Form 5500 Annual Return/Report of Employee Benefit Plan			OMB Nos. 12	210-0110	
Department of the Treasury		mployee benefit plans under sections 104 t Income Security Act of 1974 (ERISA) and		12	10-0089
Internal Revenue Service		a) of the Internal Revenue Code (the Code).		2014	
Department of Labor Employee Benefits Security Administration		tries in accordance with s to the Form 5500.			
Pension Benefit Guaranty Corporation				Form is Open to Pu Inspection	Julic
	entification Information				
For calendar plan year 2014 or fisca	I plan year beginning 01/01/2014	and ending 12/31/20	014		
A This return/report is for:	a multiemployer plan;	a multiple-employer plan (Filers checking participating employer information in acco			ons); or
	X a single-employer plan;	a DFE (specify)			
B This return/report is:	the first return/report;	the final return/report;			
	an amended return/report;	a short plan year return/report (less than 12 months).			
C If the plan is a collectively-bargain	ned plan, check here		🕨 🛛		
D Check box if filing under:	X Form 5558;	automatic extension;	the DFVC program;		
Ū.	special extension (enter description)				
Part II Basic Plan Infor	mation—enter all requested informatio	n			
1a Name of plan ALCATEL-LUCENT RETIREE WEL			1b	Three-digit plan number (PN) ▶	504
			1c	Effective date of pla 10/01/1996	an
2a Plan sponsor's name and addre	ess; include room or suite number (employ	ver, if for a single-employer plan)	2b	Employer Identifica	ition
ALCATEL-LUCENT USA INC.				Number (EIN) 22-3408857	
600 MOUNTAIN AVENUE, ROOM 6D-401A			2c Plan Sponsor's telephone number 908-582-7140		
MURRAY HILL, NJ 07974			2d	Business code (see instructions) 334200	э

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.	10/15/2015	INGRID ORAV					
HERE	Signature of plan administrator	Date	Enter name of individu	al signing as plan administrator				
SIGN HERE								
HERE	Signature of employer/plan sponsor	Date	Enter name of individu	al signing as employer or plan sponsor				
SIGN HERE								
HERE	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) Preparer's telephone number (optional)								
For Pap	For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.							

3a	Plan administrator's name and address 🛛 Same as Plan Sponsor	3b Adm	inistrator's EIN
		3c Adm	inistrator's telephone ber
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 EIN	
а	Sponsor's name	4c PN	
5	Total number of participants at the beginning of the plan year	5	95929
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		
a(1) Total number of active participants at the beginning of the plan year	. 6a(1)	0
a(2	2) Total number of active participants at the end of the plan year	6a(2)	0
b	Retired or separated participants receiving benefits	. 6b	92930
С	Other retired or separated participants entitled to future benefits	. 6c	0
d	Subtotal. Add lines 6a(2), 6b, and 6c.	. 6d	92930
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	
	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested		
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	a Plan funding arrangement (check all that apply)			9b Plan benefit arrangement (check all that apply)				
	(1)	X	Insurance		(1)	X	In	surance
	(2)		Code section 412(e)(3) insurance contracts		(2)		С	ode section 412(e)(3) insurance contracts
	(3)	X	Trust		(3)	X	Ti	rust
	(4)		General assets of the sponsor		(4)		G	eneral assets of the sponsor
10	Check	all ap	plicable boxes in 10a and 10b to indicate which schedules are at	tache	d, and, v	wher	e ind	icated, enter the number attached. (See instructions)
а	Pensic	on Sci	hedules	b General Schedules				
	(1)		R (Retirement Plan Information)		(1)	X		H (Financial Information)
	(2)		MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	Π		I (Financial Information – Small Plan)
			Purchase Plan Actuarial Information) - signed by the plan		(3)	X	2	A (Insurance Information)
			actuary		(4)	X		C (Service Provider Information)
	(3)		SB (Single-Employer Defined Benefit Plan Actuarial		(5)	X		D (DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)			G (Financial Transaction Schedules)

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)					
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)						
If "Yes" is checked, complete lines 11b and 11c.						
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)						

11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_

SCHEDULE	Α	Insuranc	e Informatio	n			
(Form 5500)					ON	1B No. 1210-0110
Department of the Treas Internal Revenue Servi	sury	This schedule is required Employee Retirement Inc					2014
Department of Labor Employee Benefits Security Ad		File as an at	tachment to Form 55	00.			
Pension Benefit Guaranty Co	 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 20	14 or fiscal plar	n year beginning 01/01/2014		and en	ding 12/3	31/2014	1
A Name of plan ALCATEL-LUCENT RETIF	REE WELFARE	E BENEFITS PLAN		B Three plan	e-digit number (PN) 🕨	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 separat		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
UHC OF COLORADO HI	ЛО						
	(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
84-1011378	95434	092027	11	13	01/01/201	4	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents, b	prokers, and c	ther persons in
(a) Total a	amount of comr			(b) To	otal amount o	of fees paid	
		0					0
3 Persons receiving com		ees. (Complete as many entries a					
	(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 ar	nd base	Fees	and other commission	ns paid			
commissions pai	d	(c) Amount		(d) Purpose	9		(e) Organization code
		I					
	(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 and base	F					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
For Denenwork Deduction Act Natio	For Departurely Deduction Act Nation and OMP Control Numbers, and the instructions for Form FEOD					

(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 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
			l
			1

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

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of								
		this report.			,			
		ent value of plan's interest under this contract in the general account at year						
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5			
6	Con	tracts With Allocated Funds:						
	a State the basis of premium rates							
	b	Premiums paid to carrier			. 6b			
	C	Premiums due but unpaid at the end of the year			6c			
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d			
		Specify nature of costs						
	-							
	е	Type of contract: (1) individual policies (2) group deferred	annuity					
		(3) other (specify)						
	4	Management was a base of the state of the st		shaalahaa N				
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin						
1		tracts With Unallocated Funds (Do not include portions of these contracts main						
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee				
		(3) guaranteed investment (4) dother ►						
	b	Balance at the end of the previous year			. 7b			
	С	Additions: (1) Contributions deposited during the year	. 7c(1)					
		(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
		•						
		(6)Total additions			7c(6)			
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d			
	е	Deductions:						
		(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)					
		•						
	f	(5) Total deductions						

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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 w					s cover individual employee	₽S,
8	Bene	efit and contract type (check all applicable boxes)						
-	a	Health (other than dental or vision)	b Dental	c∏	Vision		d Life insurance	
				느				
	е	Temporary disability (accident and sickness)	f Long-term disability		Supplemental unem	ployment	h Prescription drug	
	i	Stop loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)						
_	_							
9		rience-rated contracts:	Г	0.(1)			-	
		Premiums: (1) Amount received	-	9a(1)			-	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			-	
		(3) Increase (decrease) in unearned premium res		9a(3)		00(4)		
	-	(4) Earned ((1) + (2) - (3)) Benefit charges (1) Claims paid	F	9b(1)		9a(4)		
		o () 1	-	9b(1) 9b(2)			-	
		 (2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2))				9b(3)		_
		(4) Claims charged				9b(3) 9b(4)		
		Remainder of premium: (1) Retention charges (o				55(4)		
	Ũ	(A) Commissions		9c(1)(A)			4	
		(B) Administrative service or other fees	-	9c(1)(B)			-	
		(C) Other specific acquisition costs	-	9c(1)(C)			1	
		(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		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 b	penefits after	retirement			
		(2) Claim reserves	•			9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2).)	. 9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			10a	688	3927
	b	If the carrier, service, or other organization incurr	ed any specific costs in co	onnection with	h the acquisition or			
		retention of the contract or policy, other than repo	orted in Part I, line 2 above	e, report amo	unt	. 10b		

Specify nature of costs

Part I	Provision of Information			
11 Did	he 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	•	Incurrent	o Informatio	n			
(Form 5500		insurance	ce Information	n		OM	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).				2014	
Department of Labo Employee Benefits Security Ad		File as an a	ttachment to Form 55	600.			
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		on		m is Open to Public Inspection
For calendar plan year 20	14 or fiscal plan	year beginning 01/01/2014		and end	ding 12	2/31/2014	-
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						
UNIVERA HEALTHCARE	=						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a				ontract year
()	code	identification number	policy or contract		(†)	From	(g) To
15-0329043	52411	*SEE BELOW		74	01/01/20	014	12/31/2014
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in line 3 t	the agents,	, brokers, and o	ther persons in
(a) Total a	amount of comn	nissions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
	(a) Name ar	nd address of the agent, broker,	or other person to who	m commissi	ons or fees	s were paid	
(b) Amount of sales ar			s and other commissio				4
commissions pa	id	(c) Amount		(d) Purpose)		(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to who	m commissi	ons or fee	s were paid	
	(

(b) Amount of sales and base	F					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
For Panarwork Reduction Act Natics and OMR Control Numbers, soo the instructions for Form 5500						

(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 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
			l
			1

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

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	cts with each carrier ma	v be treated	as a unit for purposes of
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st		shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Ρ	aq	e	4

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 sa rposes if such contracts a	re experienc	e-rated as a unit. Wh	ere contract	
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	/ g	Supplemental unemp	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	l	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)		T	
		(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					4
		(A) Commissions		9c(1)(A)			4
		(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)			-
		(F) Charges for risks or other contingencies		9c(1)(F)			4
		(G) Other retention charges		9c(1)(G)		0-(4)(1)	
		(H) Total retention				9c(1)(H) 9c(2)	
	-	(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)					
	d	Status of policyholder reserves at end of year: (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		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to c				10a	241900
	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	he 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.				

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SCHEDULE		Insuran	ce Informatio	n		OM	IB No. 1210-0110
(Form 5500							
Department of the Treas Internal Revenue Serv		Employee Retirement In					2014
Department of Labo Employee Benefits Security Ad		File as an a	attachment to Form 5	500.			
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	are required to provide ERISA section 103(a)(2		ion		m is Open to Public Inspection
For calendar plan year 20	14 or fiscal plar	n year beginning 01/01/2014		and en	ding 12	2/31/2014	
A Name of plan ALCATEL-LUCENT RETI	REE WELFARE	E 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					
1 Coverage Information:							
(a) Name of insurance ca	arrier						
HIP HEALTH PLAN OF N	NY		-				
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate r persons covered a policy or contra	at end of	(f)	Policy or co From	ontract year (g) To
13-1828429	55247	*SEE BELOW		53	01/01/20	014	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	al commissions paid. I	List in line 3	the agents,	, brokers, and o	ther persons in
(a) Total :	amount of com	missions 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 al	l 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 a			es and other commission				
commissions pa	id	(c) Amount		(d) Purpose	9		(e) Organization code
		nd address of the agent, broker	or other person to who		ions or foor	s were poid	
	(a) Name a	nd address of the agent, broker,		UNICOMMISS		s were paid	

(b) Amount of sales and base	I						
commissions paid	(c) Amount	(e) Organization code					
For Penerwork Paduation Act Nation and OMP Control Numbers, son the instructions for Form 5500							

(b) Amount of sales and base	Fees and other commissions paid					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Nan	ne and address of the agent, broke	, 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		(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
			l
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(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	cts with each carrier ma	v be treated	as a unit for purposes of
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st	- Constant	shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Page	4

Pa	art II	Welfare Benefit Contract Informat						
		If more than one contract covers the same gr						
		information may be combined for reporting put the entire group of such individual contracts					is cover mainfundual 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	
	еГ	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemp	olovment	h Prescription drug	
	iΓ	Stop loss (large deductible)	j X HMO contract	, 3_ k	PPO contract	-)	I Indemnity contract	
		-		κ_				
	m	Other (specify)						
9	Expe	rience-rated contracts:						
		Premiums: (1) Amount received		9a(1)			-	
		(2) Increase (decrease) in amount due but unpaid	۱	9a(2)			7	
		(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 ne	ot include amount entered	l in line 9c(2)	.)	9e		
10	No	nexperience-rated contracts:						
		Total premiums or subscription charges paid to c				10a	40124	10
	b	If the carrier, service, or other organization incurr				4.51		
		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	Α	Insuranc	e Informatio	n			
	(Form 5500)				OMB No. 1210-0110		
Department of the Treas Internal Revenue Serv	sury	This schedule is required Employee Retirement Inc					2014
Department of Labor Employee Benefits Security Ad		File as an at	tachment to Form 55	500.			
Pension Benefit Guaranty Co	prporation	 Insurance companies ar pursuant to El 	re required to provide t RISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
For calendar plan year 20	14 or fiscal pla	n year beginning 01/01/2014		and en	ding 12	/31/2014	
A Name of plan ALCATEL-LUCENT RETII	REE WELFAR	E 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 c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
23-2399845	95199	509964	32	27	01/01/20	14	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. L	ist in line 3 t	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		ees. (Complete as many entries a					
	(a) Name a	and address of the agent, broker, o	or other person to who	m commissi	ons or fees	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	and address of the agent, broker, o	or other person to who	m commissi	ons or fees	were paid	

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

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Nan	ne and address of the agent, broke	, 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		(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
			l
			1

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

Pa	art II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of						
		this report.			,		
		ent value of plan's interest under this contract in the general account at year					
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5		
6	Con	tracts With Allocated Funds:					
	а	State the basis of premium rates					
	b	Premiums paid to carrier			. 6b		
	C	Premiums due but unpaid at the end of the year			6c		
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d		
		Specify nature of costs					
	-						
	е	Type of contract: (1) individual policies (2) group deferred	annuity				
		(3) other (specify)					
	4	Management was a base of the state of the st	- Constant	shaalahaa N			
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin					
1		tracts With Unallocated Funds (Do not include portions of these contracts main					
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee			
		(3) guaranteed investment (4) dother ►					
	b	Balance at the end of the previous year			. 7b		
	С	Additions: (1) Contributions deposited during the year	. 7c(1)				
		(2) Dividends and credits	7c(2)				
		(3) Interest credited during the year	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	7c(5)				
		•					
		(6)Total additions			7c(6)		
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d		
	е	Deductions:					
		(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)				
		•					
	f	(5) Total deductions					

