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 6057(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

2016

_						inspection		
Part I		dentification Information						
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016								
A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box participating employer information in accordance to participating employer information in accordance to participating employer information in accordance to participating employer plan (Filers checking this box parti								
		x a single-employer plan	a DFE (specif	·y)				
B This r	return/report is:	the first return/report	the final return	n/report				
an amended return/report a short plan year return/report (less than 12 mo)		
C If the	plan is a collectively-bar	gained plan, check here				× X		
D Chec	k box if filing under:	X Form 5558	automatic exte	ension	the	e DFVC program		
		special extension (enter description	on)					
Part II	Basic Plan Info	rmation—enter all requested informa	tion					
1a Nam	ne of plan EDICAL EXPENSE PLAN FOR O	·			1b	Three-digit plan number (PN) ▶	503	
					1c	Effective date of p	lan	
		yer, if for a single-employer plan)			2b	Employer Identification	ation	
		m, apt., suite no. and street, or P.O. Box e, country, and ZIP or foreign postal co		ructions)		Number (EIN) 22-3408857		
ALCATE	L-LUCENT USA INC.				2c	Plan Sponsor's tel	ephone	
						number 908-723-9869)	
600 MOL	INTAIN AVENUE, ROOM	И 6D-401A			2d	2d Business code (see		
MURRAY	/ HILL, NJ 07974					instructions) 334200		
						001200		
Caution	: A penalty for the late o	or incomplete filing of this return/rep	ort will be assessed	unless reasonable cause is e	stablis	shed.		
		her penalties set forth in the instructions well as the electronic version of this retu						
	,				,		.,	
SIGN	Filed with authorized/val	id electronic signature	07/28/2017	INGRID ORAV				
HERE					ina oo	nlan administrator		
	Signature of plan adm	imistrator	Date	Enter name of individual sign	ing as	pian auministrator		
SIGN								
HERE	Signature of employe	r/plan sponsor	Date	Enter name of individual sign	ing as	employer or plan sp	oonsor	
	. ,	•						
SIGN								
HERE	Signature of DFE		Date	Enter name of individual sign	ing as	DEE		
Preparer		ame, if applicable) and address (include				telephone number		

Form 5500 (2016) Page **2**

3a	Plan administrator's name and address X Same as Plan Sponsor	3b Administrator's EIN		
				ninistrator's telephone nber
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed EIN and the plan number from the last return/report:	for this plan, enter the name,	4b EIN	
а	Sponsor's name		4c PN	
5	Total number of participants at the beginning of the plan year		5	765
6	Number of participants as of the end of the plan year unless otherwise stated (welfare pl 6a(2), 6b, 6c, and 6d).	ans complete only lines 6a(1),		
a(1	1) Total number of active participants at the beginning of the plan year		6a(1)	491
a(2	2) Total number of active participants at the end of the plan year		6a(2)	426
b	Retired or separated participants receiving benefits		6b	181
С	Other retired or separated participants entitled to future benefits		6с	0
d	Subtotal. Add lines 6a(2), 6b, and 6c.		6d	607
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefi	ts	6e	
f	Total. Add lines 6d and 6e .		6f	
g	Number of participants with account balances as of the end of the plan year (only define complete this item)		6g	
h	Number of participants that terminated employment during the plan year with accrued be less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemploy	· · · · · · · · · · · · · · · · · · ·	7	_
b	If the plan provides pension benefits, enter the applicable pension feature codes from the lift the plan provides welfare benefits, enter the applicable welfare feature codes from the 4A	List of Plan Characteristics Codes	in the in	
9a	Plan funding arrangement (check all that apply) (1)	benefit arrangement (check all that \int \text{Insurance}	it apply)	
	(2) Code section 412(e)(3) insurance contracts (2)	Code section 412(e)(3) i	nsurance	contracts
	(3) Trust (3) (4) X General assets of the sponsor (4)	Trust X General assets of the sp	onsor	
10				ed. (See instructions)
а	Pension Schedules b Gen	eral Schedules		
	(1) R (Retirement Plan Information) (1)	H (Financial Inform	nation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3)	I (Financial Inform A (Insurance Inform C (Service Provide	mation)	,
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (6)	D (DFE/Participatii G (Financial Trans	-	

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)				
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)					
lf "Y€	es" is checked, complete lines 11b and 11c.				
11b Is the	e plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)				
Rece	r the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the eipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid eipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)				
Rece	eipt Confirmation Code				

