Registered investment company		22,226	10,435	
Total assets		847,201	770,897	
Due to Sponsor, net		11,422	9,575	
Accrued administrative costs		11,422 1,909	9,373 3,227	
Total liabilities		,		
1 Otal Hauthties		13,331	12,802	
Net assets available for benefits		833,870	758,095	
Excess of benefit obligations over net assets available for)	, -	
benefits	\$	2,988,330 \$	3,776,905	

See accompanying notes

Statement of Changes in Benefit Obligations and Net Assets Available for Benefits

Year Ended December 31, 2013 (In Thousands)

Net decrease in benefit obligations

Increase (decrease) during the period attributable to:	
Benefits paid, net	\$ (349,100)
Change in actuarial assumptions and experience	(125,500)
Benefits accumulated and other changes	140,500
Change in discount rate	(305,500)
Plan amendments	(73,200)
Net decrease in benefit obligations	(712,800)
Net change in net assets available for benefits	
Additions to Plan assets available for benefits attributable to:	
Sponsor contributions	38,554
Participant contributions	144,463
Income from insurance policies	62,966
	10 050

Net appreciation in fair value of investments	19,378
	,
Net increase in 401(h) account	18,936
Interest income	257
Total additions	284,554
Deductions from Plan assets available for benefits attributable to:	
Payments for benefits	194,328
Administrative costs	14,451
Total deductions	208,779
Net increase in net assets available for benefits	75,775
Decrease in excess of benefit obligations over net assets available for benefits	(788,575)
Excess of benefit obligations over net assets available for benefits:	
Beginning of year	3,776,905
End of year	\$ 2,988,330

See accompanying notes.

Notes to Financial Statements

December 31, 2013 (In Thousands)

1. Plan Description

The following description of the Alcatel-Lucent Retiree Welfare Benefits Plan (the "Plan") provides only general information. Participants should refer to the Plan document, and the plan documents and the summary plan descriptions of each of the component plans, for a more complete description of the Plan's provisions.

General

The Plan is an umbrella plan comprised of the following component plans: the Alcatel-Lucent Medical Expense Plan for Retired Employees (the "Retiree Medical Plan"), the Alcatel-Lucent Dental Expense Plan for Retired Employees (the "Retiree Dental Plan") and the Alcatel-Lucent Group Life Insurance Plan for Retired Employees (the "Retiree Group Life Plan"). The Retiree Medical Plan and the Retiree Dental Plan are contributory employee welfare benefit plans that provide standard health benefits to substantially all of the retired employees and eligible dependents of Alcatel-Lucent USA Inc. (the "Sponsor"), and its domestic subsidiaries. Although the Retiree Group Life Plan permits participant contributions, the plan has been non-contributory to date. It provides basic life insurance benefits to substantially all of the retired employees of the Sponsor and its domestic subsidiaries who are eligible for disability or service pensions. The Plan and its component plans are employee benefit plans subject to the provisions of Employee Retirement Income Security Act of 1974 ("ERISA").

In March 2013, the Sponsor and the Communications Workers of America and International Brotherhood of Electrical Workers (collectively the "Unions") entered into an agreement (i) to continue health benefits for formerly represented retirees through December 31, 2016, and (ii) to reduce the Sponsor's funding commitment with respect to such health benefits for the 2015 and 2016 plan years by \$40,000 each year.

Effective July 1, 2013, the Occupational LTD medical benefit transferred from the Alcatel-Lucent Medical Expense Plan for Occupational Employees to the Retiree Medical Plan.

Benefits

The Plan provides health benefits (hospital, surgical, medical, prescription drug and mental health/chemical dependency), including an HMO option, and dental benefits, including a Dental Maintenance Organization ("DMO") option and a Preferred Provider Organization ("PPO") option, to eligible retired participants, their lawful spouses, and eligible dependents. The Plan provides for continuation of certain benefits upon the occurrence of a qualifying event through the Consolidated Omnibus Budget Reconciliation Act of 1985.