	Page 4	
tion		

Part III Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting put the entire group of such individual contracts w	oup of employees of the same emplo urposes if such contracts are experier	nce-rated as a unit. Where cor	tracts cover individual employees,
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		nt h Prescription drug
i Stop loss (large deductible)	j X HMO contract k	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 res			
(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 charged			(4)
C Remainder of premium: (1) Retention charges (o	n 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		0-/1	<u></u>
(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			
e Dividends or retroactive rate refunds due. (Do no 10 Nonexperience-rated contracts:	ot include amount entered in line 9c(2	2).)	8
 a Total premiums or subscription charges paid to c 	arriar		1700045
b If the carrier, service, or other organization incurr			a 1799845
retention of the contract or policy, other than repo			lb

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	Δ	Insuranc	e Information	n			
(Form 5500						ON	/IB No. 1210-0110
Department of the Treas Internal Revenue Servi	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2014		
Department of Labor Employee Benefits Security Ad		File as an at	ttachment to Form 55	00.			
Pension Benefit Guaranty Co	prporation	 Insurance companies an pursuant to El 	re required to provide t RISA section 103(a)(2)		on	This Fo	rm is Open to Public Inspection
For calendar plan year 20	14 or fiscal plan	year beginning 01/01/2014		and end	ding 12	2/31/2014	-
A Name of plan ALCATEL-LUCENT RETIF	REE WELFARE	BENEFITS PLAN		B Three plan	e-digit number (P	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA I		e 2a of Form 5500		D Employ 22-340		cation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a					
Coverage mormation.							
(a) Name of insurance ca	rrier						
GHC PUGET SOUND							
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	contract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
91-0511770	95672	8800	6	68	01/01/20)14	12/31/2014
2 Insurance fee and com 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		ees. (Complete as many entries a					
	(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 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 Paparwork Poduction Act Notice	and OMR Control Numbers	soo the instructions for Form 5500	

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Nan	ne and address of the agent, broke	, 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		(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	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
			l		
			1		

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

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	cts with each carrier ma	v be treated	as a unit for purposes of
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er		5		
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st		shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

	Pa	qe	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 w	oup of employees of the s irposes if such contracts a	are experienc	e-rated as a unit. Wh	ere contracts	
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	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 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		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	n an accrual basis)				_
		(A) Commissions	-	9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B)			<u>_</u>
		(C) Other specific acquisition costs		9c(1)(C)			<u> </u>
		(D) Other expenses		9c(1)(D)			1
		(E) Taxes	-	9c(1)(E)			4
		(F) Charges for risks or other contingencies		9c(1)(F)			4
		(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 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		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to c				10a	333372
	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	he 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		Insuran	ce Informatio	n		ОМ	B No. 1210-0110
(Form 5500	-	This schedule is required to be filed under section 104 of the			-	0011	
Department of the Treas Internal Revenue Serv		Employee Retirement Ind					2014
Department of Labo Employee Benefits Security Ad		File as an a	ttachment to Form 5	500.			
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	are required to provide RISA section 103(a)(2		ion		m is Open to Public Inspection
For calendar plan year 20	14 or fiscal plar	vear beginning 01/01/2014		and end	ding 12	2/31/2014	-
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 as shown on line 2a of Form 5500 D Employer Identification Number (EIN) ALCATEL-LUCENT USA INC. 22-3408857							
		ing Insurance Contract (Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
UHC OF ARIZONA HMO)	1					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate n persons covered a policy or contra	at end of	(f)	Policy or co From	ontract year (g) To
94-3267522	95617	060408,060406	1	101	01/01/20)14	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. I	List in line 3 t	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 al	l persons).			
	(a) Name a	nd address of the agent, broker,	or other person to who	om commissi	ions or fees	s were paid	
(b) Amount of sales ar			s and other commission				
commissions paid (c) Amount		(c) Amount		(d) Purpose	9		(e) Organization code
	(a) Nome a	nd address of the agent braker	or other person to who		ions or foor	woro poid	
	(a) Namé a	nd address of the agent, broker,	or other person to who		ions of tees	s were paid	

(b) Amount of sales and base	F					
commissions paid	(c) Amount	(c) Amount (d) Purpose				
For Donomularly Daduation Act Natio	For Departurely Deduction Act Nation and OMP Control Numbers, and the instructions for Form FEOD					

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	 (e) Organization code 		
(a) Nan	ne and address of the agent, broke	, 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		(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	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
			l		
			1		

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

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for pur						
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st		shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Ρ	aq	e	4

Pa	art II	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting put the entire group of such individual contracts of the entire group of such individual contracts of	oup of employees of the s urposes if such contracts a	are experienc	e-rated as a unit. Wh	ere contract		
8	Bene	efit and contract type (check all applicable boxes)						
-	аſ	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance	
	e	Temporary disability (accident and sickness)	f Long-term disabilit		Supplemental unem	pioyment	h Prescription drug	
	i	Stop loss (large deductible)	j X 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						
		(3) Increase (decrease) in unearned premium res	L	9a(3)				
	-	(4) Earned ((1) + (2) - (3))	Г			. 9a(4)		
		Benefit charges (1) Claims paid	-	. ,			_	
		(2) Increase (decrease) in claim reserves	L					
		(3) Incurred claims (add (1) and (2))				. 9b(3)		
		(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (o					4	
		(A) Commissions	•	9c(1)(A)			4	
		(B) Administrative service or other fees		9c(1)(B)			-	
		(C) Other specific acquisition costs		9c(1)(C)			4	
		(D) Other expenses		9c(1)(D)			-	
		(E) Taxes	-	9c(1)(E)			4	
		(F) Charges for risks or other contingencies		9c(1)(F)			4	
		(G) Other retention charges	-			0-(4)(1))		
		(H) Total retention	_			. 9c(1)(H)		
	_	(2) Dividends or retroactive rate refunds. (These				()		
	d	Status of policyholder reserves at end of year: (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	65	0367
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than repo				. 10b		

Specify nature of costs

Par	t 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 a	Inswer to line 11 is "Yes," specify the information not provided.				

SCHEDULE A 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				2014	
Internal Revenue Serv	ice	Employee Retirement Inc					2014
Department of Labo Employee Benefits Security Ad	ministration	File as an a	ttachment to Form 55	500.		This For	m is Open to Public
Pension Benefit Guaranty Co	prporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		ion		Inspection
For calendar plan year 20	14 or fiscal plan	year beginning 01/01/2014		and en	ding 12	2/31/2014	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	• • •				
1 Coverage Information:							
(a) Name of insurance ca	rrier						
BLUECROSS BLUESHIE	ELD		1				
(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
36-1236610	70670	H73523,B73523	1	58	01/01/20	014	12/31/2014
2 Insurance fee and com descending order of the		tion. 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 paid		(c) Amount		(d) Purpose	9		(e) Organization code
		nd address of the agent, broker,	or other person to who	moommice	ione or foo	e woro poid	•
	(a) Name a	nu auuress or the agent, proker,	or other person to who	ITT COMMISS		s were paid	

(b) Amount of sales and base						
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
For Dononwork Doduction Act Natio	For Panarwork Paduation Act Nation and OMP Control Numbers, and the instructions for Form 5500					

(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 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
			l
			1

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

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for pur						
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st		shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Part III

Schedule A (Form 5500) 2014	Page 4
Welfare Benefit Contract Information	
If more than one contract covers the same group of em	ployees of the same employer(s) or members of the same employee

	If more than one contract covers the same g information may be combined for reporting the entire group of such individual contracts	ourposes if such contracts	are experienc	ce-rated as a unit. Wh	nere contrac	
8 B	enefit 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 disabili	ty g	Supplemental unem	ployment	h Prescription drug
i	Stop loss (large deductible)	j 🛛 HMO contract	k	PPO contract		I Indemnity contract
r	n ☐ Other (specify) ►					
9 E	perience-rated contracts:					
a	Premiums: (1) Amount received		9a(1)			7
	(2) Increase (decrease) in amount due but unpa	id	9a(2)			
	(3) Increase (decrease) in unearned premium re	serve	9a(3)			
	(4) Earned ((1) + (2) - (3))				. 9a(4)	
	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)	
	Remainder of premium: (1) Retention charges (on an accrual basis)				
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees					_
	(C) Other specific acquisition costs					
	(D) Other expenses					
	(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. (Thes	e amounts were 🗌 paid ir	n cash, or	credited.)	9c(2)	
	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 include amount entere	d in line 9c(2)	.)	. 9e	
10	Nonexperience-rated contracts:					
	Total premiums or subscription charges paid to	carrier			. 10a	1716514
	If the carrier, service, or other organization incurretention of the contract or policy, other than re				. 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	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).					2014
Department of Labor Employee Benefits Security Ad		File as an at	tachment to Form 55	500.			
Pension Benefit Guaranty Co	prporation		are required to provide the information ERISA section 103(a)(2).			This For	m is Open to Public Inspection
For calendar plan year 20	14 or fiscal pla	n year beginning 01/01/2014		and en	ding 12	2/31/2014	
A Name of plan ALCATEL-LUCENT RETII	REE WELFAR	E BENEFITS PLAN		B Thre- 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)
		ning Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca							
KAISER FOUNDATION H		OF SO. CA				Delieurere	ontroot voor
(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	122636	3	13	01/01/20)14	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3.	the agents,	brokers, and o	ther persons in
	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	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	s and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpos	9		(e) Organization code
	(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 and base	F			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	

(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 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		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
			l
			1

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

Pa	Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of						
		this report.			,		
		ent value of plan's interest under this contract in the general account at year					
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5		
6	Con	tracts With Allocated Funds:					
	а	State the basis of premium rates					
	b	Premiums paid to carrier			. 6b		
	C	Premiums due but unpaid at the end of the year			6c		
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d		
		Specify nature of costs					
	-						
	е	Type of contract: (1) individual policies (2) group deferred	annuity				
		(3) other (specify)					
	4	Management was a base of the state of the st		shaalahaa N			
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin					
1		tracts With Unallocated Funds (Do not include portions of these contracts main					
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee			
		(3) guaranteed investment (4) dother ►					
	b	Balance at the end of the previous year			. 7b		
	С	Additions: (1) Contributions deposited during the year	. 7c(1)				
		(2) Dividends and credits	7c(2)				
		(3) Interest credited during the year	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	7c(5)				
		•					
		(6)Total additions			7c(6)		
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d		
	е	Deductions:					
		(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)				
		•					
	f	(5) Total deductions					

	Pa	qe	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 w	oup of employees of the sa Irposes if such contracts a	re experienc	e-rated as a unit. Wh	ere contract	
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	/ g	Supplemental unemp	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	I	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)		T	
		(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					4
		(A) Commissions		9c(1)(A)			4
		(B) Administrative service or other fees		9c(1)(B)			1
		(C) Other specific acquisition costs	-	9c(1)(C)			4
		(D) Other expenses		9c(1)(D)			4
		(E) Taxes	-	9c(1)(E)			4
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)		0-(4)(1)	
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These				· · · ·	
	d	Status of policyholder reserves at end of year: (1	, 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		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to c				10a	1470206
	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.			

	•	Income						
SCHEDULE A		Insurance Information			OMB No. 1210-0110			
			required to be filed under section 104 of the ment Income Security Act of 1974 (ERISA).			2014		
Department of Labor Employee Benefits Security Ad		 File as an attachment to Form 5500. 						
Pension Benefit Guaranty Corporation		Insurance companies are required to provide the ir pursuant to ERISA section 103(a)(2).		he information		m is Open to Public Inspection		
For calendar plan year 2014 or fiscal plan year beginning 01/01/201			and ending 12/31/2014					
A Name of plan ALCATEL-LUCENT RETIF		B Three plan r	nree-digit Ian number (PN) 504					
C Plan sponsor's name a ALCATEL-LUCENT USA I			Employer Identification Number (EIN) 2-3408857					
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:								
(a) Name of insurance carrier KAISER FOUNDATION HEALTH PLAN OF CO								
	(c) NAIC	c (d) Contract or (e) Approximate nu		number of		Policy or c	Policy or contract year	
(b) EIN	code	identification number	persons covered a policy or contract	(T)		From	(g) To	
84-0591617	95669	07368	299 0		01/01/20	14	12/31/2014	
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 c	ther persons in	
(a) Total amount of co		missions paid	(b) Total amount of fees paid		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	m commissio	ons or fees	were paid		
(b) Amount of sales and base		Fee	Fees and other commissions paid					
commissions pai		(c) Amount	(d) Purpose				(e) Organization code	

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

Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.
(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Nan	ne and address of the agent, broke	, 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		(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 commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code
			l
			1

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

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purp					as a unit for purposes of	
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
5 Current value of plan's interest under this contract in separate accounts at year end						
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st		shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

	Pa	qe	4
--	----	----	---

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 irposes if such contracts a	are experienc	e-rated as a unit. Wh	ere contracts	
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	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 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		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)				4
		(A) Commissions		9c(1)(A)			4
		(B) Administrative service or other fees		9c(1)(B)			4
		(C) Other specific acquisition costs	-	9c(1)(C)			4
		(D) Other expenses		9c(1)(D)			4
		(E) Taxes	F	9c(1)(E)			4
		(F) Charges for risks or other contingencies		9c(1)(F)			-
		(G) Other retention charges	L.	9c(1)(G)		0-(4)(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	, 1			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		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to c				10a	1712234
	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	he 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			OM	IB 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).					2014
Department of Labor Employee Benefits Security Adr		File as an at	ttachment to Form 55	500.			
Pension Benefit Guaranty Co	rporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					m is Open to Public Inspection
For calendar plan year 20 ²	14 or fiscal pla	an year beginning 01/01/2014		and en	ding 12	/31/2014	
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN B Three-digit plan number (PN)					N) 🕨	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 1		•		0	
(a) Name of insurance car KAISER FOUNDATION F		N OF NORTHWEST					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
93-0798039	95540	8384		57	01/01/20	14	12/31/2014
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 a	amount of com	nmissions paid	(b) Total amount of fees paid				
	0 0						
3 Persons receiving com	missions and	fees. (Complete as many entries a	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 ar			s and other commissio				4
commissions pai	d	(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			

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Nan	ne and address of the agent, broke	, 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		(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
			l
			1