Form 5500 (2016)

Page 3

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

2016

pursuant to ERISA section 103(a)(2).				Inspection			
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016					ding 12/3	1/2016	
A Name of plan NOKIA MEDICAL EXPEN	≣S .		e-digit number (PI	N) •	503		
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500			yer Identific 3408857	ation Number (EIN)
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca UHC OF CALIFORNIA	rrier						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
95-2931460	00000	142111	2		01/01/2016	6	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).							
J Persons receiving com		and address of the agent, broke					
	(a) Ivaliic c	and address of the agent, broke	t, or other person to who	THE COMMISS	10113 01 1003	were pard	
(b) Amount of sales ar	nd base	i	ees and other commission	ns paid			
commissions pa	id	(c) Amount	(d) Purpose		(e) Organization code		
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount		(d) Purpose	<u> </u>		(e) Organization code

Schedule A (Form 5500) 2	2016	Page 2 – 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	Part					
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts w	ith each carrier may	be treated	as a unit for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs			I. I.	
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
		· · · · · · · · · · · · · · · · · · ·				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, chec	k here ▶ □		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ate participation (guarantee		
		(3) guaranteed investment (4) other	•			
		(4) 🖺 3				
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	Ч	(6)Total additions			7c(6) 7d	0
		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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

F	ane	Δ

Pa	art III							
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ing purposes if such con	tracts are expe	erience-rated as a uni	t. Where co	ontracts cove	
8	Benef	it and contract type (check all applicable boxes)						
	а ∏	Health (other than dental or vision)	b Dental	с	Vision		d Life in	surance
	e	Temporary disability (accident and sickness)	f Long-term disabil	<u></u>	Supplemental unem	plovment	h Presci	ription drug
	. ⊣		- =		PPO contract	pioyinoni	느	
	' 닏	Stop loss (large deductible)	j X HMO contract	k _	PPO contract		I Indem	nity contract
	m 📗	Other (specify)						
<u> </u>								
		ence-rated contracts:		0-(4)			4	
		remiums: (1) Amount received		9a(1)			\dashv	
	,	 Increase (decrease) in amount due but unpaid Increase (decrease) in unearned premium res 		1 1			-	
	,	4) Earned ((1) + (2) - (3))				9a(4)		0
	- `	Benefit charges (1) Claims paid				Ja(+)		
		2) Increase (decrease) in claim reserves		(-)			-	
	,	B) Incurred claims (add (1) and (2))				9b(3)		0
		4) Claims charged				9b(4)		
	,	Remainder of premium: (1) Retention charges (c						
		(A) Commissions		9c(1)(A)			7	
		(B) Administrative service or other fees		9c(1)(B)			7	
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes						
		(F) Charges for risks or other contingencies .					_	
		(G) Other retention charges		9c(1)(G)		1		
		(H) Total retention	_			9c(1)(H)	0
	(Dividends or retroactive rate refunds. (These	amounts were paid i	n cash, or	credited.)	9c(2)		
	d s	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)		
	(2) Claim reserves				9d(2)		
	,	3) Other reserves				9d(3)		
40		Dividends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c(2) .	.)	9e		
10		experience-rated contracts:				40-		5000
	_	Fotal premiums or subscription charges paid to c				10a		59687
		f the carrier, service, or other organization incurnetention of the contract or policy, other than repo				10b		
		fy nature of costs.	orted in Part I, line 2 abo	ve, report amo	Juit	100		
	Speci.	ry nature of costs.						
Pa	art IV	Provision of Information						
11	Did t	the insurance company fail to provide any inform	ation necessary to comp	lete Schedule	A?	Yes	X No	
12	If the	e answer to line 11 is "Yes," specify the informati	on not provided.					

