Wittlin, Cain & Dry, LLP 17 Beresford Court Williamsville, NY 14221 716-634-7253

October 15, 2014

CONFIDENTIAL

DSRA BENEFIT TRUST 8 GRASMERE ROAD LOCKPORT, NY 14094

RE: DSRA BENEFIT TRUST PLAN

Dear DSRA BENEFIT TRUST:

We have prepared the following return from information provided by you without verification or audit.

Annual Return/Report of Employee Benefit Plan (5500)

We suggest that you examine this return carefully to fully acquaint yourself with all items contained therein to ensure that there are no omissions or misstatements.

Form 5500, Annual Return of Employee Benefit Plan

Your Form 5500 for the tax year ended 12/31/13 has been filed electronically and is not required to be mailed. Mailing a paper copy of Form 5500 to EBSA will delay the processing of your return.

Also enclosed is any material you furnished for use in preparing the return. If the return is examined, requests may be made for supporting documentation. Therefore, we recommend that you retain all pertinent records for at least seven years.

In order that we may properly advise you of tax considerations, please keep us informed of any significant changes in your financial affairs or of any correspondence received from taxing authorities.

If you have any questions, or if we can be of assistance in any way, please call.

Sincerely,

Wittlin, Cain & Dry, LLP

DSRA BENEFIT TRUST 8 GRASMERE ROAD LOCKPORT, NY 14094

Summary Annual Report for the DSRA BENEFIT TRUST PLAN

This is the summary annual report for the DSRA BENEFIT TRUST PLAN, EIN 26-4594868, Plan number 501 for the period January 1, 2013 to December 31, 2013. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has a contract with insurance carriers to pay claims incurred under the terms of the plan. See attached list of carriers. Total premiums paid during the plan year were \$36,449,632.

Because they are so-called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending December 31, 2013, the premiums paid under such "experience-rated" contracts were \$33,251,857, and the total of all benefit claims paid under these "experience-rated" contracts during the plan year was \$32,333,181.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was \$6,341,119 as of December 31, 2013, compared to \$12,595,994 as of January 1, 2013. During the plan year the plan experienced an increase or (decrease) in its net assets of \$-6,254,875. This increase or (decrease) includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of \$37,612,600 including employer contributions of \$0, employee contributions of \$36,965,903, realized gains or (losses) of \$466,822 from the sale of assets, and earnings from investments of \$179,875.

Plan expenses were \$43,867,475. These expenses included \$652,570 in administrative expenses, \$43,214,905 in benefits paid to participants and beneficiaries, and \$0 in other expenses.

Your rights to additional information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report.

- An accountant's report
- Financial information and information on payments to service providers
- Assets held for investment
- Transactions in excess of 5% of plan assets

- Insurance information including sales commissions paid by insurance carriers

To obtain a copy of the full annual report, or any part thereof, write or call the office of DSRA BENEFIT TRUST, who is the plan administrator, 8 GRASMERE ROAD, LOCKPORT, NY, 14094, 716-628-2798. These portions of the report are furnished without charge.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan:

DSRA BENEFIT TRUST Plan Sponsor 8 GRASMERE ROAD LOCKPORT, NY 14094 26-4594868

and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

U.S. Department of Labor Employee Benefits Security Administration Public Disclosure Room 200 Constitution Avenue, N.W. Room N-1513 Washington, DC 20210 DSRA5500 DSRA BENEFIT TRUST

26-4594868

FYE: 12/31/2013

Federal Statements DSRA BENEFIT TRUST PLAN Plan: 501

10/15/2014 2:05 PM

Summary Annual Report - Insurance Carrier Information

<u>Carrier</u>		Premiums Paid
BLUE CROSS BLUE SHIELD OF MICHIGAN	\$	33,251,857
HARTFORD		80,577
HARTFORD LIFE AND ACCIDENT		1,008,147
HARTFORD		14,249
METROPOLITAN LIFE INSURANCE COMPANY		56,858
EXPRESS SCRIPTS		859,828
NATIONAL GUARDIAN LIFE (SUPERIOR VISION PLAN)		345,786
RELIANCE		832,330
Total	\$_	36,449,632

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6047(b), and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210 - 0110 1210 - 0089

2013

					ilispection
Part	Annual Report Iden	tification Inform	ation		
For ca	alendar plan year 2013 or fiscal _l	plan year beginning		and ending	
A Th	nis return/report is for:	a multiemploy	er plan;	a multiple-employ	er plan; or
		X a single-emple	oyer plan:	a DFE (specify)	
					
B Th	nis return/report is:	the first return	/report;	the final return/re	port;
	•	an amended r	eturn/report;	a short plan year	return/report (less than 12 months).
C If	the plan is a collectively-bargain				· ` ` ▶ □
	heck box if filing under:	X Form 5558;		automatic extensi	ion; the DFVC program;
	3	—	sion (enter description)		
Part I	II Basic Plan Informat				
***************************************	ame of plan				1b Three-digit plan
	A BENEFIT TRUST PLA	AN			number (PN) ▶ 501
					1c Effective date of plan
					09/01/2009
2a PI	lan sponsor's name and address	: including room or s	uite number (employer	if for a single-employer plan	
 u · ·	an sponsor s name and address	s, including room or s	and namber (employer,	ii for a single employer plan	Number (EIN)
חפת	A BENEFIT TRUST				26-4594868
Doio	A DENTE IT TROOT				2c Sponsor's telephone
					number
BOA:	RD OF DIRECTORS				716-628-2798
_	RASMERE ROAD				2d Business code (see
o G.	KADHEKE KOAD				•
TOC	KPORT	NY 14094			instructions) 525920
HOC.	RFORI	NI 14034			323920
Cauti	on: A penalty for the late or in	complete filing of the	nis return/report will be	e assessed unless reasona	ble cause is established.
	penalties of perjury and other penaltie				
	ents and attachments, as well as the				
SIGN			10/15/2	2014 james hagenbac	н
HERE	Signature of plan administra	ator	Date	Enter name of indiv	idual signing as plan administrator
SIGN					
HERE	Signature of employer/plan	sponsor	Date	Enter name of individua	al signing as employer or plan sponsor
		•			
SIGN					
HERE	Signature of DFE	-	Date	Enter name of indiv	idual signing as DFE
Prepa	arer's name (including firm name	. if applicable) and ac	ddress: include room or		Preparer's telephone number
	nes M. Dry, CPA	,		(-)	(optional)
	tlin, Cain & Dr	v. LLP			716-634-7253
	Beresford Court	. , ——-			
w _i 1	liamsville	NY 14221			

Form 5500 (2013) Page **2**

3a Plan administrator's name and address X Same as Plan Sponsor Name	Same as P	lan Spo	onsor Addre	ess	3b △	Administrator's EIN
						Administrator's telephone number
 4 If the name and/or EIN of the plan sponsor has changed since the last rEIN and the plan number from the last return/report: a Sponsor's name 	return/repo	rt filed	for this pl		Adob 4c F	
a Sponsors name						
5 Total number of participants at the beginning of the plan year					5	4196
6 Number of participants as of the end of the plan year (welfare plans cor	mplete only	lines	6a, 6b, 6d	, and 6d).		<u> </u>
a Active participants					6a	7404
b Retired or separated participants receiving benefits					6b	4288
C Other retired or separated participants entitled to future benefits				·····	6c	
d Subtotal. Add lines 6a , 6b , and 6c					6d	11692
Deceased participants whose beneficiaries are receiving or are entitled					6e	
f Total. Add lines 6d and 6e					6f	
g Number of participants with account balances as of the end of the plan complete this item)				*	6g	
h Number of participants that terminated employment during the plan yealess than 100% vested					6h	
7 Enter the total number of employers obligated to contribute to the plan (only multie	employ	er plans o	omplete this item		
 b If the plan provides pension benefits, enter the applicable pension feature b If the plan provides welfare benefits, enter the applicable welfare feature 4A 4B 4D 4E 4Q 	e codes fro	m the	List of Pla	an Characteristic (Code	es in the instructions:
9a Plan funding arrangement (check all that apply) (1) X Insurance		bene X	_	ment (check all th	nat ap	oply)
(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) (2)			ection 412(e)(3) in	surai	nce contracts
(3) X Trust	(3)	x	Trust	(-)(-)		
(4) General assets of the sponsor	(4)			assets of the spo		
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attach					ed. (S∈	ee instructions)
a Pension Schedules(1) R (Retirement Plan Information)	D Gen (1)	erai S	chedules H	(Financial Info	rmati	ion)
(2) MB (Multiemployer Defined Benefit Plan and Certain Mo		41	i	`		ion - Small Plan)
Purchase Plan Actuarial Information) - signed by the plan		x	8 A	(Insurance Info		•
actuary	(4)	x		(Service Provi		,
(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)		D			Plan Information)
Information) - signed by the plan actuary	(6)		G	(Financial Tran	nsact	tion Schedules)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2013