Notes to Financial Statements (continued)

(In Thousands)

1. Plan Description (continued)

On July 30, 2008, the Board of Directors of the Sponsor approved a change in the management retiree health benefit plan design for Medicare-eligible participants and their Medicare-eligible dependents. Effective January 1, 2009, such participants and beneficiaries had a new medical coverage option – an insured Medicare Advantage plan known as a "Private Fee For Service" plan ("PFFS") provided through United Healthcare. PFFS replaced the traditional indemnity option offered under the Plan for these participants. Affected participants could also choose a Medicare Advantage HMO, where available. Effective January 1, 2011, the PFFS plan was discontinued and replaced by the Medicare Advantage Preferred Provider Organization ("MAPPO"). Effective January 1, 2012, the formerly represented health benefit plan design was amended to add the MAPPO option.

In addition to health benefits, the Plan provides death benefits to eligible retired employees of the Sponsor which are payable to their beneficiaries. A participant may assign his or her life insurance under the Plan in accordance with the terms and conditions of his or her policy. Benefit payments for these benefits are administered under insurance contracts with Metropolitan Life Insurance Company ("MetLife").

During 2013, the Plan paid \$26,034 in HMO premiums, \$19,568 in MAPPO premiums, \$2,035 in DMO premiums and \$9,422 in dental PPO premiums to insurance carriers, which are included in payments for benefits.

Section 420 Maintenance of Cost Obligation

Section 420 of the Internal Revenue Code of 1986, as amended (the "Code") permits employers to transfer "excess pension assets" (as defined in Section 420 of the Code) from a defined benefit pension plan to a "health benefits account" within the plan and to use the assets in such account to pay for "applicable health benefits" (as defined in Section 420 of the Code) for retired employees and their spouses and dependents. On July 6, 2012, Section 420 of the Code was amended by the Moving Ahead for Progress in the 21st Century Act ("MAP 21") to permit employers to transfer excess pension assets to an "applicable life insurance account" within the pension plan and to use the assets in such account to pay for "applicable life insurance benefits" (as defined in Section 420 of the Code) set to retired employers to transfer excess pension assets to an "applicable life insurance benefits" (as defined in Section 420 of the Code) with respect to retired employees. MAP-21 also extended the period during which employers may make such asset transfers to December 31, 2021.

Notes to Financial Statements (continued)

(In Thousands)

1. Plan Description (continued)

Section 420 of the Code requires that, in connection with any such asset transfer, the group health plan or arrangement pursuant to which applicable health benefits or applicable life insurance benefits, as the case may be, are provided include certain provisions relating to minimum cost (so-called maintenance of cost requirements). Effective September 17, 2012, the maintenance of cost provisions of the Retiree Medical Plan component of the Plan were amended to reflect the extended period for making so-called "Section 420 transfers" for retiree health benefits. Also effective September 17, 2012, the Retiree Group Life Plan component of the Plan was amended to add provisions relating to transfers for life insurance coverage.

Contributions

Pursuant to a December 2004 collective bargaining agreement (the "Agreement") between the Sponsor and the Unions, the Lucent Supplemental Healthcare Benefits Trust for Formerly Represented Retirees (the "Taft Hartley Trust"), a voluntary employees' beneficiary association meeting the requirements of section 501(c)(9) of the Code and other applicable legal requirements, including Section 302 of the Labor Management Relations Act, 1947, was established for the exclusive purpose of paying a portion of the retiree healthcare benefits that eligible participants and their beneficiaries who are covered by the Agreement would otherwise be required to absorb through premiums and other payments. The trustees, appointed in equal numbers by the Sponsor and the Unions, have exclusive authority to manage the Taft Hartley Trust for the exclusive benefit of its participants. The Sponsor agreed to contribute \$400,000 to the Taft Hartley Trust by the end of 2012, with a minimum annual contribution of \$25,000. As of the end of 2012, the Sponsor had satisfied its obligation to contribute to the Taft-Hartley Trust.

The Sponsor has also created certain voluntary employees' beneficiary association trusts (the "Trusts"). According to the Trusts' agreements, the Sponsor may contribute such assets to the Trusts as it reasonably determines necessary and appropriate to pay expenses under the various medical, dental, and group life benefit plans consistent with any limitations under Section 419 of the Code, and shall specifically indicate the allocation of such assets among the plans.

Participant contributions are made primarily through pension payroll deductions and direct billing by the Sponsor, which in turn makes contributions to the Plan on the participants' behalf. Participant contributions reflect the cost of the selected coverage level and optional dependent coverage less the amount of cost paid by the Sponsor. Participant contributions also include elections to continue coverage for dependents of deceased retired participants.

