Form 5500	Annual Return/Report	of Employee Benefit Plan		OMB Nos. 12	
		mployee benefit plans under sections 104 It Income Security Act of 1974 (ERISA) and		12	10-0089
Department of the Treasury Internal Revenue Service		the Internal Revenue Code (the Code).		2016	
Department of Labor Employee Benefits Security Administration		tries in accordance with ns to the Form 5500.			
Pension Benefit Guaranty Corporation	-		This	Form is Open to Pu Inspection	blic
	entification Information				
For calendar plan year 2016 or fisca	I plan year beginning 01/01/2016	and ending 12/31/20)16		
A This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking the participating employer information in accord			ns.)
	🗙 a single-employer plan	a DFE (specify)			
B This return/report is:	the first return/report	the final return/report			
	an amended return/report	a short plan year return/report (less than 12 months)			
C If the plan is a collectively-bargai	ned plan, check here			► ×	
D Check box if filing under:	Form 5558	automatic extension	the	e DFVC program	
[special extension (enter description)				
Part II Basic Plan Inform	ation—enter all requested information				
1a Name of plan NOKIA RETIREE WELFARE BENEFITS PLAN	I		1b	Three-digit plan number (PN) ▶	504
			1c	Effective date of pla 10/01/1996	an
City or town, state or province, o	, if for a single-employer plan) apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code (if	foreign, see instructions)	2b	Employer Identifica Number (EIN) 22-3408857	tion
ALCATEL-LUCENT USA INC.			2c	Plan Sponsor's tele number 908-723-9869	phone
600 MOUNTAIN AVENUE, ROOM 6 MURRAY HILL, NJ 07974	D-401A		2d	Business code (see instructions) 334200)

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/16/2017	INGRID ORAV			
HERE	Signature of plan administrator	Date	Enter name of individu	al signing as plan administrator		
SIGN HERE						
HERE	Signature of employer/plan sponsor	Date	Enter name of individu	al signing as employer or plan sponsor		
SIGN HERE						
HERE	Signature of DFE	Date	Enter name of individua	al signing as DFE		
Preparer	's name (including firm name, if applicable) and address (include r	room or suite numbe	r)	Preparer's telephone number		
For Pap	For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Form 5500 (2016)					

3a	Plan administrator's name and address 🛛 Same as Plan Sponsor		Bb Administrator's EIN	
		3c Administrator's telephone number		
_		41		
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	4b EI	N	
а	Sponsor's name	4c PN		
5	Total number of participants at the beginning of the plan year	5	89210	
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).			
a(1) Total number of active participants at the beginning of the plan year	6a(1)	0	
a(2	2) Total number of active participants at the end of the plan year	6a(2)	0	
b	Retired or separated participants receiving benefits	6b	86166	
C	Other retired or separated participants entitled to future benefits	6c	0	
d	Subtotal. Add lines 6a(2), 6b, and 6c	6d	86166	
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e		
f	Total. Add lines 6d and 6e	6f		
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g		
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h		
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7		
8a	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Cod	es in the	instructions:	

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

9a	9a Plan funding arrangement (check all that apply)			9b	Plan ber	nefit	arrangement (check all that apply)
	(1)	X	Insurance		(1)	X	Insurance
	(2)		Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts
	(3)	X	Trust		(3)	X	Trust
	(4)		General assets of the sponsor		(4)		General assets of the sponsor
10	10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)						
а	Pensic	on Sc	nedules	b	Genera	l Sc	hedules
	(1)		R (Retirement Plan Information)		(1)	X	H (Financial Information)
	(2)		MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	Π	I (Financial Information – Small Plan)
			Purchase Plan Actuarial Information) - signed by the plan		(3)	Х	<u>26</u> A (Insurance Information)
			actuary		(4)	Х	C (Service Provider Information)
	(3)		SB (Single-Employer Defined Benefit Plan Actuarial		(5)	X	D (DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)		G (Financial Transaction Schedules)

Receipt Confirmation Code_

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
	plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR .101-2.)
lf "Ye	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 ipt 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 ipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service		Insuranc	ce Information		OMB No. 1210-0110
			to be filed under section 104 of th come Security Act of 1974 (ERISA		2016
Department of L Employee Benefits Securit		File as an at	ttachment to Form 5500.		
Pension Benefit Guarant	y Corporation		re required to provide the informa RISA section 103(a)(2).	tion This	s Form is Open to Public Inspection
For calendar plan year	2016 or fiscal plan	year beginning 01/01/2016	and er	nding 12/31/2016	
A Name of plan NOKIA RETIREE WEL	FARE BENEFITS	PLAN		e-digit number (PN) ▶	504
C Plan sponsor's nam ALCATEL-LUCENT US		e 2a of Form 5500	-	oyer Identification Nun 3408857	nber (EIN)
			Coverage, Fees, and Cor a unit in Parts II and III can be re		
1 Coverage Information	on:				
(a) Name of insurance UHC OF COLORADO	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy	/ or contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To
84-1011378	95434	092027	93	01/01/2016	12/31/2016
2 Insurance fee and c descending order of		ation. Enter the total fees and tota	I commissions paid. List in line 3	the agents, brokers, a	and other persons in
(a) To	tal amount of comr	nissions paid	(b) T	otal amount of fees pa	aid
3 Persons receiving c	ommissions and fe	ees. (Complete as many entries a	as needed to report all persons).		
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	ions or fees were paid	d
(b) Amount of sales	s and base	Fees	s and other commissions paid		
commissions	paid	(c) Amount	(d) Purpos	е	(e) Organization code

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Sche			dule A (Form 5500) 2016

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(a) Name and address of the agent, broker, 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) Name and address of the agent, broker, 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) Name and address of the agent, broker, 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) Name and address of the agent, broker, 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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(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	Part		Welfare Benefit Contract Informa								
			If more than one contract covers the same the information may be combined for report								
			employees, the entire group of such individ	ual contracts with	n each carrier mag	y be	treated as a unit for pu	irposes of th	nis rep	port.	
8	Ben	efit ar	nd contract type (check all applicable boxes)								
	а	He	ealth (other than dental or vision)	b Dental		С	Vision		d	Life insurance	
	e	Te	mporary disability (accident and sickness)	f Long-term	n disability	g	Supplemental unemp	oloyment	h	Prescription drug	
	iΓ	Sto	op loss (large deductible)	j 🛛 HMO cont	tract	k 🗌	PPO contract		ıΠ	Indemnity contract	
	m	Ot	her (specify) 🕨				-				
	L										
9	Expe	erienc	ce-rated contracts:								
	a	Prem	iums: (1) Amount received)					
		(2) Ir	ncrease (decrease) in amount due but unpaid	d b)					
		(3) Ir	ncrease (decrease) in unearned premium res	serve)					
		(4) E	arned ((1) + (2) - (3))		·····			9a(4)			0
	b	Ben	efit charges (1) Claims paid)					
		(2) Ir	ncrease (decrease) in claim reserves)					
		(3) Ir	ncurred claims (add (1) and (2))					9b(3)			0
		(4) C	laims charged					9b(4)			
	С	Rem	nainder of premium: (1) Retention charges (o	on an accrual bas	is)						
		((A) Commissions			A)					
		((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		9c(1)(G)					
		((H) Total retention					9c(1)(H)			0
		(2) E	Dividends or retroactive rate refunds. (These	e amounts were	paid in cash, or	r	credited.)	9c(2)			
	d	Stat	us of policyholder reserves at end of year: (1) Amount held to	provide benefits	after	retirement	9d(1)			
		(2) (Claim reserves					9d(2)			
		(3) (Other reserves					9d(3)			
	е	Divio	dends or retroactive rate refunds due. (Do n	ot include amoun	t entered in line 9)c(2)	.)	9e			
10) No	nexp	erience-rated contracts:								
	а	Tota	I premiums or subscription charges paid to c	arrier				10a		5798	378
	b		e carrier, service, or other organization incurrent					10b			

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

SCHEDULE	E A	Insuran	ce Informatio	n			
(Form 5500))					ON	/IB No. 1210-0110
Department of the Trea Internal Revenue Serv	sury	This schedule is required Employee Retirement In					2016
Department of Labo Employee Benefits Security Ac		File as an a	attachment to Form 55	00.			
Pension Benefit Guaranty Co	orporation	Insurance companies a pursuant to E	are required to provide to ERISA section 103(a)(2)		tion	This Fo	rm is Open to Public Inspection
For calendar plan year 20	16 or fiscal plar	year beginning 01/01/2016		and er	nding 12/3	1/2016	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (P	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		-	oyer Identific 3408857	ation Number	(EIN)
		ning Insurance Contract					
1 Coverage Information:							
HP	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(T)		(g) To
3-1828429	55247	10093PD 000	39 0		01/01/201	6	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. Li	ist in line 3	the agents,	brokers, and o	other persons in
	amount of comr	nissions paid		(b) T	otal amount	of fees paid	
3 Persons receiving corr	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid	
(b) Amount of sales a			es and other commission				_
commissions paid		(c) Amount		(d) Purpose			(e) Organization code
							1
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	lule A (Form 5500) 2016		

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

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

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

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

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

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

(a) Name and address of the agent, broker, 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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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					
8	Ren	ofit ar	nd contract type (check all applicable boxes)		ion carrier may be			
Ŭ	г		ealth (other than dental or vision)	b Dental	c	Vision	d	Life insurance
	a							
	е	Те	mporary disability (accident and sickness)	f Long-term dis		Supplemental unemp	oloyment h	Prescription drug
	i [Sto	op loss (large deductible)	j 🛛 HMO contrac	t k	PPO contract	I	Indemnity contract
	m	Ot	her (specify)					
9	Expe	erienc	ce-rated contracts:					
	a	Premi	iums: (1) Amount received		9a(1)			
		(2) Ir	ncrease (decrease) in amount due but unpaid	ł				
		(3) Ir	ncrease (decrease) in unearned premium res	erve	9a(3)			
	_	• •	arned ((1) + (2) - (3))				. 9a(4)	0
	b	Bene	efit charges (1) Claims paid					
		• •	ncrease (decrease) in claim reserves					
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)	0
		• •	Claims charged				9b(4)	
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis) -				
		((A) Commissions					
			(B) Administrative service or other fees					
			(C) Other specific acquisition costs					
		((D) Other expenses					
		```	(E) Taxes					
			(F) Charges for risks or other contingencies .		a (1)(a)			
		```	(G) Other retention charges		I I			
		```	(H) Total retention	_	_		9c(1)(H)	0
			Dividends or retroactive rate refunds. (These				9c(2)	
	d		us of policyholder reserves at end of year: (1	· · ·			9d(1)	
		(2) C	Claim reserves				9d(2)	
		(3) (	Other reserves				9d(3)	
			dends or retroactive rate refunds due. (Do no	ot include amount en	ntered in line 9c(2)	.)	9e	
10	No	•	erience-rated contracts:					
	а	Tota	al premiums or subscription charges paid to c	arrier			10a	258136
	b		e carrier, service, or other organization incurr ntion of the contract or policy, other than repu			•	10b	

Pa	art 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.			

SC	HEDULE	Α	Insuranc	e Information	۱		0	ND No. 4240.0440
(Form 5500)		-						MB No. 1210-0110
	rtment of the Treas rnal Revenue Serv		This schedule is required Employee Retirement Inco					2016
	epartment of Labo enefits Security Ad		File as an at	tachment to Form 550	00.			
Pension B	enefit Guaranty Co	orporation	<ul> <li>Insurance companies ar pursuant to EF</li> </ul>	e required to provide th RISA section 103(a)(2).		ion	This Fo	rm is Open to Public Inspection
For calenda	r plan year 20	16 or fiscal plar	n year beginning 01/01/2016		and en	iding 12/3	1/2016	•
A Name of NOKIA RET		RE BENEFITS	PLAN	-		e-digit number (PN	N) 🕨	504
	nsor's name a UCENT USA		e 2a of Form 5500		•	oyer Identific 3408857	ation Number	(EIN)
Part I			ning Insurance Contract					
1 Coverage	e Information:							
	HEALTH PLA	N (c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	contract year
(b)	EIN	code	identification number	persons covered at end of policy or contract year		(f)	From	<b>(g)</b> To
23-2399845		95199	509964	277 01/0		01/01/2016	6	12/31/2016
	e fee and com		ation. Enter the total fees and total	l commissions paid. Lis	st in line 3	the agents,	brokers, and o	other persons in
	<b>(a)</b> Total a	amount of com	nissions paid		<b>(b)</b> ⊺o	otal amount	of fees paid	
3 Porsona	rocolving.com	missions and f	ees. (Complete as many entries a	as needed to report all r	orconc)			
J Feisons	receiving com		nd address of the agent, broker, c		,	ions or fees	were paid	
							·	
		I		and all an an arrival.				
	unt of sales ar mmissions pa		c) Amount	and other commission	is paid ( <b>d)</b> Purpos	e	(e) Organizatio	
		(a) Nama -			· · · · · · · · ·			
		(a) Name a	nd address of the agent, broker, c	or other person to whon	n commiss	ions or tees	were paid	

(b) Amount of sales and base	F	Fees and other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	edule A (Form 5500) 2016		

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v. 160205

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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							Individual
8	Ben	efit ar	nd contract type (check all applicable boxes)			ier may be				
Ŭ	a	_	ealth (other than dental or vision)	<b>b</b> Dental		c	Vision		<b>d</b> Life ins	uranco
	L	_		. 💾			1		. 💾	
	е	le	mporary disability (accident and sickness)		rm disability		Supplemental unem	ployment	h Prescri	-
	i	Sto	op loss (large deductible)	j 🗙 HMO co	ontract	k	PPO contract		I Indemn	ity contract
	m	Ot	her (specify)							
9	Expe	erienc	ce-rated contracts:							
	a		iums: (1) Amount received			9a(1)			_	
		(2) Ir	ncrease (decrease) in amount due but unpaid	t		9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	erve		9a(3)		1		
		` '	arned ((1) + (2) - (3))					. 9a(4)		0
	b	Ben	efit charges (1) Claims paid			9b(1)			4	
		• •	ncrease (decrease) in claim reserves			9b(2)		1		
		• •	ncurred claims (add (1) and (2))					9b(3)		0
	_	• •	laims charged					9b(4)		
	С		nainder of premium: (1) Retention charges (o		· ·				4	
			(A) Commissions			9c(1)(A)			4	
			(B) Administrative service or other fees			9c(1)(B)			-	
			(C) Other specific acquisition costs			9c(1)(C) 9c(1)(D)			4	
			(D) Other expenses			9c(1)(E)			-	
			(E) Charges for risks or other contingencies			9c(1)(E)			4	
			(F) Charges for risks or other contingencies . (G) Other retention charges			9c(1)(G)			-	
			(H) Total retention		L			9c(1)(H)		0
			Dividends or retroactive rate refunds. (These		_	_				
	Ч		us of policyholder reserves at end of year: (1					9c(2)		
	d		Claim reserves		•			9d(1) 9d(2)		
		• •	Dialiti reserves					9d(2) 9d(3)		
	۵	``	dends or retroactive rate refunds due. (Do n					9e		
10			erience-rated contracts:			- inte <b>36(2)</b>				
	a		Il premiums or subscription charges paid to c	arrier				10a		1467192
	b							104		1407102
	D		e carrier, service, or other organization incurn ntion of the contract or policy, other than rep					10b		

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

SCHEDULE A (Form 5500)		Insuranc	e Information	)		ON	1B No. 1210-0110
Department of the Trea Internal Revenue Se	asury rvice	This schedule is required Employee Retirement Inc					2016
Department of Lab Employee Benefits Security A		File as an at	ttachment to Form 550	0.			
Pension Benefit Guaranty (	Corporation	<ul> <li>Insurance companies an pursuant to El</li> </ul>	re required to provide th RISA section 103(a)(2).				m is Open to Public Inspection
For calendar plan year 2	016 or fiscal plar	year beginning 01/01/2016		and en	nding 12/3	1/2016	
A Name of plan NOKIA RETIREE WELF	ARE BENEFITS	PLAN			e-digit number (Pl	N) 🕨	504
C Plan sponsor's name ALCATEL-LUCENT USA		e 2a of Form 5500			oyer Identific 3408857	cation Number	(EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information	:						
(a) Name of insurance c GHC PUGET SOUND	arrier				Γ	Delieu er e	
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	<ul> <li>(e) Approximate nur persons covered at</li> </ul>			Policy or contract year	
(0) 2	code	identification number	policy or contract		(f)	From	<b>(g)</b> To
91-0511770	95672	8800	60		01/01/201	6	12/31/2016
2 Insurance fee and cor descending order of th		ation. Enter the total fees and tota	I commissions paid. Lis	st in line 3	the agents,	brokers, and c	ther persons in
<b>(a)</b> Total	amount of comr	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons receiving cor	nmissions and fe	ees. (Complete as many entries a	as needed to report all p	ersons).			
	<b>(a)</b> Name a	nd address of the agent, broker, o	or other person to whom	n commiss	ions or fees	s were paid	
(b) Amount of sales a	and base	Fees	s and other commissions	s paid			_
commissions p	aid	(c) Amount	(0	d) Purpos	е		(e) Organization code
		· · · · · · ·					•
		nd address of the agent, broker, o					

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	dule A (Form 5500) 2016		

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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								
8	Ren	ofit ar	nd contract type (check all applicable boxes)		in cacin carrier i	nay be			iis iepe		—
Ŭ	Г		ealth (other than dental or vision)	<b>b</b> Dental		с	Vision		d∏∟	ife insurance	
	a	_		. 💾			1				
	е	Те	mporary disability (accident and sickness)	f Long-terr	n disability	_	Supplemental unemp	oloyment	n∐⊦	Prescription drug	
	i [	Sto	op loss (large deductible)	j 🗙 HMO con	tract	k	PPO contract		l I	ndemnity contract	
	m	Ot	her (specify)								
9	Expe	erienc	ce-rated contracts:								
	a	Premi	iums: (1) Amount received			(1)					
		(2) Ir	ncrease (decrease) in amount due but unpaid	k		(2)					
		(3) Ir	ncrease (decrease) in unearned premium res	erve		(3)		1			
	_	``	arned ( <b>(1) + (2) - (3)</b> )					. 9a(4)			0
	b	Bene	efit charges (1) Claims paid			(1)					
		• •	ncrease (decrease) in claim reserves			<b>`</b> /					
		(3) Ir	ncurred claims (add <b>(1)</b> and <b>(2)</b> )					9b(3)			0
		• •	laims charged					9b(4)			_
	С		nainder of premium: (1) Retention charges (c						4		
		```	(A) Commissions			I)(A)			_		
			(B) Administrative service or other fees			I)(B)			4		
			(C) Other specific acquisition costs)(C)			-		
		```	(D) Other expenses		0	)(D) )(E)					
			(E) Taxes			)(E)  )(F)			-		
			(F) Charges for risks or other contingencies. (G) Other retention charges		<b>a</b> (	)(G)					
		```	(H) Total retention					9c(1)(H)			0
			Dividends or retroactive rate refunds. (These	=	_	—					Ť
	d		us of policyholder reserves at end of year: (1	L				9c(2)			
	d		Claim reserves					9d(1) 9d(2)			
		• •	Dianni reserves					9d(2) 9d(3)			—
	۵	``	dends or retroactive rate refunds due. (Do n					9e			-
10			erience-rated contracts:			- JU(Z)					
	a		al premiums or subscription charges paid to c	arrier				10a		23938	32
	b									20000	~
	b		e carrier, service, or other organization incurn ntion of the contract or policy, other than rep					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 ar	nswer to line 11 is "Yes," specify the information not provided.			