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

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of						
		this report.			,			
		ent value of plan's interest under this contract in the general account at year						
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5			
6	Con	tracts With Allocated Funds:						
	а	State the basis of premium rates						
	b	Premiums paid to carrier			. 6b			
	C	Premiums due but unpaid at the end of the year			6c			
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d			
		Specify nature of costs						
	-							
	е	Type of contract: (1) individual policies (2) group deferred	annuity					
		(3) other (specify)						
	4	Management was a base of the state of the st	- Constant	shaalahaa N				
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin						
1		tracts With Unallocated Funds (Do not include portions of these contracts main						
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee				
		(3) guaranteed investment (4) dother ►						
	b	Balance at the end of the previous year			. 7b			
	С	Additions: (1) Contributions deposited during the year	. 7c(1)					
		(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
		•						
		(6)Total additions			7c(6)			
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d			
	е	Deductions:						
		(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)					
		•						
	f	(5) Total deductions						

	Page 4	
ation		

Part I	Welfare Benefit Contract Informat If more than one contract covers the same guinformation may be combined for reporting puthe entire group of such individual contracts of	oup of employees of urposes if such contra	acts are experien	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 dis	ability g	Supplemental unem	ployment	h Prescription drug
i	Stop loss (large deductible)	j X HMO contract	k [PPO contract		I Indemnity contract
m	Other (specify)	•	L			
	_					
	erience-rated contracts:					4
а	Premiums: (1) Amount received					4
	(2) Increase (decrease) in amount due but unpaid					-
	(3) Increase (decrease) in unearned premium res (4) Earned ((1) + (2) - (3))				9a(4)	
b	Benefit charges (1) Claims paid				Ja(4)	
	(2) Increase (decrease) in claim reserves					4
	(3) Incurred claims (add (1) and (2))			I	9b(3)	
	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (c					
	(A) Commissions					1
	(B) Administrative service or other fees					1
	(C) Other specific acquisition costs		9c(1)(C)]
	(D) Other expenses		9c(1)(D)]
	(E) Taxes					
	(F) Charges for risks or other contingencies					
	(G) Other retention charges		9c(1)(G)		1	
	(H) Total retention	·····	······ <u></u> ·		9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	amounts were pa	aid in cash, or	credited.)	9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to prov	vide benefits afte	r 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 ent	tered in line 9c(2] .)	. 9e	
10 No	pnexperience-rated contracts:					
а	Total premiums or subscription charges paid to c				10a	354396
b	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 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	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					2014
Department of Labo Employee Benefits Security Ad		File as an a	ttachment to Form 55	500.			
Pension Benefit Guaranty Co	prporation	 Insurance companies a pursuant to E 	are required to provide t RISA section 103(a)(2)		ion	This Form is Open to Publi Inspection	
For calendar plan year 20	14 or fiscal plai	n year beginning 01/01/2014		and en	ding 12	2/31/2014	
A Name of plan ALCATEL-LUCENT RETII	REE WELFAR	E BENEFITS 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		cation Number	(EIN)
Part I Information on a separat	on Concern e Schedule A.	ing Insurance Contract (Individual contracts grouped as	Coverage, Fees, a a unit in Parts II and III	and Com	missions orted on a 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		59	01/01/20)14	12/31/2014
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 com	missions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving com	missions and fo	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	nd base	Fee	es and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	9		(e) Organization code

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

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

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Nan	ne and address of the agent, broke	, 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		(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
			l
			1

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

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of				
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
5 Current value of plan's interest under this contract in separate accounts at year end						
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st		shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Ρ	aq	e	4

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 sauro o	are experienc	e-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	c	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unemp	ployment	h Prescription drug
	iΓ	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	1	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)		T	
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid					
		(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					4
		(A) Commissions		9c(1)(A)			4
		(B) Administrative service or other fees		9c(1)(B)			-
		(C) Other specific acquisition costs	F	9c(1)(C)			-
		(D) Other expenses		9c(1)(D)			4
		(E) Taxes		9c(1)(E)			_
		(F) Charges for risks or other contingencies		9c(1)(F)			_
		(G) Other retention charges				0.(1)(1)	
		(H) Total retention	_	_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These		I		\ /	
	d	Status of policyholder reserves at end of year: (1	, 1			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		nexperience-rated contracts:				45	
	-	Total premiums or subscription charges paid to c				10a	235871
	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	he 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	1B No. 1210-0110
(Form 5500) Department of the Treasury	This schedule is requir	This schedule is required to be filed under section 104 of the			
Internal Revenue Service		Employee Retirement Income Security Act of 1974 (ERISA).			
Department of Labor Employee Benefits Security Administration	► File as an	attachment to Form 55	500.		
Pension Benefit Guaranty Corporation		s are required to provide to ERISA section 103(a)(2)		I his For	m is Open to Public Inspection
For calendar plan year 2014 or fiscal	plan year beginning 01/01/2014	4	and ending	12/31/2014	
A Name of plan ALCATEL-LUCENT RETIREE WELF	ARE BENEFITS PLAN		B Three-digit plan number	PN)	504
C Plan sponsor's name as shown of ALCATEL-LUCENT USA INC.	C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC.			fication Number	(EIN)
	erning Insurance Contract A. Individual contracts grouped a				
1 Coverage Information:					
(a) Name of insurance carrier					
RAISER FOUNDATION REALTH FI		(e) Approximate n	umber of	Policy or c	ontract year
(b) EIN (c) NA code	C (d) Contract or identification number	persons covered a policy or contract	at end of	(f) From	(g) To
58-1592076 96237	2081		70 01/01/	2014	12/31/2014
2 Insurance fee and commission info descending order of the amount pa		otal commissions paid. L	ist in line 3 the agen	s, brokers, and o	other persons in
(a) Total amount of a	ommissions paid	(b) Total amount of fees paid			
	0				0
3 Persons receiving commissions a	nd fees. (Complete as many entrie	es as needed to report all	persons).		
(a) Nar	ne and address of the agent, broke	er, or other person to who	m commissions or fe	es were paid	
(b) Amount of sales and base	F	ees and other commissio	ns paid		
commissions paid	(c) Amount		(d) Purpose		(e) Organization code

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
For Panerwork Reduction Act Natice and OMB Control Numbers, see the instructions for Form 5500				

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

(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 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
			l
			1

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

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of				
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
5 Current value of plan's interest under this contract in separate accounts at year end						
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st	- Constant	shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Ρ	aq	e	4

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 saure o	are experienc	e-rated as a unit. Wh	ere contract	
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	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	I	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)		T	
		(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					4
		(A) Commissions		9c(1)(A)			4
		(B) Administrative service or other fees	F	9c(1)(B)			4
		(C) Other specific acquisition costs	F	9c(1)(C)			4
		(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	L	9c(1)(G)		0-(4)(1)	
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These				· · · ·	
	d	Status of policyholder reserves at end of year: (1	, 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		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to c				10a	611467
	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	he 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					OMB No. 1210-0110		
(FORM 5500) Department of the Treas	Form 5500) artment of the Treasury This schedule is required to be filed under section 104 of the						2014
Internal Revenue Servi	ce		ncome Security Act of 19				2014
Department of Labor Employee Benefits Security Adr		File as an	attachment to Form 55	500.	-		
Pension Benefit Guaranty Co	rporation	 Insurance companies pursuant to 	are required to provide t ERISA section 103(a)(2)			This Foi	rm is Open to Public Inspection
For calendar plan year 201	14 or fiscal pla	n year beginning 01/01/2014		and ending	12/3 ⁻	1/2014	1
A Name of plan ALCATEL-LUCENT RETIF	REE WELFAR	E BENEFITS PLAN		B Three-dig plan nun	git nber (PN)	•	504
		- 0- of Form 5500		D Employee	l d a setifi a seti	an Nirmahan	(FINI)
C Plan sponsor's name a ALCATEL-LUCENT USA I		te 2a of Form 5500		D Employer 22-340885		on Number	(EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance cal	rrier						
KAISER FOUNDATION H	IEALTH PLAN	N OF HI					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate ne persons covered a				contract year
	code	identification number	policy or contrac		(f) F	rom	(g) To
94-1340523	60053	639	7 01/01/2)1/01/2014	ł	12/31/2014
2 Insurance fee and comr descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3 the	agents, br	okers, and c	other persons in
(a) Total a	mount of com	missions paid		(b) Total a	amount of	fees paid	
		0					0
3 Persons receiving com	missions and f	fees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broker	, or other person to who	m commissions	s or fees w	ere paid	
(b) Amount of sales an	d base	Fe	es and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code
							1

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

(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 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
			l
			1

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

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of						
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st		shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

		Page 4		
nation		 		

Pa	art I	I Welfare Benefit Contract Information If more than one contract covers the same group information may be combined for reporting purp the entire group of such individual contracts with	p of employees of the sources if such contracts	are experien	ce-rated as a unit. Wh	ere contract	oloyee organizations(s), the s cover individual employees,
8	Ben	efit and contract type (check all applicable boxes)					
	a	-	Dental	с	Vision		d Life insurance
	еĪ	Temporary disability (accident and sickness) f	Long-term disabili	tv a	Supplemental unemp	olovment	h Prescription drug
	; [HMO contract	_	PPO contract	olo jillo la	I Indemnity contract
	ין			r L			
	m	Other (specify)					
0	-						
9	•	erience-rated contracts:		00(1)			-
	a	Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpaid		\ /			-
		(2) Increase (decrease) in amount due but unpaid(3) Increase (decrease) in unearned premium reser					4
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		1		04(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 (on a					
		(A) Commissions	,	9c(1)(A)			1
		(B) Administrative service or other fees					1
		(C) Other specific acquisition costs		9c(1)(C)			1
		(D) Other expenses		9c(1)(D)]
		(E) Taxes]
		(F) Charges for risks or other contingencies					
		(G) Other retention charges		9c(1)(G)		1	
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These an	mounts were 🗌 paid ir	n cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) A	mount 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 not	nclude amount entered	d in line 9c(2)] .)	9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to car				10a	68570
	b	If the carrier, service, or other organization incurred retention of the contract or policy, other than report			•	10b	

Specify nature of costs

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

SCHEDULE	Α	Insuranc	e Informatio	n			
(Form 5500					OMB 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).				2014	
Department of Labor Employee Benefits Security Adr		File as an at	ttachment to Form 55	500.			
Pension Benefit Guaranty Co	rporation	 Insurance companies as pursuant to E 	re required to provide t RISA section 103(a)(2)		ion	This Fo	rm is Open to Public Inspection
For calendar plan year 201	14 or fiscal plar	n year beginning 01/01/2014		and en	ding 12	2/31/2014	
A Name of plan ALCATEL-LUCENT RETIR	E 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	•	cation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance car							
KAISER FOUNDATION H	IEALTH PLAN	OF NO. CA		una ha n a f		Delievere	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate ne persons covered a policy or contract	at end of	(f)	From	(g) To
94-1340523	00000	35147	4	89	01/01/20)14	12/31/2014
2 Insurance fee and comr descending order of the		ation. Enter the total fees and tota	I commissions paid. L	ist in line 3	the agents,	brokers, and o	other persons in
	amount of com	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	and address of the agent, broker, o	or other person to who	m commissi	ions or fees	were paid	
(b) Amount of sales an	nd base	Fees	s and other commissio	ns paid			
commissions paid		(c) Amount		(d) Purpose	9		(e) Organization code
	()))	and address of the agent broker					L

(b) Amount of sales and base	F					
commissions paid	(c) Amount	(c) Amount (d) Purpose				
For Denominants Deduction Act Nation and OND Control Numbers, and the instructions for Form 5500						

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

(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 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
			l
			1

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

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a u					as a unit for purposes of	
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st	- Constant	shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Ρ	aq	e	4

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 w					s cover individual employees,
8	Bene	efit and contract type (check all applicable boxes)	with each barnet may be in				
Ŭ	a	Health (other than dental or vision)	b Dental	c∏	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	′ 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	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	۱	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))	E CONTRACTOR OF CONTRACTOR OFO			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)			
		(D) Other expenses		9c(1)(D)			_
		(E) Taxes		9c(1)(E)			_
		(F) Charges for risks or other contingencies		9c(1)(F)			4
		(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	ot include amount entered	in line 9c(2).)	9e	
10		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to c				10a	3537583
	b	If the carrier, service, or other organization incurr				106	
		retention of the contract or policy, other than repo	oneu în Part I, line 2 above	, report amo	นทแ	10b	

Specify nature of costs 🕨

Part I	Provision of Information			
11 Did	he 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	Incuranc	e Information	n			
	(Form 5500)				C	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service	This schedule is required to be filed under section 104 of the				2014	
Department of Labor Employee Benefits Security Administration	File as an at	tachment to Form 55	00.			
Pension Benefit Guaranty Corporation	 Insurance companies ar pursuant to EF 	re required to provide t RISA section 103(a)(2)		ion	This F	orm is Open to Public Inspection
For calendar plan year 2014 or fiscal p	lan year beginning 01/01/2014		and en	ding 12	/31/2014	
A Name of plan ALCATEL-LUCENT RETIREE WELFA	RE BENEFITS PLAN		B Three plan	e-digit number (PN	N) 🕨	504
C Plan sponsor's name as shown on ALCATEL-LUCENT USA INC.	line 2a of Form 5500		D Emplo 22-340	-	ation Numbe	ər (EIN)
	rning Insurance Contract C A. Individual contracts grouped as a					
1 Coverage Information:						
(a) Name of insurance carrier						
		(e) Approximate nu	imber of		Policy or	contract year
(b) EIN (c) NAIO code	c (d) Contract or identification number	persons covered a policy or contrac	it end of	(f)	From (g) To	
22-2651245 95529	77087	19	99	01/01/20	14	12/31/2014
2 Insurance fee and commission infor descending order of the amount pai		l commissions paid. L	ist in line 3	the agents,	brokers, and	l other persons in
(a) Total amount of co		(b) Total amount of fees paid				
	0					0
3 Persons receiving commissions and	d fees. (Complete as many entries a	as needed to report all	persons).			
(a) Nam	e and address of the agent, broker, c	or other person to who	m commissi	ons or fees	were paid	
(b) Amount of sales and base	Fees	Fees and other commissions paid				
commissions paid	(c) Amount		(d) Purpose)		(e) Organization code
	e and address of the agent, broker, c	or other person to who	m commissi	ons or fees	were paid	