Notes to Financial Statements (continued)

(In Thousands)

1. Plan Description (continued)

For eligible formerly represented occupational retirees who retired before March 1, 1990, the Sponsor pays the entire cost of the medical and dental coverage, except for non-grandfathered Class II dependents for whom the retiree pays the entire cost. In addition, the Sponsor reimburses the entire amount of Medicare Part B premiums for these Medicare-eligible retired employees and/or their spouses.

For eligible formerly represented occupational retirees who retire on or after March 1, 1990, sponsor contributions are limited to the following annual amounts for medical and dental coverage:

	Formerly Represented Occupational
	(In Whole Dollars)
Retired under age 65 – single coverage	\$ 4,225
Retired under age 65 – family coverage	8,600
Retired age 65 and over – single coverage	2,000
Retired age 65 and over – family coverage	4,625

In addition, the amount the Sponsor reimburses for Medicare Part B premiums for these Medicare-eligible retired employees will not exceed \$46.00 per month (\$33.00 for spouses) (in whole dollars). However, no reimbursement is made for spouses of employees who retire after May 31, 1998.

For eligible management and non-represented occupational retirees who retired before March 1, 1990, the Sponsor pays the entire cost of the medical coverage, except for non-grandfathered Class II dependents for whom the retiree pays the entire cost. Management and non-represented occupational retirees pay the full dental cost.

Notes to Financial Statements (continued)

(In Thousands)

1. Plan Description (continued)

For eligible management and non-represented occupational retirees who retire on or after March 1, 1990, Sponsor contributions are limited to the following annual amounts for medical coverage:

	Management and Non-represented Occupational
	(In Whole Dollars)
Retirees Under Age 65	
Single Coverage:	
Retiree Not Medicare Eligible	\$ 3,200
Retiree Medicare Eligible	_
Family Coverage (Non-Access):	
None Medicare Eligible	6,700
Retiree (Only) Medicare Eligible	3,500
Spouse (Only) Medicare Eligible	3,200
Both Medicare Eligible	_
Retirees Age 65 and Over	
Single Coverage	_
Family Coverage (Non-Access):	
Retiree (Only) Medicare Eligible	3,500
Both Medicare Eligible	_

Prescription drug benefits are provided for Medicare-eligible management and non-represented occupational retirees through a Medicare Prescription Drug Plan ("PDP"). In a PDP, the prescription drug vendor contracts directly with The Centers for Medicare and Medicaid Services (the "CMS") to provide Medicare Part D coverage. Plan sponsors who offer PDPs do not receive Medicare Part D Retiree Drug Subsidies for these plans. The Plan's PDP is a self insured program administered by Express Scripts.

Administrative Costs

Costs of administering the Plan are borne by the Plan or by the Sponsor.

Notes to Financial Statements (continued)

(In Thousands)

1. Plan Description (continued)

Other

At December 31, 2013 and 2012, the Plan's benefit obligations significantly exceeded its net assets available for benefits. However, management expects that the Plan's net assets available for benefits and future Sponsor contributions will be sufficient to fund obligations as they are incurred.

Although it has not expressed any intention to do so, the Sponsor has the right under the Plan, subject to collective bargaining agreements, to modify the benefits provided to participants, to discontinue its contributions at any time, and to terminate the Plan, subject to the provisions set forth in ERISA. In the event of such termination, the net assets of the Plan shall be allocated to pay the benefit obligations of the Plan in accordance with ERISA.

2. Summary of Significant Accounting Policies

Basis of Presentation

The accompanying financial statements have been prepared under the accrual method of accounting.

Valuation of Investments

The Plan invests in common/collective trusts, a registered investment company and a guaranteed interest rate contract. Investments in common/collective trusts are valued at fair value based on the common/collective trusts' net asset values on the last business day of the Plan year as determined by the trusts' managers. Investments in the registered investment company are valued at fair value based on the fund's net asset value on the last business day of the Plan year as determined by the fund's manager. The guaranteed interest rate contract is valued at fair value based on the guaranteed interest crediting rate. The net asset value is based on the value of the principal balance plus any accrued interest. See Note 3 for additional information.

Purchases and sales of investments are recorded on a trade-date basis. Interest income is recorded as earned.