on a separate Schedule A. I 1 Coverage Information: (a) Name of insurance carrier UHC OF ARIZONA (b) EIN (c) NAIC code 94-3267522 95617 0 2 Insurance fee and commission informatic descending order of the amount paid. (a) Total amount of commis 3 Persons receiving commissions and fees	Employee Retirement Inc File as an ar Insurance companies a pursuant to E ear beginning 01/01/2016 AN	D Coverage, Fees, and	(ERISA). information and ending Three-digit plan numb D Employer Id 22-34088	This Fo 12/31/2016 er (PN) entification Number 57 Sions Provide info	ormation for each contract
Internal Revenue Service Department of Labor Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation For calendar plan year 2016 or fiscal plan y A Name of plan NOKIA RETIREE WELFARE BENEFITS PL OKIA RETIREE WELFARE BENEFITS PL C Plan sponsor's name as shown on line 2 ALCATEL-LUCENT USA INC. Part I Information Concerni on a separate Schedule A. I 1 Coverage Information: (a) Name of insurance carrier UHC OF ARIZONA (b) EIN (c) NAIC code 0 94-3267522 95617 0 2 Insurance fee and commission informatic descending order of the amount paid. (a) Total amount of commis 3 Persons receiving commissions and feese	Employee Retirement Inc File as an ar Insurance companies a pursuant to E ear beginning 01/01/2016 AN a of Form 5500 ng Insurance Contract	come Security Act of 1974 (ttachment to Form 5500. re required to provide the ir RISA section 103(a)(2). B D Coverage, Fees, and	(ERISA). information and ending Three-digit plan numb D Employer Id 22-34088	12/31/2016 er (PN) entification Number 67 sions Provide info	rm is Open to Public Inspection 504
Employee Benefits Security Administration Pension Benefit Guaranty Corporation For calendar plan year 2016 or fiscal plan y A Name of plan NOKIA RETIREE WELFARE BENEFITS PL C Plan sponsor's name as shown on line 2 ALCATEL-LUCENT USA INC. Part I Information Concerni on a separate Schedule A. I 1 Coverage Information: (a) Name of insurance carrier UHC OF ARIZONA (b) EIN (c) NAIC code 94-3267522 95617 0 2 Insurance fee and commission information descending order of the amount paid. (a) Total amount of commis 3 Persons receiving commissions and fees	 File as an ar pursuant to E Insurance companies a pursuant to E ear beginning 01/01/2016 _AN a of Form 5500 ng Insurance Contract 	ttachment to Form 5500. re required to provide the ir RISA section 103(a)(2). B D Coverage, Fees, and	information and ending Three-digit plan numb Employer Id 22-34088	12/31/2016 er (PN) entification Number 67 sions Provide info	Inspection 504 (EIN)
Pension Benefit Guaranty Corporation For calendar plan year 2016 or fiscal plan year A Name of plan NOKIA RETIREE WELFARE BENEFITS PL C Plan sponsor's name as shown on line 2 ALCATEL-LUCENT USA INC. Part I Information Concerni on a separate Schedule A. I 1 Coverage Information: (a) Name of insurance carrier UHC OF ARIZONA (b) EIN (c) NAIC code 94-3267522 95617 0 2 Insurance fee and commission informatio descending order of the amount paid. (a) Total amount of commis 3 Persons receiving commissions and fees	pursuant to E ear beginning 01/01/2016 _AN a of Form 5500 ng Insurance Contract	RISA section 103(a)(2).	and ending Three-digit plan numb Employer Id 22-34088	12/31/2016 er (PN) entification Number 67 sions Provide info	Inspection 504 (EIN)
A Name of plan NOKIA RETIREE WELFARE BENEFITS PL C Plan sponsor's name as shown on line 2 ALCATEL-LUCENT USA INC. Part I Information Concerni on a separate Schedule A. I 1 Coverage Information: (a) Name of insurance carrier UHC OF ARIZONA (b) EIN (c) NAIC code 94-3267522 95617 0 2 Insurance fee and commission information descending order of the amount paid. (a) Total amount of commis 3 Persons receiving commissions and fees	AN a of Form 5500 ng Insurance Contract	D Coverage, Fees, and	 Three-digit plan numb Employer Id 22-34088 Commis 	er (PN)	504 (EIN)
NOKIA RETIREE WELFARE BENEFITS PL C Plan sponsor's name as shown on line 2 ALCATEL-LUCENT USA INC. Part I Information Concernion on a separate Schedule A. I 1 Coverage Information: (a) Name of insurance carrier UHC OF ARIZONA (b) EIN (c) NAIC code 94-3267522 95617 0 2 Insurance fee and commission information descending order of the amount paid. (a) Total amount of commissions and fees 3 Persons receiving commissions and fees 3	a of Form 5500	D Coverage, Fees, and	plan numb D Employer Id 22-34088	entification Number 57 SiONS Provide info	(EIN)
Part I Information Concernion on a separate Schedule A. I 1 Coverage Information: (a) Name of insurance carrier UHC OF ARIZONA (b) EIN (c) NAIC code 94-3267522 95617 0 2 Insurance fee and commission information descending order of the amount paid. (a) Total amount of commissions and fees 3 Persons receiving commissions and fees	ng Insurance Contract	Coverage, Fees, and	22-34088	57 Sions Provide info	ormation for each contract
on a separate Schedule A. I 1 Coverage Information: (a) Name of insurance carrier UHC OF ARIZONA (b) EIN (c) NAIC code 94-3267522 95617 0 2 Insurance fee and commission informatic descending order of the amount paid. (a) Total amount of commis 3 Persons receiving commissions and fees					
(a) Name of insurance carrier UHC OF ARIZONA (b) EIN (c) NAIC code 94-3267522 95617 0 2 Insurance fee and commission informatic descending order of the amount paid. (a) Total amount of commission (a) Total amount of commissions and fees					
(b) EIN (c) NAIC code 94-3267522 95617 0 2 Insurance fee and commission information descending order of the amount paid. (a) Total amount of commissions and fees 3 Persons receiving commissions and fees					
(b) EIN code 94-3267522 95617 0 2 Insurance fee and commission informatic descending order of the amount paid. 0 (a) Total amount of commissions and fees 3 Persons receiving commissions and fees	(d) Contract or	(e) Approximate number		Policy or c	contract year
 2 Insurance fee and commission information descending order of the amount paid. (a) Total amount of commissions and fees 3 Persons receiving commissions and fees 	identification number	persons covered at energy policy or contract year		(f) From	(g) To
descending order of the amount paid. (a) Total amount of commis 3 Persons receiving commissions and fees	60408,060406	83	01/01	/2016	12/31/2016
3 Persons receiving commissions and fees	on. Enter the total fees and tota	I commissions paid. List in	in line 3 the ag	ents, brokers, and o	other persons in
	sions paid		(b) Total an	ount of fees paid	
(a) Name and	<u>, , , ,</u>				
	address of the agent, broker,	or other person to whom co	commissions o	fees were paid	
· · · · · · · · · · · · · · · · · · ·					
(b) Amount of sales and base		s and other commissions pa			
commissions paid	(c) Amount	(d) F	Purpose		(e) Organization code
(a) Name and					

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	dule A (Form 5500) 2016		

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier n					who trooted	as a unit for nurnages of
		this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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 su	uch contracts are ex	perience-rated as a unit for	nit. Where con	itracts cover individual
8	Ren	ofit ar	nd contract type (check all applicable boxes)		reach carner may b			
Ŭ	a [-	alth (other than dental or vision)	b Dental	C	Vision		d 🗌 Life insurance
	L	_		- H				
	e	Te	mporary disability (accident and sickness)	f Long-term		Supplemental uner	mployment I	h Prescription drug
	i	Sto	op loss (large deductible)	j 🗙 HMO cont	tract k	PPO contract		I Indemnity contract
	m	Ot	her (specify) 🕨					
		_						
9	Expe	erienc	e-rated contracts:			1		
	a		iums: (1) Amount received					
			ncrease (decrease) in amount due but unpaid					
		• •	crease (decrease) in unearned premium res					
		• •	arned ((1) + (2) - (3))				9a(4)	(
	b	Bene	efit charges (1) Claims paid					
		``	crease (decrease) in claim reserves					
		• •	ncurred claims (add (1) and (2))					(
	_	• •	laims charged				. 9b(4)	
	С		nainder of premium: (1) Retention charges (c					
		```	A) Commissions					
		```	B) Administrative service or other fees					
		```	(C) Other specific acquisition costs		a (1)(D)			{
		```	D) Other expenses		0.(1)(5)			
		```	E) Taxes F) Charges for risks or other contingencies .					4
		```	G) Other retention charges		a (1)(a)			
		```	H) Total retention				. 9c(1)(H)	(
		```	Dividends or retroactive rate refunds. (These			-		
	d		us of policyholder reserves at end of year: (1		-	-		
	ŭ		Claim reserves					
		• •	Other reserves					
	е	()	dends or retroactive rate refunds due. (Do n					
10			erience-rated contracts:			,,		
-			I premiums or subscription charges paid to c	arrier			. 10a	531494
	b		e carrier, service, or other organization incur					
			ation of the contract or policy other than rep				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 ar	nswer to line 11 is "Yes," specify the information not provided.			

Improve Bindle Starting Johnnettation Person Bendet Guaranty Corporation This Form is Open to Public insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This Form is Open to Public inspection A Name of plan NoKIA RETIREE WELFARE BENEFITS PLAN Bar Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier BLUECROSS BLUESHIELD (b) EIN (c) NAIC (c) Contract or identification number paticy or contract year paticy or contract year pati	SCHEDULE (Form 5500) Department of the Treas Internal Revenue Servi Department of Labor)) sury ice r	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			OMB No. 1210-0110		
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016 A Name of plan B Three-digit 504 NOKIA RETIREE WELFARE BENEFITS PLAN B Three-digit 504 C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN) 22-3408857 Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 1 Coverage Information: (a) Name of insurance carrier BLUECROSS BLUESHELD (b) EIN (c) NAIC (d) Contract or identification number (e) Approximate number of policy or contract year Policy or contract year 98-1236610 70670 H73523,B73523 35 01/01/2016 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. (b) 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). (e) Organization code (b) Amount of sales and base commissions pai			Insurance companies ar	re required to provide t	he informat	tion	This For	•
NOKIA RETIREE WELFARE BENEFITS PLAN Introduction of the second secon	For calendar plan year 20	16 or fiscal plan	year beginning 01/01/2016		and er	nding 12/3	1/2016	•
ALCATEL-LUCENT USA INC. 22-3408857 Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier BLUECROSS BLUESHIELD (b) EIN (c) NAIC code (d) Contract or identification number Policy or contract year persons covered at end of policy or contract year 36-1236610 70670 H73523,B73523 35 01/01/2016 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. (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	•	RE BENEFITS	PLAN			-	N) ►	504
on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier BLUECROSS BLUESHIELD (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year Policy or contract year 36-1236610 70670 H73523,B73523 35 01/01/2016 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. (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid Fees and other commissions paid (e) Organization code						(EIN)		
(a) Name of insurance carrier BLUECROSS BLUESHIELD (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year Policy or contract year 36-1236610 70670 H73523,B73523 35 01/01/2016 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. (b) 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). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid Fees and other commissions paid (e) Organization code								
BLUECROSS BLUESHIELD (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year Policy or contract year 36-1236610 70670 H73523,B73523 35 01/01/2016 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. (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid Fees and other commissions paid (e) Organization code	1 Coverage Information:							
(b) EIN (c) NAIC code (d) Contract or identification number persons covered at end of policy or contract year (f) From (g) To 36-1236610 70670 H73523,B73523 35 01/01/2016 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. (b) Total amount of fees paid (a) Total amount of commissions paid (b) Total amount of fees paid (c) Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (e) Organization code (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	()	D		(e) Approximate p	umber of		Policy or c	ontract year
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 commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid Fees and other commissions paid (c) Amount (d) Purpose (e) Organization code	(b) EIN	• • •	.,	persons covered a	at end of	(f)		
descending order of the amount paid. (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). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	36-1236610	70670	H73523,B73523	35	i	01/01/201	6	12/31/2016
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base (c) Amount (d) Purpose (e) Organization code			tion. Enter the total fees and tota	I commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	(a) Total a	amount of comr	nissions paid		(b) To	otal amount	of fees paid	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code								
(b) Amount of sales and base commissions paid Fees and other commissions paid (e) Organization code	3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all	persons).			
(b) Amount of sales and base (c) Amount (d) Purpose (e) Organization code		(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales and base (c) Amount (d) Purpose (e) Organization code								
	(b) Amount of sales ar	nd base	Fees	s and other commissio	ns paid			4
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	commissions paid		(c) Amount		(d) Purpos	е		(e) Organization code
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
		(a) Name a	nd address of the agent broker of	or other person to who	m commiss	ions or fees	were naid	
		(a) Name a						

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Schee			dule A (Form 5500) 2016
			v. 160205