For calendar plan year 20 A Name of plan DSRA BENEFIT C Plan sponsor's name DSRA BENEFIT Part I Informatio on a separate 1 Coverage Information	TRUST as shown TRUST n Conce	PLAN on line 2a of Form 5500 erning Insurance Con	tract Co		-digit umber (PN) yer Identification Number	501 er (EIN)
DSRA BENEFIT C Plan sponsor's name DSRA BENEFIT Part I Informatio on a separate	as shown TRUST n Conce	on line 2a of Form 5500 erning Insurance Con	tract Co	plan n D Emplo	umber (PN) yer Identification Number	
C Plan sponsor's name DSRA BENEFIT Part I Informatio on a separate	as shown TRUST n Conce	on line 2a of Form 5500 erning Insurance Con	tract Co	D Emplo	yer Identification Number	
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Part I Informatio on a separate	n Conce	erning Insurance Con	tract Co	26-4		
on a separate	Schedule	erning Insurance Con	tract (a			
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Coverage information	•	3 - 1				
Name of insurance carr	rier					
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(D) FIN I '	ode	identification number		sons covered at end of olicy or contract year	(f) From	(g) To
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commissions paid		(c) Amount		(d) Purpose		(e) Organization code
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Schedule A (Form 5500) 2013

Page **2-** 1

(a) Nam	e and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
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commissions paid	(c) Amount	(d) Purpose	code
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commissions paid	(c) Amount	(d) Purpose	code
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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2013

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DSRA BENEFI			_		594868	
Part I Information a separa	tion Con rate Schedu	cerning Insurance Confile A. Individual contracts group	tract Coverage, Fee ped as a unit in Parts II an	s, and C d III can be	ommissions Provid reported on a single So	e information for each co chedule A.
Coverage Informat	tion:					
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Name of modrance (Carrier					
ARTFORD					T	
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nur persons covered at		-	contract year
(,	code	identification number	policy or contract		(f) From	(g) To
06-0838648	70815	AGP-003846	63		01/01/2013	12/31/2013
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Schedule A	(LOIIII	5500) ZU I S

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(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Nam		Divident of the person to whom commissions or fees were paid	
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commissions paid	(c) Amount	(d) Purpose	code
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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2013

For calendar plan yea	ar 2013 or fi	scal plan year beginning		and en	ding	
A Name of plan				B Three-	_	
DSRA BENEFIT TRUST PLAN			plan nu	ımber (PN) ▶	501	
C Plan sponsor's na	ame as show	vn on line 2a of Form 5500		D Employ	er Identification Numb	er (EIN)
DODA DENIES	mp	ım.		26.4	504060	
DSRA BENEF Part I Informa			tract Co	_	594868	a information for each contra
	arate Schedu	cerning Insurance Con ule A. Individual contracts group	ped as a u	nit in Parts II and III can be i	reported on a single Sc	e information for each contra chedule A.
1 Coverage Informa	ation:					
(a) Name of insurance						
(a) Name of modiance	Carrier					
HARTFORD LIF	E AND A	CCIDENT	1			
(b) EIN	(c) NAIC	(d) Contract or	(e) A	approximate number of sons covered at end of	Policy or	contract year
(,	code	identification number		olicy or contract year	(f) From	(g) To
06-0838648	70815	AGP-003845		678	01/01/2013	12/31/2013
2 Insurance fee and	d commission	on information. Enter the total fe	es and tot	al commissions paid. List in	line 3 the agents, brok	ers, and other persons in
descending order	r of the amo	unt paid.		<u> </u>		
(a) [¬]	Total amoun	t of commissions paid	0	(b) T	otal amount of fees pa	
2 5			0	1.14		0
3 Persons receiving		ons and fees. (Complete as mai		· · · · · · · · · · · · · · · · · · ·	•	
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HARTFORD LIFE AND ACCIDENT

Schedule A (Form 5500) 2013

Page **2-** 1

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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2013

For calendar plan year 20°	IS OF IIS						
A Name of plan		bear plair year beginning		В	and e		
DSRA BENEFIT	TRUS	T PI.AN				-digit lumber (PN) ►	501
					ρ.ω		
<u> </u>				D			(ED)
Plan sponsor's name a	as show	n on line 2a of Form 5500		l D	Emplo	yer Identification Nun	nber (EIN)
DSRA BENEFIT					_	594868	
Part I Information	n Con e Schedu	cerning Insurance Con le A. Individual contracts group	tract Co	verage, Fees, a	and Co	ommissions Prov	ide information for each co Schedule A.
Coverage Information:							
) Name of insurance carri							
I Name of mountaince cam	ici						
HARTFORD	1		(0) /	Approximate number	of	Policy	r contract year
(D) FIN I '	NAIC ode	(d) Contract or identification number	pers	sons covered at end	of	(f) From	r contract year (g) To
			ро	olicy or contract year	<u> </u>		
06-0838648 70	815	ACP-003192		14		01/01/2013	3 12/31/2013
Insurance fee and con descending order of th		n information. Enter the total fe	es and tot	al commissions paid	d. List ir	n line 3 the agents, bro	okers, and other persons in
		of commissions paid			(b)	Total amount of fees p	paid
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Persons receiving com	nmission	ns and fees. (Complete as mar	ny entries	as needed to report	all pers	sons).	
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Page **2-** 1

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(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code		
commissions paid	(b) / timoditi	(a) i dipose			
(a) Namo	e and address of the agent, bro	oker, 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		

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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▶ File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2013

		F 4 9 4.9						Пореспол
For calendar plan yea	r 2013 or fis	scal plan year beginning		r	and en	ding		
A Name of plan				В	Three-o	J		
DSRA BENEFIT TRUST PLAN				plan nu	ımber (PN)	<u> </u>	501	
C Plan sponsor's na	me as show	vn on line 2a of Form 5500		D	Employ	er Identification	n Numh	per (FIN)
• Train openiour o na	1110 40 01101	VII 611 IIII 6 24 61 1 61111 6666			Linploy	or identification	Jii i taiiik	or (Eliv)
DSRA BENEF						594868		
Part I Informa on a separ	tion Con	cerning Insurance Con ule A. Individual contracts grou	tract Co ped as a u	overage, Fees, a unit in Parts II and III	and Co can be r	eported on a	S Provid	le information for each cor chedule A.
1 Coverage Informa	ition:							
(a) Name of insurance	carrier							
(a) Name of modranes	odino:							
METROPOLITAN	LIFE I	NSURANCE COMPANY	1			1		
(b) EIN	(c) NAIC	(d) Contract or	(e) A	Approximate number sons covered at end	r of l of	F	Policy or	contract year
(0) 2.11	code	identification number		olicy or contract yea		(f) Fro	om	(g) To
13-5581829	65978	0149752		6051		01/01/	2013	12/31/2013
2 Insurance fee and	l commissio	on information. Enter the total fe	es and to	tal commissions naid	l list in	line 3 the age	nts hrol	ers, and other persons in
descending order			JCS and to	tai commissions paid	a. List iii	inic o tric ago	1113, 5101	ters, and other persons in
(a) T	otal amoun	t of commissions paid			(b) To	otal amount of	f fees pa	iid
			0					0
3 Persons receiving	commissio	ns and fees. (Complete as ma	ny entries	as needed to report	all perso	ons).		
	(a) Name	e and address of the agent, bro	oker, or oth	ner person to whom	commiss	sions or fees v	vere paid	d
	-	ı	Food and a	other commissions p	oid			
(b) Amount of sales a commissions p		(c) Amount	rees and c		Purpose			(e) Organization code
остиновоно р	dia	(b) / tillount		(4)	агросс			(c) Organization code
	(a) Na					·		
	(a) Name	e and address of the agent, bro	oker, or our	ier person to whom	commiss	sions or lees v	vere paid	<u>, , , , , , , , , , , , , , , , , , , </u>
(b) Amount of sales a	and base		Fees and o	other commissions p	aid			
commissions p		(c) Amount		(d) F	Purpose			(e) Organization code

METROPOLITAN LIFE INSURANCE COMPANY

Schedule A (Form 5500) 2013

Page **2-** 1

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
	(0,1	(,				
(a) Name	e and address of the agent, bro	oker, 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			
commissions paid	(o) / timedin	(u) i dipose	Couc			
(a) Namo	e and address of the agent, bro	oker, or other person to whom commissions or fees were paid				
` '		•				
		Face and other commissions would	<u> </u>			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Name	e and address of the agent hr	oker, or other person to whom commissions or fees were paid				
(a) Name	s and address of the agent, bit	oker, or other person to whom commissions or rees were paid				
			1			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Name		alian anathan naraan ta wham as maisis an anfasa war naid				
(a) Name	and address of the agent, bro	oker, or other person to whom commissions or fees were paid				
			Т			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
		•	•			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