(b) Amount of sales and base	F					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
Fan Dememoral De dustien Ast Nation and OND Osstarl Numbers, see the instructions for Fam. 5500						

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

(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 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
			l
			1

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

Pa	Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of						
		this report.			,		
		ent value of plan's interest under this contract in the general account at year					
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5		
6							
	а	State the basis of premium rates					
	b	Premiums paid to carrier			. 6b		
	C	Premiums due but unpaid at the end of the year			6c		
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d		
		Specify nature of costs					
	-						
	е	Type of contract: (1) individual policies (2) group deferred	annuity				
		(3) other (specify)					
	4	Management was a base of the state of the st	- Constant	shaalahaa N			
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin					
1		tracts With Unallocated Funds (Do not include portions of these contracts main					
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee			
		(3) guaranteed investment (4) dother ►					
	b	Balance at the end of the previous year			. 7b		
	С	Additions: (1) Contributions deposited during the year	. 7c(1)				
		(2) Dividends and credits	7c(2)				
		(3) Interest credited during the year	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	7c(5)				
		•					
		(6)Total additions			7c(6)		
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d		
	е	Deductions:					
		(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)				
		•					
	f	(5) Total deductions					

Page	4

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 w					is cover maividual 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	
	еГ	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemp	olovment	h Prescription drug	
	iΓ	Stop loss (large deductible)	j X HMO contract	, 3_ k	PPO contract	- ,	I Indemnity contract	
				κ_				
	m	Other (specify)						
9	Expe	erience-rated contracts:						
		Premiums: (1) Amount received		9a(1)			-	
		(2) Increase (decrease) in amount due but unpaid	l	9a(2)			7	
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			7	
		(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 no	ot include amount entered	t in line 9c(2) .	.)	9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			10a	160664	ł2
	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	<u> </u>	

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 Information	n			
(Form 5500)						ON	/B No. 1210-0110
Department of the Treasu Internal Revenue Servic	ry	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2014	
Department of Labor Employee Benefits Security Adm	inistration	File as an at	tachment to Form 55	600.			
Pension Benefit Guaranty Corp	ooration	 Insurance companies ar pursuant to El 	re required to provide t RISA section 103(a)(2)		ion	This For	rm is Open to Public Inspection
For calendar plan year 201	4 or fiscal plar	an year beginning 01/01/2014 and ending 12			/31/2014	-	
A Name of plan ALCATEL-LUCENT RETIR	EE WELFARE	BENEFITS PLAN		B Three plan	e-digit number (Pl	N) 🕨	504
C Plan sponsor's name as ALCATEL-LUCENT USA IN		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							
UHC OF CALIFORNIA HM	10	T					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a policy or contrac	at end of	(f)	From	contract year (g) To
95-2931460	00000	142111	18	88	01/01/20	14	12/31/2014
2 Insurance fee and comm descending order of the a		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and c	other persons in
(a) Total ar	mount of comr	nissions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving comm	nissions 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	ions or fees	were paid	
(b) Amount of sales and			s and other commission				4
commissions paid		(c) Amount		(d) Purpose	e		(e) Organization code
	(-) N'	a dia dalam ang af th					•
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or tees	were paid	

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

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

(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 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
			l
			1

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

Pa	art II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of						
		this report.			,		
		ent value of plan's interest under this contract in the general account at year					
5 Current value of plan's interest under this contract in separate accounts at year end							
6	Con	tracts With Allocated Funds:					
	а	State the basis of premium rates					
	b	Premiums paid to carrier			. 6b		
	C	Premiums due but unpaid at the end of the year			6c		
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d		
		Specify nature of costs					
	-						
	е	Type of contract: (1) individual policies (2) group deferred	annuity				
		(3) other (specify)					
	4	Management was a base of the state of the st	- Constant	shaalahaa N			
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin					
1		tracts With Unallocated Funds (Do not include portions of these contracts main					
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee			
		(3) guaranteed investment (4) dother ►					
	b	Balance at the end of the previous year			. 7b		
	С	Additions: (1) Contributions deposited during the year	. 7c(1)				
		(2) Dividends and credits	7c(2)				
		(3) Interest credited during the year	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	7c(5)				
		•					
		(6)Total additions			7c(6)		
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d		
	е	Deductions:					
		(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)				
		•					
	f	(5) Total deductions					

Page	4

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 w					ts cover individual employees,
8	Bene	efit and contract type (check all applicable boxes)	,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,,			-1	
-	a	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disabilit	· • _	Supplemental unemp	ployment	h Prescription drug
	i	Stop loss (large deductible)	j 🕺 HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
9		rience-rated contracts:					
		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		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 no	ot include amount entered	t in line 9c(2) .	.)	9e	
10		nexperience-rated contracts:					
		Total premiums or subscription charges paid to c				10a	108805
	b	If the carrier, service, or other organization incurr				404	
		retention of the contract or policy, other than repo	orred 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	×	< No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuranc	e Informatio	n			
(Form 5500						OM	IB No. 1210-0110
Department of the Treas Internal Revenue Servi	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2014	
Department of Labor Employee Benefits Security Ad		► File as an attachment to Form 5500.					
Pension Benefit Guaranty Co	rporation		 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 20	14 or fiscal plar	n year beginning 01/01/2014		and en	ding 12	/31/2014	-
A Name of plan ALCATEL-LUCENT RETIR	REE WELFARE	E BENEFITS PLAN		B Three plan	ə-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)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:				•		0	
(a) Name of insurance ca	rrier						
PARTNERS NATL. HEAL	TH PLANS OF	F NC INC.					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
56-0894904	54631	011453	7	19	01/01/20	14	12/31/2014
2 Insurance fee and comp 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 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 who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fees	and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	9		(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	1

(b) Amount of sales and base	F				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
For Panarwork Poduction Act Natica and OMB Control Numbers, soo the instructions for Form 5500					

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

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Nan	ne and address of the agent, broke	, 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		(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
			l
			1

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

Part II		II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purp					
		this report.			,		
		rent value of plan's interest under this contract in the general account at year	. 4				
5		rent value of plan's interest under this contract in separate accounts at year en	nd		. 5		
6	Con	tracts With Allocated Funds:					
	а	State the basis of premium rates					
	h				Ch		
	b	Premiums paid to carrier			. 6b		
	с С	Premiums due but unpaid at the end of the year If the carrier, service, or other organization incurred any specific costs in cor			. 6c		
	d	retention of the contract or policy, enter amount.			6d		
		Specify nature of costs					
	е	Type of contract: (1) individual policies (2) group deferred	d annuity				
		(3) ☐ other (specify) ►					
	f	If contract purchased in whole or in part to distribute herefits from a termin	oting plan				
7		If contract purchased, in whole or in part, to distribute benefits from a termin					
'		tracts With Unallocated Funds (Do not include portions of these contracts ma					
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	lion guarantee			
		(3) guaranteed investment (4) dother ►					
	_						
	b	Balance at the end of the previous year			. 7b		
	С	Additions: (1) Contributions deposited during the year	. 7c(1)				
		(2) Dividends and credits	7c(2)				
		(3) Interest credited during the year	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	. 7c(5)				
		•					
					- (-)		
		(6)Total additions			. 7c(6)		
		Total of balance and additions (add lines 7b and 7c(6))	 1		. 7d		
	е	Deductions:	7-(4)				
		(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) 7e(4)				
		(4) Other (specify below)	. / e(4)				
		7					
		(5) Total deductions			. 7e(5)		
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			. 7f		

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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 w	oup of employees of the saure o	re experienc	e-rated as a unit. Wh	ere contract	
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	/ g	Supplemental unemp	ployment	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	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)		T	
		(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					4
		(A) Commissions		9c(1)(A)			4
		(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)			-
		(F) Charges for risks or other contingencies		9c(1)(F)			4
		(G) Other retention charges		9c(1)(G)		0-(4)(1)	
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	· · · ·				
	d	Status of policyholder reserves at end of year: (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		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to c				10a	1120264
	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	Δ	Insuran	ce Informatio	n			
(Form 5500		mourain				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).			2014		
Department of Labo Employee Benefits Security Ad		File as an a	File as an attachment to Form 5500.				
Pension Benefit Guaranty Co	orporation		urance 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	14 or fiscal plar	year beginning 01/01/2014		and end	ding 12	2/31/2014	
A Name of plan ALCATEL-LUCENT RETII	REE WELFARE	E 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)
		ing Insurance Contract (Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
UHC OF OKLAHOMA H	ЛО						
	(c) NAIC	(d) Contract or	(e) Approximate nun persons covered at policy or contract y			Policy or contract year	
(b) EIN	code	identification number			(f)	From	(g) To
33-0115166	96903	008102	1:	36	01/01/20	014	12/31/2014
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	the agents,	brokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount				tal amount	nt 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 commissi	ons or fees	s were paid	
(b) Amount of sales and base Fees and other commissions paid					_		
commissions paid		(c) Amount		(d) Purpose)		(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to who	m commissi	ons or fee	s were paid	
	(a) Name a	na addrood of the agent, broker,					

(b) Amount of sales and base	F						
commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
For Denominant's Padriation Act Nation and OMP Control Numbers, and the instructions for Form FEOD							

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.
(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Nan	ne and address of the agent, broke	, 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	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	 (e) Organization code 	
			l	
			1	

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

Pa	Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of					
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st		shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Ρ	aq	e	4

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	Ben	efit and contract type (check all applicable boxes)	with each barnet may be in			Topon.	
Ŭ	a	Health (other than dental or vision)	b Dental	c∏	Vision		d Life insurance
	L.						
	е	Temporary disability (accident and sickness)	f Long-term disability	′ 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	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)		n	
		(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)			_
		(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	redited.)	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 not	ot include amount entered	in line 9c(2).)	9e	
10		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to c				10a	63788
	b	If the carrier, service, or other organization incurr				106	
		retention of the contract or policy, other than repo	oneu în Part I, line 2 above	, report amo	นาแ	10b	

Specify nature of costs 🕨

Part I	Provision of Information			
11 Did	he 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	ce Information	n			
(Form 5500						ON	//B No. 1210-0110
Department of the Treas Internal Revenue Servi	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2014	
Department of Labor Employee Benefits Security Ad		File as an at	ttachment to Form 55	600.			
Pension Benefit Guaranty Co	prporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		ion	This Fo	rm is Open to Public Inspection
For calendar plan year 20	14 or fiscal plar	n year beginning 01/01/2014		and en	ding 12	/31/2014	-
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN B Three-digit plan number				-	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 separat		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
HUMANA HEALTH PLAN	IS, INC						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a				contract year
	code	identification number	policy or contrac		(f)	From	(g) To
61-1013183	95885	B2941	1	14	01/01/20	14	12/31/2014
2 Insurance fee and comp descending order of the		ation. Enter the total fees and tota	I commissions paid. L	ist in line 3	the agents,	brokers, and c	other persons in
(a) Total a	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, o	or other person to who	m commissi	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fees	s and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose		9		(e) Organization code
		and address of the agent broker	or other person to whe	moommissi	ions or foco	woro poid	
		ind address of the agent, broker, o		III COMINISS		were paiu	

(b) Amount of sales and base	-		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Donorwork Poduction Act Notice	and OMP Control Numbers	and the instructions for Form FF00	

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

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Nan	ne and address of the agent, broke	, 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
			l
			1

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

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes o						as a unit for purposes of		
		this report.			,			
		ent value of plan's interest under this contract in the general account at year						
-	Curr	5						
6	Contracts With Allocated Funds:							
	а	State the basis of premium rates						
	b	Premiums paid to carrier			. 6b			
	C	Premiums due but unpaid at the end of the year			6c			
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d			
		Specify nature of costs						
	-							
	е	Type of contract: (1) individual policies (2) group deferred	annuity					
		(3) other (specify)						
	4	Management was a base of the state of the st	- Constant	shaalahaa N				
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin						
1		tracts With Unallocated Funds (Do not include portions of these contracts main						
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee				
		(3) guaranteed investment (4) dother ►						
	b	Balance at the end of the previous year			. 7b			
	С	Additions: (1) Contributions deposited during the year	. 7c(1)					
		(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
		•						
		(6)Total additions			7c(6)			
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d			
	е	Deductions:						
		(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)					
		•						
	f	(5) Total deductions						

	Pa	qe	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 w	oup of employees of the s irposes if such contracts a	are experienc	e-rated as a unit. Wh	ere contracts	
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	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	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)				4
		(A) Commissions	-	9c(1)(A)			4
		(B) Administrative service or other fees		9c(1)(B)			4
		(C) Other specific acquisition costs		9c(1)(C)			4
		(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)		0-(4)(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	, 1			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		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to c				10a	352400
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	

Specify nature of costs 🕨

Par	t 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 a	Inswer to line 11 is "Yes," specify the information not provided.				