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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								
8	Ren	ofit ar	nd contract type (check all applicable boxes)			y DC			113 100		
Ŭ	г		ealth (other than dental or vision)	b Dental		с	Vision		d∏	Life insurance	
	a	_		. 🛏			1				
	e	Те	mporary disability (accident and sickness)			_	Supplemental unemp	ployment	n	Prescription drug	
	i	Sto	op loss (large deductible)	j 🗙 HMO cor	ntract	k	PPO contract			Indemnity contract	
	m	Ot	her (specify)								
9	Expe	erienc	ce-rated contracts:								
	a		iums: (1) Amount received						_		
		(2) Ir	ncrease (decrease) in amount due but unpaid	t							
		• •	ncrease (decrease) in unearned premium res					1			
	-	``	arned ((1) + (2) - (3))			1		. 9a(4)			0
	b	Bene	efit charges (1) Claims paid						_		
		• •	ncrease (decrease) in claim reserves		· · · · · ·	/					
		• •	ncurred claims (add (1) and (2))					9b(3)	_		0
		• •	laims charged					9b(4)			
	С		nainder of premium: (1) Retention charges (c			• • •			_		
		```	(A) Commissions						_		
			(B) Administrative service or other fees		<b>a</b> (1)(				_		
			(C) Other specific acquisition costs						-		
		```	(D) Other expenses		0 - (4) (				-		
			(E) Charges for risks or other contingencies						-		
			(F) Charges for risks or other contingencies. (G) Other retention charges		a (1)(-		
		```	(H) Total retention					9c(1)(H)			0
			Dividends or retroactive rate refunds. (These			_			-		
	d		us of policyholder reserves at end of year: (1	L				9c(2) 9d(1)			
	u		Claim reserves					9d(1) 9d(2)			
		• •	Dther reserves					9d(3)			
	е	``	dends or retroactive rate refunds due. (Do n					9e			
10			erience-rated contracts:				,				
			al premiums or subscription charges paid to c	arrier				10a		588	3282
	b								1		
	~	<b>b</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									

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 ar	nswer to line 11 is "Yes," specify the information not provided.			

SC	HEDULE A	A	Insuranc	e Information			OMB No. 1210-0110
(Form 5500)							OMB NO. 1210-0110
	tment of the Treasury nal Revenue Service	/	This schedule is required Employee Retirement Inco				2016
	epartment of Labor enefits Security Admir	istration	File as an at	tachment to Form 5500.	. ,		
	enefit Guaranty Corpo		<ul> <li>Insurance companies ar pursuant to EF</li> </ul>	e required to provide the in RISA section 103(a)(2).	nformation	This	Form is Open to Public
For calendar	plan year 2016	or fiscal plan	year beginning 01/01/2016		and endin	ig 12/31/2016	
A Name of NOKIA RET	plan IREE WELFARE	E BENEFITS	PLAN	В		ligit Imber (PN) ►	504
•	nsor's name as a JCENT USA IN		2a of Form 5500	D	Employer 22-340	r Identification Num	ber (EIN)
Part I			ning Insurance Contract				
1 Coverage	Information:						
(b)	EIN	(c) NAIC	(d) Contract or	(e) Approximate numb persons covered at en		,	or contract year
.,		code	identification number	policy or contract yea	ar	(f) From	<b>(g)</b> To
4-1340523	0	0000	122636	254	01	1/01/2016	12/31/2016
	e fee and comming order of the a		tion. Enter the total fees and total	commissions paid. List ir	n line 3 the	e agents, brokers, a	and other persons in
	(a) Total am	ount of comr	nissions paid		<b>(b)</b> Total	amount of fees pa	id
3 Persons		ssions and fe	es. (Complete as many entries a	is needed to report all pers	sons)		
	cociving comm		nd address of the agent, broker, c			s or fees were paid	1
<b>(b)</b> Amo	unt of sales and	base	Fees	and other commissions p	aid		
COI	mmissions paid		(c) Amount	(d)	Purpose		(e) Organization code
		(a) Name a	nd address of the agent, broker, c	or other person to whom co	ommission	s or fees were paid	1

(b) Amount of sales and base commissions paid	F		
	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	dule A (Form 5500) 2016		

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

P	Part		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					
8	Ren	ofit ar	nd contract type (check all applicable boxes)		cach camer may be			
Ŭ	г		ealth (other than dental or vision)	<b>b</b> Dental	c	Vision	d	Life insurance
	a							
	е	Te	mporary disability (accident and sickness)	f Long-term		Supplemental unemp	ployment <b>h</b>	Prescription drug
	i	Sto	op loss (large deductible)	j 🛛 HMO contra	act <b>k</b>	PPO contract	I	Indemnity contract
	m	Ot	her (specify)					
9	Expe	erienc	ce-rated contracts:			-		
	a	Premi	iums: (1) Amount received					
		(2) In	ncrease (decrease) in amount due but unpaid	1				
		(3) In	ncrease (decrease) in unearned premium res	erve			-	
	_	• •	arned ( <b>(1) + (2) - (3)</b> )				. 9a(4)	(
	b	Bene	efit charges (1) Claims paid					
		· /	ncrease (decrease) in claim reserves				1	
		(3) In	ncurred claims (add (1) and (2))				9b(3)	C
		• •	laims charged				9b(4)	
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis		1		
		(	(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 .		a (1)(a)			
		```	(G) Other retention charges					
		```	(H) Total retention	_	_		9c(1)(H)	(
			Dividends or retroactive rate refunds. (These				9c(2)	
	d		us of policyholder reserves at end of year: (1	, , ,			9d(1)	
		(2) C	Claim reserves				9d(2)	
		(3) C	Other reserves				9d(3)	
	е	Divic	dends or retroactive rate refunds due. (Do not	ot include amount	entered in line 9c(2	<b>]</b> .)	9e	
10	) No	nexpe	erience-rated contracts:					
	а	Tota	Il premiums or subscription charges paid to c	arrier			10a	1177810
	b		e carrier, service, or other organization incurr				10b	

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

SCHEDULE A (Form 5500)		Insurance Information				ОМ	B No. 1210-0110	
Department of the Trea Internal Revenue Ser	sury vice	This schedule is required Employee Retirement Inc					2016	
Department of Labo Employee Benefits Security Ac		File as an at	ttachment to Form 55	600.				
Pension Benefit Guaranty C	orporation	<ul> <li>Insurance companies and pursuant to E</li> </ul>	re required to provide t RISA section 103(a)(2)		ion		m is Open to Public Inspection	
For calendar plan year 20	16 or fiscal pla	n year beginning 01/01/2016		and en	iding 12/3	1/2016	-	
A Name of plan NOKIA RETIREE WELFA	ARE BENEFITS	PLAN			e-digit number (P	N) ►	504	
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500			oyer Identific 3408857	cation Number (	(EIN)	
		ning Insurance Contract Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca KAISER FOUNDATION HI		DF CO	(e) Approximate n	umbor of		Policy or or	ontract vear	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	at end of	(f)	From	(g) To	
84-0591617	95669	07368	245	245 01/01/2		16 12/31/2016		
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and of	ther persons in	
(a) Total	amount of com	missions paid		<b>(b)</b> To	otal amount	of fees paid		
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all	persons)				
		and address of the agent, broker, o			ions or fees	were paid		
(b) Amount of sales and base		Fees	s and other commissio	ns paid				
commissions pa	aid	(c) Amount		(d) Purpos	e		(e) Organization code	
	(a) Name a	and address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid		

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	e, see the Instructions for Forr	n 5500. Sched	dule A (Form 5500) 2016 v. 160205

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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							r individual
8	Ren	ofit ar	nd contract type (check all applicable boxes)							
Ŭ	a [	_	ealth (other than dental or vision)	<b>b</b> Dental		c	Vision		<b>d</b> 🗌 Life in	isurance
	L	_		. 🗄			1		. 💾	
	е	Те	mporary disability (accident and sickness)		rm disability		Supplemental unemp	oloyment	<b>n</b> Presc	ription drug
	i [	Sto	op loss (large deductible)	j 🗙 HMO co	ontract	k	PPO contract		I Indem	nity contract
	m	Ot	her (specify)							
9	Expe	erienc	ce-rated contracts:						_	
	a		iums: (1) Amount received			9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	t		9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	erve		9a(3)		1		
		• •	arned ((1) + (2) - (3))		-			9a(4)		0
	b	Bene	efit charges (1) Claims paid			9b(1)			4	
		``	ncrease (decrease) in claim reserves			9b(2)				
		• •	ncurred claims (add (1) and (2))					9b(3)		0
	_	• •	laims charged					9b(4)		
	С		nainder of premium: (1) Retention charges (c			(4)(4)			4	
		```	(A) Commissions			c(1)(A)			4	
			(B) Administrative service or other fees			c(1)(B)			-	
			(C) Other specific acquisition costs			c(1)(C) c(1)(D)			-	
		```	(D) Other expenses			c(1)(E)			4	
			(E) Charges for risks or other contingencies			c(1)(E)			-	
			(F) Charges for risks or other contingencies. (G) Other retention charges			c(1)(G)			-	
		```	(H) Total retention					9c(1)(H)		0
			Dividends or retroactive rate refunds. (These		_	_				
	А		us of policyholder reserves at end of year: (1					9c(2)		
	d		Claim reserves					9d(1) 9d(2)		
		` '	Dianni reserves					9d(2) 9d(3)		
	۵	• •	dends or retroactive rate refunds due. (Do n					9e		
10			erience-rated contracts:			1111C JU(Z)				
	a	•	al premiums or subscription charges paid to c	arrier				10a		1282162
	b									1202102
	D		e carrier, service, or other organization incurn ntion of the contract or policy, other than rep					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 ar	swer to line 11 is "Yes," specify the information not provided.			

SCHEDULE A (Form 5500)		Insurance Information			OMB No. 1210-0110			
Department of the Treasury Internal Revenue Service		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2016			
Department of Labo Employee Benefits Security Ac		File as an attachment to Form 5500.						
Pension Benefit Guaranty Corporation		 Insurance companies are required to provide the pursuant to ERISA section 103(a)(2) 					This Form is Open to Public Inspection	
	16 or fiscal pla	n year beginning 01/01/2016		and en	ding <u>12/3</u>	1/2016	1	
A Name of plan NOKIA RETIREE WELFARE BENEFITS PLAN					e-digit number (Pl	N) 🕨	504	
C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC.					D Employer Identification Number (EIN) 22-3408857			
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca KAISER FOUNDATION HI	EALTH PLAN N		(e) Approximate nu	imber of		Policy or c	ontract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end ((g) To	
93-0798039	95540	8384	40		01/01/2010	6	12/31/2016	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. Li	ist in line 3	the agents,	brokers, and o	other persons in	
	amount of com	missions paid	(b) Total amount of fees paid					
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all	persons).				
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales and base		Fees and other commissions paid						
commissions paid		(c) Amount	(d) Purpose			(e) Organization code		

(b) Amount of sales and base	F					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
For Paperwork Reduction Act Notice	lule A (Form 5500) 2016					

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppuist.			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	Part		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									
8	Ren	ofit a	nd contract type (check all applicable boxes)			anter may b				1113 10		
U	F	_	, , , , , , , , , , , , , , , , , , ,	b	Dental	0	П	Vision		d∏	Life incurrence	
	a	_	ealth (other than dental or vision)	. 🗄		С					Life insurance	
	е	Те	emporary disability (accident and sickness)	f	Long-term disabilit	ty g		Supplemental unemp	oloyment	h	Prescription drug	
	i [Sto	op loss (large deductible)	јX	HMO contract	k		PPO contract		I 🗌	Indemnity contract	
	m	Ot	ther (specify)									
9	Expe	erienc	ce-rated contracts:									
	a	Prem	iums: (1) Amount received			9a(1)						
		(2) Ir	ncrease (decrease) in amount due but unpaid	d b		9a(2)						
		• •	ncrease (decrease) in unearned premium res			9a(3)			1			
		(4) E	Earned ((1) + (2) - (3))				<u></u>	<u></u>	. 9a(4)			0
	b	Ben	efit charges (1) Claims paid			9b(1)				_		
		• •	ncrease (decrease) in claim reserves			9b(2)			1			
		(3) Ir	ncurred claims (add (1) and (2))						9b(3)	_		0
		` '	Claims charged						9b(4)			
	С		nainder of premium: (1) Retention charges (c		,	- (I) (I)	-1			4		
			(A) Commissions			9c(1)(A)				4		
			(B) Administrative service or other fees			9c(1)(B)				4		
			(C) Other specific acquisition costs			9c(1)(C)	_			4		
			(D) Other expenses			9c(1)(D)				4		
			(E) Taxes			9c(1)(E)				4		
			(F) Charges for risks or other contingencies.			9c(1)(F) 9c(1)(G)				_		
			(G) Other retention charges						0~(1)/[]	<u> </u>		0
			(H) Total retention				-		9c(1)(H)	'		
			Dividends or retroactive rate refunds. (These						9c(2)			
	d		us of policyholder reserves at end of year: (1	'	•				9d(1)	_		
		` '	Claim reserves						9d(2)	_		
	-	· · /	Other reserves						9d(3)	_		
40			dends or retroactive rate refunds due. (Do n		ude amount entered	a in line 9C(2	2).	<u> </u>	9e			_
nu	_	•	erience-rated contracts:	orrior					100			044
	a		al premiums or subscription charges paid to c						10a		2778	511
	b		e carrier, service, or other organization incur ntion of the contract or policy, other than rep						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 ar	swer to line 11 is "Yes," specify the information not provided.			

			Insuranc	ce Information		O	MB No. 1210-0110
				to be filed under section 104 come Security Act of 1974 (E		2016	
	artment of Labor fits Security Administr	ration	File as an a	ttachment to Form 5500.			
Pension Bene	efit Guaranty Corporati	ion		re required to provide the info RISA section 103(a)(2).	rmation	This Fo	rm is Open to Public Inspection
For calendar p	lan year 2016 or	r fiscal plan	year beginning 01/01/2016	a	d ending 12/3	31/2016	·
A Name of pla NOKIA RETIR	an EE WELFARE E	BENEFITS	PLAN	В	Three-digit plan number (P	PN)	504
•	or's name as she CENT USA INC.	own on line	2a of Form 5500	D E	mployer Identifi 22-3408857	cation Number	(EIN)
Part I			ning Insurance Contract Individual contracts grouped as				
1 Coverage Ir	nformation:						
(b) El		c) NAIC	(d) Contract or	(e) Approximate number persons covered at end	of	,	contract year
(*) -		code	identification number	policy or contract year	(f)) From	(g) To
52-0954463	956	39	2204	51	01/01/201	6	12/31/2016
	ee and commissi order of the amo		tion. Enter the total fees and tota	I commissions paid. List in l	ne 3 the agents	, brokers, and o	other persons in
	(a) Total amou	unt of comn	nissions paid		b) Total amount	t of fees paid	
2 Damagna na				en annalad in annait all annan			
J Persons red			es. (Complete as many entries) and address of the agent, broker,			s were paid	
			.	·		·	
			Faa	s and other commissions pai	1		
(b) Amoun	t of sales and ba	ase	1,00	o and other commissions par			
	t of sales and ba missions paid	ise	(c) Amount	(d) Pu			(e) Organization code
		ase —		•			(e) Organization code

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	dule A (Form 5500) 2016		

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year		4		
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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								
8	Ren	ofit ar	nd contract type (check all applicable boxes)		n cach canter may	50			13 10		
Ŭ	г	_	ealth (other than dental or vision)	b Dental		сГ	Vision		d∏	Life insurance	
	a	_		. 💾			-				
	е	Те	mporary disability (accident and sickness)	f Long-terr	-		Supplemental unemp	oloyment	h	Prescription drug	
	i [Sto	op loss (large deductible)	j 🗙 HMO con	ntract	k	PPO contract			Indemnity contract	
	m	Ot	her (specify)								
	L										
9	Expe	erienc	ce-rated contracts:								
	a	Prem	iums: (1) Amount received								
		(2) Ir	ncrease (decrease) in amount due but unpaid	ا							
		(3) Ir	ncrease (decrease) in unearned premium res	erve							
		(4) E	arned ((1) + (2) - (3))			<u></u>		. 9a(4)			0
	b	Ben	efit charges (1) Claims paid								
		(2) Ir	ncrease (decrease) in claim reserves					1			
		(3) Ir	ncurred claims (add (1) and (2))					9b(3)	_		0
		(4) C	Claims charged					9b(4)			_
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual bas					4		
		((A) Commissions						4		
		((B) Administrative service or other fees						_		
		((C) Other specific acquisition costs						4		
		((D) Other expenses			-			4		
			(E) Taxes						4		
			(F) Charges for risks or other contingencies .		A (1)/4				4		
			(G) Other retention charges			-					
			(H) Total retention	=	_	_		9c(1)(H)	_		0
			Dividends or retroactive rate refunds. (These	L.				9c(2)			
	d		us of policyholder reserves at end of year: (1	,	•			9d(1)			
		(2) (Claim reserves					9d(2)			
		(3) (Other reserves					9d(3)	_		
			dends or retroactive rate refunds due. (Do no	ot include amour	nt entered in line 9	c(2)	.)	9e	_		
10) No		erience-rated contracts:								
	а	Tota	al premiums or subscription charges paid to c	arrier				10a		2208	318
	b		e carrier, service, or other organization incurr ntion of the contract or policy, other than repu					10b			

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

SCHEDULE		Insuranc	e Information	n		ОМ	B No. 1210-0110
(Form 5500 Department of the Treas Internal Revenue Serv	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2016	
Department of Labo Employee Benefits Security Ad			tachment to Form 55		,		
Pension Benefit Guaranty Co	orporation	 Insurance companies ar pursuant to El 	re required to provide t RISA section 103(a)(2)		ion	This Form is Open to Public Inspection	
For calendar plan year 20	16 or fiscal plar	year beginning 01/01/2016		and er	iding 12/3	1/2016	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (Pl	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		-	oyer Identific 3408857	ation Number (EIN)
on a separ		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE		F GA (d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
58-1592076	96237	2081	47	,	01/01/2010	6	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and of	ther persons in
	amount of com	nissions paid		(b) To	otal amount	of fees paid	
2 Demonstrativities com							
3 Persons receiving com		ees. (Complete as many entries a nd address of the agent, broker, o			ions or fees	were paid	
(b) Amount of sales a	nd booo	Fees	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	•