Notes to Financial Statements (continued)

(In Thousands)

2. Summary of Significant Accounting Policies (continued)

Valuation of Group Life Insurance Policies

The Plan has prepaid premiums for life insurance policies with an insurance company. The prepaid premiums are invested by the insurance company in equity, fixed income and international separate accounts and a general account, all of which are valued by the insurance company. The Plan is allocated a portion of the earnings from these investments. The underlying investments in the accounts are valued at fair value generally using readily available market values. If there is no readily available market value for any asset in the separate accounts, the insurance company determines, at its discretion and in accordance with any applicable laws and regulations, the value to be used as such asset's market value. The policies are valued by the insurance company based on the fair value of the underlying assets.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Accumulated Postretirement Benefit Obligation ("APBO")

The APBO represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered to December 31 of the applicable year. Accumulated postretirement benefits include future benefits expected to be paid to or for (1) currently retired employees and eligible dependents and beneficiaries, (2) active management employees with more than 15 years service as of June 30, 2001, eligible dependents and beneficiaries and (3) all represented employees and eligible dependents and beneficiaries after retirement from the Sponsor. Prior to an active employee's full eligibility date, the APBO is the portion of the expected postretirement benefit obligation that is attributed to that employee's service performed prior to the valuation date.

The APBO is determined by the Plan's actuary, Aon Hewitt, and is the amount which results from applying actuarial assumptions to historic claims-cost data to estimate future annual incurred claims-cost per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal or retirement) between the valuation date and the expected date of payment.

Notes to Financial Statements (continued)

(In Thousands)

2. Summary of Significant Accounting Policies (continued)

For purposes of determining the actuarial present value of accumulated plan benefits as of December 31, 2013, an 8.2% post-65 medical, 8.8% pre-65 medical and 7.8% pre and post-65 prescription drug annual rate of increase in the per capita cost of covered benefits were assumed for 2014 for formerly represented occupational retirees and a 8.5% post-65 medical, 8.8% pre-65 medical and 8.4% pre and post-65 prescription drug annual rate of increase in the per capita cost of covered benefits were assumed for 2014 for management and non-represented occupational retirees. These rates were assumed to decline gradually after 2014 to 5.0% by the year 2024 and then remain constant. For purposes of determining the actuarial present value of accumulated plan benefits as of December 31, 2012, an 8.6% post-65 medical, 9.2% pre-65 medical and 8.1% pre and post-65 prescription drug annual rate of increase in the per capita cost of covered benefits were assumed for 2013 for formerly represented occupational retirees and a 9.0% post-65 medical, 9.2% pre-65 medical and 8.9% pre and post-65 prescription drug annual rate of increase in the per capita cost of covered benefits were assumed for 2013 for management and non-represented occupational retirees. These rates were assumed to decline gradually after 2013 to 5.2% by the year 2022 and then remain constant. These assumptions could greatly affect the amounts reported. To illustrate, increasing the assumed trend rate by 1% in each year could increase the APBO by \$93,900 and \$113,000 at December 31, 2013 and 2012, respectively.

For dental care benefits, the rate is 3.5% for 2014 and beyond. For 2013, the rate was 3.5%. These assumptions could greatly affect the amounts reported. To illustrate, increasing the assumed trend rate by 1% in each year could increase the APBO by \$3,400 and \$3,900 at December 31, 2013 and 2012, respectively.

For group life costs, the APBO is the amount that results from applying actuarial assumptions to participant census data to estimate future annual incurred claims-cost per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal or retirement) between the valuation date and the expected date of payment.

The following summarizes other significant actuarial assumptions used in the valuations as of December 31, 2013 and 2012, respectively:

Weighted-average discount rate:	4.03% (2013), 3.13% (2012)
Mortality:	RP-2000 Combined Healthy Mortality with generational
	projection using the Society of Actuaries Scale AA
Weighted average rate of	
compensation increase:	2.25% (2013), 3.92% (2012)

Notes to Financial Statements (continued)

(In Thousands)

2. Summary of Significant Accounting Policies (continued)

The foregoing assumptions are based on the presumption that the benefits will continue. Were the benefits to terminate, different actuarial assumptions and other factors might be applicable in determining the APBO.