SCHEDULE	Α	Insuranc	e Information	n		O	MB No. 1210-0110
(Form 5500 Department of the Treas		This schoolule is required to be filed under section 104 of the			2014		
Internal Revenue Serv	ice	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2014	
Department of Labo Employee Benefits Security Ad		File as an at	ttachment to Form 55	600.			mu is Ou ou (s Dadella
Pension Benefit Guaranty Co	prporation	 Insurance companies an pursuant to E 	re required to provide t RISA section 103(a)(2)		ion	Inis Fo	rm is Open to Public Inspection
For calendar plan year 20	14 or fiscal plar	year beginning 01/01/2014		and en	iding 12	/31/2014	1
A Name of plan ALCATEL-LUCENT RETII	REE WELFARE	E BENEFITS 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)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
METROPOLITAN LIFE IN	NSURANCE CO	OMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	contract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
13-5581829	65978	95083-G	9293	30	01/01/20	14	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total a	amount of comr	nissions paid		(b) To	otal amount	of fees paid	
		195000					534978
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	•	m commiss	ions or fees	were paid	
AON CONSULTING INC			DX 905494 LOTTE, NC 28290-549	94			
(b) Amount of sales ar	nd base	Fees	s and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) Purpose			(e) Organization code
	195000	534978 SU MC	IPPLEMENTAL COMP INETARY COMPENS	ENSATION ATION	I ADMIN FE	ES NON-	3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
	(i /) u						
		_					

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice			

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Nan	ne and address of the agent, broke	, 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		(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
			l
			1

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

Part II		II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes o				
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-	Current value of plan's interest under this contract in separate accounts at year end					
6						
	a State the basis of premium rates					
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st	- Constant	shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Page 4

	Part I	art 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 employee 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. Whe	ere contracts o	
	8 Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	c	Vision	d	X Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	oloyment h	Prescription drug
	i	Stop loss (large deductible)	j 🗌 HMO contract	· · · ·	PPO contract	-	Indemnity contract
	m	Other (specify)	, []]	-	
_							
	•	erience-rated contracts:					
	а	Premiums: (1) Amount received		~ /		1479095	
		(2) Increase (decrease) in amount due but unpair					
		(3) Increase (decrease) in unearned premium res				0.(1)	4 470005
	L	(4) Earned ((1) + (2) - (3))				9a(4)	1479095
	b	Benefit charges (1) Claims paid				84807434	
		(2) Increase (decrease) in claim reserves				-525481	04004052
		(3) Incurred claims (add (1) and (2))				9b(3)	84281953 84281953
	•	(4) Claims charged				9b(4)	04201900
	С	Remainder of premium: (1) Retention charges (c		9c(1)(A)		405000	
		(A) Commissions				195000	
		(B) Administrative service or other fees					
		(C) Other specific acquisition costs		0 (4)(D)		1855651	
		(D) Other expenses		0 (4)(E)		1381664	
		(E) Taxes (F) Charges for risks or other contingencies.				513065	
		(G) Other retention charges				-719366	
		(H) Total retention				9c(1)(H)	3226014
		(2) Dividends or retroactive rate refunds. (These				9c(2)	0220014
	d	Status of policyholder reserves at end of year: (1				90(2) 9d(1)	336699978
	ŭ	(2) Claim reserves				9d(1)	22303065
		(3) Other reserves				9d(2)	22000000
	е	Dividends or retroactive rate refunds due. (Do n				9e	
-		prexperience-rated contracts:			,		
	а	Total premiums or subscription charges paid to o	carrier			10a	
	b	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 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				-	OMB No. 1210-0110		
Department of the Treas Internal Revenue Servi	sury	This schedule is required Employee Retirement Inc					2014
Department of Labor Employee Benefits Security Ad		File as an attachment to Form 5500.					
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			on	This For	rm is Open to Public Inspection		
For calendar plan year 20 [°]	14 or fiscal plan	vear beginning 01/01/2014		and end	ding 12	2/31/2014	
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN				B Three plan	-digit number (P	N) 🕨	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)		
on a separat		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 nu	umber of		Policy or c	contract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
52-1270921	95287	US28740	11	17	01/01/20	014	12/31/2014
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 c	other persons in
(a) Total a	amount of comn		(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 commissi	ons or fees	s were paid	
(b) Amount of sales ar	nd base	Fees	s and other commission	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 Panarwork Poduction Act Natics and OMB Control Numbers, soo the instructions for Form 5500					

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

(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 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
			l
			1

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

Part II		II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes o				
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-	Current value of plan's interest under this contract in separate accounts at year end					
6						
	a State the basis of premium rates					
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st	- Constant	shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Ρ	aq	e	4

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 irposes if such contracts a	are experienc	e-rated as a unit. Wh	ere contract	
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	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	I	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)		T	
		(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	n an accrual basis)				4
		(A) Commissions		9c(1)(A)			4
		(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	F	9c(1)(E)			-
		(F) Charges for risks or other contingencies		9c(1)(F)			4
		(G) Other retention charges	L.	9c(1)(G)		0-(4)(1)	
		(H) Total retention				9c(1)(H)	
	-	(2) Dividends or retroactive rate refunds. (These				· · · ·	
	d	Status of policyholder reserves at end of year: (1	, 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		nexperience-rated contracts:				40	
	-	Total premiums or subscription charges paid to c				10a	785697
	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	he 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		Insuranc	ce Informatio	n		OM	IB No. 1210-0110
(Form 5500 Department of the Treas	(Form 5500) Department of the Treasury This schedule is required to be filed under section 104 of the						2014
Internal Revenue Serv	ice	Employee Retirement Inc					2014
Department of Labo Employee Benefits Security Ad		File as an a	ttachment to Form 55	500.			
Pension Benefit Guaranty Co	prporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		ion		m is Open to Public Inspection
For calendar plan year 20	14 or fiscal plar	year beginning 01/01/2014		and en	ding 12	2/31/2014	
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 Emplo 22-340	•	cation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
BLUE ADVANTAGE HM	0						
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate ne persons covered a policy or contract	at end of	(f)	From	ontract year (g) To
36-1236610	70670	H73525,B73524	1:	33	01/01/20	014	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. L	ist 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	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 pa	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	
		na address of the agent, broker,				s were paid	

(b) Amount of sales and base							
commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
For Panarwork Paduation Act Nation and OMP Control Numbers, son the instructions for Form 5500							

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

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Nan	ne and address of the agent, broke	, 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		(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
			l
			1

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

Pa	Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be					as a unit for purposes of
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st	- Constant	shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Ρ	aq	e	4

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 s urposes if such contracts a	are experienc	e-rated as a unit. Wh	ere contract	
8	Ben	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	h Prescription drug
	iΓ	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	۱	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)		T	
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid					
		(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					4
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			4
		(C) Other specific acquisition costs	-	9c(1)(C)			4
		(D) Other expenses		9c(1)(D)			4
		(E) Taxes	-	9c(1)(E)			-
		(F) Charges for risks or other contingencies		9c(1)(F)			-
		(G) Other retention charges				0-(4)(1)	
		(H) Total retention	_	_		9c(1)(H)	
	_	(2) Dividends or retroactive rate refunds. (These		I			
	d	Status of policyholder reserves at end of year: (1	, 1			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		nexperience-rated contracts:				40	
	-	Total premiums or subscription charges paid to c				10a	1595506
	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	he 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	•	Incurrent	alpformation				
(Form 5500		Insurance Information				ОМ	B No. 1210-0110
Department of the Treas Internal Revenue Serv	sury	This schedule is required Employee Retirement Inc					2014
Department of Labo Employee Benefits Security Ad		File as an attachment to Form 5500.					
Pension Benefit Guaranty Co	prporation	 Insurance companies a pursuant to E 	re required to provide th RISA section 103(a)(2).		on		m is Open to Public Inspection
For calendar plan year 20	14 or fiscal plan	year beginning 01/01/2014		and end	ding 12	2/31/2014	
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 (
on a separat		ing Insurance Contract C 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 number of persons covered at end of policy or contract year (f) Fr		Policy or co From	ontract year (g) To	
06-6033492	60054	700140-RET	3321	8	01/01/20	014	12/31/2014
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. Lis	st in line 3 t	he agents,	, brokers, and o	ther persons in
(a) Total a	amount of comn	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 p	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to whon	n commissi	ons or fees	s were paid	
(b) Amount of sales ar			s and other commission				
commissions pa	id	(c) Amount	(d) Purpose	9		(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to whon	n commissi	ons or fees	s were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
Fan Dava annual - Davids attain Aat Matter		the instructions for E-ms 5500	

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

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Nan	ne and address of the agent, broke	, 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		(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
			l
			1

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

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	cts with each carrier ma	v be treated	as a unit for purposes of
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st	- Constant	shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Page **4**

Part III Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting put the entire group of such individual contracts v	oup of employees of the s rposes if such contracts	are experien	ce-rated as a unit. Wh	ere contract	
8 Benefit and contract type (check all applicable boxes)					
a Health (other than dental or vision)	b X Dental	с	Vision		d Life insurance
e Temporary disability (accident and sickness)	f Long-term disabili		Supplemental unemp	olovment	h Prescription drug
i Stop loss (large deductible)	j HMO contract		PPO contract	,	I Indemnity contract
		ĸ			
m _ Other (specify) ►					
9 Experience-rated contracts:					T
a Premiums: (1) Amount received		9a(1)			4
(2) Increase (decrease) in amount due but unpaid					-
(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)	
C Remainder of premium: (1) Retention charges (o	n an accrual basis)		T		
(A) Commissions		9c(1)(A)			4
(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					4
(F) Charges for risks or other contingencies		9C(1)(F)			4
(G) Other retention charges				0c(1)(LI)	
(H) Total retention	_			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These				1	
d Status of policyholder reserves at end of year: (1	•			9d(1)	
(2) Claim reserves				9d(2)	
(3) Other reservese Dividends or retroactive rate refunds due. (Do not set the set of th				9d(3) 9e	
10 Nonexperience-rated contracts:		a in inte 30(2)	J ·) · · · · · · · · · · · · · · · · · ·	36	
a Total premiums or subscription charges paid to c	arrier			10a	11752153
b If the carrier, service, or other organization incurr				100	11702100
retention of the contract or policy, other than repo				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	Δ	Insuranc	e Information	า			
(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).					2014
Department of Labor Employee Benefits Security Ad		File as an at	tachment to Form 550	00.			
Pension Benefit Guaranty Co	orporation	 Insurance companies ar pursuant to EF 	e required to provide the RISA section 103(a)(2).		ion	This For	m is Open to Public Inspection
For calendar plan year 20	14 or fiscal plan	year beginning 01/01/2014		and en	ding 12	2/31/2014	
A Name of plan ALCATEL-LUCENT RETII	REE WELFARE	BENEFITS 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	rrier						
HUMANA HEALTH PLAN	NS, INC.						
(b) EIN	(c) NAIC	(d) Contract or	 (e) Approximate nu persons covered at 		(0)	,	ontract year
(-)	code	identification number	policy or contract		(†)	From	(g) To
61-1103898	95270	* SEE BELOW	6	64	01/01/20)14	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	l commissions paid. Li	st 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		ees. (Complete as many entries a		· · · ·			
	(a) Name a	nd address of the agent, broker, c	or other person to whon	n commiss	ions or fees	s were paid	
(b) Amount of sales ar			and other commission				
commissions pa	IC	(c) Amount	((d) Purpose	9		(e) Organization code
	(a) Name a	nd address of the agent, broker, c	or other person to whon	n commiss	ions or fees	s were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Poduction Act Notice	and OMB Control Numbers	soo the instructions for Form 5500	

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

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Nan	ne and address of the agent, broke	, 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		(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
			l
			1

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

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	cts with each carrier ma	v be treated	as a unit for purposes of
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st	- Constant	shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

	Pa	qe	4
--	----	----	---

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 w					s cover individual employees	3,
8	Bene	efit and contract type (check all applicable boxes)						
-	аſ	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance	
	e	Temporary disability (accident and sickness)	f Long-term disabilit			ipioyment	h Prescription drug	
	i	Stop loss (large deductible)	j 🕺 HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)						
9		erience-rated contracts:	Г				4	
		Premiums: (1) Amount received		9a(1)			4	
		(2) Increase (decrease) in amount due but unpaid					4	
		(3) Increase (decrease) in unearned premium res	L	9a(3)		0-(4)		_
	-	(4) Earned ((1) + (2) - (3))	T I I I I I I I I I I I I I I I I I I I			9a(4)		
		Benefit charges (1) Claims paid	-	9b(1)			4	
		(2) Increase (decrease) in claim reserves	L	9b(2)		06/2)		
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged Remainder of premium: (1) Retention charges (o				9b(4)		
	C	, .	· · · · ·	9c(1)(A)			-	
		(A) Commissions(B) Administrative service or other fees	-	9c(1)(A) 9c(1)(B)			-	
		(C) Other specific acquisition costs	1	9c(1)(C)			4	
		(D) Other expenses	ľ	9c(1)(D)			-	
		(E) Taxes	ľ	9c(1)(E)			4	
		(F) Charges for risks or other contingencies	-	9c(1)(F)			4	
		(G) Other retention charges					1	
		(H) Total retention	L			. 9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These						
		Status of policyholder reserves at end of year: (1						
	ŭ	(2) Claim reserves	•					
		(3) Other reserves						
	е	Dividends or retroactive rate refunds due. (Do no						
10		nexperience-rated contracts:			,			
-		Total premiums or subscription charges paid to c	arrier			. 10a	743	385
	-	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	he insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	< No
12 If th	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	A	Insuranc	ce Information				
(Form 5500))					/IB No. 1210-0110	
Department of the Trea Internal Revenue Serv		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2014	
Department of Labo Employee Benefits Security Ac		File as an at	ttachment to Form 550	0.			
Pension Benefit Guaranty Co	orporation	 Insurance companies an pursuant to El 	re required to provide the RISA section 103(a)(2).	e informati	on	This Fo	rm is Open to Public Inspection
For calendar plan year 20	14 or fiscal plar	vear beginning 01/01/2014		and end	ding 12	2/31/2014	
A Name of plan B Three-digit ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN Plan 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)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	arrier						
HUMANA HEALTH PLAI	NS, INC.						
	(c) NAIC	(d) Contract or	(e) Approximate number of			Policy or c	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
65-1137990	10126	H9248	111	1	01/01/20)14	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. Lis	st in line 3 t	he agents,	brokers, and o	other 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 a	as needed to report all p	ersons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whom	n commissi	ons or fees	s were paid	
(b) Amount of sales a		Fees	s and other commissions				4
commissions pa	id	(c) Amount	(0	d) Purpose			(e) Organization code
					-		L
	(a) Name a	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	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Peduction Act Notice	and OMB Control Numbers	see the instructions for Form 5500	

Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. ⊢or

(b) Amount of sales and base commissions paid	Fees and other commissions paid				
	(c) Amount	(d) Purpose	(e) Organization code		
(a) Nan	ne and address of the agent, broke	, 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		(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
			l
			1

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

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for pu						as a unit for purposes of
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st		shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Ρ	aq	e	4

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 irposes if such contracts a	are experienc	e-rated as a unit. Wh	ere contracts	
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	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	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)				4
		(A) Commissions	-	9c(1)(A)			4
		(B) Administrative service or other fees		9c(1)(B)			4
		(C) Other specific acquisition costs		9c(1)(C)			4
		(D) Other expenses		9c(1)(D)			4
		(E) Taxes	-	9c(1)(E)			4
		(F) Charges for risks or other contingencies		9c(1)(F)			-
		(G) Other retention charges	-	9c(1)(G)		0-(4)(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	, 1			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		nexperience-rated contracts:				4.5	
	-	Total premiums or subscription charges paid to c				10a	258388
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	

Specify nature of costs 🕨

Par	t 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 a	Inswer to line 11 is "Yes," specify the information not provided.				