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Scher			dule A (Form 5500) 2016

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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 su	uch contracts are ex	perience-rated as a uni	it. Where conf	tracts cover individual
8	Ren	ofit ar	nd contract type (check all applicable boxes)		reach camer may b			
Ŭ	a	-	ealth (other than dental or vision)	b Dental	6	Vision	d	Life insurance
	L F	_		. 💾				
	е	Te	mporary disability (accident and sickness)	f Long-term		Supplemental unem	ployment h	Prescription drug
	i [Sto	op loss (large deductible)	j 🗙 HMO cont	tract k	PPO contract	I	Indemnity contract
	m	Ot	her (specify)					
		_						
9	•		ce-rated contracts:			-		
	a		iums: (1) Amount received					
			ncrease (decrease) in amount due but unpaid					
		• •	ncrease (decrease) in unearned premium res					
		• •	arned ((1) + (2) - (3))				9a(4)	С
	b	Bene	efit charges (1) Claims paid					
		``	ncrease (decrease) in claim reserves					
		• •	ncurred claims (add (1) and (2))				9b(3)	0
	_	• •	laims charged				9b(4)	
	С		nainder of premium: (1) Retention charges (c					
		```	(A) Commissions					
		```	(B) Administrative service or other fees					
		```	(C) Other specific acquisition costs		a (1)(D)			
		```	(D) Other expenses		0 (4)(E)			
		```	<ul> <li>(E) Taxes</li> <li>(F) Charges for risks or other contingencies .</li> </ul>					
		```	(G) Other retention charges		0 (1)(0)			
		```	(H) Total retention				9c(1)(H)	C
		```	Dividends or retroactive rate refunds. (These	_			9c(2)	
	d		us of policyholder reserves at end of year: (1		-		9d(1)	
	ŭ		Claim reserves				9d(2)	
		• •	Other reserves				9d(3)	
	е	()	dends or retroactive rate refunds due. (Do n				9e	
10			erience-rated contracts:			,,		
-	а		Il premiums or subscription charges paid to c	arrier			10a	333954
	b		e carrier, service, or other organization incur					
			ntion of the contract or policy other than rep				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 ar	nswer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuranc	e Information	n		OM	1B No. 1210-0110
(Form 5500 Department of the Treas Internal Revenue Serv	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2016		
Department of Labo Employee Benefits Security Ad		File as an at	tachment to Form 55	00.			
Pension Benefit Guaranty Co	prporation	 Insurance companies an pursuant to El 	re required to provide t RISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
For calendar plan year 20	16 or fiscal pla	n year beginning 01/01/2016		and en	ding 12/3	1/2016	•
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (Pl	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		-	oyer Identific 3408857	cation Number	(EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE		DF HI				Deliau an a	
(b) EIN	(c) NAIC	(d) Contract or identification number	 (e) Approximate nu persons covered a 		(6)		ontract year
	code		policy or contrac	t year	(1)	From	(g) To
94-1340523	60053	639	8		01/01/201	6	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount	of fees paid	
0 -							
3 Persons receiving com		ees. (Complete as many entries a and address of the agent, broker, o			ions or fees	were paid	
	(4) 114.110 0						
(b) Amount of sales ar	nd base	Fees	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
	(a) Name a	Ind address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Sche			dule A (Form 5500) 2016 v. 160205