► File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2013

			pursuar	nt to ERIS	A section 103(a)	(2).			Inspection
For calendar plan yea	r 2013 or fi	scal plan year b	peginning				and en	ding	
A Name of plan						В	Three-o	digit	
DSRA BENEF	IT TRUS	T PLAN					plan nu	ımber (PN)	501
Plan sponsor's na	me as show	vn on line 2a of	Form 5500			D	Employ	er Identification Num	ber (EIN)
DSRA BENEF	IT TRUS	Т					26-45	594868	
Part I Informa on a separ	tion Con rate Schedu	cerning Insule A. Individua	surance Con I contracts grou	tract Co	overage, Fee init in Parts II an	s, a	and Co can be r	emmissions Provi reported on a single S	de information for each cont Schedule A.
Coverage Informa	tion:								
Name of insurance	carrier								
rame of modrance	oarrior								
XPRESS SCRIE	PTS							1	
(b) EIN	(c) NAIC		ntract or		Approximate nur sons covered at				r contract year
(0) = 11	code	identificat	ion number		olicy or contract			(f) From	(g) To
43-1420563	60025				902			01/01/2013	
Insurance fee and descending order			Enter the total fe	ees and to	tal commissions	paid	d. List in	line 3 the agents, bro	okers, and other persons in
(a) T	otal amoun	of commission	ns paid				(b) To	otal amount of fees p	
				0	l				43308
Persons receiving	commissio	ns and fees. (C	Complete as ma	ny entries	as needed to re	port	all perso	ons).	
	(a) Name	and address	of the agent, bro	oker, or oth	ner person to wh	om (commiss	sions or fees were pa	id
MARSH .2421 MEREDIT	TH DR								
INDIANAPOLIS		IN 503	398						
b) Amount of sales a	and base		ſ	Fees and	other commissio	ns p	aid		
commissions p		(c) A	mount			(d) F	urpose		(e) Organization code
				DTTT	ING FEES				
			43308		ING PEED				3
	(a) Name	and address	of the agent, bro	oker, or oth	ner person to wh	om (commiss	sions or fees were pa	id
b) Amount of sales a	and base		F	Fees and o	other commissio	ns p	aid		
commissions p		(c) A	mount		((d) F	urpose		(e) Organization code

Page **2-** 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			
(a) Name	e and address of the agent, bro	oker, or other person to whom commissions or fees were paid				
(4)	and address of the agent, and	, , , , , , , , , , , , , , , , , , ,				
(b) Amount of sales and base	F	Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
422						
(a) Nam	e and address of the agent, bro	oker, 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) Nam	e and address of the agent, bro	oker, 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) Nam	e and address of the agent, bro	oker, or other person to whom commissions or fees were paid				
(a) Name	and address of the agent, bre	short, or outloof person to which commissions or less were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

Department of the Treasury Internal Revenue Service

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OMB No. 1210-0110

2013

		pursuar	IL IU ERIO	A Section Too(a)	/(∠).			Inspection
For calendar plan ye	ar 2013 or fi	scal plan year beginning				and ending		
A Name of plan					В	Three-digit		_
DSRA BENEF	TRUS	T PLAN				plan number	(PN) ▶	501
C Plan sponsor's n	ame as show	vn on line 2a of Form 5500			D	Employer Ide	entification Numb	er (EIN)
DSRA BENEF	פווקד ידי	т				26-45948	868	
		cerning Insurance Con	tract Co	verage Fee	· ·			a information for each contr
on a sepa	arate Schedu	ule A. Individual contracts grou	ped as a u	init in Parts II an	id III	can be report	ed on a single So	chedule A.
1 Coverage Inform	ation:							
(a) Name of insurance	carrier							
NATTONAL CITA	RDTAN T.	IFE (SUPERIOR VISI	ON DI.A	N)				
NATIONAL GUA		-	1	Approximate nur	mhei	r of	Policy or	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	pér	sons covered at	end	of		
	code	identification number	p	olicy or contract	yea	r	(f) From	(g) To
26-4594868	66583	29352		5280		0	1/01/2013	12/31/2013
2 Insurance fee an	d commissio	on information. Enter the total fe	ees and to	tal commissions	naid	d. List in line 3	the agents, brok	ers, and other persons in
descending orde			, , , , , , , , , , , , , , , , , , ,		Pane	a. <u> </u>	and agoine, and	toro, and ourse persons in
(a)	Total amoun	t of commissions paid				(b) Total a	mount of fees pa	id
			893					0
3 Persons receiving	g commissio	ns and fees. (Complete as ma	ny entries	as needed to re	port	all persons).		
	(a) Name	e and address of the agent, bro	ker, or oth	ner person to wh	nom (commissions	or fees were paid	<u> </u>
FIRST PERSON		<u> </u>	,	<u> </u>				
9000 KEYSTON	E CROSS	ING						
INDIANAPOLIS		IA 46240						
(b) Amount of sales	and base	Ī	Fees and o	other commissio	ns p	aid		
commissions	paid	(c) Amount			(d) F	Purpose		(e) Organization code
	893							
	(a) Name	e and address of the agent, bro	ker. or oth	ner person to wh	om (commissions	or fees were paid	<u> </u>
	(-7		, - ,					<u> </u>
(b) Amount of sales	and base	F	ees and c	other commissio	ns p	aid		
commissions		(c) Amount			(d) F	Purpose		(e) Organization code
					_			
			1					i

NATIONAL GUARDIAN LIFE (SUPERIOR VISION PLAN)

Schedule A (Form 5500) 2013

Page **2-** 1

26-4594868

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(b) Amount of sales and base	1	Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
commissions para	(e) / iiiieaiii	(4) 1 4.15555				
(a) Namo	e and address of the agent, bro	oker, or other person to whom commissions or fees were paid				
		, , ,				
		Fees and other commissions paid				
(b) Amount of sales and base			(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Name	and address of the agent bro	oker, or other person to whom commissions or fees were paid				
(a) Name	and address of the agent, bit	oker, or other person to whom commissions or lees were paid				
(b) Amount of sales and base	F	Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
·	, ,					
(a) Name	e and address of the agent, bro	oker, or other person to whom commissions or fees were paid				
(1) A	1	Fees and other commissions paid	(-) 0			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
commissions paid	(c) Amount	(u) i dipose	Code			
(a) Namo	e and address of the agent, bro	oker, or other person to whom commissions or fees were paid				
(1)						
	r	Food and other commissions paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

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OMB No. 1210-0110

2013

		pursuar	it to ERISA section 103(a)(∠).			Inspection
For calendar plan yea	ar 2013 or fi	scal plan year beginning			and ending		
A Name of plan				В	Three-digit		
DSRA BENEFIT TRUST		T PLAN			plan number	(PN) >	501
C Plan sponsor's na	ame as show	vn on line 2a of Form 5500		D	Employer Id	entification Num	per (EIN)
·							
DSRA BENEF	'IT TRUS	T			26-45948	368	
Part I Information on a separation	ation Con arate Schedu	cerning Insurance Con ule A. Individual contracts grou	tract Coverage, Fee	es, a	and Comm can be report	i issions Provided on a single S	de information for each contrac chedule A.
1 Coverage Informa	ation:						
(a) Name of insurance	carrier						
RELIANCE							
VEDIVICE	1		(e) Approximate nu	mha	r of	Policy or	contract year
(b) EIN	(c) NAIC	(d) Contract or	persons covered a			•	contract year
()	code	identification number	policy or contract	t yea	r	(f) From	(g) To
36-0883760	68381	GL 150478	1641		0	1/01/2013	12/31/2013
		on information. Enter the total fe	ees and total commissions	s paid	d. List in line 3	the agents, bro	kers, and other persons in
descending order		•	T				
(a) 1	Fotal amoun	t of commissions paid			(b) Total a	mount of fees pa	
			0				0
3 Persons receiving	g commissio	ns and fees. (Complete as ma	ny entries as needed to re	port	all persons).		
	(a) Name	e and address of the agent, bro	ker, or other person to wh	nom	commissions	or fees were pai	
FIRST PERSON	<u>``</u>						
9000 KEYSTON		ING					
INDIANAPOLIS		IA 46240					
			ees and other commission	ns n	aid		<u> </u>
(b) Amount of sales commissions		(c) Amount	1		Purpose		(e) Organization code
COMMISSIONS	paid	(c) Amount		(u) i	игрозс		(c) Organization code
	(a) Name	e and address of the agent, bro	ker, or other person to wh	nom	commissions	or fees were pai	d
	. ,	<u> </u>	<u> </u>			· ·	
(In) A		ſ	ees and other commission	ne n	aid		
(b) Amount of sales commissions		(c) Amount			Purpose		(e) Organization code
COMMISSIONS	paiu	(C) Amount		(u) [uipuac		(e) Organization code

Page **2-** 1

(a) Namo	e and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
()	<u> </u>		
(b) Amount of sales and base		ees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Name	and address of the agent bro	bker, or other person to whom commissions or fees were paid	
(a) Nami	e and address of the agent, bit	oker, or other person to whom commissions or rees were paid	
(l-) A	•	Fees and other commissions paid	(2) Oiti
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
•	, ,	, , ,	
(a) Name	e and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		ees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Namo	e and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(4)	and address of the agent, and	,, e. ee. person toe.	
(b) Amount of sales and base	·	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Name	e and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		- and other commissions will	
(b) Amount of sales and base commissions paid	(c) Amount	ees and other commissions paid (d) Purpose	(e) Organization code
commissions palu	(o) Amount	(a) i dipose	ooue