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

OMB No. 1210-0110

2016

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016							
A Name of plan NOKIA MEDICAL EXPEN	:	B Three	e-digit number (PN	N) •	503		
C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC.					yer Identific 3408857	ation Number (EIN)
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca		F S. CA					
	(c) NAIC	(d) Contract or	(e) Approximate nur			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
94-1340523	00000	122636	8		01/01/2016	6	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. Lis	st in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all p	ersons).			
	(a) Name a	nd address of the agent, broker,	or other person to whom	commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fee	s and other commissions	s paid			
commissions pa		(c) Amount	(0	(d) Purpose			(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to whom	commiss	ions or fees	were paid	
	,	<u> </u>				·	
(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount	(0	d) Purpose	е		(e) Organization code

Schedule A (Form 5500) 2	2016	Page 2 – 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	Part					
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts w	ith each carrier may	be treated	as a unit for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs			I. I.	
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
		· · · · · · · · · · · · · · · · · · ·				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, chec	k here ▶ □		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ate participation (guarantee		
		(3) guaranteed investment (4) other	•			
		(4) 🖺 3				
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	Ч	(6)Total additions			7c(6) 7d	0
		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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

F	ane	Δ

Pa	art II							
		If more than one contract covers the same group of the information may be combined for reporting purposemployees, the entire group of such individual contract.	ses if such contr	acts are expe	rience-rated as a uni	. Where con	tracts co	
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision) b De	ental	с	Vision	C	Life	insurance
	e 🗀		ng-term disability	=	Supplemental unem	olovment k		scription drug
	·					pioyinoni i	브	
	' ⊨		MO contract	k∐	PPO contract		ı 📗 inde	emnity contract
	m	Other (specify)						
		erience-rated contracts:	Г	- (1)				
		Premiums: (1) Amount received	F	9a(1)				
	•	(2) Increase (decrease) in amount due but unpaid	F	9a(2)				
	•	(3) Increase (decrease) in unearned premium reserve	Ŀ	9a(3)		0.74		
	_ `	(4) Earned ((1) + (2) - (3))	Г			. 9a(4)		0
		Benefit charges (1) Claims paid	F	9b(1)				
	,	(2) Increase (decrease) in claim reserves	<u> </u>	9b(2)		01- (0)		
		(3) Incurred claims (add (1) and (2))				9b(3)		0
	,	(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on an acci	′ г	00(4)(A)				
		(A) Commissions	F	9c(1)(A)				
		(B) Administrative service or other fees	F	9c(1)(B) 9c(1)(C)				
		(C) Other specific acquisition costs(D) Other expenses	F	9c(1)(D)				
		(E) Taxes	F	9c(1)(E)				
		(F) Charges for risks or other contingencies	F	9c(1)(F)				
		(G) Other retention charges	F	9c(1)(G)				
		(H) Total retention	L			9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These amounts	_	_		9c(2)		
		Status of policyholder reserves at end of year: (1) Amount				9d(1)		
		(2) Claim reserves	•			9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do not include				9e		
10		nexperience-rated contracts:	<u> </u>	• • • • • • • • • • • • • • •	,			
-		Total premiums or subscription charges paid to carrier				10a		116564
	_	If the carrier, service, or other organization incurred any sp						
		retention of the contract or policy, other than reported in P			•	10b		
		cify nature of costs.		•				
_								
Pa	art I\	V Provision of Information					_	
11	Did	I the insurance company fail to provide any information neo	essary to comple	ete Schedule	A?	Yes	No	_
12	If th	ne answer to line 11 is "Yes," specify the information not pr	ovided.					

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

2016

pursuant to ERISA section 103(a)(2).					Inspection			
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and					and en	ding 12/3	1/2016	
A Name of pla NOKIA MEDICA		SE PLAN FO	R OCCUPATIONAL EMPLOYE	ES		e-digit number (Pl	V) •	503
C Plan sponso			ine 2a of Form 5500			oyer Identific 3408857	ation Number (EIN)
			erning Insurance Contra A. Individual contracts grouped					
1 Coverage Inf	formation:							
(a) Name of ins			OF CO					
		(c) NAIC	(d) Contract or	(e) Approximate n	umber of		Policy or co	ontract year
(b) EIN	N	code	identification number	persons covered a policy or contract		(f)	From	(g) To
84-0591617		95669	7368	2	2	01/01/2016	6	12/31/2016
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.								
	(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons rece	eiving comi		fees. (Complete as many entrie	· · · · · · · · · · · · · · · · · · ·				
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount	of sales an	nd base	F	ees and other commissio	ns paid			
comm	issions pai	d	(c) Amount		(d) Purpose			(e) Organization code
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount	of sales an	nd base	F	ees and other commissio	ns paid			
(issions pai		(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500) 2	2016	Page 2 – 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, bro	sker, 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
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	Part					
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts w	ith each carrier may	be treated	as a unit for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs			I. I.	
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
		· · · · · · · · · · · · · · · · · · ·				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, chec	k here ▶ □		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ate participation (guarantee		
		(3) guaranteed investment (4) other	•			
		(4) 🖺 3				
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	Ч	(6)Total additions			7c(6) 7d	0
		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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