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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 su	uch contracts are ex	perience-rated as a uni	it. Where cont	tracts cover individual
8	Bon	ofit ar	nd contract type (check all applicable boxes)		reach canter may b			
U	г	-					d	
	a	_	alth (other than dental or vision)	b Dental		Vision	d	
	е	Te	mporary disability (accident and sickness)	f Long-term		Supplemental unem	ployment h	Prescription drug
	i	Sto	op loss (large deductible)	j 🗙 HMO cont	tract k	PPO contract	I	Indemnity contract
	m	Ot	her (specify)					
9	Expe	erienc	ce-rated contracts:			-		
	a		iums: (1) Amount received					
		(2) In	ncrease (decrease) in amount due but unpaid	t				
		(3) In	ncrease (decrease) in unearned premium res	erve				
	_	• •	arned ((1) + (2) - (3))				9a(4)	0
	b	Bene	efit charges (1) Claims paid					
		``	ncrease (decrease) in claim reserves				I	
		(3) In	ncurred claims (add (1) and (2))				9b(3)	0
		• •	laims charged				9b(4)	
	С		nainder of premium: (1) Retention charges (c					
		```	(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.		a (1)(a)			
		```	(G) Other retention charges				0c(1)(∐)	0
		```	(H) Total retention	_			9c(1)(H)	U
			Dividends or retroactive rate refunds. (These		-		9c(2)	
	a		us of policyholder reserves at end of year: (1				9d(1)	
		(2) Claim reserves					9d(2) 9d(3)	
	~	(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)						
10				ot include amount	t entered in line 9c(∠j .)	9e	
10			erience-rated contracts:				100	70000
			Il premiums or subscription charges paid to c				10a	76329
	b		e carrier, service, or other organization incurn ation of the contract or policy, other than rep				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 ar	nswer to line 11 is "Yes," specify the information not provided.			

(Form 5500) Department of the Treasury This schedule is required to be filed under sect Department of Labor This schedule is required to be filed under sect Employee Benefits Security Administration Pension Benefit Guaranty Corporation Pension Benefit Guaranty Corporation Pension Benefit Guaranty Corporation Pension Benefit Guaranty Corporation Notice Colspan="2">Insurance companies are required to provide pursuant to ERISA section 103(a)(2 Or calendar plan year 2016 or fiscal plan year beginning 01/01/2016 A Name of plan NOKIA RETIREE WELFARE BENEFITS PLAN Pen	 and en B Three plan D Emploi 22-3 and Con). ion ding 12/31 e-digit number (PN yer Identifica 3408857 nmissions	Ation Number	ormation for each contract
Employee Benefits Security Administration File as an attachment to Form 5 Insurance companies are required to provide pursuant to ERISA section 103(a)(2 For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 A Name of plan NOKIA RETIREE WELFARE BENEFITS PLAN C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. Part I Information Concerning Insurance Contract Coverage, Fees, on a separate Schedule A. Individual contracts grouped as a unit in Parts II and 1 C Coverage Information: (a) Name of insurance carrier KAISER FOUNDATION HEALTH PLAN OF N. CA (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate r persons covered policy or contract (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate r persons covered policy or contract (a) Coverage Information (b) EIN (c) NAIC code (c) NAIC code (c) NAIC code (c) Contract or identification number (c) Approximate r persons covered policy or contract (c) NAIC code (c) Contract or identification number (c) Approximate r persons covered policy or contract (c) NAIC code (c) Contract or identification number (c) Approximate r persons covered policy or contract (c) NAIC code (c) Contract or identification number (c) Approximate r persons covered policy or contract (c) NAIC code (c) Contract or identification nu	B Three plan D Emplo 22-3 and Con	ding 12/31 e-digit number (PN yer Identifica 3408857	Ation Number	Inspection 504 r (EIN) ormation for each contract
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 A Name of plan NOKIA RETIREE WELFARE BENEFITS PLAN C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. Part I Information Concerning Insurance Contract Coverage, Fees, on a separate Schedule A. Individual contracts grouped as a unit in Parts II and 1 Coverage Information: (a) Name of insurance carrier KAISER FOUNDATION HEALTH PLAN OF N. CA (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate r persons covered policy or contract). and en B Three plan D Emplo 22-3 and Con	ding 12/31 e-digit number (PN yer Identifica 3408857	Ation Number	Inspection 504 r (EIN) ormation for each contract
A Name of plan Nokia Retire welfare benefits plan C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. Part I Information Concerning Insurance Contract Coverage, Fees, on a separate Schedule A. Individual contracts grouped as a unit in Parts II and 1 Coverage Information: (a) Name of insurance carrier KAISER FOUNDATION HEALTH PLAN OF N. CA (b) EIN (c) NAIC code (d) Contract or persons covered policy or contract	B Three plan D Emplo	e-digit number (PN vyer Identifica 3408857	ation Number	r (EIN)
NOKIA RETIREE WELFARE BENEFITS PLAN C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. Part I Information Concerning Insurance Contract Coverage, Fees, on a separate Schedule A. Individual contracts grouped as a unit in Parts II and 1 Coverage Information: (a) Name of insurance carrier KAISER FOUNDATION HEALTH PLAN OF N. CA (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate r persons covered policy or contra	D Emplo	yer Identifica 3408857	ation Number	r (EIN)
ALCATEL-LUCENT USA INC. Part I Information Concerning Insurance Contract Coverage, Fees, on a separate Schedule A. Individual contracts grouped as a unit in Parts II and 1 Coverage Information: (a) Name of insurance carrier KAISER FOUNDATION HEALTH PLAN OF N. CA (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate r persons covered policy or contract	and Con	3408857	S Provide info	ormation for each contract
on a separate Schedule A. Individual contracts grouped as a unit in Parts II and 1 Coverage Information: (a) Name of insurance carrier KAISER FOUNDATION HEALTH PLAN OF N. CA (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate r persons covered policy or contract				
(a) Name of insurance carrier KAISER FOUNDATION HEALTH PLAN OF N. CA (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate r persons covered policy or contract				
KAISER FOUNDATION HEALTH PLAN OF N. CA (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate r persons covered policy or contract				
(b) EIN code identification number persons covered policy or contra	umber of		Policy or o	contract year
94-1340523 00000 35147 42	(T)		From	(g) To
	422 01			12/31/2016
2 Insurance fee and commission information. Enter the total fees and total commissions paid. descending order of the amount paid.	ist in line 3.	the agents, I	prokers, and	other persons in
(a) Total amount of commissions paid	(b) To	otal amount o	of fees paid	
3 Persons receiving commissions and fees. (Complete as many entries as needed to report al				
(a) Name and address of the agent, broker, or other person to who	m commiss	ions or tees	were paid	
(b) Amount of sales and base Fees and other commission	ons paid			
commissions paid (c) Amount	(d) Purpose	e		(e) Organization code
(a) Name and address of the agent, broker, or other person to who			were paid	•

F						
(c) Amount	(d) Purpose	(e) Organization code				
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Schedule A						
	(c) Amount					

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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								
8	Ren	ofit ar	nd contract type (check all applicable boxes)		in each earlier may	50			13 10		
Ŭ	г	-	ealth (other than dental or vision)	b Dental		c 🗆	Vision		d∏	Life insurance	
	a	_		. 🛏							
	e	Те	mporary disability (accident and sickness)		-		Supplemental unemp	oloyment	h	Prescription drug	
	i	Sto	op loss (large deductible)	j 🗙 HMO con	tract	K	PPO contract		Ι	Indemnity contract	
	m	Ot	her (specify)								
9	Expe	erienc	ce-rated contracts:								
	a		iums: (1) Amount received						_		
		(2) Ir	ncrease (decrease) in amount due but unpaid	k					_		
		(3) Ir	crease (decrease) in unearned premium res	erve				1			
	_	• •	arned ((1) + (2) - (3))		1			. 9a(4)	_		0
	b	Ben	efit charges (1) Claims paid						4		
		• •	ncrease (decrease) in claim reserves								
		(3) Ir	ncurred claims (add (1) and (2))					9b(3)	_		0
		• •	laims charged					9b(4)			
	С		nainder of premium: (1) Retention charges (o						4		
			(A) Commissions						4		
			(B) Administrative service or other fees						4		
			(C) Other specific acquisition costs						4		
			(D) Other expenses			-			4		
			(E) Taxes						4		
			(F) Charges for risks or other contingencies.		a (1)(a				4		
			(G) Other retention charges			-		00(1)(1)			0
			(H) Total retention	-	_			9c(1)(H)			0
			Dividends or retroactive rate refunds. (These	L				9c(2)	_		
	d		us of policyholder reserves at end of year: (1	,	•			9d(1)	_		
		• •	Claim reserves					9d(2)	_		
		(-)	Other reserves					9d(3)	_		
4.0			dends or retroactive rate refunds due. (Do no	ot include amour	nt entered in line 9c	:(2)	.)	9e	_		
10	_		erience-rated contracts:					10			
	a		I premiums or subscription charges paid to c					10a	_	2771	469
	b		e carrier, service, or other organization incurr ation of the contract or policy, other than repo					10b			

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

SCHEDULE (Form 5500) Department of the Treas Internal Revenue Servi Department of Labor Employee Benefits Security Ad	y) sury ice r ministration	This schedule is required Employee Retirement Inc	ired to be filed under section 104 of the t Income Security Act of 1974 (ERISA).			OMB No. 1210-0110 2016	
Pension Benefit Guaranty Co	rporation	 Insurance companies ar pursuant to El 	re required to provide t RISA section 103(a)(2)		ion		m is Open to Public Inspection
For calendar plan year 20	16 or fiscal plan	year beginning 01/01/2016		and en	iding 12/3	1/2016	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (P	N) ►	504
C Plan sponsor's name a ALCATEL-LUCENT USA I		e 2a of Form 5500			oyer Identific 3408857	cation Number ((EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca HORIZON BCBS OF NJ		(1) 2	(e) Approximate n	umber of		Policy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	at end of	(f)	From	(g) ⊤o
22-0999690	55069	67-77087	1		01/01/201	6	12/31/2016
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	I commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comr	nissions paid		(b) To	otal amount	of fees paid	
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all	persons).			
		nd address of the agent, broker, o			ions or fees	were paid	
(b) Amount of sales ar		Fees	and other commissio	ns paid			
commissions paid		(c) Amount	(d) Purpose			(e) Organization code	
	(a) Name o	nd address of the agent, broker, o	or other person to who	m commise	ions or fear	were paid	
	(a) Name a	The address of the agent, broker, t					

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	dule A (Form 5500) 2016		
			400005

v. 160205

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	4			
5	Curr	ent 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	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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								
8	Ren	ofit ar	nd contract type (check all applicable boxes)		in each carner may	50			1310		
Ŭ	a	_	ealth (other than dental or vision)	b Dental		сГ	Vision		d∏	Life insurance	
	L F	_		. 💾			-				
	e	Те	mporary disability (accident and sickness)				Supplemental unemp	oloyment	h	Prescription drug	
	i	Sto	op loss (large deductible)	j 🗙 HMO con	tract	k	PPO contract		I	Indemnity contract	
	m	Ot	her (specify)								
9	Expe	erienc	ce-rated contracts:								
	a	Prem	iums: (1) Amount received						_		
		(2) Ir	ncrease (decrease) in amount due but unpaid	k							
		(3) Ir	ncrease (decrease) in unearned premium res	erve				1			
	_	• •	arned ((1) + (2) - (3))					. 9a(4)			0
	b	Ben	efit charges (1) Claims paid						_		
		• •	ncrease (decrease) in claim reserves					1			
		(3) Ir	ncurred claims (add (1) and (2))					9b(3)			0
		• •	Claims charged					9b(4)			
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual bas					_		
		((A) Commissions						_		
			(B) Administrative service or other fees						_		
			(C) Other specific acquisition costs						4		
		((D) Other expenses			-			_		
			(E) Taxes						4		
			(F) Charges for risks or other contingencies .		A (1)/A				4		
			(G) Other retention charges			-		0.4141			
			(H) Total retention	=	_	_		9c(1)(H)			0
			Dividends or retroactive rate refunds. (These	L.				9c(2)			
	d		us of policyholder reserves at end of year: (1	,	•			9d(1)			
		(2) (Claim reserves					9d(2)			
		(3) (Other reserves					9d(3)			
			dends or retroactive rate refunds due. (Do no	ot include amour	nt entered in line 90	c(2)	.)	9e			_
10) No		erience-rated contracts:								
	а	Tota	al premiums or subscription charges paid to c	arrier				10a	_	20	046
	b		e carrier, service, or other organization incurr ntion of the contract or policy, other than repu					10b			

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

SCHEDULE A Insurance Information (Form 5500) Experiment of the Treasury This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). Department of Labor File as an attachment to Form 5500.			OMB No. 1210-0110				
Pension Benefit Guaranty Co	rporation	 Insurance companies ar pursuant to El 	e required to provide t RISA section 103(a)(2)		tion	This For	m is Open to Public Inspection
For calendar plan year 207	16 or fiscal plan	year beginning 01/01/2016		and er	nding 12/3	1/2016	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (P	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA I		e 2a of Form 5500			oyer Identific 3408857	cation Number	(EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance car UHC OF CALIFORNIA		(1) Contract or	(e) Approximate nu	umber of		Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	t end of	(f)	From	(g) To
95-2931460	00000	142111	165		01/01/201	6	12/31/2016
2 Insurance fee and commended descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comr	nissions paid		(b) To	otal amount	of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales ar	nd base	Fees	and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpos	е		(e) Organization code
	(a) Name o	nd address of the agent, broker, o	or other person to who	m commiss	ions or fear	were paid	
		na address of the ayent, bloker, t				were paiu	

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
For Paperwork Reduction Act Notice	dule A (Form 5500) 2016			

v. 160205

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may						as a unit for nurnages of				
		this report.		icis with each camer ma	y be treated	as a unit for purposes of				
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4					
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5					
6	Con	tracts With Allocated Funds:								
	а	State the basis of premium rates								
					·					
	b	Premiums paid to carrier			6b					
	С	Premiums due but unpaid at the end of the year			6C					
	d	If the carrier, service, or other organization incurred any specific costs in co			6d					
		retention of the contract or policy, enter amount								
		Specify nature of costs								
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity							
	е		u annuity							
		(3) other (specify)								
				_						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here						
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)						
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee						
		(3) guaranteed investment (4) other								
	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)							
		•								
		(6)Total additions			7c(6)	0				
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0				
	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)							
		•								
		(5) Total deductions			7e(5)	0				
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0				

Ρ	art		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 su	uch contracts are ex	perience-rated as a un	it. Where cont	tracts cover individual
8	Ren	efit ar	nd contract type (check all applicable boxes)		reach carner may b			
Ŭ	a	-	ealth (other than dental or vision)	b Dental	c	Vision	d	Life insurance
	L F	_		. 💾				
	е	Те	mporary disability (accident and sickness)	f Long-term		Supplemental unem	ployment h	Prescription drug
	i [Sto	op loss (large deductible)	j 🗙 HMO cont	tract k	PPO contract	I	Indemnity contract
	m	Ot	her (specify) 🕨					
		_						
9	•		e-rated contracts:					
	a		iums: (1) Amount received					
			ncrease (decrease) in amount due but unpaid					
		• •	ncrease (decrease) in unearned premium res					
		• •	arned ((1) + (2) - (3))				9a(4)	С
	b	Bene	efit charges (1) Claims paid					
		``	ncrease (decrease) in claim reserves					
		• •	ncurred claims (add (1) and (2))				9b(3)	C
	_	• •	laims charged				9b(4)	
	С		nainder of premium: (1) Retention charges (c					
		```	(A) Commissions					
		```	(B) Administrative service or other fees					
		```	(C) Other specific acquisition costs		a (1)(D)			
		```	(D) Other expenses		0.(1)(5)			
		```	<ul> <li>(E) Taxes</li> <li>(F) Charges for risks or other contingencies .</li> </ul>					
		```	(G) Other retention charges		a (1)(a)			
		```	(H) Total retention				9c(1)(H)	(
		```	Dividends or retroactive rate refunds. (These	_	- –		9c(2)	
	d		us of policyholder reserves at end of year: (1				9d(1)	
	ŭ		Claim reserves				9d(2)	
		• •	Other reserves				9d(3)	
	е	()	dends or retroactive rate refunds due. (Do n				9e	
10			erience-rated contracts:			,,		
-	а		Il premiums or subscription charges paid to c	arrier			10a	983453
	b		e carrier, service, or other organization incur					
			ntion of the contract or policy other than rep				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 ar	nswer to line 11 is "Yes," specify the information not provided.			

SCHEDULE		Insuranc	e Information	n		ON	IB No. 1210-0110
(Form 5500 Department of the Treat		This schedule is required	to be filed under section	on 104 of th	e		<u> </u>
Internal Revenue Serv	rice	Employee Retirement Income Security Act of 1974 (ERISA).				2016	
Department of Labo Employee Benefits Security Ac		▶ File as an attachment to Form 5500.					
Pension Benefit Guaranty Co	orporation	 Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). 			This For	m is Open to Public Inspection	
			and en	ding 12/3	1/2016		
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (Pl	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		-	yer Identific 3408857	cation Number	(EIN)
		ning Insurance Contract					
1 Coverage Information:						0	
(a) Name of insurance ca PARTNERS NATL HEALT	H PLANS OF N		(e) Approximate nu	umber of		Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	t end of	(f)	From	(g) To
56-0894904	54631	011453	620		01/01/2010	6	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
	amount of com	missions paid		(b) To	otal amount	of fees paid	
3 Persons receiving com		ees. (Complete as many entries a					
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	Fees	and other commission	ns paid			_
commissions pa	id	(c) Amount		(d) Purpose	Э		(e) Organization code
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were naid	
	(a) Name a	ina address of the agent, DIOKEL, C		01111155		were paiu	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice, see the Instructions for Form 5500.			Schedule A (Form 5500) 2016

Т

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Т

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		Welfare Benefit Contract Information If more than one contract covers the same			0 0000 000		vor(c) or mombors of	the same o	mploy	voo organizations(s)	
			the information may be combined for report	ing pi	urposes if such cont	racts are ex	εpe	rience-rated as a unit	. Where co	ontract	ts cover individual	
			employees, the entire group of such individ	ual co	ontracts with each ca	arrier may be	e	reated as a unit for pu	irposes of t	his rep	port.	
8	Ben	_	nd contract type (check all applicable boxes)	. –	7					. —		
	а	He	ealth (other than dental or vision)	b	Dental	С		Vision		d	Life insurance	
	е	Te	mporary disability (accident and sickness)	f	Long-term disabili	ty g		Supplemental unemp	oloyment	h	Prescription drug	
	i [Sto	op loss (large deductible)	јX	HMO contract	k		PPO contract		I 🗌	Indemnity contract	
	m	Ot	her (specify)									
												_
9	Expe	eriend	ce-rated contracts:				-			_		
	a		iums: (1) Amount received			9a(1)				_		
		• •	ncrease (decrease) in amount due but unpaid									
		• •	ncrease (decrease) in unearned premium res			· · · · ·						
			arned ((1) + (2) - (3))						9a(4)	-		0
	b		efit charges (1) Claims paid							_		
		``	ncrease (decrease) in claim reserves			,						
		(3) Ir	ncurred claims (add (1) and (2))						9b(3)	_		0
		• •	Claims charged						9b(4)			_
	С	Rem	nainder of premium: (1) Retention charges (o	n an a	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)				4		
			(F) Charges for risks or other contingencies .							_		
			(G) Other retention charges				_			_		
			(H) Total retention		_				9c(1)(H))		0
		(2) [Dividends or retroactive rate refunds. (These	amo	unts were paid ir	n cash, or	C	redited.)	9c(2)			
	d		us of policyholder reserves at end of year: (1	,	•				9d(1)			
		(2) (Claim reserves						9d(2)			
		(3) (Other reserves						9d(3)			
	е	Divi	dends or retroactive rate refunds due. (Do n	ot incl	ude amount entered	d in line 9c(2	2).)	9e	_		
10) No		erience-rated contracts:									
	а	Tota	al premiums or subscription charges paid to c	arrier					10a		7304	44
	b		e carrier, service, or other organization incurrent of the contract or policy, other than repu						10b			

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

SCHEDULE (Form 5500))		ce Information	the	OM	1B No. 1210-0110
Department of the Treas Internal Revenue Serv			to be filed under section 104 of ome Security Act of 1974 (ERIS			2016
Department of Labo Employee Benefits Security Ad		File as an at	tachment to Form 5500.			
Pension Benefit Guaranty Co	orporation		re required to provide the inform RISA section 103(a)(2).	ation	This For	m is Open to Public Inspection
For calendar plan year 20	16 or fiscal plar	year beginning 01/01/2016	and	ending 12/3	31/2016	-
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN		ree-digit an number (P	YN) ►	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		oloyer Identifi 2-3408857	cation Number	(EIN)
on a separ		ning Insurance Contract Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca UHC OF OKLAHOMA	rrier					
	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or contract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f)) From	(g) To
33-0115166	96903	008102	93	01/01/201	6	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. List in line	3 the agents	, brokers, and c	ther persons in
(a) Total	amount of comr	nissions 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 persons)			
	(a) Name a	nd address of the agent, broker, o	or other person to whom commi	ssions or fees	s were paid	
(b) Amount of sales an			s and other commissions paid			4
commissions paid (c) Amount		(c) Amount	(d) Purpo	ose		(e) Organization code
		nd address of the agent, broker, o				

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notic	dule A (Form 5500) 2016		
			v. 160205

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

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

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

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

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

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

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

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

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

I	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	4			
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(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

Ρ	art		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 su	uch contracts are ex	perience-rated as a un	it. Where cont	tracts cover individual	
8	Bon	ofit ar	nd contract type (check all applicable boxes)		reach canter may b	e treated as a unit for p			—
U	Г								
	a		ealth (other than dental or vision)	b Dental		Vision		Life insurance	
	е	Te	mporary disability (accident and sickness)	f Long-term		Supplemental unem	ployment h	Prescription drug	
	i [Sto	op loss (large deductible)	j 🗙 HMO cont	tract k	PPO contract	l	I Indemnity contract	
	m	Ot	her (specify)						
9	Expe	erienc	ce-rated contracts:			1			
	a		iums: (1) Amount received						
		(2) In	ncrease (decrease) in amount due but unpaid	t					
		• •	ncrease (decrease) in unearned premium res				1		
		• •	arned ((1) + (2) - (3))				9a(4)		0
	b	Bene	efit charges (1) Claims paid						
		``	ncrease (decrease) in claim reserves						
		. ,	ncurred claims (add (1) and (2))				9b(3)		0
		` '	laims charged				9b(4)		
	С		nainder of premium: (1) Retention charges (c						
		```	(A) Commissions						
		```	(B) Administrative service or other fees						
		```	(C) Other specific acquisition costs						
		```	(D) Other expenses		0.(1)(5)				
		```	(E) Taxes						
		```	(F) Charges for risks or other contingencies. (G) Other retention charges		a (1)(a)				
		```	(H) Total retention				9c(1)(H)		0
		```	Dividends or retroactive rate refunds. (These						Ť
	Ч		us of policyholder reserves at end of year: (1		-		9c(2) 9d(1)		—
	a		Claim reserves				9d(1) 9d(2)		—
		• •	Dither reserves				9d(2) 9d(3)		
	e	``	dends or retroactive rate refunds due. (Do n				9e		—
10			erience-rated contracts:			-, .,			
	a		al premiums or subscription charges paid to c	arrier			10a	4899	56
	b		e carrier, service, or other organization incuri					1000	
			ntion of the contract or policy other than rep				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 ar	nswer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuranc	e Information				
(Form 5500))					OM	B No. 1210-0110
Department of the Treas Internal Revenue Serv		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2016
Department of Labo Employee Benefits Security Ad		File as an at	ttachment to Form 5500	0.			
Pension Benefit Guaranty Co	orporation	 Insurance companies ar pursuant to El 	re required to provide the RISA section 103(a)(2).	e informat	ion		m is Open to Public Inspection