In March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Act") were enacted. The primary focus of the Act is to significantly reform health care in the U.S. The Plan has included the estimated effect of the Act in the valuation of its postretirement benefit obligation as of December 31, 2013 and 2012. The Plan continues to evaluate the various provisions of the Act.

Medicare Subsidy

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 provides for a government subsidy to Plan Sponsors that maintain a prescription drug plan for Medicareeligible participants that is at least actuarially equivalent to the benefit provided by Medicare Part D. The Plan does provide an actuarially equivalent benefit, so the Sponsor expects to receive a subsidy. The Plan's benefit obligation does not reflect the subsidy because the subsidy is provided to the Sponsor and not the Plan.

Claims Incurred But Not Reported

Plan obligations at December 31, 2013 and 2012 for incurred but not reported claims are estimated by the Plan's actuary in accordance with accepted actuarial principles based on claims data provided by the Plan's third-party administrator. These amounts are paid by the Plan only if claims are submitted and approved for payment.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make significant estimates and assumptions that affect the reported amounts of assets and benefit obligations and changes therein and disclosures of contingent assets and liabilities. These significant estimates include the Plan's accumulated benefit obligations and market value of investments. Actual results could differ from those estimates.

Notes to Financial Statements (continued)

(In Thousands)

2. Summary of Significant Accounting Policies (continued)

Risks and Uncertainties

Plan contributions and the actuarial present value of Plan benefit obligations are determined based on certain assumptions pertaining to per capita claim estimates, interest and mortality rates, inflation rates and participant demographics, all of which are subject to change. As of the date of these financial statements, the Sponsor believes these estimates and assumptions concerning matters such as interest rates and participant demographics are reasonable. However, due to the uncertainties inherent in making any estimate or assumption, it is at least reasonably possible that actual results may differ materially from what has been estimated or assumed.

Investment securities held by the Trusts are exposed to various risks, such as interest rate, market and credit risk. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is at least reasonably possible that changes in market conditions could differ materially from what has been reported in the financial statements.

Payment of Benefits

Benefits are recorded when paid. Certain premiums and claims are paid from the general assets of the Sponsor; however, all premiums and claims are recorded in the accompanying statement of changes in net assets available for benefits, regardless of whether they were paid from Plan assets or from the general assets of the Sponsor.

Rebates and Refunds

Rebates and refunds are recorded when earned from the provider and netted with claims paid in the accompanying statement of changes in net assets available for benefits.

Due to Sponsor, Net

The Sponsor traditionally makes benefit payments on behalf of the Plan, net of participant contributions, and may opt to receive subsequent reimbursement from the Trusts. As a result of timing, a liability has been reported on the Statements of Benefit Obligations and Net Assets Available for Benefits as Due to Sponsor relating to such benefit payments made by the Sponsor that are not yet reimbursed by the Trusts as of December 31, 2013 and 2012. Such reimbursements may be made subsequent to the Plan's year-end.
Notes to Financial Statements (continued)

(In Thousands)

3. Investments

Plan investments are held in two separate Trusts: (1) the Lucent Technologies Inc. Postretirement Welfare Benefits Trust for Represented Employees (the "Represented Trust"), and (2) the Lucent Technologies Inc. Postretirement Welfare Benefits Trust for Nonrepresented Employees (the "Nonrepresented Trust"). Each of these trusts qualifies as a Voluntary Employees' Beneficiary Association ("VEBA") under Section 501(c)(9) of the Code. The exclusive purpose of these trusts is to fund future postretirement health and life benefits to eligible participants of the Plan.

During the year ended December 31, 2013, the Plan's investments (including investments bought and sold, as well as held during the year) appreciated in fair value as follows:

Blackrock EAFE Equity Index Fund	\$ 3,982
Blackrock Equity Index Fund	15,876
Blackrock U.S. Debt Index Fund	(480)
	\$ 19,378

Investments which exceed 5% of the current value of net assets available for benefits at December 31, 2013 and 2012 were as follows:

	December 31				
		2013 2012		2012	
Blackrock Equity Index Fund	\$	60,747	\$	51,403	

Fair Value Measurements

The Plan follows a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

Level 1 – inputs to the valuation methodology are quoted prices (unadjusted) for identical assets or liabilities in active markets.

Level 2 – inputs to the valuation methodology include quoted prices for similar assets and liabilities in active markets, quoted market prices for identical or similar assets or liabilities in markets that are not active, and inputs that are observable for the assets or liability, either directly or indirectly, for substantially the full term of the financial statements.