F	ane	Δ

Pa	art III							
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ing purposes if such con	tracts are expe	erience-rated as a uni	t. Where co	ontracts cov	
8	Benef	it and contract type (check all applicable boxes)						
	а ∏	Health (other than dental or vision)	b Dental	с	Vision		d Life i	insurance
	e	Temporary disability (accident and sickness)	f Long-term disabil	<u></u>	Supplemental unem	plovment	h Pres	cription drug
	. ⊟		- =			pioyinon	브	
	' 닏	Stop loss (large deductible)	j X HMO contract	k _	PPO contract		I Inder	mnity contract
	m 📗	Other (specify)						
<u> </u>								
		ence-rated contracts:		0-(4)			\dashv	
		remiums: (1) Amount received		9a(1)			-	
	,	 Increase (decrease) in amount due but unpaid Increase (decrease) in unearned premium res 		1 1			\dashv	
	,	4) Earned ((1) + (2) - (3))				9a(4)		0
	- `	Benefit charges (1) Claims paid				1 3a(+)		
		2) Increase (decrease) in claim reserves		(-)			-	
	,	B) Incurred claims (add (1) and (2))				9b(3)		0
		4) Claims charged				9b(4)	_	
	,	Remainder of premium: (1) Retention charges (c						
		(A) Commissions		9c(1)(A)			7	
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)			7	
		(D) Other expenses		9c(1)(D)				
		(E) Taxes					_	
		(F) Charges for risks or other contingencies .						
		(G) Other retention charges		9c(1)(G)		T		
		(H) Total retention	_			9c(1)(H)	0
	(Dividends or retroactive rate refunds. (These	amounts were paid i	n cash, or	credited.)	9c(2)		
	d s	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)		
	(2) Claim reserves				9d(2)		
	,	3) Other reserves				9d(3)		
40		Dividends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c(2) .	.)	9e		
10		experience-rated contracts:				40		
	_	Total premiums or subscription charges paid to c				10a	+	33961
		f the carrier, service, or other organization incurr	, .		•	10b		
		etention of the contract or policy, other than report fy nature of costs.	orted in Part I, line 2 abo	ve, report amo	Juit	100		
	Speci	ry nature of costs.						
Pa	art IV	Provision of Information						
11	Did t	the insurance company fail to provide any inform	nation necessary to comp	lete Schedule	A?	Yes	X No	
12	If the	e answer to line 11 is "Yes," specify the informati	on not provided.					

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

2016

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and endi					ding 12/3	1/2016	
A Name of plan NOKIA MEDICAL EXPEN	ISE PLAN FO	R OCCUPATIONAL EMPLOYEE	ES		e-digit number (PN	V) •	503
C Plan sponsor's name a ALCATEL-LUCENT USA		ne 2a of Form 5500			yer Identific 3408857	ation Number (EIN)
		rning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		OF MID ATLANTIC					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
52-0954463	95639	2204	2		01/01/2016	6	12/31/2016
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.							
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com		fees. (Complete as many entrie	· · · · · · · · · · · · · · · · · · ·		. ,	.,	
	(a) Name	and address of the agent, broke	r, or other person to who	TI COMMISS	ions or rees	were paid	
(b) Amount of sales a	nd base		ees and other commission				
commissions pa	id	(c) Amount		(d) Purpose			(e) Organization code
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500) 2	2016	Page 2 – 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, bro	sker, 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
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	Part					
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts w	ith each carrier may	be treated	as a unit for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs			I	
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
		· · · · · · · · · · · · · · · · · · ·				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, chec	k here ▶ □		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ate participation (guarantee		
		(3) guaranteed investment (4) other	•			
		(4) 🖺 3				
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	Ч	(6)Total additions			7c(6) 7d	0
		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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