	16 or fiscal plan	year beginning 01/01/2016		and en	ding 12/3	1/2016	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN	-	B Three plan	e-digit number (P	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		•	yer Identific 3408857	cation Number ((EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:		÷ .					
(a) Name of insurance ca HUMANA HEALTH PLANS		(d) Contract or	(e) Approximate num			Policy or co	pntract year
(b) EIN	code	identification number	persons covered at e policy or contract y		(f)	From	(g) To
61-1013183	95885	*SEE BELOW	224		01/01/201	6	12/31/2016
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	I commissions paid. List	t in line 3	the agents,	brokers, and of	ther persons in
(a) Total amount of commissions paid (b) Tot			otal amount	tal amount of fees paid			
3 Persons receiving com		es. (Complete as many entries a		,			
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commiss	ions or fees	were paid	
(b) Amount of sales and base Fees and other commissions paid							
commissions paid		(c) Amount	(d) Purpose			(e) Organization code	
		nd address of the agent, broker, o	or other person to whom	commiss	ions or foor	were paid	
	(a) Name a	nu audress or the agent, broker, t		COMINISS		were paid	

(b) Amount of sales and base	F				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
For Paperwork Reduction Act Notice	lule A (Form 5500) 2016				

v. 160205

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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								
8	Ben	efit a	nd contract type (check all applicable boxes)								
Ū	a	_	ealth (other than dental or vision)	b	Dental	c	Π	Vision		d∏	Life insurance
	L F	_	· ,	. H	1						
	e	_	mporary disability (accident and sickness)	f		-	_	Supplemental unemp	oloyment	n	Prescription drug
	i	Sto	op loss (large deductible)	јX	HMO contract	k		PPO contract			Indemnity contract
	m	Ot	her (specify)								
										_	
9	Expe	erienc	ce-rated contracts:				_			_	
	a		iums: (1) Amount received			9a(1)				_	
		• •	ncrease (decrease) in amount due but unpai			9a(2)				_	
		. ,	ncrease (decrease) in unearned premium res			9a(3)				_	
			arned ((1) + (2) - (3))						. 9a(4)		С
	b		efit charges (1) Claims paid			9b(1)	_			_	
		• •	ncrease (decrease) in claim reserves			9b(2)			01 (0)	_	
		• •	ncurred claims (add (1) and (2))						9b(3)		C
	•	• •	Claims charged				••••		9b(4)	_	
	С		nainder of premium: (1) Retention charges (c			00(1)(A)				-	
			(A) Commissions (B) Administrative service or other fees			9c(1)(A) 9c(1)(B)				-	
			(C) Other specific acquisition costs			9c(1)(C)				-	
			(D) Other expenses			9c(1)(D)	_			-	
			(E) Taxes			9c(1)(E)	_				
			(F) Charges for risks or other contingencies.			9c(1)(F)					
			(G) Other retention charges			9c(1)(G)					
			(H) Total retention						9c(1)(H)		C
		(2) E	Dividends or retroactive rate refunds. (These	amo	unts were paid in	cash, or	c	redited.)	9c(2)		
	d		us of policyholder reserves at end of year: (1						9d(1)		
		(2) (Claim reserves	, 	·				9d(2)		
		(3) (Other reserves						9d(3)		
	е	Divio	dends or retroactive rate refunds due. (Do n	ot incl	ude amount entered	d in line 9c(2	2).)	9e		
10) No	nexp	erience-rated contracts:								
	а	Tota	al premiums or subscription charges paid to o	arrier					10a		711801
	b	If the	e carrier, service, or other organization incur	red an	y specific costs in c	onnection w	vitł	n the acquisition or			
		rete	ntion of the contract or policy, other than rep	orted i	in Part I, line 2 abov	e report an	no	unt	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 ar	nswer to line 11 is "Yes," specify the information not provided.			

				ce Information	n		ОМ	B No. 1210-0110
Depa	Form 5500 Intrment of the Treas Inal Revenue Serv	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2016
D	epartment of Laborenefits Security Ad	r		attachment to Form 55	•).		2010
	enefit Guaranty Co		Insurance companies		he informa	ion		m is Open to Public Inspection
For calenda	r plan year 20	16 or fiscal plar	year beginning 01/01/2016	(u) (0000000 (000(u)(_)	and er	Iding 12/31/20		Inspection
A Name of NOKIA RET		RE BENEFITS	PLAN			e-digit number (PN)	•	504
	nsor's name a UCENT USA I		2a of Form 5500		-	oyer Identification 3408857	n Number (EIN)
Part I	on a separa		ning Insurance Contrac Individual contracts grouped a					
1 Coverage	e Information:							
.,	f insurance ca ITAN LIFE INS	rrier SURANCE CON	IPANY					
		(c) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or co	ontract year
(b)	EIN	code	identification number	persons covered at end o policy or contract year		(f) Fro	m	(g) To
3-5581829		65978	95083-G	85375		01/01/2016		12/31/2016
	e fee and coming order of the		tion. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, brok	kers, and of	ther persons in
	(a) Total a	amount of comr			(b) T	otal amount of fe	es paid	
			171667					718919
3 Persons	receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		(a) Name a	nd address of the agent, broker,	· · · · · · · · · · · · · · · · · · ·	m commiss	ions or fees wer	e paid	
AON CONSL	JLTING			NETWORK PI GO, IL 60673-1298				
(b) Amo	unt of sales ar	nd base	Fe	es and other commission	ns paid			
	mmissions pai		(c) Amount		(d) Purpos			(e) Organization code
		171667	718919 Al M	DMIN FEES SUPPLEME ONETARY COMPENSA	ENTAL CO TION	MPENSATION N	NON-	3
		(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees wer	e paid	·
		- d b - s	Fo	es and other commission	ns paid			
	unt of sales ar mmissions pai		(c) Amount		(d) Purpos	۵		(e) Organization code

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art	If mor the int	are Benefit Contract Inform e than one contract covers the same formation may be combined for repor oyees, the entire group of such individ	group of employee	ch contracts are exp	erience-rated as a unit	. Where contra	cts cover individual
8	Ben	efit and cont	ract type (check all applicable boxes)	1				
	a	Health (ot	her than dental or vision)	b Dental	С	Vision	d	Life insurance
	е	Temporar	y disability (accident and sickness)	f Long-term	disability g	Supplemental unemp	oloyment h	Prescription drug
	iΓ		(large deductible)	j HMO contr		PPO contract	I	Indemnity contract
	m	Other (sp		, [] into conta			- [
		Other (sp	echy) 🖡					
9	Expe	erience-rated	contracts:					
-			1) Amount received				1472704	
		(2) Increase	(decrease) in amount due but unpai	d				
			(decrease) in unearned premium res					
		(4) Earned	((1) + (2) - (3))				. 9a(4)	1472704
	b	Benefit cha	rges (1) Claims paid				85583487	
		(2) Increase	e (decrease) in claim reserves				-733603	
		(3) Incurred	claims (add (1) and (2))				9b(3)	84849884
		(4) Claims of	harged				9b(4)	84849884
	С	Remainder	of premium: (1) Retention charges (c	on an accrual basis	·			
		(A) Con	nmissions				171667	
		(B) Adn	ninistrative service or other fees					
		()	er specific acquisition costs					
		(D) Oth	er expenses				1905877	
		()	es				1224704	
			rges for risks or other contingencies				513421	
			er retention charges				-1119345	0000004
		()	al retention	_	_		9c(1)(H)	2696324
			ds or retroactive rate refunds. (These				9c(2)	395394
	d	•	olicyholder reserves at end of year: (1	, ,			9d(1)	269218320
		· /	eserves				9d(2)	22387251
	-	(-)	eserves				9d(3)	
10			or retroactive rate refunds due. (Do n	ot include amount	entered in line 9c(2)	.)	9e	
10		•	-rated contracts:	orrior			102	
	a		ums or subscription charges paid to				10a	
	b		r, service, or other organization incur the contract or policy, other than rep				10b	

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

SCHEDULE (Form 5500 Department of the Treas)	Insurance This schedule is required	to be filed under section		ne.	OM	IB No. 1210-0110
Internal Revenue Servi	ice	Employee Retirement Income Security Act of 1974 (ERISA).				2016	
Department of Labor Employee Benefits Security Ad		File as an at	tachment to Form 55	600.			
Pension Benefit Guaranty Co	rporation	 Insurance companies ar pursuant to EF 	e required to provide t RISA section 103(a)(2)		lion	This For	m is Open to Public Inspection
	16 or fiscal plar	year beginning 01/01/2016		and er	nding 12/3	31/2016	T
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (P	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA I		e 2a of Form 5500			oyer Identific 3408857	cation Number	(EIN)
		ning Insurance Contract					
1 Coverage Information:							
(a) Name of insurance ca AETNA HEALTH PLANS	rrier	(d) Contract or	(e) Approximate ni			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
52-1270921	95287	*SEE BELOW	106	;	01/01/201	6	12/31/2016
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comr	nissions paid		(b) To	otal amount	of fees paid	
3 Persons receiving com		es. (Complete as many entries a	•	. /			
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales ar			s and other commissio				4
commissions paid		(c) Amount		(d) Purpos	e		(e) Organization code
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Sched			edule A (Form 5500) 2016

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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 su	uch contracts are e	expe	erience-rated as a unit	. Where co	ntrac	ts cover individual	
8	Ren	ofit ar	nd contract type (check all applicable boxes)		reach camer may	be			113 10	port.	
U	Г						Vicion		ч П	Life incurrence	
	a		ealth (other than dental or vision)	b Dental			Vision		d	Life insurance	
	е	Te	mporary disability (accident and sickness)	f Long-term			Supplemental unemp	oloyment	h	Prescription drug	
	i [Sto	op loss (large deductible)	j 🗙 HMO cont	tract k	(PPO contract			Indemnity contract	
	m	Ot	her (specify)								
9	Expe	erienc	ce-rated contracts:								
	a		iums: (1) Amount received								
		(2) In	ncrease (decrease) in amount due but unpaid	k							
		(3) In	ncrease (decrease) in unearned premium res	erve				I			
	_	• •	arned ((1) + (2) - (3))					9a(4)			0
	b	Bene	efit charges (1) Claims paid						_		
		``	ncrease (decrease) in claim reserves					1			
		(3) In	ncurred claims (add (1) and (2))					9b(3)	_		0
		` '	Claims charged					9b(4)			_
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basi					_		
		```	(A) Commissions						_		
		```	(B) Administrative service or other fees						_		
		```	(C) Other specific acquisition costs			_			4		
		```	(D) Other expenses			-			4		
		```	(E) Taxes			_			4		
		```	(F) Charges for risks or other contingencies .		a (1)(a				4		
		```	(G) Other retention charges			· .		0.4141			_
		```	(H) Total retention			_		9c(1)(H)			0
			Dividends or retroactive rate refunds. (These					9c(2)	_		
	d		us of policyholder reserves at end of year: (1					9d(1)	_		
		(2) C	Claim reserves					9d(2)	_		
		(3) C	Other reserves					9d(3)	_		
			dends or retroactive rate refunds due. (Do n	ot include amoun	t entered in line 9c	(2).)	9e	_		_
10	No		erience-rated contracts:								
	а	Tota	al premiums or subscription charges paid to c	arrier				10a		6460	59
	b		e carrier, service, or other organization incuri					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 ar	nswer to line 11 is "Yes," specify the information not provided.			

SCHEDULE (Form 5500		Insuranc	ce Information	I		OM	B No. 1210-0110	
Department of the Treas Internal Revenue Serv	sury rice	This schedule is required Employee Retirement Inc					2016	
Department of Labo Employee Benefits Security Ad		File as an at	ttachment to Form 550	00.				
Pension Benefit Guaranty Co	orporation	 Insurance companies an pursuant to El 	re required to provide th RISA section 103(a)(2).		ion		orm is Open to Public Inspection	
For calendar plan year 20	16 or fiscal plan	year beginning 01/01/2016		and en	iding 12/3	1/2016		
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN		B Thre plan	e-digit number (P	N) •	504	
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		•	oyer Identific 3408857	cation Number ((EIN)	
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca BLUE ADVANTAGE	(c) NAIC	(d) Contract or	(e) Approximate nu	mber of		Policy or co	ontract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To	
36-1236610	70670	H73525,B73524	21 01/01		01/01/201	6	12/31/2016	
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. Lis	st in line 3	the agents,	brokers, and o	ther persons in	
(a) Total a	amount of comr	nissions paid		(b) To	otal amount	of fees paid		
3 Persons receiving com		ees. (Complete as many entries a		,				
	(a) Name a	nd address of the agent, broker, o	or other person to whon	n commiss	ions or fees	s were paid		
(b) Amount of sales ar			s and other commission					
commissions pa	id	(c) Amount	(d) Purpos	6		(e) Organization code	
	(a) Name a	nd address of the agent, broker, o	or other person to whom	n commiss	ions or fees	were paid		
	(,							

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Schedule				
			100005	

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		Welfare Benefit Contract Information If more than one contract covers the same		of the same amply	over(a) or members of	the same amp	lovoo organizationa(a)
			the information may be combined for report					
			employees, the entire group of such individ	lual contracts with eac	ch carrier may be	treated as a unit for pu	urposes of this	report.
8	Ben	efit a	nd contract type (check all applicable boxes)			_		
	а	He	ealth (other than dental or vision)	b Dental	c	Vision	d	Life insurance
	е	Те	mporary disability (accident and sickness)	f 🗌 Long-term disa	ability g	Supplemental unemp	oloyment h	Prescription drug
	i [Sto	op loss (large deductible)	j 🗙 HMO contract	k	PPO contract	I	Indemnity contract
	m	Ot	her (specify)					
	L							
9	Expe	eriend	ce-rated contracts:					
	а	Prem	iums: (1) Amount received		9a(1)			
		(2) Ir	ncrease (decrease) in amount due but unpaid	d	9a(2)			
		(3) Ir	ncrease (decrease) in unearned premium res	serve	9a(3)		-	
		(4) E	arned ((1) + (2) - (3))				9a(4)	0
	b	Ben	efit charges (1) Claims paid					
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)			
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)	0
		(4) C	Claims charged				9b(4)	
	С	Rem	nainder of premium: (1) Retention charges (o	on an accrual basis)				
			(A) Commissions		9c(1)(A)			
			(B) Administrative service or other fees					
			(C) Other specific acquisition costs					
			(D) Other expenses					
			(E) Taxes					
			(F) Charges for risks or other contingencies .					
			(G) Other retention charges		9c(1)(G)			
			(H) Total retention				9c(1)(H)	0
		(2) [Dividends or retroactive rate refunds. (These	e amounts were pa	id in cash, or	credited.)	9c(2)	
	d	Stat	us of policyholder reserves at end of year: (1) Amount held to prov	vide benefits after	retirement	9d(1)	
		(2) (Claim reserves				9d(2)	
		(3) (Other reserves				9d(3)	
	е	Divi	dends or retroactive rate refunds due. (Do n	ot include amount ent	ered in line 9c(2)	.)	9e	
10) No	nexp	erience-rated contracts:					
	а	Tota	al premiums or subscription charges paid to c	carrier			10a	372519
	b		e carrier, service, or other organization incurrent of the contract or policy, other than report				10b	

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

SCHEDULE A (Form 5500)		Insuranc	e Informatior	ı		ON	1B No. 1210-0110
Department of the Treas Internal Revenue Serv	sury ice	This schedule is required Employee Retirement Inc					2016
Department of Labo Employee Benefits Security Ad		File as an at	ttachment to Form 550	00.			
Pension Benefit Guaranty Co	prporation	 Insurance companies an pursuant to El 	re required to provide th RISA section 103(a)(2).		tion	This For	m is Open to Public Inspection
	16 or fiscal plar	year beginning 01/01/2016		and er	nding 12/3	1/2016	Γ
A Name of plan NOKIA RETIREE WELFARE BENEFITS PLAN					e-digit number (Pl	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500		•	oyer Identific 3408857	cation Number	(EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca AETNA LIFE INSURANCE							
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or contract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
06-6033492	60054	0700140-RET	24114		01/01/201	6	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. Lis	st in line 3	the agents,	brokers, and c	other persons in
(a) Total a	amount of comr	nissions 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 p	persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whon	n commiss	ions or fees	were paid	
(b) Amount of sales ar			s and other commission				4
commissions pa	id	(c) Amount	(d) Purpos	e		(e) Organization code
		nd address of the agent burgling	or other nerson to when		iono orfe	wara naid	
	(a) Name a	nd address of the agent, broker, o	or other person to whom	n commiss	ions or tees	were paid	

Fees an			
(c) Amount	(d) Purpose	(e) Organization code	
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Sc			
	(c) Amount		

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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						
8	Ren	ofit ar	nd contract type (check all applicable boxes)		reach carner may b				
Ŭ	a	_	ealth (other than dental or vision)	b X Dental	C	Vision		Life insurance	
	L F	_		. 🗄					
	е	Те	mporary disability (accident and sickness)	f Long-term		Supplemental unem	ployment r	Prescription drug	
	i	Sto	op loss (large deductible)	j 📙 HMO cont	tract k	PPO contract		Indemnity contract	ct
	m	Ot	her (specify)						
9	Expe	erienc	e-rated contracts:			1			
	a		iums: (1) Amount received						
			ncrease (decrease) in amount due but unpaid						
		• •	ncrease (decrease) in unearned premium res						
		• •	arned ((1) + (2) - (3))				9a(4)		0
	b	Bene	efit charges (1) Claims paid						
		``	ncrease (decrease) in claim reserves						
		• •	ncurred claims (add (1) and (2))				9b(3)		0
	_	• •	laims charged				9b(4)		
	С		nainder of premium: (1) Retention charges (c						
		```	(A) Commissions						
			(B) Administrative service or other fees						
			(C) Other specific acquisition costs		a (1)(D)			{	
		``	(D) Other expenses		0.(1)(5)				
		```	<ul> <li>(E) Taxes</li> <li>(F) Charges for risks or other contingencies .</li> </ul>						
			(G) Other retention charges		a (1)(a)				
		``	(H) Total retention				9c(1)(H)		0
		``	Dividends or retroactive rate refunds. (These	_		-	9c(2)		
	d		us of policyholder reserves at end of year: (1		-	4	9d(1)		
	ŭ		Claim reserves				9d(2)		
		. ,	Other reserves				9d(3)		
	е	• •	dends or retroactive rate refunds due. (Do n				9e		
10			erience-rated contracts:			,,			
-	а	•	Il premiums or subscription charges paid to c	arrier			10a	11	289128
	b		e carrier, service, or other organization incur						
			ntion of the contract or policy other than rep				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 ar	swer to line 11 is "Yes," specify the information not provided.			

SCHEDULE A (Form 5500)		Insuranc	e Information	n		OM	B No. 1210-0110
Department of the Treas Internal Revenue Serv	sury vice	This schedule is required Employee Retirement Inc					2016
Department of Labo Employee Benefits Security Ad		File as an at	ttachment to Form 55	00.			
Pension Benefit Guaranty Co	prporation	 Insurance companies an pursuant to El 	re required to provide to RISA section 103(a)(2)		tion		m is Open to Public Inspection
	16 or fiscal plan	year beginning 01/01/2016		and er	nding 12/3	1/2016	I
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit 1 number (P	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA		2a of Form 5500			oyer Identific 3408857	cation Number (EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca HUMANA HEALTH PLANS	S, INC.	1	(e) Approximate nu	imber of	Ι	Policy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac	t end of	(f)	From	(g) To
61-1103898	95270	* SEE BELOW 55			01/01/201	6	12/31/2016
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	I commissions paid. Li	ist in line 3	the agents,	brokers, and of	ther persons in
(a) Total a	amount of comn	nissions paid		(b) To	otal amount	of fees paid	
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whor	m commiss	ions or fees	were paid	
(b) Amount of sales ar			s and other commission				-
commissions pa	id	(c) Amount		(d) Purpos	e		(e) Organization code
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice, see the Instructions for Form 5500.			dule A (Form 5500) 2016
			100005

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

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

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

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

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

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

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

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

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

Part II			who trooted	as a unit for nurnages of		
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year		4		
5	Curr	ent 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	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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 si	uch contracts are e	xperi	ence-rated as a unit	. Where co	ntract	s cover individual	
8	Bon	ofit ar	nd contract type (check all applicable boxes)		reach camer may r				113 164	John.	
U	Г	-				Π,	<i>l</i> 'aiaa		ا ل		
	a	_	alth (other than dental or vision)	b Dental			Vision			Life insurance	
	е	Te	mporary disability (accident and sickness)	f Long-term			Supplemental unemp	oloyment	h	Prescription drug	
	i [Sto	op loss (large deductible)	j 🗙 HMO cont	tract k	F	PPO contract			Indemnity contract	
	m	Ot	her (specify)								
9	Expe	erienc	ce-rated contracts:								
	a		iums: (1) Amount received								
		(2) In	ncrease (decrease) in amount due but unpaid	t							
		(3) In	ncrease (decrease) in unearned premium res	erve							
	_	• •	arned ((1) + (2) - (3))			<u></u>		9a(4)	_		0
	b	Bene	efit charges (1) Claims paid								
		• •	ncrease (decrease) in claim reserves					1			
		(3) In	ncurred claims (add (1) and (2))	••••••		•••••		9b(3)	_		0
		• •	laims charged			•••••		9b(4)			
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual bas		-					
		```	(A) Commissions						_		
		```	(B) Administrative service or other fees						_		
		```	(C) Other specific acquisition costs						4		
		```	(D) Other expenses						4		
		```	(E) Taxes						4		
		```	(F) Charges for risks or other contingencies .		a (1)(a)				4		
		```	(G) Other retention charges					0.(1)(1)			
		```	(H) Total retention	_		-		9c(1)(H)			0
			Dividends or retroactive rate refunds. (These		-			9c(2)	_		
	d		us of policyholder reserves at end of year: (1					9d(1)	_		
		(2) C	Claim reserves			•••••		9d(2)	_		
		(3) C	Other reserves					9d(3)	_		
			dends or retroactive rate refunds due. (Do no	ot include amoun	t entered in line 9c	(2) .)		9e	_		
10	No	•	erience-rated contracts:								
	а	Tota	I premiums or subscription charges paid to c	arrier				10a	+	73	8669
	b		e carrier, service, or other organization incurr					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 ar	nswer to line 11 is "Yes," specify the information not provided.			

SCHEDULE A (Form 5500)		Insuranc	ce Information		ОМ	B No. 1210-0110
Department of the Trea Internal Revenue Serv	sury vice		to be filed under section 104 of t come Security Act of 1974 (ERIS			2016
Department of Labo Employee Benefits Security Ac		File as an a	ttachment to Form 5500.			
Pension Benefit Guaranty Co	orporation		re required to provide the informa RISA section 103(a)(2).	ation	This For	m is Open to Public Inspection
	16 or fiscal plar	year beginning 01/01/2016	and e	nding 12/3	31/2016	1
A Name of plan NOKIA RETIREE WELFA	ARE BENEFITS	PLAN		ee-digit n number (P	N) 🕨	504
C Plan sponsor's name a ALCATEL-LUCENT USA		e 2a of Form 5500	-	oyer Identific -3408857	cation Number ((EIN)
		ning Insurance Contract . Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca AETNA HEALTH PLANS (b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		,	ontract year
	code	identification number	policy or contract year	(f)	From	(g) To
23-2169745	95109	*SEE BELOW	82	01/01/201	6	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. List in line 3	3 the agents,	, brokers, and o	ther persons in
(a) Total	amount of comr	nissions paid	(b) 1	otal amount	of fees paid	
3 Persons receiving com		ees. (Complete as many entries	1 1 /			
	(a) Name a	nd address of the agent, broker,	or other person to whom commis	sions or fees	s were paid	
(b) Amount of sales a			s and other commissions paid			4
commissions pa	aid	(c) Amount	(d) Purpo	Se		(e) Organization code

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Sched			dule A (Form 5500) 2016
			40000

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

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

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

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

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

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

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

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

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

F	Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carri					as a unit for nurnages of
		this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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 su	uch contracts are ex	perience-rated	as a unit. Where	contra	cts cover individual
8	Bon	ofit ar	nd contract type (check all applicable boxes)		reach canter may b	e llealeu as a u		111516	
0	Г							_ ام]
	a		alth (other than dental or vision)	b Dental		Vision		d	Life insurance
	е	Te	mporary disability (accident and sickness)	f Long-term			al unemployment	h	Prescription drug
	i [Sto	op loss (large deductible)	j 🛛 HMO cont	tract k	PPO contra	ct		Indemnity contract
	m	Ot	her (specify) 🕨						
9	Expe	erienc	ce-rated contracts:			-			
	a		iums: (1) Amount received						
		(2) In	ncrease (decrease) in amount due but unpaid	t					
		(3) In	ncrease (decrease) in unearned premium res	erve			1		
	_	• •	arned ((1) + (2) - (3))					_	0
	b	Bene	efit charges (1) Claims paid						
		``	ncrease (decrease) in claim reserves						
		(3) In	ncurred claims (add (1) and (2))						0
		` '	laims charged						
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basi					
		```	(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 .		a (1)(a)				
		```	(G) Other retention charges				0.(1)(1		
		```	(H) Total retention	_		-		1)	0
			Dividends or retroactive rate refunds. (These			1			
	d		us of policyholder reserves at end of year: (1						
		(2) C	Claim reserves						
		(3) C	Other reserves						
			dends or retroactive rate refunds due. (Do n	ot include amount	t entered in line 9c(2) .)			
10	No		erience-rated contracts:						
	а	Tota	I premiums or subscription charges paid to c	arrier			10a		615508
	b		e carrier, service, or other organization incurr ation of the contract or policy, other than rep						