SCHEDULE	A	Insuranc	ce Informatio	n			
(Form 5500					OMB No. 1210-0110		
Department of the Treas Internal Revenue Servi	sury	This schedule is required Employee Retirement Inc					2014
Department of Labor Employee Benefits Security Ad		File as an at	ttachment to Form 55	500.			
Pension Benefit Guaranty Co	prporation	 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	14 or fiscal plar	n year beginning 01/01/2014		and end	ding 12	2/31/2014	-
A Name of plan ALCATEL-LUCENT RETIR	REE WELFARE	E BENEFITS PLAN		B Three plan	-digit number (P	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA I		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						
AETNA HEALTH INC.		1				Dellassa	
(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
23-2169745	95109	US28740		99	01/01/20	014	12/31/2014
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	other persons in
(a) Total a	amount of comr	missions paid		(b) Tot	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	and 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 commissio	ns paid			
commissions paid (c) Amount		(c) Amount		(d) Purpose			(e) Organization code
	(a) Name a	and address of the agent, broker, i	or other person to who	m commissio	ons or fees	s were paid	1
	.,		,				

(b) Amount of sales and base						
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
For Denemicarly Deduction Act Nation	For Denominant's Reduction Act Nation and OMR Control Numbers, and the instructions for Form FEOD					

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

(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 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
			l
			1

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

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for pu						as a unit for purposes of
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st		shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

	Ра	qe	4
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Pa	art II							
		If more than one contract covers the same gr						
		information may be combined for reporting put the entire group of such individual contracts w					s cover individual employees	
8	Bene	efit and contract type (check all applicable boxes)				Topola		
Ū	a [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 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:	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)		1		
	-	(4) Earned ((1) + (2) - (3))	F			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)				
		(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.)						
	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	7104	51
	b	If the carrier, service, or other organization incurr						
		retention of the contract or policy, other than repo	orted in Part I, line 2 above	e, report amo	unt	. 10b		

Specify nature of costs 🕨

Part I	Provision of Information			
11 Dic	he 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	Δ	Insuranc	e Information	า			
(Form 5500		insulatio		•		C	DMB No. 1210-0110
Department of the Treas	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).					2014	
Department of Labor Employee Benefits Security Adr		File as an at	tachment to Form 55	00.			
Pension Benefit Guaranty Co	rporation	 Insurance companies are pursuant to EF 	e required to provide to RISA section 103(a)(2)		ion	This Fo	orm is Open to Public Inspection
For calendar plan year 20 ⁴	14 or fiscal pla	n year beginning 01/01/2014		and end	ding 12/	31/2014	-
A Name of plan ALCATEL-LUCENT RETIR	REE WELFAR	E BENEFITS PLAN		B Three plan	ə-digit number (PN	J) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA I		e 2a of Form 5500		D Employ 22-340		ation Numbe	er (EIN)
		ning Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance car HORIZON BCBS OF NJ	rrier						
(c) NAIC (d) Contract or (e) Approximate number of Policy or contract year							contract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
22-0999690	55069	77087	1 01/01/2014 12/3			12/31/2014	
2 Insurance fee and comp descending order of the		ation. Enter the total fees and total	l commissions paid. Li	ist in line 3 f	the agents,	brokers, and	other persons in
(a) Total a		(b) To	tal amount o	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 whor	m commissi	ons or fees	were paid	
(b) Amount of sales and base		es and other commissions paid					
commissions paid		(c) Amount	(d) Purpose)		(e) Organization code
	(a) Name a	and address of the agent, broker, o	or other person to whor	m commissi	ons or fees	were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
Fan Dan annual Daduation Act Nation	and OND Ore tool North Land	the instructions for E-ms 5500	

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.
(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 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	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
			l
			1

(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

Schedule A (Form 5500) 2014

Page 3

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of						as a unit for purposes of	
		this report.			,		
		ent value of plan's interest under this contract in the general account at year					
-	5 Current value of plan's interest under this contract in separate accounts at year end						
6							
	а	State the basis of premium rates					
	b	Premiums paid to carrier			. 6b		
	C	Premiums due but unpaid at the end of the year			6c		
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d		
		Specify nature of costs					
	-						
	е	Type of contract: (1) individual policies (2) group deferred	annuity				
		(3) other (specify)					
	4	Management was a base of the state of the st	- Constant	shaalahaa N			
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin					
1		tracts With Unallocated Funds (Do not include portions of these contracts main					
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee			
		(3) guaranteed investment (4) dother ►					
	b	Balance at the end of the previous year			. 7b		
	С	Additions: (1) Contributions deposited during the year	. 7c(1)				
		(2) Dividends and credits	7c(2)				
		(3) Interest credited during the year	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	7c(5)				
		•					
		(6)Total additions			7c(6)		
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d		
	е	Deductions:					
		(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)				
		•					
	f	(5) Total deductions					

Schedule A (Form 5500) 2014

Р	ad	е	4

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)	will cach caller may be in				
Ŭ	a [Health (other than dental or vision)	b Dental	с	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	/ 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)		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)			
		(D) Other expenses		9c(1)(D)			_
		(E) Taxes		9c(1)(E)			_
		(F) Charges for risks or other contingencies		9c(1)(F)			4
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention		_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in a	cash, or	redited.)	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	ot include amount entered	in line 9c(2).)	9e	
10		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to c				10a	15625
	b	If the carrier, service, or other organization incurr				10b	
		retention of the contract or policy, other than repo	nieu in Part I, line z above	, report amo	นที่เ	100	

Specify nature of costs 🕨

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

	•						
SCHEDULE (Form 5500		Insurance Information			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).					2014
Department of Labo Employee Benefits Security Ad		File as an at	ttachment to Form 55	600.			
Pension Benefit Guaranty Co	orporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This For	rm is Open to Public Inspection	
For calendar plan year 20	14 or fiscal pla	an year beginning 01/01/2014		and en	ding 12	/31/2014	1
A Name of plan ALCATEL-LUCENT RETI	RE BENEFITS PLAN		B Three plan	e-digit number (Pl	N) 🕨	504	
•	C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC.				oyer Identific 08857	ation Number	(EIN)
		ning Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:		- · ·					
(a) Name of insurance ca	rrier						
UNITED HEALTHCARE	INSURANCE	COMPANY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a	at end of		Policy or contract year	
(,	code	identification number	policy or contrac		(f)	From	(g) To
36-2739571	79413	SRSUP H1509	8190	66	01/01/20)14	12/31/2014
2 Insurance fee and com descending order of the		nation. Enter the total fees and tota	I commissions paid. L	ist in line 3.	the agents,	brokers, and c	other persons in
(a) Total a	amount of con	nmissions paid	(b) Total amount of fees paid				
		0					0
3 Persons receiving com		fees. (Complete as many entries a					
	(a) Name	and address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	Fees	s and other commissio	ns paid			
commissions paid (c) Amount			(d) Purpos	Э		(e) Organization code	
	(a) Name	and address of the agent, broker, of	or other person to who	m commiss	ions or fees	were paid	•
	(a) Name	and address of the agent, bloker, (more paid	

(b) Amount of sales and base	F					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
For Denerwork Deduction Act Nation and OMD Control Numbers, and the instructions for Form FEOD						

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

Schedule A (Form 5500) 2014 v. 140124

(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 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	(b) Amount of sales and base Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
			l
			1

(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

Schedule A (Form 5500) 2014

Page 3

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	cts with each carrier ma	v be treated	as a unit for purposes of
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st	- Constant	shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:				
		(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)			
		•				
	f	(5) Total deductions				

Schedule A (Form 5500) 2014

Page 4	

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If more that informatio	Benefit Contract Informat an one contract covers the same gr n may be combined for reporting pu group of such individual contracts of	oup of employees of the s urposes if such contracts	are experienc	ce-rated as a unit. Whe	ere contracts	
8 Benefit and contract	ct type (check all applicable boxes)					
a Health (othe	r than dental or vision)	b Dental	c	Vision	C	d Life insurance
e Temporary o	disability (accident and sickness)	f Long-term disabilit	ty q	Supplemental unemp		h Prescription drug
	rge deductible)	j HMO contract		PPO contract	-	I Indemnity contract
			N C			
m Other (spec	ту) 🕨					
9 Experience-rated c	ontracts					
	Amount received		9a(1)			
()	decrease) in amount due but unpaid		9a(2)			1
	decrease) in unearned premium res					
) + (2) - (3))				9a(4)	
	es (1) Claims paid					
(2) Increase (c	lecrease) in claim reserves					1
(3) Incurred cla	aims (add (1) and (2))				9b(3)	
	arged				9b(4)	
	premium: (1) Retention charges (o					
(A) Comm	iissions		9c(1)(A)]
(B) Admin	istrative 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) Charge	es for risks or other contingencies		9c(1)(F)			
(G) Other	retention charges		9c(1)(G)		1	
()	retention	_			9c(1)(H)	
(2) Dividends	or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
d Status of polic	cyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	
(2) Claim rese	erves				9d(2)	
(3) Other rese	erves				9d(3)	
e Dividends or r	etroactive rate refunds due. (Do not	ot include amount entered	d in line 9c(2)	.)	9e	
10 Nonexperience-ra	ited contracts:					
	ns or subscription charges paid to c				10a	38207276
	service, or other organization incurr e contract or policy, other than repo				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 C	Service Provider	Information	OMB No. 1210-0110
(Form 5500)		2014	
Department of the Treasury	This schedule is required to be filed und		
Internal Revenue Service Department of Labor Employee Benefits Security Administration	Retirement Income Security / ▶ File as an attachmer	, , , , , , , , , , , , , , , , , , ,	This Form is Open to Public Inspection.
Pension Benefit Guaranty Corporation	-		
For calendar plan year 2014 or fiscal p	plan year beginning 01/01/2014	and ending 12/31	1/2014
A Name of plan ALCATEL-LUCENT RETIREE WELF	ARE BENEFITS PLAN	B Three-digit plan number (PN)	504
C Plan sponsor's name as shown on ALCATEL-LUCENT USA INC.	line 2a of Form 5500	D Employer Identificati 22-3408857	ion Number (EIN)
Part I Service Provider Int	formation (see instructions)		
or more in total compensation (i.e., plan during the plan year. If a pers	cordance with the instructions, to report the info money or anything else of monetary value) in o on received only eligible indirect compensation o include that person when completing the rem	connection with services rendered to n for which the plan received the requ	the plan or the person's position with the
a Check "Yes" or "No" to indicate whe	eceiving Only Eligible Indirect Com ether you are excluding a person from the rema	ainder of this Part because they recei	
 a Check "Yes" or "No" to indicate whe indirect compensation for which the b If you answered line 1a "Yes," ent received only eligible indirect comp 	ether you are excluding a person from the remain plan received the required disclosures (see in- er the name and EIN or address of each perso ensation. Complete as many entries as neede	ainder of this Part because they receins structions for definitions and condition on providing the required disclosures and (see instructions).	for the service providers who
 a Check "Yes" or "No" to indicate whe indirect compensation for which the b If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r 	ether you are excluding a person from the remain plan received the required disclosures (see in er the name and EIN or address of each perso	ainder of this Part because they receins structions for definitions and condition on providing the required disclosures and (see instructions).	for the service providers who
 a Check "Yes" or "No" to indicate whe indirect compensation for which the b If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r 	ether you are excluding a person from the remain plan received the required disclosures (see in- er the name and EIN or address of each perso ensation. Complete as many entries as neede	ainder of this Part because they receins structions for definitions and condition on providing the required disclosures and (see instructions).	for the service providers who
 a Check "Yes" or "No" to indicate whe indirect compensation for which the b If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r THE DREYFUS CORPORATION 13-5673135 	ether you are excluding a person from the remain plan received the required disclosures (see in- er the name and EIN or address of each perso ensation. Complete as many entries as neede	ainder of this Part because they receins structions for definitions and condition on providing the required disclosures and (see instructions).	ons) Xes No
 a Check "Yes" or "No" to indicate whe indirect compensation for which the b If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r THE DREYFUS CORPORATION 13-5673135 (b) Enter r 	ether you are excluding a person from the remain plan received the required disclosures (see in- er the name and EIN or address of each perso ensation. Complete as many entries as neede mame and EIN or address of person who provid	ainder of this Part because they receins structions for definitions and condition on providing the required disclosures and (see instructions).	ons) Xes No
 a Check "Yes" or "No" to indicate whe indirect compensation for which the b If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r THE DREYFUS CORPORATION 13-5673135 (b) Enter r 	ether you are excluding a person from the remain plan received the required disclosures (see in- er the name and EIN or address of each perso ensation. Complete as many entries as neede mame and EIN or address of person who provid	ainder of this Part because they receins structions for definitions and condition on providing the required disclosures and (see instructions).	ons) Xes No
A Check "Yes" or "No" to indicate whe indirect compensation for which the b If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r THE DREYFUS CORPORATION 13-5673135 (b) Enter r METLIFE 13-5881829	ether you are excluding a person from the remain plan received the required disclosures (see in- er the name and EIN or address of each perso ensation. Complete as many entries as neede mame and EIN or address of person who provid	ded you disclosure on eligible indirect	t compensation
 a Check "Yes" or "No" to indicate whe indirect compensation for which the indirect compensation for which the received only eligible indirect comp (b) Enter r THE DREYFUS CORPORATION 13-5673135 (b) Enter r METLIFE 13-5881829 	ether you are excluding a person from the remain plan received the required disclosures (see in- er the name and EIN or address of each perso ensation. Complete as many entries as needed mame and EIN or address of person who provid	ded you disclosure on eligible indirect	t compensation
 a Check "Yes" or "No" to indicate whe indirect compensation for which the indirect compensation for which the received only eligible indirect comp (b) Enter r THE DREYFUS CORPORATION 13-5673135 (b) Enter r METLIFE 13-5881829 	ether you are excluding a person from the remain plan received the required disclosures (see in- er the name and EIN or address of each perso ensation. Complete as many entries as needed mame and EIN or address of person who provid	ded you disclosure on eligible indirect	t compensation
a Check "Yes" or "No" to indicate whe indirect compensation for which the b If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r THE DREYFUS CORPORATION 13-5673135 (b) Enter r METLIFE 13-5881829 (b) Enter r	ether you are excluding a person from the remain plan received the required disclosures (see in- er the name and EIN or address of each perso ensation. Complete as many entries as needed mame and EIN or address of person who provid	ainder of this Part because they receinstructions for definitions and conditions and conditions and conditions and conditions and conditions and conditions are providing the required disclosures are disclosures and (see instructions).	ons) Xes No for the service providers who Image: Compensation Image: Compensation t compensation Image: Compensation Image: Compensation ct compensation Image: Compensation Image: Compensation ct compensation Image: Compensation Image: 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