F	ane	Δ

Part II	Welfare Benefit Contract Information If more than one contract covers the same the information may be combined for report employees, the entire group of such individuals.	group of employees of the ing purposes if such cont	racts are ex	cperience-	rated as a ur	nit. Where co	ntracts cover	
8 Bene	fit and contract type (check all applicable boxes)	_		_			_	
а	Health (other than dental or vision)	b Dental	С	Vision			d Life inst	urance
е	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supple	emental unen	nployment	h Prescrip	otion drug
i 🗖	Stop loss (large deductible)	j X HMO contract	k	PPO d	contract		I Indemn	ty contract
m	Other (specify)	, n						
∟	T canon (openity)							
9 Exper	ience-rated contracts:							
•	remiums: (1) Amount received		9a(1)					
(Increase (decrease) in amount due but unpaid	d					7	
	3) Increase (decrease) in unearned premium res							
,	4) Earned ((1) + (2) - (3))					9a(4)		0
	Benefit charges (1) Claims paid							
	2) Increase (decrease) in claim reserves		(-)					
,	3) Incurred claims (add (1) and (2))					9b(3)		0
	4) Claims charged					9b(4)		
,	Remainder of premium: (1) Retention charges (c							
	(A) Commissions	,	9c(1)(A)					
	(B) Administrative service or other fees		9c(1)(B)				7	
	(C) Other specific acquisition costs		9c(1)(C)					
	(D) Other expenses		9c(1)(D)					
	(E) Taxes		9c(1)(E)					
	(F) Charges for risks or other contingencies .		9c(1)(F)					
	(G) Other retention charges		9c(1)(G)					
	(H) Total retention					9c(1)(H)		0
	(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	credited	.)	9c(2)		
	Status of policyholder reserves at end of year: (1			_				
	(2) Claim reserves	•				9d(2)		
	(3) Other reserves							
	Dividends or retroactive rate refunds due. (Do n							
	experience-rated contracts:		,	•				
a [.]	Total premiums or subscription charges paid to o	arrier				10a		37213
_	If the carrier, service, or other organization incur							
	retention of the contract or policy, other than rep					10b		
Spec	ify nature of costs.					1		
Part I\	Provision of Information							
11 Did	the insurance company fail to provide any inform	nation necessary to compl	lete Schedu	ıle A?		Yes	X No	
	e answer to line 11 is "Yes," specify the informat							

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

2016

			pursuant to	ERISA section 103(a)(2)).			Inspection
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and endi						ding 12/3	1/2016	-
A Name of p		SE PLAN FO	R OCCUPATIONAL EMPLOYE	ES		e-digit number (PN	N) •	503
C Plan spons			ne 2a of Form 5500		-	oyer Identific 3408857	ation Number (EIN)
Part I			rning Insurance Contra A. Individual contracts grouped					
1 Coverage I	nformation:							
(a) Name of i			OF HI					
		(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ontract year
(b) E	:IN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
94-1340523		60053	639	2	!	01/01/2016	5	12/31/2016
		mission inform amount paid.	nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid								
3 Persons re	ceiving com		fees. (Complete as many entrie					
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amour	nt of sales ar	nd base	F	ees and other commission	ns paid			
	missions pai		(c) Amount	(d) Purpose				(e) Organization code
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
		(a)		,				
(h) Amour	(b) Amount of sales and base Fees and other commissions paid							
	missions pai		(c) Amount		(d) Purpose	e		(e) Organization code

Schedule A (Form 5500) 2	2016	Page 2 – 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, bro	sker, 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
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	Part					
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts w	ith each carrier may	be treated	as a unit for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs			I	
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
		· · · · · · · · · · · · · · · · · · ·				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, chec	k here ▶ □		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ate participation (guarantee		
		(3) guaranteed investment (4) other	•			
		(4) 🖺 3				
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	Ч	(6)Total additions			7c(6) 7d	0
		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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