Notes to Financial Statements (continued)

(In Thousands)

3. Investments (continued)

Level 3 – inputs to the valuation methodology are unobservable and significant to the fair value measurements.

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value, as of December 31, 2013 and 2012. Assets are classified in their entirety based upon the lowest level of input that is significant to the fair value measurement.

	Assets at Fair Value as of December 31, 2013								
]	Level 1		Level 2	Level 3		Total		
	(In Thousands)								
Group life insurance policies Assets held in Lucent Technologies Inc. Master Pension Trust	\$	-	\$	-	\$ 410,493	\$	410,493		
Restricted for 401(h) account		_		232,865	_		232,865		
Restricted for applicable life insurance account		_		1	_		1		
Common/collective trusts		-		106,707	_		106,707		
Guaranteed interest rate contract		-		_	10,367		10,367		
Registered investment company		22,226		_	_		22,226		
Total assets at fair value	\$	22,226	\$	339,573	\$ 420,860	\$	782,659		

	Assets at Fair Value as of December 31, 2012									
	J	Level 1		Level 2		Level 3		Total		
	(In Thousands)									
Group life insurance policies	\$	-	\$	_	\$	375,624	\$	375,624		
Assets held in Lucent Technologies Inc. Master Pension Trust Restricted for 401(h) account		_		213,929		_		213,929		
Restricted for applicable life insurance account		-		1		-		1		
Common/collective trusts		-		92,216		_		92,216		
Guaranteed interest rate contract		-		-		11,599		11,599		
Registered investment company		10,435		-		-		10,435		
Total assets at fair value	\$	10,435	\$	306,146	\$	387,223	\$	703,804		

Notes to Financial Statements (continued)

(In Thousands)

3. Investments (continued)

The table below sets forth a summary of changes in the fair value of the Level 3 assets held by the Plan for the year ended December 31, 2013.

	roup Life nsurance Policies	Int	uaranteed erest Rate Contract	Total
Balance, beginning of year Purchases Realized gains	\$ 375,624 60,000 –	\$	11,599 10,312 127	\$ 387,223 70,312 127
Unrealized gains Settlements	63,094 (88,225)		_ (11,671)	63,094 (99,896)
Balance, end of year	\$ 410,493	\$	10,367	\$ 420,860

4. Section 420 Transfers

From time to time, the Sponsor makes "Collectively Bargained Transfers" of excess pension assets of the Lucent Technologies Inc. Master Pension Trust held for the Lucent Technologies Inc. Pension Plan (the "Pension Plan") to an account of the Pension Plan under the Master Pension Trust established under section 401(h) of the Code, pursuant to Section 420 of the Code to cover retiree healthcare costs, for Plan participants covered by the Agreement. Effective commencing in 2012, the Sponsor began making collectively bargained transfers of excess pension assets of the Pension Plan to an applicable life insurance account of the Pension Plan under the Master Plan under the Master Pension Trust established under Section 420 of the Code, pursuant to Section 420 of the Code, pension Plan under the Master Pension Trust established under Section 420 of the Code, pursuant to Section 420 of the Code, to pay for retiree life insurance coverage.

In accordance with sections 401(h) and 420 of the Code, the Plan's investments in the 401(h) account may not be used for or diverted to any purpose other than providing health benefits for the participants as well as administration costs and the Plan's investments in the applicable life insurance account may not be used for or diverted to any purpose other than providing applicable life insurance benefits with respect to participants as well as administrative costs. The related obligations for health benefits and applicable life insurance benefits are not reported in the Pension Plan's statement of accumulated plan benefits but are reported as obligations in the Plan.

Notes to Financial Statements (continued)

(In Thousands)

4. Section 420 Transfers (continued)

The following tables present the components of the net assets available for retiree healthcare obligations funded under Code section 401(h) as of December 31, 2013 and 2012 and the related changes in net assets available for the year ended December 31, 2013.