(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

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

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(a) Enter name and EIN or address (see instructions)

HEWITT ASSOCIATES LLC

36-2235791

(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?
13 50	NONE	2952052	Yes 🗌 No 🛛	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)	·	
MEDCO CO 42-142523	ONTAINMENT LIFE IN	NSURANCE CO				
(b) Service Code(s)	(c) Relationship to employer, employee	(d) Enter direct compensation paid	(e) Did service provider receive indirect	(f) Did indirect compensation include eligible indirect	(g) Enter total indirect compensation received by	(h) Did the service provider give you a

Code(s)	employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	receive indirect compensation? (sources other than plan or plan sponsor)	include eligible indirect compensation, for which the plan received the required disclosures?	compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
13 50	NONE	1995638	Yes 🗌 No 🛛	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		

UNITED HEALTHCARE

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be		(e) Did service provider receive indirect compensation? (sources other than plan or plan	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required	(g) Enter total indirect compensation received by service provider excluding eligible indirect	(h) Did the service provider give you a formula instead of 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	1531469	Yes 🗌 No 🗙	Yes 🗌 No 🗌		Yes 🗌 No 🗍

Page 3 - 2

(a) Enter name and EIN or address (see instructions)

ERNST & YOUNG LLP

34-6565596

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(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?			
10 50	NONE	150034	Yes 🗌 No 🛛	Yes No		Yes 🗌 No 🗍			
			(a) Enter name and EIN or	address (see instructions)					
	(a) Enter name and EIN or address (see instructions)								
TRUVEN HEALTH ANALYTICS									
06-146792	3								
(b) Service	(c) Relationship to	(d) Enter direct	(e) Did service provider	(f) Did indirect compensation	(g) Enter total indirect	(h) Did the service			

Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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 compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?	
15 50	NONE	129760	Yes 📔 No 🛛	Yes 🗌 No 🗌		Yes No	
(a) Enter name and EIN or address (see instructions)							

AON CONSULTING, INC.

(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 compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
11 16 38 50	NONE	71314	Yes 🗌 No 🛛	Yes 🗌 No 🗌		Yes 📔 No 🗍

|--|

(a) Enter name and EIN or address (see instructions)

MAX-IT MAILING & FULFULLMENT

22-3788849

(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 organization, or person known to be a party-in-interest	by the plan. If none,	receive indirect compensation? (sources other than plan or plan sponsor)	include eligible indirect compensation, for which the plan received the required disclosures?	compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	provider give you a formula instead of an amount or estimated amount?		
38 50	NONE	53296	Yes 🗌 No 🛛	Yes No		Yes 🗌 No 🗌		
(a) Enter name and EIN or address (see instructions)								
BLACKROCK INSTITUTIONAL TRUST CO.								
94-311218	94-3112180							

(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(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?	
28 49 50 51	NONE	29790	Yes 🛛 No 🗌	Yes 🛛 No 🗌	42000	Yes 🗌 No 🛛	
(a) Enter name and EIN or address (see instructions)							

TAX SAVER

(b) Service Code(s)		by the plan. If none,	(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	formula instead of an amount or estimated amount?
13 50	NONE	24025	Yes 🗌 No 🛛	Yes 🗌 No 🗌		Yes 🗌 No 🗍

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(a) Enter name and EIN or address (see instructions)

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	by the plan. If none,	(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?	
19 21 25 49 50 62	NONE	20000	Yes 🛛 No 🗌	Yes 🕅 No 🗌	0	Yes 🗙 No 🗌	
(a) Enter name and EIN or address (see instructions)							
UNIVERSA	L MAILING SERVICE						
22-238166	3						

(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 organization, or person known to be a party-in-interest	compensation paid by the plan. If none, enter -0		include eligible indirect compensation, for which the plan received the required disclosures?	compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element				
					(f). If none, enter -0				
38 50	NONE	16337	Yes 🗌 No 🗙	Yes No		Yes No No			
	(a) Enter name and EIN or address (see instructions)								

ALCATEL-LUCENT INVESTMENT MGMT CORP

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(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	formula instead of an amount or estimated amount?
31 50	AFFILIATE	16204	Yes 🗌 No 🛛	Yes 🗌 No 🗌		Yes 🗌 No 🗌

(a) Enter name and EIN or address (see instructions)

CANDID LITHO

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee organization, or		Did service provider receive indirect compensation? (sources	Did indirect compensation include eligible indirect compensation, for which the	Enter total indirect compensation received by service provider excluding	Did the service provider give you a formula instead of
	person known to be a party-in-interest	enter -0	other than plan or plan sponsor)	plan received the required disclosures?	eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	an amount or estimated amount?
36 50	NONE	13041	Yes 🗌 No 🛛	Yes No		Yes No
	(a) Enter name and EIN or address (see instructions)					

(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?		
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗌		
	(a) Enter name and EIN or address (see instructions)							

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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 compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
			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 of	compensation, including any
	formula used to determine	the service provider's eligibility
		ne 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		ompensation, including any the service provider's eligibility
		ne 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 of	compensation, including any
	formula used to determine for or the amount of th	the service provider's eligibility ne indirect compensation.

Page **5-** 1

Pa	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) En	ter 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) En	ter 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) En	ter 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) En	ter 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) En	ter 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) En	ter 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	C Position:				
d Address:		SS:	e Telephone:		
Exp	lanatio	n:			

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

Explanation:

Name:	b EIN:
Position:	
Address:	e Telephone:
	Position:

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) Department of the Treasury Internal Revenue Service	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			OMB No. 1210-0110 2014	
Department of Labor Employee Benefits Security Administration		File as an attachment to Form 5500.		This Form is C Inspec	
For calendar plan year 2014 or fiscal p A Name of plan ALCATEL-LUCENT RETIREE WELFA		01/01/2014 and	ending 12/ B Three-digit plan numb	31/2014 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 7	(EIN)
	entries as needed	Ts, PSAs, and 103-12 IEs (to be co to report all interests in DFEs) EQUITY INDEX FUND	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	e Dollar value of interest in MTIA, CCT, P 103-12 IE at end of year (see instruction)		6	3528967
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	c EIN-PN 94-6581674-001 d Entity code c e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 20226077				20226077
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, P 103-12 IE at end of year (see instructio		2	27415959
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, P 103-12 IE at end of year (see instructio			
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, P 103-12 IE at end of year (see instructio			
a Name of MTIA, CCT, PSA, or 103-	-12 IE:				
b Name of sponsor of entity listed in	(a):				
C EIN-PN	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, P 103-12 IE at end of year (see instructio			

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Schedule D (Form 5500) 20)14	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	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)		

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F	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	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	
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	Plan na		
b	Name o plan spo		C EIN-PN

SCHEDULE H F	inancial Informati	on			(OMB No. 1210	-0110	
	This schedule is required to be filed under section 104 of the Employee				2014			
Department of Labor	of Labor urity Administration File as an attachment to Form 5500.					This Form is Open to Public Inspection		
)1/2014	and	endir	g 12/31/2	2014			
A Name of plan ALCATEL-LUCENT RETIREE WELFARE BENEFITS PLAN			в	Three-digi	t			
ALCATEL-LUCENT RETIREE WELFARE DENEFTTS FLAN				plan numb	oer (PN)	•	504	
C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC.			D	Employer lo 22-340885		on Number (E	IN)	
Part I Asset and Liability Statement								
1 Current value of plan assets and liabilities at the beginning a the value of the plan's interest in a commingled fund contain lines 1c(9) through 1c(14). Do not enter the value of that por benefit at a future date. Round off amounts to the nearest and 1i. CCTs, PSAs, and 103-12 IEs also do not complete li	ing the assets of more than on tion of an insurance contract w dollar. MTIAs, CCTs, PSAs, a	e plan on a hich guarar and 103-12	line-l	by-line basis , during this	unless the plan year,	e value is rep to pay a spe	oortable on cific dollar	
Assets		(a) B	eginr	ning of Year		(b) End	of Year	
a Total noninterest-bearing cash	1a							
b Receivables (less allowance for doubtful accounts):								
(1) Employer contributions								
(2) Participant contributions	1b(2)							
(3) Other	1b(3)			64542	2000		60609000	
 C General investments: (1) Interest-bearing cash (include money market accounts of deposit) 				10367	000		0	
(2) U.S. Government securities	(()							
(3) Corporate debt instruments (other than employer secu	ities):							
(A) Preferred	, , , , , , , , , , , , , , , , , , , ,							
(B) All other	1c(3)(B)							
(4) Corporate stocks (other than employer securities):								
(A) Preferred	1c(4)(A)							
(B) Common	1c(4)(B)							
(5) Partnership/joint venture interests	4 ~ (5)							
(6) Real estate (other than employer real property)	1c(6)							
(7) Loans (other than to participants)	1c(7)							
(8) Participant loans	1 = (0)							
(9) Value of interest in common/collective trusts	4 (9)	Ī		106707	000		111171000	
(10) Value of interest in pooled separate accounts	1c(10)							
(11) Value of interest in master trust investment accounts	4 (44)							
(12) Value of interest in 103-12 investment entities	4 (10)	Ī						
(13) Value of interest in registered investment companies (e funds)	.g., mutual 1c(13)			22226	000		14633000	
(14) Value of funds held in insurance company general according contracts)	10(14)			410493	000		395776000	
(15) Other	1c(15)							

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

Cohodulo II		FEOO	0014
Schedule H	(FOIIII	2200) 2014

1d	Employer-related investments:	Γ	(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	614335000	582189000
	Liabilities			
g	Benefit claims payable	1g	25100000	25000000
h	Operating payables	1h	1909000	485000
i	Acquisition indebtedness	1i		
j	Other liabilities	1j	11422000	13622000
k	Total liabilities (add all amounts in lines 1g through1j)	1k	38431000	39107000
	Net Assets			
I	Net assets (subtract line 1k from line 1f)	11	575904000	543082000

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
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	34313000	
(B) Participants	2a(1)(B)	145779000	
(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)		180092000
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)	120000	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		120000
(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) Amoun	t	(b)	Total
	(6) Net investment gain (loss) from common/collective trusts	2b(6)				8683000
	(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				26752000
d	Total income. Add all income amounts in column (b) and enter total	2d				215647000
	Expenses					
е	Benefit payment and payments to provide benefits:					
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	16	5142000		
	(2) To insurance carriers for the provision of benefits	2e(2)	72	2051000		
	(3) Other	2e(3)				
	(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)				237193000
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)	11	1276000		
	(2) Contract administrator fees	2i(2)				
	(3) Investment advisory and management fees	2i(3)				
	(4) Other	2i(4)				
	(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)				11276000
j	Total expenses. Add all expense amounts in column (b) and enter total	2j				248469000
	Net Income and Reconciliation					
k	Net income (loss). Subtract line 2j from line 2d	2k				-32822000
I.	Transfers of assets:			Ī		
	(1) To this plan	21(1)				
	(2) From this plan	21(2)				
D		· · · · ·				
_	Accountant's Opinion Complete lines 3a through 3c if the opinion of an independent qualified public a	ccountant is attac	hed to this Form	5500. Comp	plete line 3d if a	an opinion is not
	attached. The attached aninian of an independent qualified public accountant for this play		no).			
a	The attached opinion of an independent qualified public accountant for this plar (1) Unqualified (2) Qualified (3) Disclaimer (4)	-	ns):			
-		Adverse				
	Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103	-8 and/or 103-12(d)?		Yes	X No
C	Enter the name and EIN of the accountant (or accounting firm) below:			00		
- d	(1) Name: ERNST & YOUNG LLP The opinion of an independent qualified public accountant is not attached bec		2) EIN: 34-65655	90		
u	(1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attac		orm 5500 pursua	nt to 29 CFR	2520.104-50.	
Ра	Int IV Compliance Questions					
4	CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do n 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete		4a, 4e, 4f, 4g, 4h	n, 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 within period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any p					
	until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correct	•	4a	Х		
b	Were any loans by the plan or fixed income obligations due the plan in defau					
	close of the plan year or classified during the year as uncollectible? Disregar secured by participant's account balance. (Attach Schedule G (Form 5500) F	d participant loans	3			
	checked.)		4b	X		

			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		×	
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		X	
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		X	
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		X	
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		X	
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		
j	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	х		
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		X	
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 5b	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			Amour	
50	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s),	, iuent	iny une pla	(1)(S) (O WNI	ICH assets of hadilities were

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or litransferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)		
5c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No Not d				
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, 2014 and 2013 With Report of Independent Auditors

Ernst & Young LLP





Financial Statements and Supplemental Schedules

December 31, 2014 and 2013

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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

To the Employee Benefits Committee of the 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, 2014 and 2013, and the related statement of changes in benefit obligations and net assets available for benefits for the year ended December 31, 2014, 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, 2014 and 2013, and the changes in its financial status for the year ended December 31, 2014, 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, 2014, 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.