F	ane	Δ

Pa	art I	Welfare Benefit Contract Informa	ation					
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ing purposes if such cont	racts are expe	erience-rated as a un	it. Where co	ntracts cover indiv	
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insuran	ce
	e 🗀		f Long-term disabili	_	Supplemental unem	nnlovment	h Prescription	drug
	-	Stop loss (large deductible)	j X HMO contract		PPO contract	ipioyiiioiit	I Indemnity c	-
	m∫	Other (specify)) M TIMO COMMACT	κ_	110 contract		I III III III C	Jillact
	∟] Giller (opeony)						
9	=xne	rience-rated contracts:						
•	•	Premiums: (1) Amount received		9a(1)			_	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			7	
		(3) Increase (decrease) in unearned premium res		9a(3)			1	
		(4) Earned ((1) + (2) - (3))		<u>`</u>		9a(4)		0
	_	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves		(-)				
		(3) Incurred claims (add (1) and (2))				9b(3)		0
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies .					_	
		(G) Other retention charges		9c(1)(G)		1		
		(H) Total retention	_	_		9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2) .	.)	9e		
10		nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			10a		16946
		If the carrier, service, or other organization incurr				406		
		retention of the contract or policy, other than reporting nature of costs.	orted in Part I, line 2 abov	e, report amo	ount	10b		
	Орсс	my hattire or costs.						
Pa	art l'	V Provision of Information						
11	Did	the insurance company fail to provide any inform	ation necessary to comp	lete Schedule	A?	Yes	X No	
		ne answer to line 11 is "Yes," specify the informati						
_		too . roo, opeony the infollitati						

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

OMB No. 1210-0110

2016

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection				
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016									
A Name of plan NOKIA MEDICAL EXPEN	ISE PLAN FOR	OCCUPATIONAL EMPLOYEES	;	B Three	e-digit number (PN	N) •	503		
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500			yer Identific 3408857	ation Number (EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance ca		F N. CA							
	(c) NAIC	(d) Contract or	(e) Approximate nun			Policy or co	contract year		
(b) EIN	code	identification number	persons covered at o		(f)	From	(g) To		
94-1340523	00000	35147	1		01/01/2016	3	12/31/2016		
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. List	t in line 3	the agents,	brokers, and ot	her persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid									
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all pe	ersons).					
	(a) Name a	nd address of the agent, broker,	or other person to whom	commiss	ions or fees	were paid			
(b) Amount of sales ar	nd base	Fee	s and other commissions	s paid					
commissions pa		(c) Amount	(d) Purpose				(e) Organization code		
	(a) Name a	nd address of the agent, broker,	or other person to whom	commiss	ions or fees	were paid			
		,				·			
(b) Amount of sales and base Fees and other commissions paid									
commissions pa		(c) Amount	(d) Purpose			(e) Organization code			

Schedule A (Form 5500) 2	2016	Page 2 – 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, bro	sker, 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
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	Part					
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts w	ith each carrier may	be treated	as a unit for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs			I	
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
		· · · · · · · · · · · · · · · · · · ·				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, chec	k here ▶ □		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ate participation (guarantee		
		(3) guaranteed investment (4) other	•			
		(4) 🖺 3				
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	Ч	(6)Total additions			7c(6) 7d	0
		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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

F	ane	Δ

Р	art	Welfare Benefit Contract Information								
		If more than one contract covers the same group of employees the information may be combined for reporting purposes employees, the entire group of such individual contracts of the same group of the	f such contracts are	expe	erience-rated as a	unit.	Where co	ontract	s cover individual	
8	Ben	nefit and contract type (check all applicable boxes)	•			•	•	•		_
	a 「	Health (other than dental or vision) b Dental		сГ	Vision			d□	Life insurance	
					<u>.</u>					
	е			g	Supplemental u	nemp	ioyment	- =	Prescription drug	
	i	Stop loss (large deductible) j 🗓 HMO c	ontract	k _	PPO contract			IЦ	Indemnity contract	
	m	Other (specify)								
9	Expe	perience-rated contracts:								
	a	Premiums: (1) Amount received								
		(2) Increase (decrease) in amount due but unpaid		_				_		
		(3) Increase (decrease) in unearned premium reserve								
	_	(4) Earned ((1) + (2) - (3))					9a(4)			_
	b							_		
		(2) Increase (decrease) in claim reserves				ı				_
		(3) Incurred claims (add (1) and (2))				Г	9b(3)			_(
		(4) Claims charged		•••••			9b(4)			_
	С	. , ,						_		
		(A) Commissions								
		(B) Administrative service or other fees	2 (1)(6					_		
		(C) Other specific acquisition costs	0 (4)/5	_				_		
		(D) Other expenses	0-(4)/5					_		
		(E) Charges for risks or other contingencies	2 (1)(=	_				-		
		(F) Charges for risks or other contingencies	0-/4\/6	_				_		
		(G) Other retention charges(H) Total retention					9c(1)(H)			_
		(2) Dividends or retroactive rate refunds. (These amounts were						_		_
	٨			_		-	9c(2)			_
	d	Status of policyholder reserves at end of year: (1) Amount held (2) Claim reserves	•				9d(1)			_
		(3) Other reserves				F	9d(2) 9d(3)	-		_
	е					-	90(3) 9e			_
10		onexperience-rated contracts:	ant entered in line 3	C(2)	.)		36			
	a						10a		178	a.
	b								1700	Ť
	D	retention of the contract or policy, other than reported in Part I,					10b			
	Spe	ecify nature of costs.				L				
Р	art l	IV Provision of Information								
11	Dic	id the insurance company fail to provide any information necessa	ry to complete Sche	dule	A?		Yes	X No)	
12	lf t	the answer to line 11 is "Yes." specify the information not provide	ed.							