Net Assets Available for Accumulated Postretirement Obligations as of:

	Decer	nber	· 31
	 2013		2012
Accrued interest receivable	\$ 25	\$	45
JPMCB Liquidity Fund	232,840		213,884
	\$ 232,865	\$	213,929

Changes in Net Assets Available for Accumulated Postretirement Obligations for the year ended December 31, 2013:

Transfer from Pension Plan	\$ 200,000
Interest income	273
Administrative expenses	(11,306)
Benefit payments	(170,031)
Net increase	\$ 18,936

The following tables present the components of the net assets available for applicable life insurance benefits under Code section 420 as of December 31, 2013 and 2012 and the related changes in net assets available for the year ended December 31, 2013.

Net Assets Available for Accumulated Postretirement Obligations as of:

		December 31						
	20	13	2012					
Accrued interest receivable	\$	- \$	1					
JPMCB Liquidity Fund		1	_					
	\$	1 \$	1					

Notes to Financial Statements (continued)

(In Thousands)

4. Section 420 Transfers (continued)

Changes in Net Assets Available for Accumulated Postretirement Obligations for the year ended December 31, 2013:

Transfer from Pension Plan	\$ 60,000
Benefit payments	 (60,000)
Net increase	\$ _

5. Tax Status

The Plan was originally funded by means of a trust established effective as of October 1, 1996 known as the Lucent Technologies Inc. Postretirement Life Insurance Benefits Trust (the "Life Insurance Benefits Trust"). The Life Insurance Benefits Trust obtained a recognition of exemption letter from the Internal Revenue Service (the "IRS") dated November 25, 1998. The Trust was amended and restated in 2002, and its tax-exempt status was confirmed by a private letter ruling issued by the IRS on October 10, 2002. Pursuant to the private letter ruling, a further trust was established – the Nonrepresented Trust, and certain life insurance assets associated with the Life Insurance Trust were transferred to the Nonrepresented Trust. The Life Insurance Trust was also renamed the Represented Trust. The Represented Trust and the Nonrepresented Trust were each further amended in 2004. The Company thereafter submitted the Nonrepresented Trust to the IRS for a separate recognition of exemption letter on February 24, 2004. Although that request remains pending, the IRS confirmed the tax-exempt status of both the Represented Trust and the Nonrepresented Trust by a private letter ruling issued September 8, 2004.

The Plan, the Represented Trust and the Nonrepresented Trust are required to operate in conformity with the Code to maintain their tax-exempt status. The Plan Administrator believes the Plan is being operated in compliance with the applicable requirements of the Code and, therefore, believes the related trusts are tax exempt.

Accounting principles generally accepted in the United States require the Plan Administrator to evaluate uncertain tax positions taken by the Plan. The financial statement effects of a tax position are recognized when the position is more likely than not, based on the technical merits, to be sustained upon examination by the IRS. The Plan Administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2013, there are no uncertain tax positions taken or expected to be taken. The Plan has recognized no interest or penalties related to uncertain tax positions. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Plan Administrator believes it is no longer subject to income tax examinations for years prior to 2010.

Notes to Financial Statements (continued)

(In Thousands)

6. Party-in-interest Transactions

Certain Plan investments are managed by affiliates of the trustee, Bank of New York Mellon, and, therefore, these transactions might qualify as party-in-interest transactions under ERISA. However, these transactions meet the requirements of one or more prohibited transaction exemptions under ERISA.

7. Reconciliation of Financial Statements to 5500

The following is a reconciliation of net assets available for benefits per the financial statement to the Form 5500 as of December 31, 2013 and 2012:

	 2013	2012
Net assets available for benefits per the financial statements	\$ 833,870 \$	758,095
Less:		
Medical claims payable and claims incurred		
but not reported	(25,100)	(35,600)
Net assets held in Pension Plan – 401(h) account	(232,865)	(213,929)
Net assets held in Pension Plan – Applicable life	. , ,	
insurance account	(1)	(1)
Net assets available for benefits per Form 5500	\$ 575,904 \$	508,565

The following is a reconciliation of total additions per the financial statements to the Form 5500 for the year ended December 31, 2013:

Total additions per the financial statements	\$ 284,554
Less:	
Net increase in 401(h) account	(18,936)
Total income per Form 5500	\$ 265,618

Notes to Financial Statements (continued)

(In Thousands)

7. Reconciliation of Financial Statements to 5500 (continued)

The following is a reconciliation of payments for benefits per the financial statements to the Form 5500 for the year ended December 31, 2013:

Total payments for benefits per the financial statements	\$ 194,328
Add: Medical claims payable and liability for claims incurred but not	
reported at 12/31/13	25,100
Less: Medical claims payable and liability for claims incurred but not	
reported at 12/31/12	 (35,600)
Total payments for benefits per Form 5500	\$ 183,828

8. Subsequent Events

Management has evaluated subsequent events through October 14, 2014, the date the financial statements were available to be issued. There were no material subsequent events that occurred between December 31, 2013 through October 14, 2014 that required disclosure in the financial statements, except as follows:

In August 2014, the Sponsor and the Unions entered into an agreement (i) to continue health benefits for formerly represented retirees through December 31, 2019, and (ii) to reduce the Sponsor's funding commitment with respect to such health benefits for the 2017, 2018, and 2019 plan years by \$40,000 each year.

Supplemental Schedules

EIN #22-3408857 Plan #504

Schedule H, Line 4i – Schedule of Assets (Held at End of Year)

December 31, 2013

Description of Investment		Cost		Fair Value
Common/collective trust	\$	42,541,737	\$	60,746,862
Common/collective trust		15,495,113		20,322,173
Common/collective trust		25,399,015		25,637,592
Guaranteed interest rate contract		10,367,170		10,367,170
Registered investment company		22,225,986		22,225,986
	\$	116,029,021	\$	139,299,783
	Common/collective trust Common/collective trust Common/collective trust Guaranteed interest rate contract	Common/collective trust \$ Common/collective trust Common/collective trust Guaranteed interest rate contract	Common/collective trust\$ 42,541,737Common/collective trust15,495,113Common/collective trust25,399,015Guaranteed interest rate contract10,367,170Registered investment company22,225,986	Common/collective trust\$ 42,541,737Common/collective trust15,495,113Common/collective trust25,399,015Guaranteed interest rate contract10,367,170Registered investment company22,225,986

* Represents party-in-interest

EIN #22-3408857 Plan #504

Schedule H, Line 4j – Schedule of Reportable Transactions

Year Ended December 31, 2013

Identity of Party Involved Description of Asset		Purchase Price*	Selling Price*	Cost of Assets	Current Value of Asset on Transaction Date	Net Gain (Loss)				
Category (iii) Series of transactions in excess of 5%										
Dreyfus Dreyfus	Treasury & Agency Cash Management Fund Treasury & Agency Cash Management Fund	\$ 170,382,623	\$	\$	\$ 170,382,623 158,591,043	\$ _				

There were no category (i), (ii) or (iv) reportable transactions during the year ended December 31, 2013.

* At market

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Plan Name	Alcatel-Lucent Retiree Welfare Benefits Plan
Plan Sponsor EIN	22-3408857
ERISA Plan No.	504
Plan Year End	12/31/2013

The required attachment noted below is included within the Accountant's Opinion attachment to the Form 5500 Schedule H, Part III, which consists of the entire Audit report issued by the Plan's Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line Item	Description
5500 Schedule H	Line 4i	Schedule of Assets (Held at End of Year)

Plan Name	Alcatel-Lucent Retiree Welfare Benefits Plan
Plan Sponsor EIN	22-3408857
ERISA Plan No.	504
Plan Year End	12/31/2013

The required attachment noted below is included within the Accountant's Opinion attachment to the Form 5500 Schedule H, Part III, which consists of the entire Audit report issued by the Plan's Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line Item	Description
5500 Schedule H	Line 4j	Schedule of Reportable Transactions

Attachment to 2013 Form 5500 Form M-1 Compliance Information

Plan	Name Alcatel-L	EIN: 22-3408857				
Plan	Sponsor's Name	Alcatel-Lucent USA Inc.	PN:	504		
1.	If the plan provides v requirements during	welfare benefits, was the plan subject to the Form M-1 filing the plan year?	Ye	s No X		
	If "Yes" is checked, complete lines 2 and 3.					
2.	Is the plan currently	in compliance with Form M-1 filing requirements?	Ye	s No		
3.	to file the 2013 Form M-1 that was require	onfirmation Code for the 2013 Form M-1 annual report. If the plan M-1 annual report, enter the Receipt Confirmation Code for the ed to be filed under the Form M-1 filing requirements. (Failure to n Code will subject the Form 5500 filing to rejection as incompleted	most re enter a	cent Form		

Receipt Confirmation Code