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such	individual contracts with each ca	rrier mav be tre	eated as a unit for purposes o
		this report.		· · · · · · · · · · · · · · · · · · ·	
		rrent value of plan's interest under this contract in the general account	-	4	
5		rrent value of plan's interest under this contract in separate accounts a	at year end	5	
6		ntracts With Allocated Funds:			
	а	State the basis of premium rates			
	h	Drawit was world to source		6h	
	b	Premiums paid to carrier		6b 6c	0
	c d	Premiums due but unpaid at the end of the year If the carrier, service, or other organization incurred any specific cost	e in connection with the acquisition	n or	
	u			" 6d	
		Specify nature of costs			-
		openity flattare or cooks p			
	е	Type of contract: (1) individual policies (2) group defe	erred annuity		
		(3) ☐ other (specify) ▶	,		
		(3) United (specify)			
	£	If a contract according to the land of the second to distribute be a fit for a	Annocionation ordere about the Da		
_	t	If contract purchased, in whole or in part, to distribute benefits from a			
1		ntracts With Unallocated Funds (Do not include portions of these cont			
	а	Type of contract: (1) deposit administration (2) i	mmediate participation guarantee	•	
		(3) guaranteed investment (4)	other >		
	b	Balance at the end of the previous year	7-4)	7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2) 7c(3)		
		(3) Interest credited during the year	7c(4)		
		(4) Transferred from separate account	7c(5)		
		(5) Other (specify below)	70(3)		
				= 453	
		(6) Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		7d	
	е	Deductions:	7.40		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7	d)	7f	0

26-4594868

Schedule A (Form 5500) 2013

Pa	Irt III Welfare Benefit Contract Information	o omplovor(o)	or mambara of the com	o omplovoo organi	ization(a) the
	If more than one contract covers the same group of employees of the same information may be combined for reporting purposes if such contracts are e				
	the entire group of such individual contracts with each carrier may be treate				addi employees,
8	Benefit and contract type (check all applicable boxes)				
	a X Health (other than dental or vision) b Dental	c	Vision		d Life insurance
		disability ©	Supplementa	al unemployment	
	i Stop loss (large deductible) j HMO cont		PPO contrac		I Indemnity contract
			TI O contrac		i Indemnity contract
	m ☐ Other (specify) ►				
9	Experience-rated contracts:				
3	C Promiser (4) Amount as a six a	9a(1)		33251857	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	•	3323237	
	(3) Increase (decrease) in unearned premium reserve	9a(3)			
	(4) Earned ((1) + (2) - (3))			9a(4)	33251857
	b Benefit charges (1) Claims paid			35508307	
	(2) Increase (decrease) in claim reserves	9b(2)		-100048	
	(3) Incurred claims (add (1) and (2))	-		9b(3)	35408259
	(4) Claims charged			0h(4)	32333181
	c Remainder of premium: (1) Retention charges (on an accrual basis)				
	(A) Commissions	9c(1)(A)			
	(B) Administrative service or other fees	9c(1)(B)		1965995	
	(C) Other specific acquisition costs	9c(1)(C)			
	(D) Other expenses	9c(1)(D)		405102	
	(E) Taxes	9c(1)(E)			
	(F) Charges for risks or other contingencies	9c(1)(F)		665038	
	(G) Other retention charges	9c(1)(G)		1810902	
	(H) Total retention		<u></u>	9c(1)(H)	4847037
	(2) Dividends or retroactive rate refunds. (These amounts were p			9c(2)	
	d Status of policyholder reserves at end of year: (1) Amount held to pro	ovide benefit	ts after retirement .	9d(1)	
	(2) Claim reserves			9d(2)	2406981
	(3) Other reserves			9d(3)	
	e Dividends or retroactive rate refunds due. (Do not include amount en	tered in line	9c(2).)	9e	
10				40	
				10a	
	b If the carrier, service, or other organization incurred any specific costs in connec			405	
	retention of the contract or policy, other than reported in Part I, item 2 above, rep	oort amount		10b	
	Specify nature of costs ►				
Pa	art IV Provision of Information				
11	Did the insurance company fail to provide any information necessary to	complete So	chedule A?	Yes X	No
12	If the answer to line 11 is "Yes," specify the information not provided.	•			

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such	individual contracts with each ca	rrier mav be tre	eated as a unit for purposes o
		this report.		· · · · · · · · · · · · · · · · · · ·	
		rrent value of plan's interest under this contract in the general account	-	4	
5		rrent value of plan's interest under this contract in separate accounts a	at year end	5	
6		ntracts With Allocated Funds:			
	а	State the basis of premium rates			
	h	Drawit was world to source		6h	
	b	Premiums paid to carrier		6b 6c	0
	c d	Premiums due but unpaid at the end of the year If the carrier, service, or other organization incurred any specific cost	e in connection with the acquisition	n or	
	u			" 6d	
		Specify nature of costs			-
		openity flattare or cooks p			
	е	Type of contract: (1) individual policies (2) group defe	erred annuity		
		(3) ☐ other (specify) ▶	,		
		(3) United (specify)			
	£	If a contract according to the land of the second to distribute be a fit for a	Annocionation ordere about the Da		
_	t	If contract purchased, in whole or in part, to distribute benefits from a			
1		ntracts With Unallocated Funds (Do not include portions of these cont			
	а	Type of contract: (1) deposit administration (2) i	mmediate participation guarantee	•	
		(3) guaranteed investment (4)	other >		
	b	Balance at the end of the previous year	7-4)	7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2) 7c(3)		
		(3) Interest credited during the year	7c(4)		
		(4) Transferred from separate account	7c(5)		
		(5) Other (specify below)	70(3)		
				= 453	
		(6) Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		7d	
	е	Deductions:	7.70		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7	d)	7f	0

DSRA BENEFIT TRUST

26-4594868

Schedule A (Form 5500) 2013

Pa	rt III	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same information may be combined for reporting purposes if such contracts are e the entire group of such individual contracts with each carrier may be treated.	xperience-rated as a unit. Where co	ntracts cover individ	
8	Benefi a e i m x	Stop loss (large deductible) j HMO contr		al unemploymeni t	d Life insurance t h Prescription drug l Indemnity contrac
9	a Pre (2) (3) (4)	ence-rated contracts: emiums: (1) Amount received Increase (decrease) in amount due but unpaid Increase (decrease) in unearned premium reserve Earned ((1) + (2) - (3)) nefit charges (1) Claims paid	9a(1) 9a(2) 9a(3) 9b(1)	9a(4)	0
	(2) (3) (4)	Increase (decrease) in claim reserves Incurred claims (add (1) and (2)) Claims charged mainder of premium: (1) Retention charges (on an accrual basis)	9b(2)	9b(3) 9b(4)	0
		(B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses (E) Taxes	9c(1)(B) 9c(1)(C) 9c(1)(D) 9c(1)(E) 9c(1)(F)		
	d Sta (2) (3)	(H) Total retention Dividends or retroactive rate refunds. (These amounts were partus of policyholder reserves at end of year: (1) Amount held to pro Claim reserves Other reserves idends or retroactive rate refunds due. (Do not include amount entertaille.)	aid in cash, or credited.)	9c(1)(H) 9c(2) 9d(1) 9d(2) 9d(3) 9e	
10	Nonex a Tot b If the rete	perience-rated contracts: al premiums or subscription charges paid to carrier e carrier, service, or other organization incurred any specific costs in connect ntion of the contract or policy, other than reported in Part I, item 2 above, rep y nature of costs	ion with the acquisition or	10a 10b	80577
	rt IV	Provision of Information			
11		e insurance company fail to provide any information necessary to		Yes X N	No
12	If the a	answer to line 11 is "Yes," specify the information not provided.			

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such	individual contracts with each car	rier mav be t	reated as a unit for purposes o
4		this report.			
		rrent value of plan's interest under this contract in the general account		4	_
5		rrent value of plan's interest under this contract in separate accounts a	at year end	5	
6		ntracts With Allocated Funds:			
	а	State the basis of premium rates			
	h	Drawit was world to sowier		6h	-
	b	Premiums paid to carrier		6b 6c	0
	c d	Premiums due but unpaid at the end of the year If the carrier, service, or other organization incurred any specific cost	s in connection with the acquisition	n or	
	u			" 6d	
		Specify nature of costs			
		openity material of cools p			
	е	Type of contract: (1) individual policies (2) group defe	erred annuity		
		(3) ☐ other (specify) ▶	•		
		(a) Carior (specify)			
	f	If contract numbered in whole or in part to distribute banefits from a	terminating plan, shock has		
_		If contract purchased, in whole or in part, to distribute benefits from a			
1		ntracts With Unallocated Funds (Do not include portions of these cont			
	а		mmediate participation guarantee		
		(3) guaranteed investment (4)	other >		
	L			76	
	<u>D</u>	Balance at the end of the previous year	70(1)	7b	
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(2) Dividends and credits	7c(3)		
		(3) Interest credited during the year(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		(b) Carlot (opcomy scient)	. 3(0)		
		(O) T (I I I''		7-(0)	
	٨	(6) Total additions		7c(6) 7d	
	a	Total of balance and additions (add lines 7b and 7c(6)).		/u	
	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)		
		(4) Other (specify below)	15(4)		
				/	
		(5) Total deductions		7e(5)	
	<u>t</u>	Balance at the end of the current year (subtract line 7e(5) from line 7	d)	7f	0