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.

OMB No. 1210-0110

2016

,			ERISA section 103(a)(2)		lion	This For	m is Open to Public Inspection
For calendar plan year 20	16 or fiscal plai	n year beginning 01/01/2016		and en	nding 12/31/	2016	
A Name of plan NOKIA MEDICAL EXPEN	SE PLAN FOR	OCCUPATIONAL EMPLOYER	ES	B Three	e-digit number (PN)	•	503
C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. D Employer Identification Number (EIN) 22-3408857							
		rning Insurance Contract. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca HORIZON BCBS OF NJ	rrier	1			ı	Daliana	
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a				ontract year
(4) =	code	identification number	policy or contrac		(f) I	From	(g) To
22-0999690	55069	67-77087	4		01/01/2016		12/31/2016
2 Insurance fee and come descending order of the		ation. Enter the total fees and to	otal commissions paid. L	st in line 3	the agents, b	rokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com	missions and fo	ees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees v	vere paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			_
commissions pa	id	(c) Amount		(d) Purpose			(e) Organization code
	(a) Name a	and address of the agent, broke	r, or other person to who	n commiss	ions or fees v	vere paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

Schedule A (Form 5500) 2	2016	Page 2 – 1		
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid		
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Nar	me and address of the agent, bro	sker, 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	
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	Part					
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts w	ith each carrier may	be treated	as a unit for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs			I	
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
		· · · · · · · · · · · · · · · · · · ·				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, chec	k here ▶ □		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ate participation (guarantee		
		(3) guaranteed investment (4) other	•			
		(4) 🖺 3				
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	Ч	(6)Total additions			7c(6) 7d	0
		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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

F	ane	Δ

Pa	art	Ш	Welfare Benefit Contract Informa	ation					
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a u	nit. Where co	ontracts cover inc	ations(s), lividual
8	Ben	efit a	nd contract type (check all applicable boxes)					· · · · · · · · · · · · · · · · · · ·	
	a 「	_	ealth (other than dental or vision)	b Dental	c۲	Vision		d Life insura	ance
		=			<u> </u>	3		<u> </u>	
	e	_		f Long-term disabili		Supplemental une	mpioyment	h Prescription	_
	ַ ו	St	op loss (large deductible)	j X HMO contract	K _	PPO contract		I Indemnity	contract
	m	Ot	ther (specify)						
9 E	Ехре	erien	ce-rated contracts:						
	a I		iums: (1) Amount received		9a(1)				
		(2) lı	ncrease (decrease) in amount due but unpaid	l	9a(2)				
			ncrease (decrease) in unearned premium res		9a(3)				
	_		Earned ((1) + (2) - (3))				9a(4)		0
	b		efit charges (1) Claims paid		9b(1)				
		` '	ncrease (decrease) in claim reserves						
		(3) lı	ncurred claims (add (1) and (2))						0
		, ,	Claims charged				. 9b(4)		
	С		nainder of premium: (1) Retention charges (o	•					
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees		9c(1)(B)				
			(C) Other specific acquisition costs		9c(1)(C)			_	
			(D) Other expenses		9c(1)(D)				
			(E) Taxes		9c(1)(E)			_	
			(F) Charges for risks or other contingencies .		9c(1)(F) 9c(1)(G)			_	
			(G) Other retention charges				. 9c(1)(H)	\	0
			(H) Total retention	_	_			'	
			Dividends or retroactive rate refunds. (These	_					
	d		tus of policyholder reserves at end of year: (1	•			_ ` `		
		` '	Claim reserves						
	_	` '	Other reserves						_
10			dends or retroactive rate refunds due. (Do no erience-rated contracts:	ot include amount entered	in line 9c(2)	.)	. 9e		
10				orrior			. 10a		102215
	_		al premiums or subscription charges paid to c				. 10a		103215
	b		e carrier, service, or other organization incurr ntion of the contract or policy, other than repo				. 10b		
	Spe		nature of costs.	inted in Fait I, line 2 abov	e, report and	Juni		l .	
	Opo	oy .	lataro di occio.						
_									
Pa	ırt l	V	Provision of Information				_		
11	Dic	d the	insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	X No	
12	If t	he ar	nswer to line 11 is "Yes," specify the informati	on not provided.					