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 ar	nswer to line 11 is "Yes," specify the information not provided.			

Persion Benefit Guaranty Cognization Insurance companies are required to provide the information pursuant to ERISA section 103(q)(2). This Form is Open to Public Inspection For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016 An an ending 12/31/2016 A Name of plan NOKIA RETIREE WELFARE BENEFITS PLAN B Three-digit plan number (PN) 504 C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. D Employer Identification Number (EIN) 22-3408857 Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier HORIZON BCBS OF NJ (b) EIN (c) NAIC (b) EIN (c) NAIC (d) Contract or policy or contract year policy or contract year policy or contract year policy or contract year (a) Total amount of commissions paid (b) Total amount of commissions paid (c) Total amount of fees paid (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (e) Organization code (b) Armount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code (b) Armount of sales and bases of the agent, broker, or other person to who	SCHEDULE (Form 5500) Department of the Treas Internal Revenue Servi Department of Labor Employee Benefits Security Adi)) sury ice r	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		
A Name of plan NOKIA RETIREE WELFARE BENEFITS PLAN B Three-digit plan number (PN) 504 C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. D Employer Identification Number (EIN) 22:3408857 Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier HORIZON BCBS OF NJ (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year Policy or contract year 22-2651245 95529 67-77087 134 01/01/2016 12/31/2016 2 Insurance fee and commission information. Enter the total fees and total commissions paid (b) Total amount of commissions paid (c) Total amount of commissions paid 01/01/2016 12/31/2016 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (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 (d) Purpose (e) Organization code						ion	This For	
NOKIA RETIREE WELFARE BENEFITS PLAN Interview 504 C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (PN) 504 C 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 C overage Information: (a) Name of insurance carrier HORIZON BCBS OF NJ (b) EIN (c) NAIC (d) Contract or identification number of policy or contract year Policy or contract year (b) EIN (c) NAIC (d) Contract or identification number Policy or contract year (f) From (g) To 22-2651245 95529 67-77087 134 01/01/2016 12/31/2016 2 Instrument paid. (a) Total amount of commissions paid (b) Total amount of fees paid (a) Total amount of commissions paid (b) Total amount of fees paid (c) Amount Fees and other commissions paid (e) Organization code	For calendar plan year 20	16 or fiscal plan	year beginning 01/01/2016		and er	ding 12/3	1/2016	•
ALCATEL-LUCENT USA INC. 22-3408857 Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier HORIZON BCBS OF NJ (b) EIN (c) NAIC code (c) NAIC (d) Contract or identification number persons coverat at end of policy or contract year (c) EIN (c) NAIC code (d) Contract or identification number Policy or contract year 22-2651245 95529 67-77087 134 01/01/2016 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 commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code <	•	RE BENEFITS	PLAN			-	N) 🕨	504
on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier HORIZON BCBS OF NJ (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate number of policy or contract year 22-2651245 95529 67-77087 134 01/01/2016 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 commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Armount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code						(EIN)		
(a) Name of insurance carrier HORIZON BCBS OF NJ (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year Policy or contract year 22-2651245 95529 67-77087 134 01/01/2016 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. (b) Total amount of fees paid (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid Fees and other commissions paid (e) Organization code								
HORIZON BCBS OF NJ (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year Policy or contract year 22-2651245 95529 67-77087 134 01/01/2016 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. (b) Total amount of fees paid (a) Total amount of commissions paid (b) Total amount of fees paid 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (e) Organization code (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	1 Coverage Information:							
(b) EIN (c) NALC code (d) Contract or identification number persons covered at end of policy or contract year (f) From (g) To 22-2651245 95529 67-77087 134 01/01/2016 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. (b) Total amount of fees paid (a) Total amount of commissions paid (b) Total amount of fees paid (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid Fees and other commissions paid (c) Amount (d) Purpose (e) Organization code	()	rrier						
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 commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid Fees and other commissions paid (c) Amount (d) Purpose (e) Organization code	(b) EIN	• •		persons covered a	at end of	(f)		
descending order of the amount paid. (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). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base (c) Amount (d) Purpose (e) Organization code	22-2651245	95529	67-77087	134	ŀ	01/01/201	6	12/31/2016
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base (c) Amount (d) Purpose (e) Organization code			tion. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid Fees and other commissions paid (e) Organization code (c) Amount (d) Purpose (e) Organization code	(a) Total a	amount of comr	nissions paid		(b) ⊺o	otal amount	of fees paid	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid Fees and other commissions paid (e) Organization code (c) Amount (d) Purpose (e) Organization code								
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid Fees and other commissions paid (e) Organization code (c) Amount (d) Purpose (e) Organization code	3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all	persons).			
(b) Annount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	0					ions or fees	were paid	
(b) Annount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code								_
commissions paid (c) Amount (d) Purpose (e) Organization code	(b) Amount of sales ar	nd base	Fees	s and other commissio	ns paid			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			(c) Amount		(d) Purpos	е		(e) Organization code
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
		(a) Name a	nd address of the agent broker of	or other person to who	m commiss	ions or fees	were paid	
		() . tarrio u						

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	dule A (Form 5500) 2016		

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

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

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

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

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

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

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

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

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

F	Part		dual contra	oto with anoth corrier ma	who trooted	as a unit for nurnages of
		Where individual contracts are provided, the entire group of such individual this report.		icis with each camer ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					·	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6C	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	~	Type of contract: (1) individual policies (2) group deferre	d oppulity			
	е		u annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) guaranteed investment (4) other				
	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	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)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

Ρ	art		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								
8	Ren	ofit ar	nd contract type (check all applicable boxes)		reach carrier may				1010	5011.	
Ŭ	г	_	ealth (other than dental or vision)	b Dental		:П	Vision		d∏	Life insurance	
	a	_									
	e	Те	mporary disability (accident and sickness)	f Long-term			Supplemental unemp	oloyment	h	Prescription drug	
	i	Sto	op loss (large deductible)	j 🗙 HMO cont	tract k	(PPO contract			Indemnity contract	
	m	Ot	her (specify)								
9	Expe	erienc	ce-rated contracts:								
	a		iums: (1) Amount received								
		(2) Ir	ncrease (decrease) in amount due but unpaid	t							
		(3) Ir	crease (decrease) in unearned premium res	erve				1			
	_	• •	arned ((1) + (2) - (3))		1	<u>.</u>		9a(4)			0
	b	Ben	efit charges (1) Claims paid	••••••					_		
		• •	ncrease (decrease) in claim reserves								
		(3) Ir	ncurred claims (add (1) and (2))	••••••				9b(3)	_		0
		• •	laims charged					9b(4)	_		
	С		nainder of premium: (1) Retention charges (o						4		
			(A) Commissions						_		
			(B) Administrative service or other fees						_		
			(C) Other specific acquisition costs						-		
			(D) Other expenses			-			_		
			(E) Taxes						4		
			(F) Charges for risks or other contingencies.		a (1)(a				_		
			(G) Other retention charges					0~(1)(1)			0
			(H) Total retention	_		_		9c(1)(H)	_		0
			Dividends or retroactive rate refunds. (These					9c(2)	_		
	d		us of policyholder reserves at end of year: (1	,	•			9d(1)	_		
		• •	Claim reserves					9d(2)	_		
	_	(-)	Other reserves					9d(3)			
4.0			dends or retroactive rate refunds due. (Do no	ot include amoun	it entered in line 9c	: (2) .))	9e	_		
10			erience-rated contracts:					10	_		
	a		I premiums or subscription charges paid to c					10a	+	1316	5265
	b		e carrier, service, or other organization incurr ation of the contract or policy, other than repo					10b			

Pa	art 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.			

	E A	Insuranc	e Information		OM	IB No. 1210-0110
(Form 5500	-	This sales date is as wire d	te ha file dan den e atien 404 e	the s	2016	
Department of the Trea Internal Revenue Ser			to be filed under section 104 c ome Security Act of 1974 (ER			
	Department of Labor Employee Benefits Security Administration File as an attachment to Form 55					
Pension Benefit Guaranty C	 Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). 			nation		m is Open to Public Inspection
For calendar plan year 20)16 or fiscal plar	n year beginning 01/01/2016	and	ending 12/31	1/2016	•
A Name of plan NOKIA RETIREE WELFA	ARE BENEFITS	PLAN		ree-digit an number (PN	J) 🕨	504
C Plan sponsor's name a		e 2a of Form 5500		ployer Identifica 2-3408857	ation Number ((EIN)
		ning Insurance Contract				
on a separation: 1 Coverage Information:		. Individual contracts grouped as	a unit in Parts II and III can be	reported on a s	single Schedul	le A.
(a) Name of insurance ca SIERRA HEALTH AND LII		COMPANY, INC.	(e) Approximate number o		Policy or co	ontract year
			managers accorded at and af			
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f)	From	(g) To
(b) EIN 4-0734860	• • •		•	(f) 01/01/2016		(g) To 12/31/2016
4-0734860	code 71420 mission informa	identification number	policy or contract year 80293	01/01/2016	;	12/31/2016
4-07348602 Insurance fee and corr descending order of the	code 71420 mission informa	identification number H2001 ation. Enter the total fees and total	policy or contract year 80293	01/01/2016	brokers, and o	12/31/2016
 4-0734860 2 Insurance fee and com descending order of the (a) Total 	code 71420 amission information amount paid. amount of commit	identification number H2001 ation. Enter the total fees and total missions paid	policy or contract year 80293 commissions paid. List in line (b	01/01/2016 3 the agents, Total amount o	brokers, and o	12/31/2016
 4-0734860 2 Insurance fee and com descending order of the (a) Total 	code 71420 amission informate amount paid. amount of commonstance amount of commonstance	identification number H2001 ation. Enter the total fees and total missions paid ees. (Complete as many entries a	policy or contract year 80293 I commissions paid. List in line (b as needed to report all persons	01/01/2016 3 the agents, Total amount o	brokers, and o of fees paid	12/31/2016
 4-0734860 2 Insurance fee and com descending order of the (a) Total 	code 71420 amission informate amount paid. amount of commonstance amount of commonstance	identification number H2001 ation. Enter the total fees and total missions paid	policy or contract year 80293 I commissions paid. List in line (b as needed to report all persons	01/01/2016 3 the agents, Total amount o	brokers, and o of fees paid	12/31/2016
 4-0734860 2 Insurance fee and com descending order of the (a) Total 	code 71420 amission informate amount paid. amount of commonstance amount of commonstance	identification number H2001 ation. Enter the total fees and total missions paid ees. (Complete as many entries a	policy or contract year 80293 I commissions paid. List in line (b as needed to report all persons	01/01/2016 3 the agents, Total amount o	brokers, and o of fees paid	12/31/2016
 4-0734860 2 Insurance fee and com descending order of the (a) Total 3 Persons receiving com (b) Amount of sales a 	T1420 T1420 T1420 The amount paid. The amount of common the amount of co	identification number H2001 ation. Enter the total fees and total missions paid ees. (Complete as many entries a and address of the agent, broker, o	policy or contract year 80293 commissions paid. List in line (b) as needed to report all persons or other person to whom comm	01/01/2016 3 the agents, Total amount of issions or fees	brokers, and o of fees paid	12/31/2016 ther persons in
 4-0734860 2 Insurance fee and com descending order of the (a) Total 3 Persons receiving com 	T1420 T1420 T1420 The amount paid. The amount of common the amount of co	identification number H2001 ation. Enter the total fees and total missions paid ees. (Complete as many entries a and address of the agent, broker, o	policy or contract year 80293 commissions paid. List in line (b as needed to report all persons or other person to whom comm	01/01/2016 3 the agents, Total amount of issions or fees	brokers, and o of fees paid	12/31/2016
 4-0734860 2 Insurance fee and com descending order of the (a) Total 3 Persons receiving com (b) Amount of sales a 	T1420 T1420 T1420 The amount paid. The amount of common the amount of co	identification number H2001 ation. Enter the total fees and total missions paid ees. (Complete as many entries a and address of the agent, broker, o	policy or contract year 80293 commissions paid. List in line (b) as needed to report all persons or other person to whom comm	01/01/2016 3 the agents, Total amount of issions or fees	brokers, and o of fees paid	12/31/2016 ther persons in

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Sched			dule A (Form 5500) 2016
			400005

v. 160205

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

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

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

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

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

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

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

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

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

	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indi	vidual contracts with each carrier may	/ be treated	d as a unit for purposes of
		this report.			
_		rent value of plan's interest under this contract in the general account at year		4	
5		rent value of plan's interest under this contract in separate accounts at year of	end	5	
6		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	c	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in co			
		retention of the contract or policy, enter amount		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
		(3) other (specify)			
		—			
	f	If contract purchased, in whole or in part, to distribute benefits from a termi	nating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts m	aintained in separate accounts)		
	а		ate participation guarantee		
		(3) guaranteed investment (4) dther			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits			
		(3) Interest credited during the year			
		(4) Transferred from separate account			
		(5) Other (specify below)	7c(5)		
		•			
				7(0)	0
	h	(6)Total additions		7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6)) Deductions:		7d	0
	е	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier			
		(2) Fransferred to separate account	= (0)		
		(4) Other (specify below)	- (1)		
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Ρ	Part		Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for report	grou	o of employees of the						
			employees, the entire group of such individu	ial c	ontracts with each ca	arrier may be	treated as a unit for p	urposes of t	his re	port.	
8	Ben	efit an	nd contract type (check all applicable boxes)								
	а	Hea	alth (other than dental or vision)	b	Dental	С	Vision		d	Life insurance	
	е	Ter	mporary disability (accident and sickness)	f	Long-term disabilit	ty g	Supplemental unem	ployment	h∏	Prescription drug	
	ίĪ	Sto	op loss (large deductible)	iΓ	HMO contract	k	PPO contract		ıΠ	Indemnity contract	
	m		her (specify)	• -		L				,	
	[0.									
9	Expe	erienc	e-rated contracts:								
			ums: (1) Amount received			9a(1)			1		
		(2) In	crease (decrease) in amount due but unpaid			9a(2)					
		(3) In	crease (decrease) in unearned premium res	erve		9a(3)					
		(4) Ea	arned ((1) + (2) - (3))					9a(4)			0
	b	Bene	efit charges (1) Claims paid			9b(1)					
		(2) In	crease (decrease) in claim reserves			9b(2)					
		(3) In	curred claims (add (1) and (2))					9b(3)			0
		(4) Cl	laims charged					9b(4)			_
	С	Rem	ainder of premium: (1) Retention charges (o	n an	accrual basis)						
		(/	A) Commissions			9c(1)(A)					
		(B) Administrative service or other fees			9c(1)(B)					
		(C) Other specific acquisition costs			9c(1)(C)					
			D) Other expenses			9c(1)(D)					
		(E) Taxes			9c(1)(E)					
		(F) Charges for risks or other contingencies			9c(1)(F)					
		(G) Other retention charges			9c(1)(G)					
		(H) Total retention					9c(1)(H)		0
		(2) D	Dividends or retroactive rate refunds. (These	amo	ounts were paid in	cash, or	credited.)	9c(2)			
	d	Statu	us of policyholder reserves at end of year: (1)	Am	ount held to provide	benefits afte	r retirement	9d(1)			
			Claim reserves					9d(2)			
		(3) O	Other reserves					9d(3)			_
	е	Divid	lends or retroactive rate refunds due. (Do no	ot inc	clude amount entered	d in line 9c(2)) .)	9e			_
10) No		erience-rated contracts:								
	а	Tota	I premiums or subscription charges paid to c	arrie	r			10a		3395247	73
	b	If the	e carrier, service, or other organization incurr	ed a	ny specific costs in c	onnection wi	th the acquisition or				_
			ntion of the contract or policy, other than repo					10b			