DSRA BENEFIT TRUST

26-4594868

Schedule A (Form 5500) 2013

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the sam information may be combined for reporting purposes if such contracts are	experience-rated as a unit. Where conf	racts cover individual employees,
the entire group of such individual contracts with each carrier may be treat 8 Benefit and contract type (check all applicable boxes) a	c Vision n disability g Supplemental	d ☐ Life insurance unemployment h ☐ Prescription drug
Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpaid (3) Increase (decrease) in unearned premium reserve (4) Earned ((1) + (2) - (3)) b Benefit charges (1) Claims paid (2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2)) (4) Claims charged c Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges (H) Total retention (2) Dividends or retroactive rate refunds. (These amounts were proceed of the process of policyholder reserves at end of year: (1) Amount held to proceed of the process of policyholder reserves at end of year: (1) Amount held to process of the process	9b(1) 9b(2) 9c(1)(A) 9c(1)(B) 9c(1)(C) 9c(1)(D) 9c(1)(E) 9c(1)(F) 9c(1)(G) paid in cash, or credited.) povide benefits after retirement	9a(4) 0 9b(3) 0 9b(4) 9c(1)(H) 9c(2) 9d(1) 9d(2) 9d(3) 9e
 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier b If the carrier, service, or other organization incurred any specific costs in connec retention of the contract or policy, other than reported in Part I, item 2 above, representing the specify nature of costs ► 		10a 1008147 10b
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.	•	

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such	individual contracts with each car	rier mav be t	reated as a unit for purposes o
4		this report.			
		rrent value of plan's interest under this contract in the general account		4	_
5		rrent value of plan's interest under this contract in separate accounts a	at year end	5	
6		ntracts With Allocated Funds:			
	а	State the basis of premium rates			
	h	Drawit was world to sowier		6h	-
	b	Premiums paid to carrier		6b 6c	0
	c d	Premiums due but unpaid at the end of the year If the carrier, service, or other organization incurred any specific cost	s in connection with the acquisition	n or	
	u			" 6d	
		Specify nature of costs			
		openity material of cools p			
	е	Type of contract: (1) individual policies (2) group defe	erred annuity		
		(3) ☐ other (specify) ▶	•		
		(a) Carior (specify)			
	f	If contract numbered in whole or in part to distribute banefits from a	terminating plan, shock has		
_		If contract purchased, in whole or in part, to distribute benefits from a			
1		ntracts With Unallocated Funds (Do not include portions of these cont			
	а		mmediate participation guarantee		
		(3) guaranteed investment (4)	other >		
	L			76	
	<u>D</u>	Balance at the end of the previous year	70(1)	7b	
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(2) Dividends and credits	7c(3)		
		(3) Interest credited during the year(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		(b) Carlot (opcomy scient)	. 3(0)		
		(O) T (I I I''		7-(0)	
	٨	(6) Total additions		7c(6) 7d	
	a	Total of balance and additions (add lines 7b and 7c(6)).		/u	
	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)		
		(4) Other (specify below)	15(4)		
				/	
		(5) Total deductions		7e(5)	
	<u>t</u>	Balance at the end of the current year (subtract line 7e(5) from line 7	d)	7f	0

Page 4

	rt II		Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same information may be combined for reporting purposes if such contracts are exthe entire group of such individual contracts with each carrier may be treated.	xperience-	rated	l as a	unit. Where con	racts cover ind			_
8		efit	and contract type (check all applicable boxes)		_		10.1		al [7	
	а	Ц	Health (other than dental or vision) b Dental		С	Ц	Vision		d [Life insurance	
	е		Temporary disability (accident and sickness) f Long-term	disability	g		Supplemental	unemploym	ent h	Prescription drug	g
	i		Stop loss (large deductible) j HMO contr	act	k		PPO contract		I	Indemnity contra	act
	m	X	Other (specify) MEDICARE SUPPLEMENT								
9	Exp	erie	ence-rated contracts:								
	a i	rei	miums: (1) Amount received	9a(1))						
	(2)	Increase (decrease) in amount due but unpaid	9a(2)							
			Increase (decrease) in unearned premium reserve	9a(3)							
			Earned ((1) + (2) - (3))					9a(4)		ı	0
	b E	3en	efit charges (1) Claims paid	9b(1))						
	(2)	Increase (decrease) in claim reserves	9b(2))						
	(3)	Incurred claims (add (1) and (2))					9b(3)			0
	(4)	Claims charged					9b(4)			_
	,		nainder of premium: (1) Retention charges (on an accrual basis) -	- -							
				9c(1)(A	4)						
				9c(1)(E							
			(C) Other specific acquisition costs	9c(1)(0							
			(D) Other expenses	9c(1)(E							
			(Γ) Toyon	9c(1)(E							
				9c(1)(F							
			(G) Other retention charges	9c(1)(0							
								9c(1)(H)			
	,	2)	(H) Total retention	id in ood	 h o		oroditod \	9c(2)			_
			us of policyholder reserves at end of year: (1) Amount held to pro					9d(1)			_
							•				_
			Claim reserves					9d(2)			
			Other reserves					9d(3)			_
40			dends or retroactive rate refunds due. (Do not include amount ent	tered in lii	ne 9	c(2)	.)	9e			
10			perience-rated contracts:					40		1404	_
								10a		1424	9
	r	eter	e carrier, service, or other organization incurred any specific costs in connecti tion of the contract or policy, other than reported in Part I, item 2 above, repo					10b			
	art I	/	Provision of Information	complete	Sch	nedul	le A2	Yes X	No		
11	Did	the	insurance company fail to provide any information necessary to	complete	Sch	nedul	le A?	res X	No		

12 If the answer to line 11 is "Yes," specify the information not provided.

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such	individual contracts with each car	rier mav be t	reated as a unit for purposes o
4		this report.			
		rrent value of plan's interest under this contract in the general account		4	_
5		rrent value of plan's interest under this contract in separate accounts a	at year end	5	
6		ntracts With Allocated Funds:			
	а	State the basis of premium rates			
	h	Drawit was world to sowier		6h	-
	b	Premiums paid to carrier		6b 6c	0
	c d	Premiums due but unpaid at the end of the year If the carrier, service, or other organization incurred any specific cost	s in connection with the acquisition	n or	
	u			" 6d	
		Specify nature of costs			
		openity material of cools p			
	е	Type of contract: (1) individual policies (2) group defe	erred annuity		
		(3) ☐ other (specify) ▶	•		
		(a) Carior (specify)			
	f	If contract numbered in whole or in part to distribute banefits from a	terminating plan, shock has		
_		If contract purchased, in whole or in part, to distribute benefits from a			
1		ntracts With Unallocated Funds (Do not include portions of these cont			
	а		mmediate participation guarantee		
		(3) guaranteed investment (4)	other >		
	L			76	
	<u>D</u>	Balance at the end of the previous year	70(1)	7b	
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(2) Dividends and credits	7c(3)		
		(3) Interest credited during the year(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		(b) Carlot (opcomy scient)	. 3(0)		
		(O) T (I I I''		7-(0)	
	٨	(6) Total additions		7c(6) 7d	
	a	Total of balance and additions (add lines 7b and 7c(6)).		/u	
	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)		
		(4) Other (specify below)	15(4)		
				/	
		(5) Total deductions		7e(5)	
	<u>t</u>	Balance at the end of the current year (subtract line 7e(5) from line 7	d)	7f	0

Pai	Tt III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same	e employer(s) or members of the same	e emplovee orgai	nization(s), the
	information may be combined for reporting purposes if such contracts are e	experience-rated as a unit. Where con	tracts cover indiv	
	the entire group of such individual contracts with each carrier may be treated	ed as a unit for purposes of this report		
8	Benefit and contract type (check all applicable boxes)			. 🖃
	a Health (other than dental or vision)	C Vision		d X Life insurance
	e Temporary disability (accident and sickness) f Long-term	disability g Supplementa	l unemploymer	nt h Prescription drug
	i Stop loss (large deductible) j HMO cont	ract k PPO contract		I Indemnity contract
	m X Other (specify) ▶ ADD			
9	Experience-rated contracts:			
	a Premiums: (1) Amount received	9a(1)		
	(2) Increase (decrease) in amount due but unpaid	9a(2)		
	(3) Increase (decrease) in unearned premium reserve	9a(3)		
	(4) Earned ((1) + (2) - (3))		9a(4)	0
	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)	0
	(4) Claims charged		9b(4)	
	C Remainder of premium: (1) Retention charges (on an accrual basis)	1		
	(A) Commissions	9c(1)(A)		
	(B) Administrative service or other fees	9c(1)(B) 9c(1)(C)		
	(C) Other specific acquisition costs	9c(1)(D)		
	(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. (These amounts were p	aid in cash, or credited.)	9c(2)	
	d Status of policyholder reserves at end of year: (1) Amount held to pro		9d(1)	
	(2) Claim reserves	•	9d(2)	
	(3) Other reserves		9d(3)	
	e Dividends or retroactive rate refunds due. (Do not include amount en		9e	
10	Nonexperience-rated contracts:			
	Total premiums or subscription charges paid to carrier		10a	56858
	b If the carrier, service, or other organization incurred any specific costs in connec			
	retention of the contract or policy, other than reported in Part I, item 2 above, rep	oort amount.	10b	
	Specify nature of costs ▶			
Pa	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 answer to line 11 is "Yes," specify the information not provided.	•		