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

2016

pursuant to ERISA section 103(a)(2).					Inspection			
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016								
A Name of plan NOKIA MEDICAL EXPEN	ISE PLAN FOR	R OCCUPATIONAL EMPLOYER	ES		e-digit number (Pl	V) •	503	
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500			yer Identific 3408857	ation Number (EIN)	
		rning Insurance Contract. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca								
	(c) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or co	ontract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
36-1236610	70670	H73523/B73523	0		01/01/2016	6	12/31/2016	
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.							
(a) Total	amount of com	missions paid		(b) To	tal amount	of fees paid		
3 Persons receiving com		ees. (Complete as many entrie	· · · · · · · · · · · · · · · · · · ·					
	(a) Name a	and address of the agent, broke	r, or other person to whor	m commiss	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid				
commissions pa	id	(c) Amount		(d) Purpose			(e) Organization code	
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid		
(-),								
(b) Amount of sales and base Fees and other commissions paid								
commissions pa		(c) Amount		(d) Purpose				

Schedule A (Form 5500) 2	2016	Page 2 – 1		
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid		
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Nar	me and address of the agent, bro	sker, 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	
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

Part II						
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts witl	h each carrier may	be treated	as a unit for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year		4		
		rent value of plan's interest under this contract in separate accounts at year e		5		
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
				6b		
	b	•				
	۲ C	Premiums due but unpaid at the end of the year				
	d	d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount				
		Specify nature of costs				
	e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity					
	(3) other (specify)					
		· · · · · · · · · · · · · · · · · · ·				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check	here • П		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ate participation gu	arantee		
		(3) guaranteed investment (4) other	•			
		(4) 🖺 3				
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	Ч	(6)Total additions			7c(6) 7d	0
		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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	0

F	ane	Δ

Pa	art	Ш	Welfare Benefit Contract Informa	ition					
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a	unit. Where co	ontracts cover indivi	ons(s), dual
8	Ben	efit a	nd contract type (check all applicable boxes)		•		<u> </u>	·	
	a 「	_	ealth (other than dental or vision)	b Dental	c۲	Vision		d Life insurance	20
		=			<u> </u>	-			
	e [f Long-term disabili		Supplemental une	employment	h Prescription	-
	į	Sto	op loss (large deductible)	j X HMO contract	k _	PPO contract		I Indemnity co	ntract
	m	Ot	her (specify)						
9 E	Ехре	eriend	ce-rated contracts:						
	a Premiums: (1) Amount received			9a(1)					
		(2) Ir	ncrease (decrease) in amount due but unpaid	l	9a(2)				
			ncrease (decrease) in unearned premium res		9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		0
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
		(S) Ir	ncurred claims (add (1) and (2))				9b(3)		0
		. ,	Claims charged				9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (o	n an accrual basis)					
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees		9c(1)(B)				
			(C) Other specific acquisition costs		9c(1)(C)				
			(D) Other expenses		9c(1)(D)				
			(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)					
			(G) Other retention charges						
		(H) Total retention			, , , ,	<u>i) </u>	0		
					··· 9c(2)				
	d	d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement				retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) (Other reserves				9d(3)		
	е	Divi	dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)	9e		
10	No	nexp	erience-rated contracts:						
	а	Tota	al premiums or subscription charges paid to c	arrier			10a		8459
	b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or							
	_	retention of the contract or policy, other than reported in Part I, line 2 above, report amount				10b			
	Spe	cify r	ature of costs.						
Da	. p.t. l	IV.	Provision of Information						
	rt l								
11	Dic	the	insurance company fail to provide any inform	ation necessary to comp	ete Schedule	A?	Yes	X No	
12	If t	he ar	nswer to line 11 is "Yes," specify the informati	on not provided.					