Ernst + Young LLP

October 15, 2015

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

		December 31		
		2014	2013	
Benefit obligations				
Accumulated postretirement benefit obligation:	~			
Current retirees	\$	3,844,700 \$	3,682,800	
Medical claims payable and liability for claims incurred but			25 100	
not reported		25,000	25,100	
Other participants fully eligible for benefits		7,600	15,400	
Other participants not yet fully eligible for benefits		65,100	98,900	
Total benefit obligations		3,942,400	3,822,200	
Net assets				
Refund receivable		9,425	13,782	
Rebates receivable		51,184	50,760	
Group life insurance policies		395,776	410,493	
Assets held in Lucent Technologies Inc. Master Pension Trust		,	,	
Restricted for 401(h) account		226,653	232,865	
Restricted for applicable life insurance account		-	1	
Common/collective trusts		111,171	106,707	
Guaranteed interest rate contract		_	10,367	
Registered investment company		14,633	22,226	
Total assets		808,842	847,201	
Due to Sponsor, net		13,622	11,422	
Accrued administrative costs		485	1,909	
Total liabilities		14,107	13,331	
Net assets available for benefits		794,735	833,870	
Excess of benefit obligations over net assets				
available for benefits	\$	3,147,665 \$	2,988,330	

See accompanying notes

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

Year Ended December 31, 2014 (In Thousands)

Net increase in benefit obligations	
Increase (decrease) during the period attributable to:	ф (2 .1.1.0.0)
Benefits paid, net	\$ (341,100)
Change in actuarial assumptions and experience	209,200
Interest due to the passage of time	147,200
Change in discount rate	244,700
Plan amendments	(139,800)
Net increase in benefit obligations	120,200
Net change in net assets available for benefits	
Additions to Plan assets available for benefits attributable to:	
Sponsor contributions	34,313
Participant contributions	145,779
Income from insurance policies	26,752
Net appreciation in fair value of investments	8,683
Interest income	120
Total additions	215,647
Deductions from Plan assets available for benefits attributable to:	
Payments for benefits	237,293
Net decrease in 401(h) account	6,212
Net decrease in applicable life insurance account	1
Administrative costs	11,276
Total deductions	254,782
Net decrease in net assets available for benefits	(39,135)
Increase in excess of benefit obligations over net assets available for benefits	159,335
Excess of benefit obligations over net assets available for benefits:	
Beginning of year	2,988,330
End of year	\$ 3,147,665
5	, - ,

See accompanying notes.

Notes to Financial Statements

December 31, 2014 (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 August 2014, 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, 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.

Benefits

The Plan provides health benefits (hospital, surgical, medical, prescription drug and mental health/chemical dependency), including an HMO option and a Medicare Advantage Preferred Provider Organization ("MAPPO") 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)

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 2014, the Plan paid \$22,092 in HMO premiums, \$38,207 in MAPPO premiums, \$2,040 in DMO premiums and \$9,712 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) with respect to retired employees. MAP-21 also extended the period during which employers may make such asset transfers to December 31, 2021.

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.

Notes to Financial Statements (continued)

(In Thousands)

1. Plan Description (continued)

Contributions

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.

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	

Notes to Financial Statements (continued)

(In Thousands)

1. Plan Description (continued)

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.

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 prior to January 1, 2015:

	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	_

Notes to Financial Statements (continued)

(In Thousands)

1. Plan Description (continued)

Effective January 1, 2015, the annual caps were set equal to zero for post-3/1/1990 non-Medicare eligible management retirees and their dependents. All management retirees now pay non-subsidized contribution rates for access to coverage. Post-3/1/1990 non-represented occupational retirees now pay contributions equal to 50% of the cost of coverage.

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.

Other

At December 31, 2014 and 2013, 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.

Notes to Financial Statements (continued)

(In Thousands)

2. Summary of Significant Accounting Policies (continued)

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. There are currently no redemption restrictions on the common/collective trusts. 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.

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.
Notes to Financial Statements (continued)

(In Thousands)

2. Summary of Significant Accounting Policies (continued)

New Accounting Pronouncements

In May 2015, the FASB issued Accounting Standards Update 2015-07, *Disclosures for Investments in Certain Entities that Calculate Net Asset Value Per Share (or its Equivalent),* (ASU 2015-07). ASU 2015-07 removes the requirement to categorize within the fair value hierarchy investments for which fair values are estimated using the net asset value practical expedient provided by Accounting Standards Codification 820, *Fair Value Measurement.* Disclosures about investments in certain entities that calculate net asset value per share are limited under ASU 2015-07 to those investments for which the entity has elected to estimate the fair value using the net asset value practical expedient. ASU 2015-07 is effective for entities (other than public business entities) for fiscal years beginning after December 15, 2016, with retrospective application to all periods presented. Early application is permitted. Plan management is currently evaluating the effect that the provisions of ASU 2015-07 will have on the Plan's financial statements.

In July 2015, the FASB issued ASU 2015-12, Plan Accounting: Defined Benefit Pension Plans (Topic 960), Defined Contribution Pension Plans (Topic 962), Health and Welfare Benefit Plans (Topic 965): (Part I) Fully Benefit-Responsive Investment Contracts, (Part II) Plan Investment Disclosures, (Part III) Measurement Date Practical Expedient. Part I of the ASU eliminates the requirements to measure the fair value of fully benefit-responsive investment contracts and provide certain disclosures. Contract value is the only required measure for fully benefit-responsive investment contracts. Part II of the ASU eliminates the requirements to disclose individual investments that represent 5 percent or more of net assets available for benefits and the net appreciation or depreciation in fair value of investments by general type. It also simplifies the level of disaggregation of investments that are measured using fair value. Plans will continue to disaggregate investments that are measured using fair value by general type; however, plans are no longer required to also disaggregate investments by nature, characteristics and risks. Further, the disclosure of information about fair value measurements shall be provided by general type of plan asset. Part III of the ASU allows a plan with a fiscal year end that doesn't coincide with the end of a calendar month to measure its investments and investment-related accounts using the month end closest to its fiscal year end. The ASU is effective for fiscal years beginning after December 15, 2015. Parts I and II are to be applied retrospectively. Part III is to be applied prospectively. Plans can early adopt any of the ASU's three parts without early adopting the other parts. Plan management is currently evaluating the effect that Part II of ASU 2015-12 will have on the Plan's financial statements. Parts I and III are not applicable to the Plan.

Notes to Financial Statements (continued)

(In Thousands)

2. Summary of Significant Accounting Policies (continued)

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.

For purposes of determining the actuarial present value of accumulated plan benefits as of December 31, 2014, an 7.8% post-65 medical, 8.3% pre-65 medical and 9.7% pre and post-65 prescription drug annual rate of increase in the per capita cost of covered benefits were assumed for 2015 for formerly represented occupational retirees and a 8.1% post-65 medical, 8.3% pre-65 medical and 10.1% pre and post-65 prescription drug annual rate of increase in the per capita cost of covered benefits were assumed for 2015 for management and non-represented occupational retirees. These rates were assumed to decline gradually after 2015 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, 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. 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 \$99,300 and \$93,900 at December 31, 2014 and 2013, respectively.

Notes to Financial Statements (continued)

(In Thousands)

2. Summary of Significant Accounting Policies (continued)

For dental care benefits, the rate is 3.5% for 2015 and beyond. For 2014, 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 \$3,300 and \$3,400 at December 31, 2014 and 2013, 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, 2014 and 2013, respectively:

Weighted-average discount rate: Mortality:	 3.42% (2014), 4.03% (2013) 2014:Society of Actuaries RP-2014 amounts - weighted, white collar for management retirees and blue collar for occupational retirees with MP-2014 generational
	projection scale 2013:RP-2000 Combined Healthy Mortality with generational projection using the Society of Actuaries Scale AA
Weighted average rate of compensation increase:	2.26% (2014), 2.25% (2013)

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, 2014 and 2013. The Plan continues to evaluate the various provisions of the Act.

Notes to Financial Statements (continued)

(In Thousands)

2. Summary of Significant Accounting Policies (continued)

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, 2014 and 2013 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.

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.

Notes to Financial Statements (continued)

(In Thousands)

2. Summary of Significant Accounting Policies (continued)

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, 2014 and 2013. Such reimbursements may be made subsequent to the Plan's year-end.

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.

Notes to Financial Statements (continued)

(In Thousands)

3. Investments (continued)

During the year ended December 31, 2014, 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	\$ (946)
Blackrock Equity Index Fund	8,011
Blackrock U.S. Debt Index Fund	1,618
	\$ 8,683

Investments which exceed 5% of the current value of net assets available for benefits at December 31, 2014 and 2013 were as follows:

	December 31			
		2013		
Blackrock Equity Index Fund	\$	63,529 \$	60,747	

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.

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

Notes to Financial Statements (continued)

(In Thousands)

3. Investments (continued)

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value, as of December 31, 2014 and 2013. Assets are classified in their entirety based upon the lowest level of input that is significant to the fair value measurement.

			A	ssets at Fa Decembe			
]	Level 1		Level 2		Level 3	Total
				(In The	ousa	nds)	
Group life insurance policies Assets held in Lucent Technologies Inc. Master	\$	-	\$	-	\$	395,776	\$ 395,776
Pension Trust – Restricted for 401(h) account		-		226,653		-	226,653
Common/collective trusts		-		111,171		-	111,171
Registered investment company		14,633		_		_	14,633
Total assets at fair value	\$	14,633	\$	337,824	\$	395,776	\$ 748,233
			A	ssets at Fa Decembe			
]	Level 1		Level 2		Level 3	Total
				(In The	ousa	nds)	
Group life insurance policies Assets held in Lucent Technologies Inc. Master	\$	_	\$	_	\$	410,493	\$ 410,493
Pension Trust – 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

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, 2014.

	roup Life nsurance Policies	Int	uaranteed terest Rate Contract	Total
Balance, beginning of year Purchases Realized gains Unrealized gains	\$ 410,493 45,000 - 26,860	\$	10,367 	\$ 420,860 45,000 10 26,860
Settlements Balance, end of year	\$ (86,577) 395,776	\$	(10,377)	\$ (96,954) 395,776

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 Pension Trust established under Section 420 of the Code, pursuant to Section 420 of the Code, pension assets of the Pension Plan to an applicable life insurance account of the 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, 2014 and 2013 and the related changes in net assets available for the year ended December 31, 2014.

Net Assets Available for Accumulated Postretirement Obligations as of:

	December 31					
		2014				
Accrued interest receivable	\$	38	\$	25		
JPMCB Liquidity Fund		226,615		232,840		
	\$	226,653	\$	232,865		

Changes in Net Assets Available for Accumulated Postretirement Obligations for the year ended December 31, 2014:

Transfer from Pension Plan	\$ 180,000
Interest income	250
Administrative expenses	(10,298)
Benefit payments	(176,164)
Net decrease	\$ (6,212)

The following tables present the components of the net assets available for applicable life insurance benefits under Code section 420 as of December 31, 2014 and 2013 and the related changes in net assets available for the year ended December 31, 2014.

Net Assets Available for Accumulated Postretirement Obligations as of:

	December 31					
	 2014					
JPMCB Liquidity Fund	\$ - \$	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, 2014:

Transfer from Pension Plan	\$ 44,999
Benefit payments	 (45,000)
Net decrease	\$ (1)

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 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 and the Nonrepresented Trust and the Nonrepresented Trust and the Represented 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, 2014, 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 2011.

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, 2014 and 2013:

	 2014	2013
Net assets available for benefits per the financial statements	\$ 794,735 \$	833,870
Less:		
Medical claims payable and claims incurred		
but not reported	(25,000)	(25,100)
Net assets held in Pension Plan – 401(h) account	(226,653)	(232,865)
Net assets held in Pension Plan – Applicable life		
insurance account	_	(1)
Net assets available for benefits per Form 5500	\$ 543,082 \$	575,904

The following is a reconciliation of total deductions per the financial statements to the Form 5500 for the year ended December 31, 2014:

Total deductions per the financial statements	\$ 254,782
Add: Medical claims payable and liability for claims incurred but not reported at December 31, 2014	25,000
Less:	
Medical claims payable and liability for claims incurred but not	
reported at December 31, 2013	(25,100)
Net decrease in 401(h) account	(6,212)
Net decrease in applicable life insurance account	(1)
Total deductions per Form 5500	\$ 248,469

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, 2014:

Total payments for benefits per the financial statements	\$ 237,293
Add: Medical claims payable and liability for claims incurred but not	
reported at December 31, 2014	25,000
Less: Medical claims payable and liability for claims incurred but not	
reported at December 31, 2013	(25,100)
Total payments for benefits per Form 5500	\$ 237,193

8. Subsequent Events

Management has evaluated subsequent events through October 15, 2015, the date the financial statements were available to be issued. There were no material subsequent events that occurred between December 31, 2014 through October 15, 2015 that required disclosure in the financial statements, except as follows:

On April 15, 2015, Alcatel-Lucent (the parent company of the Sponsor) and Nokia announced their intention to combine through a public exchange offer whereby Nokia would acquire all of Alcatel-Lucent, with Alcatel-Lucent shareholders receiving shares of Nokia. The transaction, which remains subject to the satisfaction of various conditions, is currently expected to be completed sometime in the first half of 2016, although the transaction could be completed sooner.

Supplemental Schedules

EIN #22-3408857 Plan #504

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

December 31, 2014

Name of Issuer and Title of Issue	Description of Investment	Cost	Fair Value
Blackrock Equity Index Fund Blackrock EAFE Equity Index Fund	Common/collective trust Common/collective trust	\$ 39,196,151 21,371,259	\$ 63,528,967 20,226,077
Blackrock U.S. Debt Index Fund Dreyfus Treasury & Agency Cash	Common/collective trust	25,614,597	27,415,959
Management Fund*	Registered investment company	\$ 14,633,068 100,815,075	\$ 14,633,068 125,804,071

* Represents party-in-interest

EIN #22-3408857 Plan #504

Schedule H, Line 4j – Schedule of Reportable Transactions

Year Ended December 31, 2014

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) Serie Dreyfus Dreyfus	s of transactions in excess of 5% Treasury & Agency Cash Management Fund Treasury & Agency Cash Management Fund	\$ 165,874,200 _	\$ 173,467,118	\$ 173,467,118	\$ 165,874,200 173,467,118	\$

There were no category (i), (ii) or (iv) reportable transactions during the year ended December 31, 2014.

* 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	12/31/2014		

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	12/31/2014		

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