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such	individual contracts with each car	rier mav be t	reated as a unit for purposes o
4		this report.			
		rrent value of plan's interest under this contract in the general account		4	_
5		rrent value of plan's interest under this contract in separate accounts a	at year end	5	
6		ntracts With Allocated Funds:			
	а	State the basis of premium rates			
	h	Drawit was world to sowier		6h	-
	b	Premiums paid to carrier		6b 6c	0
	c d	Premiums due but unpaid at the end of the year If the carrier, service, or other organization incurred any specific cost	s in connection with the acquisition	n or	
	u			" 6d	
		Specify nature of costs			
		openity material of cools p			
	е	Type of contract: (1) individual policies (2) group defe	erred annuity		
		(3) ☐ other (specify) ▶	•		
		(a) Carior (specify)			
	f	If contract numbered in whole or in part to distribute banefits from a	terminating plan, shock has		
_		If contract purchased, in whole or in part, to distribute benefits from a			
1		ntracts With Unallocated Funds (Do not include portions of these cont			
	а		mmediate participation guarantee		
		(3) guaranteed investment (4)	other >		
	L			76	
	<u>D</u>	Balance at the end of the previous year	70(1)	7b	
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(2) Dividends and credits	7c(3)		
		(3) Interest credited during the year(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		(b) Carlot (opcomy scient)	. 3(0)		
		(O) T (I I I''		7-(0)	
	٨	(6) Total additions		7c(6) 7d	
	a	Total of balance and additions (add lines 7b and 7c(6)).		/u	
	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)		
		(4) Other (specify below)	15(4)		
				/	
		(5) Total deductions		7e(5)	
	<u>t</u>	Balance at the end of the current year (subtract line 7e(5) from line 7	d)	7f	0

DSRA BENEFIT TRUST

26-4594868

Schedule A (Form 5500) 2013

	rt 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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.						
8	Benefi	t 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	n disability	g	Supplementa	l unemploymer	nt h X	Prescription drug
	i 🗌	Stop loss (large deductible) j HMO con	tract	k 🗌	PPO contract		1	Indemnity contract
	$m \ \Box$	Other (specify)						-
9	Experi	ence-rated contracts:						
		miums: (1) Amount received						
		Increase (decrease) in amount due but unpaid						
		Increase (decrease) in unearned premium reserve	•					
		Earned ((1) + (2) - (3))		<u></u>		9a(4)		0
	b Ber	nefit charges (1) Claims paid	9b(1)					
	(2)	Increase (decrease) in claim reserves	9b(2)					
	(3)	Incurred claims (add (1) and (2))				9b(3)		0
		Claims charged				9b(4)		
	C Rer	mainder of premium: (1) Retention charges (on an accrual basis)	- <u>-</u>					
		(A) Commissions	9c(1)(A))				
		(B) Administrative service or other fees	9c(1)(B))				
		(C) Other specific acquisition costs	9c(1)(C)				
		(D) Other expenses	9c(1)(D)				
		(E) Taxes	00(1)(E)					
		(F) Charges for risks or other contingencies						
		(G) Other retention charges	9c(1)(G					
		(H) Total retention	33(1)(3	/		9c(1)(H)		
	(2)	Dividends or retroactive rate refunds. (These amounts were	naid in cash		credited)	9c(2)		
		tus of policyholder reserves at end of year: (1) Amount held to pi				9d(1)		
		• • • • • • • • • • • • • • • • • • • •			•	9d(2)		
	(2)	Claim reserves				9d(3)		
	(3)	Other reserves	ntorod in lin			9e 9e		
		idends or retroactive rate refunds due. (Do not include amount eleperience-rated contracts:	ntered in ilh	e 9C(2	· J ·)	3 C		
		•				100		859828
		al premiums or subscription charges paid to carrier				10a		039020
		e carrier, service, or other organization incurred any specific costs in conne		acquisi	lion or	406		
		ntion of the contract or policy, other than reported in Part I, item 2 above, re	eport amount.			10b		
	Specif	y nature of costs ▶						
Pa	rt IV	Provision of Information						
	Did the	e insurance company fail to provide any information necessary to	complete S	Schedi	ıle A?	Yes X	No	

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such	individual contracts with each car	rier mav be t	reated as a unit for purposes o
4		this report.			
		rrent value of plan's interest under this contract in the general account		4	_
5		rrent value of plan's interest under this contract in separate accounts a	at year end	5	
6		ntracts With Allocated Funds:			
	а	State the basis of premium rates			
	h	Drawit was world to sowier		6h	-
	b	Premiums paid to carrier		6b 6c	0
	c d	Premiums due but unpaid at the end of the year If the carrier, service, or other organization incurred any specific cost	s in connection with the acquisition	n or	
	u			" 6d	
		Specify nature of costs			
		openity material of cools p			
	е	Type of contract: (1) individual policies (2) group defe	erred annuity		
		(3) ☐ other (specify) ▶	•		
		(a) Carior (specify)			
	f	If contract numbered in whole or in part to distribute banefits from a	terminating plan, shock has		
_		If contract purchased, in whole or in part, to distribute benefits from a			
1		ntracts With Unallocated Funds (Do not include portions of these cont			
	а		mmediate participation guarantee		
		(3) guaranteed investment (4)	other >		
	L			76	
	<u>D</u>	Balance at the end of the previous year	70(1)	7b	
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(2) Dividends and credits	7c(3)		
		(3) Interest credited during the year(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		(b) Carlot (opcomy scient)	. 3(0)		
		(O) T (I I I''		7-(0)	
	٨	(6) Total additions		7c(6) 7d	
	a	Total of balance and additions (add lines 7b and 7c(6)).		/u	
	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)		
		(4) Other (specify below)	15(4)		
				/	
		(5) Total deductions		7e(5)	
	<u>t</u>	Balance at the end of the current year (subtract line 7e(5) from line 7	d)	7f	0

DSRA BENEFIT TRUST

26-4594868

Schedule A (Form 5500) 2013

Pa	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the sam information may be combined for reporting purposes if such contracts are the entire group of such individual contracts with each carrier may be treated.	experience-rated as a unit. Where con	tracts cover individ	
8		_		
	a Health (other than dental or vision) b Dental	C X Vision		d Life insurance
	e Temporary disability (accident and sickness) f Long-terr	m disability g Supplementa	l unemployment	h Prescription drug
	i Stop loss (large deductible) j HMO cor	ntract k PPO contract	t	I Indemnity contract
	m ☐ Other (specify) ▶			
9	Experience-rated contracts:			
	a Premiums: (1) Amount received	9a(1)		
	(2) Increase (decrease) in amount due but unpaid	9a(2)		
	(3) Increase (decrease) in unearned premium reserve			
	(4) Earned ((1) + (2) - (3))		9a(4)	0
	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)	0
	(4) Claims charged		9b(4)	
	C Remainder of premium: (1) Retention charges (on an accrual basis)			
	(A) Commissions	9c(1)(A)		
	(B) Administrative service or other fees	9c(1)(B)		
	(C) Other specific acquisition costs	9c(1)(C)		
	(D) Other expenses	9c(1)(D)		
	(E) Taxes	9c(1)(E)		
	(F) Charges for risks or other contingencies	9c(1)(F)		
	(G) Other retention charges	9c(1)(G)	0 (4)(1)	
	(H) Total retention		9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These amounts were		9c(2)	
	d Status of policyholder reserves at end of year: (1) Amount held to p	•	9d(1)	
	(2) Claim reserves		9d(2)	
	(3) Other reserves		9d(3)	
10	Dividends or retroactive rate refunds due. (Do not include amount e	ntered in line 9c(2).)	9e	
10	Nonexperience-rated contracts:		100	245706
	Total premiums or subscription charges paid to carrier	attended the control of the control	10a	345786
	b If the carrier, service, or other organization incurred any specific costs in conne		10h	
	retention of the contract or policy, other than reported in Part I, item 2 above, re	eport amount.	10b	
	Specify nature of costs ▶			
Pa	art IV Provision of Information			
11	Did the insurance company fail to provide any information necessary to	complete Schedule A?	Yes X N	0
	If the answer to line 11 is "Yes," specify the information not provided.			

Schedule A (Form 5500) 2013

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such	n individual contracts with each	carrier may be treated as	a unit for purposes o
		this report.			
4		rrent value of plan's interest under this contract in the general accour	•		
5		rent value of plan's interest under this contract in separate accounts	at year end	5	
6		ntracts With Allocated Funds:			
	а	State the basis of premium rates			
	h	Dramiuma naid to carrier		6b	
		Premiums paid to carrier Premiums due but unpaid at the end of the year		60	0
	c d	If the carrier, service, or other organization incurred any specific cos	ts in connection with the acquis	cition or	
	u		to in connection with the acquir		
		Specify nature of costs ▶			
		Cposity thatallo of cools p			
	е	Type of contract: (1) individual policies (2) group def	erred annuity		
		(3) ☐ other (specify) ▶	•		
		(c) suits (opening) p			
	f	If contract purchased, in whole or in part to distribute banefits from	a terminating plan, shock ha		
_		If contract purchased, in whole or in part, to distribute benefits from a			<u> </u>
1		ntracts With Unallocated Funds (Do not include portions of these con	·	,	
	а		immediate participation guaran	itee	
		(3) guaranteed investment (4)	other >		
		Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits			
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
	_				
		Total of balance and additions (add lines 7b and 7c(6)).		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)		
		(4) Other (specify below)	7e(4)		
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e/5) from line 7	7d)	7f	0

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Schedule A (Form 5500) 2013

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Pa	i	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the sam information may be combined for reporting purposes if such contracts are the entire group of such individual contracts with each carrier may be treat	experience-ra	ited as	s a unit. Where cont	racts cover indi		
8		and contract type (check all applicable boxes)			_		_	_
	а	Health (other than dental or vision) b Dental		С	Vision		d 2	Life insurance
	е	Temporary disability (accident and sickness) f Long-term	n disability	g	Supplemental	unemployme	nt h	Prescription drug
	i 🗌	Stop loss (large deductible) j HMO con	tract	k 🗌	PPO contract		1	Indemnity contract
	m [Other (specify)						
9	Experie	nce-rated contracts:						
	a Prem	iums: (1) Amount received	9a(1)					
	(2) Ir	ncrease (decrease) in amount due but unpaid	9a(2)					
		ncrease (decrease) in unearned premium reserve	9a(3)					
		arned ((1) + (2) - (3))				9a(4)		0
	b Bene	fit charges (1) Claims paid	9b(1)					
	(2) Ir	ncrease (decrease) in claim reserves						
	(3) Ir	ncurred claims (add (1) and (2))				9b(3)		0
	(4) C	laime charged				9b(4)		
	. ,	ainder of premium: (1) Retention charges (on an accrual basis)				,		
		(A) Commissions	9c(1)(A))				
		(B) Administrative service or other fees	9c(1)(B)					
		(C) Other specific acquisition costs	9c(1)(C)					
		(D) Other expenses	9c(1)(D)					
			9c(1)(E)					
		(F) Charges for risks or other contingencies	9c(1)(F)					
		(C) Other retention charges	9c(1)(G					
		(G) Other retention charges				9c(1)(H)		
	(2) [(H) Total retention ividends or retroactive rate refunds. (These amounts were p		· · · · · ·	orodited)	9c(2)		
		is of policyholder reserves at end of year: (1) Amount held to pr				9d(1)		
		u -			•			
	` '	Claim reserves				9d(2)		
	` '	Other reserves				9d(3)		
40		ends or retroactive rate refunds due. (Do not include amount en	ntered in line	e 9c (2	2) .)	9e		
10		erience-rated contracts:				- 40		
						10a		832330
	retent	carrier, service, or other organization incurred any specific costs in connection of the contract or policy, other than reported in Part I, item 2 above, re				10b		
	rt IV	Provision of Information	ocemplate S	Cahad	Julo A2	Yes X	No	
11	טוט tne	insurance company fail to provide any information necessary to	complete S	cnea	iule A?	162	INU	

12 If the answer to line 11 is "Yes," specify the information not provided.

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

For calendar plan year 2013 or fiscal plan year beginning

Service Provider Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ File as an attachment to Form 5500.

and ending

OMB No. 1210-0110

2013

This Form is Open to Public Inspection.

A Name of plan	B Three-digit plan number (PN) ▶	501
	pian number (FN)	501
DSRA BENEFIT TRUST PLAN		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Num	ber (EIN)
DSRA BENEFIT TRUST	26-4594868	
Part I Service Provider Information (see instructions)	20-4394000	
You must complete this Part, in accordance with the instructions, to report th \$5,000 or more in total compensation (i.e., money or anything else of moneta position with the plan during the plan year. If a person received only eligible you are required to answer line 1 but are not required to include that person	ary value) in connection with services rendered indirect compensation for which the plan recei	to the plan or the person's
1 Information on Persons Receiving Only Eligible Indirect C	Compensation	
a Check "Yes" or "No" to indicate whether you are excluding a person from the indirect compensation for which the plan received the required disclosures (s	e remainder of this Part because they received	
b If you answered line 1a "Yes," enter the name and EIN or address of each perceived only eligible indirect compensation. Complete as many entries as new		e service providers who
(b) Enter name and EIN or address of person who provide	ed you disclosures on eligible indirect compens	sation
(b) Enter name and EIN or address of person who provide	ed you disclosures on eligible indirect compens	sation
(b) Enter name and EIN or address of person who provide	ed you disclosures on eligible indirect compens	sation
(b) Enter name and EIN or address of person who provide	ed you disclosures on eligible indirect compens	sation

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Schedule C (Form 5500) 2013

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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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answ	ormation on Other Service Providered "Yes" to line 1a above, complete as no money or anything else of value) in connection	nany entries as ne	eeded to list each pers	son receiving, directly	or indirectly, \$5,000 o	r more in total comp
	(a	Enter name and	d EIN or address (see	instructions)		
	MAF	RSH		1:	3-3109248	
(b) Service Code(s)	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)	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	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	NONE	312790	Yes No X	Yes No		Yes No
	(a	Enter name and	d EIN or address (see	instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none enter -0	compensation? (sources other than plan or plan sponsor)	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?
70	NONE	328296	Yes No X	Yes No		Yes No
	(a) Enter name and	d EIN or address (see	instructions)		
	FIF	RST PERSON	BENEFIT	3!	5-2045879	
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none enter -0		(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	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?
16	NONE	189378	Yes No X	Yes No		Yes No

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Figure 1 Service Provider Information (continued) Figure 1 you reported on line 2 receipt of indirect compensation, other than eligible indirect or provides contract administrator, consulting, custodial, invest. advisory, investment juestions for (a) each source from whom the service provider received \$1,000 or motorovider gave you a formula used to determine the indirect compensation instead of its many entries as needed to report the required information for each source.	management, broker, or record re in indirect compensation and	dkeeping services, answer the follo d (b) each source for whom the ser
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determin	et compensation, including any e the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determin	et compensation, including any e the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect	ct compensation, including any e the service provider's eligibility the indirect compensation.

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Part II Service Providers Who Fail or Refuse to		-
Provide, to the extent possible, the following information for exthis Schedule.	ach service prov	rider who failed or refused to provide the information necessary to comp
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refuse to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refuse to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refuse to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refuse to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refuse to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refuse to provide

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Schedule C (Form 5500) 2013

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(complete as many entries as needed) a Name:	b EIN:
C Position:	
d Address:	e Telephone:
	·
Explanation:	
a Name:	b EIN:
C Position:	
d Address:	e Telephone:
Explanation:	
a Name:	b EIN:
C Position:	
d Address:	e Telephone:
Explanation:	
a Name:	b EIN:
C Position:	
d Address:	e Telephone:
Explanation:	
a Name:	b EIN:
C Position:	
d Address:	e Telephone:
Explanation:	

Schedule C (Form 5500) 2013

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answ	rmation on Other Service Providered "Yes" to line 1a above, complete as remoney or anything else of value) in connection	nany entries as ne	eeded to list each pers	on receiving, directly	or indirectly, \$5,000 o	r more in total com
	(a	Enter name and	d EIN or address (see	instructions)		_
	T F	ROWE PRICE		52	2-0556948	
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0		(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	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	NONE	45461	Yes No X	Yes No		Yes No
	(a	Enter name and	d EIN or address (see	instructions)		
(b) Service Code(s)	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?
29	NONE	10260	Yes No X	Yes No		Yes No
	(a	Enter name and	d EIN or address (see	instructions)		
	GAI	INES KRINER	ELLIOT LLP	10	6-0773396	
(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?	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
10	NONE	18281	Yes No X	Yes No		Yes No

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Schedule C (Form 5500) 2013

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		(a) Enter name and	d EIN or address (see i	instructions)		
	C	OMERICA BANK		38	8-0477375	
(b) bervice code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none, enter -0		(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	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?
21	NONE	10004	Yes No X	Yes No		Yes No
		(a) Enter name and	d EIN or address (see i	inetructions)		
(b) ervice ode(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none enter -0		(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	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
(b) ervice ode(s)	Relationship to employer, employee organization, or person known to be	Enter direct compensation paid by the plan. If none	Did service provider receive indirect compensation? (sources other than plan or plan	Did indirect compensation include eligible indirect compensation, for which the plan received the required	Enter total indirect compensation received by service provider excluding eligible in- direct compensation for which you answered "Yes" to element	Did the service provider give you a formula instead of an amount or
(b) ervice ode(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none enter -0	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? Yes No	Enter total indirect compensation received by service provider excluding eligible in- direct compensation for which you answered "Yes" to element	Did the service provider give you a formula instead of an amount or estimated amount?
ode(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none enter -0 (a) Enter name and	Did service provider receive indirect compensation? (sources other than plan or plan sponsor) Yes No	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? Yes No I	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
(b) ervice ode(s) (b) ervice ode(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none enter -0	Did service provider receive indirect compensation? (sources other than plan or plan sponsor) Yes No Did EIN or address (see in the provider see in the provider receive indirect receive indirect sources.	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? Yes No	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 formula instead c an amount or estimated amount

SCHEDULE H (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

A Name of plan

For calendar plan year 2013 or fiscal plan year beginning

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500.

and ending

1c(13)

1c(14)

1c(15)

12,595,994

B Three-digit

OMB No. 1210-0110

2013

This Form is Open to Public Inspection

			plan number (PN)	▶ 501	_
	DSRA BENEFIT TRUST PLAN				
C	Plan sponsor's name as shown on line 2a of Form 5500		D Employer Identification	n Number (EIN)	
			06 4504060		
	DSRA BENEFIT TRUST		26-4594868		-
	art I Asset and Liability Statement				
t I k	Current value of plan assets and liabilities at the beginning and end of the plan year. Conclude the plan's interest in a commingled fund containing the assets of more than ines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contraction of an insurance contraction of a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSA and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.	one plan ct which g as, and 10	on a line-by-line basis unlous a line-by-line basis unlous unites, during this plar	ess the value is reportate n year, to pay a specific	ole on dollar
	Assets		(a) Beginning of Year	(b) End of Year	_
	Total noninterest-bearing cash	1a			-
	Receivables (less allowance for doubtful accounts):				
•	1) Employer contributions	1b(1)			_
(2) Participant contributions	1b(2)			_
(3) Other	1b(3)			_
	Seneral investments:				
(Interest-bearing cash (include money market accounts & certificates				
	of deposit)	1c(1)			_
(2) U.S. Government securities	1c(2)			=
(Corporate debt instruments (other than employer securities):				
	(A) Preferred	1c(3)(A)			_
	(B) All other	1c(3)(B)			_
(4	4) Corporate stocks (other than employer securities):				
	(A) Preferred	1c(4)(A)			_
	(B) Common	1c(4)(B)			_
(5) Partnership/joint venture interests	1c(5)			_
(Real estate (other than employer real property)	1c(6)			_
(7) Loans (other than to participants)	1c(7)			_
	3) Participant loans	1c(8)			_
(Value of interest in common/collective trusts	1c(9)			_
(1	0) Value of interest in pooled separate accounts	1c(10)			_
(1	Value of interest in master trust investment accounts	1c(11)			_
(1	2) Value of interest in 103-12 investment entities	1c(12)			_

(13) Value of interest in registered investment companies (e.g., mutual

(14) Value of funds held in insurance company general account (unallocated

contracts)
(15) Other

6,341,119

Schedule H (Form 5500) 2013

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1d	Employer-related investments:		(a) Beginning of Year	(b) End of Year
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
е	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	12,595,994	6,341,119
	Liabilities		·	
g	Benefit claims payable	1g		
h	Operating payables	1h		
i	Acquisition indebtedness	1i		
j	Other liabilities	1j		
k		1k		
	Net Assets		·	
I	Net assets (subtract line 1k from line 1f)	11	12,595,994	6,341,119

Part II Income and Expense Statement

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 Contrib	outions:			
(1) Red	ceived or receivable in cash from: (A) Employers	2a(1)(A)		
(B)	Participants	2a(1)(B)	10,517,167	
(C)	Others (including rollovers)	2a(1)(C)	26,448,736	
(2) Nor	ncash contributions	22(2)		
(3) Tota	al contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		36,965,903
	gs on investments:			
(1) Inte	prest:			
` ,	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)		
(G)	Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0
(2) Divi	idends: (A) Preferred stock	2b(2)(A)		
	Common stock	2h/2\/R\		
(C)	Registered investment company shares (e.g. mutual funds)	2b(2)(C)	228,649	
(D)	Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		228,649
(3) Rer		2b(3)		<u> </u>
(4) Net	gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	12,366,022	
(B)	Aggregate carrying amount (see instructions)	2b(4)(B)	11,899,200	
(C)	Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		466,822
(5) Unr	realized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B)	Other	2b(5)(B)		
	Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

Schedule H (Form 5500) 2013

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	_		(a	a) Amo	unt		(b) Total	
	(6) Net investment gain (loss) from common/collective trusts	2b(6)						
	(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	2b(10)						
	companies (e.g., mutual funds)	20(10)					-4	8,774
	Other income	2c						
d	Total income. Add all income amounts in column (b) and enter total	2d					37,61	2,600
	Expenses							
е	Benefit payment and payments to provide benefits:							
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)			75,561			
	(2) To insurance carriers for the provision of benefits	2e(2)		37,03	39,344			
	(3) Other	2e(3)						
	(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)					43,21	4,905
f	Corrective distributions (see instructions)	2f						
g	Certain deemed distributions of participant loans (see instructions)	2g						
	Interest expense	2h						
i	Administrative expenses: (1) Professional fees	2i(1)		3	37,508			
	(2) Contract administrator fees	2i(2)		48	38,215			
	(3) Investment advisory and management fees	2i(3)			55,473			
	(4) Other	2i(4)		7	71,374			
	(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)						2,570
j	Total expenses. Add all expense amounts in column (b) and enter total Net Income and Reconciliation	2j					43,86	7,475
k	Net income (loss). Subtract line 2j from line 2d	2k					-6,25	4,875
	Transfers of assets:						-	-
-	(1) To this plan	21(1)						
	(2) From this plan	21(2)						
		, , III						
P	art III Accountant's Opinion							
3	Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to	this Form 5	500. Co	mplete li	ne 3d if an o	opinion is	not	
	attached.							
а	The attached opinion of an independent qualified public accountant for this plan is (see in	nstruction	s):					
	(1) X Unqualified (2) Qualified (3) Disclaimer (4) Advers	se				_		
	Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or	103-12(d))?			Yes	X No)
С	Enter the name and EIN of the accountant (or accounting firm) below:							
	(1) Name: WITTLIN, CAIN & DRY, LLP	(2) EIN:	16-1	5943	74			
d	The opinion of an independent qualified public accountant is not attached because:							
	(1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attached to the	next Form	า 5500	pursuar	nt to 29 CF	FR 2520	.104-50.	
P	art IV Compliance Questions							
4	CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not comple	te lines 4a	a, 4e, 41	f, 4g, 4h	n, 4k, 4m,	4n, or 5.		
	103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.		-					
	During the plan year:			Yes	No	Ar	mount	
a	, , , ,							
	period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year for							
	until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Progra		4a		Х			
b	, , ,							
	close of the plan year or classified during the year as uncollectible? Disregard participa							
	secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Ye	es" is						
	checked.)		4b		X			

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			res	NO		Am	ount
С	Were any leases to which the plan was a party in default or classified during the year as						
	uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		Х			
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions						
	reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is						
	checked.)	4d		Х			
е	Was this plan covered by a fidelity bond?	4e	Х				500000
t	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused						
	by fraud or dishonesty?	4f		Х			
g	Did the plan hold any assets whose current value was neither readily determinable on an						
_	established market nor set by an independent third party appraiser?	4g		Х			
h	Did the plan receive any noncash contributions whose value was neither readily						
	determinable on an established market nor set by an independent third party appraiser?	4h		Х			
İ	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							
	plan, or brought under the control of the PBGC?	4k		Х			
I	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		Х			
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					
āa āb	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 Y				nount:	ch asso	ets or liabilities wer
	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?					ch asse	ets or liabilities wer
	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 Yes, during this plan year, any assets or liabilities were transferred from this plan to another plan(s) transferred. (See instructions.)		ify the	plan(s) to whic	ch asse	ets or liabilities wer
	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 Yes, during this plan year, any assets or liabilities were transferred from this plan to another plan(s)		ify the		s) to whic	ch asso	Г
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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 Yes, during this plan year, any assets or liabilities were transferred from this plan to another plan(s) transferred. (See instructions.)	, identi	5k	plan(s) to whic		Г
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 Yelf, during this plan year, any assets or liabilities were transferred from this plan to another plan(s) transferred. (See instructions.) 5b(1) Name of plan(s)	, identi	5k	plan(s	EIN(s)		5b(3) PN(s)
5b Fa	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 Y If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s) transferred. (See instructions.) 5b(1) Name of plan(s) If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)?	, identi	5k	plan(s	EIN(s)) []	5b(3) PN(s)
5b Fa	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 Year. If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s) transferred. (See instructions.) 5b(1) Name of plan(s) If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Trust Information (optional)	, identi	5k	plan(s	ilN(s)) []	5b(3) PN(s)
5b Fa	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 Year. If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s) transferred. (See instructions.) 5b(1) Name of plan(s) If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Trust Information (optional)	, identi	5k	plan(s	ilN(s)) []	5b(3) PN(s)

DSRA5500 DSRA BENEFIT TRUST

26-4594868 FYE: 12/31/2013

Federal Statements DSRA BENEFIT TRUST PLAN

10/15/2014 2:05 PM

Plan: 501

Statement 1 - Form 5500, Schedule H, Line 2i(4) - Other Expenses

Description	 Amount
INSURANCE EXPENSE	\$ 17,904
PRINTING & MAILING	18,105
ADMIN EXPENSE	 35,365
Total	\$ 71,374

Statement 2 - Schedule H, Line 4i - Schedule of Assets Held for Investment

Party in Interest	Identity	Description	Cost	Current Value
	SCHEDULE ATTACHED		\$	s

DSRA5500 DSRA BENEFIT TRUST

26-4594868

FYE: 12/31/2013

Federal Statements DSRA BENEFIT TRUST PLAN Plan: 501

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Statement 3 - Schedule H, Line 4j - Schedule of Reportable Transactions (5%)

Name								
	Description	Purchase Price	Selling Price	Lease Rental	Expenses	Cost of Asset	Current Value	Net Gain or Loss
SCHEDULE ATTACHED		\$	\$	\$	\$	\$	\$	\$