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

SCHEDULE C	Service Provider	Information	OMB No. 1210-0110	
(Form 5500)				
Department of the Treasury Internal Revenue Service	This schedule is required to be filed unc Retirement Income Security		2016	
Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	− File as an attachmer	nt to Form 5500.	This Form is Open to Public Inspection.	
For calendar plan year 2016 or fiscal p	Dan year beginning 01/01/2016	and ending 12/3	1/2016	
Name of plan NOKIA RETIREE WELFARE BENEI		B Three-digit	504	
		plan number (PN)		
Plan sponsor's name as shown on ALCATEL-LUCENT USA INC.	line 2a of Form 5500	D Employer Identification	on Number (EIN)	
Part I Service Provider In	formation (see instructions)			
	on received only eligible indirect compensatio o include that person when completing the rem		uired disclosures, you are required to	
 Information on Persons R Check "Yes" or "No" to indicate whe indirect compensation for which the only of the second second	eceiving Only Eligible Indirect Con ether you are excluding a person from the remain plan received the required disclosures (see in er the name and EIN or address of each person ensation. Complete as many entries as needed name and EIN or address of person who provide	npensation ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures for ad (see instructions).	ns) Yes No	
 Information on Persons R Check "Yes" or "No" to indicate whe indirect compensation for which the If you answered line 1a "Yes," ent received only eligible indirect comp 	eceiving Only Eligible Indirect Con ether you are excluding a person from the remain plan received the required disclosures (see in er the name and EIN or address of each person ensation. Complete as many entries as needed	npensation ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures for ad (see instructions).	ns) Yes No	
Information on Persons R Check "Yes" or "No" to indicate whe indirect compensation for which the Jo If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r THE DREYFUS CORPORATION 13-5673135	eceiving Only Eligible Indirect Con ether you are excluding a person from the remain plan received the required disclosures (see in er the name and EIN or address of each person ensation. Complete as many entries as needed	Apensation ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures f and (see instructions).	ns) Yes No	
Information on Persons R Check "Yes" or "No" to indicate whe indirect compensation for which the Jo If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r THE DREYFUS CORPORATION 13-5673135	eceiving Only Eligible Indirect Con ether you are excluding a person from the rema- plan received the required disclosures (see in er the name and EIN or address of each perso ensation. Complete as many entries as needed name and EIN or address of person who provid	Apensation ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures f and (see instructions).	ns) Yes No	
Information on Persons R Check "Yes" or "No" to indicate whe indirect compensation for which the Jo If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r THE DREYFUS CORPORATION 13-5673135 (b) Enter r	eceiving Only Eligible Indirect Con ether you are excluding a person from the rema- plan received the required disclosures (see in er the name and EIN or address of each perso ensation. Complete as many entries as needed name and EIN or address of person who provid	Apensation ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures f and (see instructions).	ns) Yes No	
Information on Persons R Check "Yes" or "No" to indicate whe indirect compensation for which the O If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r THE DREYFUS CORPORATION 13-5673135 (b) Enter r METLIFE 13-5881829	eceiving Only Eligible Indirect Con ether you are excluding a person from the rema- plan received the required disclosures (see in er the name and EIN or address of each perso ensation. Complete as many entries as needed name and EIN or address of person who provid	Apensation ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures f and (see instructions).	ns) Yes No for the service providers who et compensation	
Information on Persons R Check "Yes" or "No" to indicate whe indirect compensation for which the O If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r THE DREYFUS CORPORATION 13-5673135 (b) Enter r METLIFE 13-5881829	eceiving Only Eligible Indirect Con ether you are excluding a person from the rema- plan received the required disclosures (see in er the name and EIN or address of each perso ensation. Complete as many entries as needed ame and EIN or address of person who provid	Apensation ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures f and (see instructions).	ns) Yes No for the service providers who et compensation	
Information on Persons R Check "Yes" or "No" to indicate whe indirect compensation for which the O If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r THE DREYFUS CORPORATION 13-5673135 (b) Enter r METLIFE 13-5881829	eceiving Only Eligible Indirect Con ether you are excluding a person from the rema- plan received the required disclosures (see in er the name and EIN or address of each perso ensation. Complete as many entries as needed ame and EIN or address of person who provid	Apensation ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures f and (see instructions).	ns) Yes No	

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Page 2- 1

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

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

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

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

HEWITT ASSOCIATES LLC

36-2235791

(b)	(c)	(d)	(e)	(f)	(g)	(h)			
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect	Did the service provider give you a formula instead of an amount or estimated amount?			
13 50	NONE	3528668	Yes 🗌 No 🔀	Yes No		Yes 🗌 No 🗍			
	(a) Enter name and EIN or address (see instructions)								

EXPRESS SCRIPTS, INC

22-3461740

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)		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 indirect	Did the service provider give you a formula instead of an amount or
	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element (f). If none, enter -0	
13 50	NONE	1905036	Yes 🗌 No 🛛	Yes No		Yes 🗌 No 🗍
		(a) Enter name and EIN or	address (see instructions)		

UNITED HEALTHCARE

(b) Service Code(s)		by the plan. If none,	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
13 50	NONE	662165	Yes 🗌 No 🔀	Yes 🗌 No 🗌		Yes No

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

AON CONSULTING, INC.

22-2232264

(b)	(c)	(d)	(e)	(f)	(g)	(h)			
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	Did the service provider give you a formula instead of an amount or estimated amount?			
11 16 38 50	NONE	210112	Yes 🗌 No 🔀	Yes 🗌 No 🗌		Yes 🗌 No 🗍			
	(a) Enter name and EIN or address (see instructions)								

ERNST & YOUNG LLP

34-6565596

(b)	(c)	(d)	(e)	(f)	(g)	(h)			
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest		Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you	Did the service provider give you a formula instead of an amount or			
			-1)		answered "Yes" to element (f). If none, enter -0				
10 50	NONE	168289	Yes 🗌 No 🔀	Yes 🗌 No 🗌		Yes 🗌 No 🗍			
		(a) Enter name and EIN or	address (see instructions)					

MAX-IT MAILING & FULFULLMENT

(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
38 50	NONE	131019	Yes 🗌 No 🛛	Yes 🗌 No 🗌		Yes 🗌 No 🗍

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

TRUVEN HEALTH ANALYTICS

06-1467923

(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
15 50	NONE	88774	Yes 🗌 No 🗙	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		

BLACKROCK INSTITUTIONAL TRUST CO

94-3112180

(b)	(c)	(d)	(e)	(f)	(g)	(h)			
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	Did service provider receive indirect	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0				
21 24 28 50 51	NONE	27020	Yes 🔀 No 🗌	Yes 🛛 No 🗌	40018	Yes 🗌 No 🗙			
		(a) Enter name and EIN or	address (see instructions)					

BANK OF NEW YORK MELLON

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest		(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
19 21 25 49 50 62	TRUSTEE	21250	Yes 🛛 No 🗌	Yes 🗴 No 🗌	0	Yes 🛛 No 🗌

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

UNIVERSAL MAILING SERVICE

22-2381663

(b)	(c)	(d)	(e)	(f)	(g)	(h)			
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	Did the service provider give you a formula instead of an amount or estimated amount?			
38 50	NONE	21216	Yes 🗌 No 🔀	Yes No		Yes 🗌 No 🗍			
	(a) Enter name and EIN or address (see instructions)								

TAX SAVER

75-1761182

(b)	(c)	(d)	(e)	(f)	(g)	(h)			
Service Code(s)	Relationship to employer, employee	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?	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			
13 50	NONE	15201	Yes 🗌 No 🔀	Yes 🗌 No 🗌		Yes 🗌 No 🗍			
	(a) Enter name and EIN or address (see instructions)								

ALCATEL-LUCENT INVESTMENT MNGT CORP

(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest		(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
31 50	AFFILIATE	13234	Yes 🗌 No 🛛	Yes 🗌 No 🗌		Yes 🗌 No 🗍

Part I	Service Provider Information (continued)		
or provid question provider	ported on line 2 receipt of indirect compensation, other than eligible indirect comp les contract administrator, consulting, custodial, investment advisory, investment is s for (a) each source from whom the service provider received \$1,000 or more in gave you a formula used to determine the indirect compensation instead of an an tries as needed to report the required information for each source.	management, broker, or recordkeeping indirect compensation and (b) each so	g services, answer the following ource for whom the service
	(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 determine	L compensation, including any 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	compensation, including any
		formula used to determine	the service provider's eligibility the indirect compensation.
	(a) Enter service provider name as it appears on line 2	(b) Service Codes	(C) Enter amount of indirect
		(see instructions)	compensation
	(d) Enter name and EIN (address) of source of indirect compensation		compensation, including any
			the indirect compensation.

Page **5 -** 1

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

Page **6 -** 1

Part III	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)					
a Name		b EIN:				
C Positio	n:					
d Addres	SS:	e Telephone:				
Explanatio	n:					

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500)	DFE/P	articipating Plan Informa	tion	OMB No. 1	1210-0110
Department of the Treasury		s required to be filed under section 104 of th ement Income Security Act of 1974 (ERISA	2016		
Internal Revenue Service Retirement Income Security Act of 1974 (ERISA). Department of Labor File as an attachment to Form 5500.).	2016		
Employee Benefits Security Administration				This Form is C Inspe	
For calendar plan year 2016 or fis	cal plan year beginning	01/01/2016 an	Ŭ	1/2016	
A Name of plan NOKIA RETIREE WELFARE BEN	EFITS PLAN		B Three-digit plan numb		504
C Plan or DFE sponsor's name as ALCATEL-LUCENT USA INC.	shown on line 2a of Form	n 5500	D Employer I 22-340885	dentification Number	(EIN)
	ny entries as needed	Ts, PSAs, and 103-12 IEs (to be co to report all interests in DFEs)	ompleted by pl	ans and DFEs)	
b Name of sponsor of entity lister		INSTITUTIONAL TRUST CO. N.A.			
C EIN-PN 94-3167617-001	d Entity C	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instruction)		6	60245951
a Name of MTIA, CCT, PSA, or 1	03-12 IE: BLACKROCK	EAFE EQUITY INDEX FUND	,		
b Name of sponsor of entity lister	t in (a): BLACKROCK	INSTITUTIONAL TRUST CO. N.A.			
C EIN-PN 94-6581674-001	d Entity C code	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instruction		2	20592785
a Name of MTIA, CCT, PSA, or 1	03-12 IE: BLACKROCK	U.S. DEBT INDEX FUND			
b Name of sponsor of entity lister	I in (a): BLACKROCK	INSTITUTIONAL TRUST CO. N.A.			
C EIN-PN 94-3138366-001	d Entity C code	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instruction		2	26667230
a Name of MTIA, CCT, PSA, or 1	03-12 IE:				
b Name of sponsor of entity lister	d in (a):				
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instruction)			
a Name of MTIA, CCT, PSA, or 1	03-12 IE:				
b Name of sponsor of entity lister	l in (a):				
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instruction)			
a Name of MTIA, CCT, PSA, or 1	03-12 IE:				
b Name of sponsor of entity lister	l in (a):				
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instruction)			
a Name of MTIA, CCT, PSA, or 1	03-12 IE:				
b Name of sponsor of entity lister	d in (a):				
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, 1 103-12 IE at end of year (see instruction			

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Schedule D (Form 5500) 201	6	Page 2 - 1
a Name of MTIA, CCT, PSA, or 103-	12 IE:	
b Name of sponsor of entity listed in	(a):	
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-	12 IE:	
b Name of sponsor of entity listed in	(a):	
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-	12 IE:	
b Name of sponsor of entity listed in	(a):	
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-	12 IE:	
b Name of sponsor of entity listed in	(a):	
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-	12 IE:	
b Name of sponsor of entity listed in	(a):	
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-	12 IE:	
b Name of sponsor of entity listed in	(a):	
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-	12 IE:	
b Name of sponsor of entity listed in	(a):	
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-	12 IE:	
b Name of sponsor of entity listed in	(a):	
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-	12 IE:	
b Name of sponsor of entity listed in	(a):	
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-	12 IE:	
b Name of sponsor of entity listed in	(a):	
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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Page **3 -** 1

F	art II	Information on Participating Plans (to be completed by DFEs) (Complete as many entries as needed to report all participating plans)	
а	Plan na		
b	Name o plan sp		C EIN-PN
а	Plan na	me	
b	Name o plan sp		C EIN-PN
а	Plan na	me	
b	Name o plan sp		C EIN-PN
а	Plan na	me	
b	Name o plan sp		C EIN-PN
а	Plan na	me	
b	Name o plan sp		C EIN-PN
а	Plan na	me	
b	Name o plan sp		C EIN-PN
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	Plan na		
b	Name o plan sp		C EIN-PN
а	Plan na	me	
b	Name o plan sp		C EIN-PN

(Form 5500) This schedule is required to be filed under ascelon 104 of the Employee Description 5005(a) of the Employee Description 5005(b) of the Employee Description 50	SCHEDULE H	Financial In	formatic	n			C	OMB No. 1210	-0110
2016 2016 2016 2016 Description of any section 040 of the Employee Retirement licence Secting VA col 1974 (ERISA) and section 0505(6) of the Internal Reveue Code (the Code). The Secting VA code (the Code). The schedule is regulared to be filed under section 104 of the Employee Period and any section 050(6) of the Code). The Schedule is regulared to be filed under section 104 of the Employee Period Schedule (the Code). Code of the Schedule in regulared to Schedule (the Code). Period Returns 100 of the Schedule (the Code). Code of the Schedule (the Schedule (the Code). Code of the Schedule (the Schedule (the Code). Code of the Schedule (the									
Descrete of Labor Produce South Analysis	· · · ·	This schedule is required to be filed under section 104 of the Employee					2016		
Improve Reading Society Administration The form is Open to Public Inspection Fore a section during Corporation This Form is Open to Public Inspection Fore a section during Corporation This Form is Open to Public Inspection A Name of plan An and open to Public Inspection NCKA RETIREE WELFARE BENEFITS PLAN B Three-digit plan number (PN) 504 C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN) 22.340867 Part I Asset and Liability Statement O Employer Identification Number (EIN) Common Value of plan assets and liabilities at the beginning and end of the plan open an an ine-by-line base unless the value is reportable on these type and the the plan on a line-by-line base unless the value of the plan is there at a commigned fund containing the assets of more than one plan on a line-by-line base unless the value is reportable on these type and to 103-12 lies also on or complete lines 100-120-120-1200 Assets (a) Beginning of Year (b) End of Year A Total noniteriest-barding cash. 1a D Employer contributions 1b(2) (a) England on the fire value of plan assets for a commigned fund contain the value of plan assets for a complete lines 100-120-12000 (c) Participant contributions I a D England to the the value of plan assets and table the plan temploy ore the value of plan as									
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C Plan sponsor's name as shown on line 2a of Form 5500 ALCATEL-LUCENT USA INC. Part Asset and Liability Statement 1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one toust. Report them set of the plane's (1). Do a contribution on a new-lyme plane of the plane's (1). Do a contribution on a new-lyme plane set of plane sets to plane sets	•	S PLAN				0		•	504
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the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines to(3) through to(14). Do not enter the value of that provide the lines to(10) through to(14). Do not enter the value of that provide the lines to(10) to(10			vear Combin	e the valu	e of plan a	ssets he	ld in mo	re than one	trust Report
benefit at a future date. Round off amounts to the nearest dollar. MTAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1d, 1d, 1d, 1d, 1d, 1d, 1d, 1d, 1d, 1d	the value of the plan's interest in a c	ommingled fund containing the assets of m	nore than one	plan on a	line-by-line	e basis u	inless the	e value is re	portable on
and 1i. CCTs, PSAs, and 103-12 lEs also do not complete lines 1d and 1e. See instructions. (a) Beginning of Year (b) End of Year a Total noninterest-bearing cash. 1a 1a 1a b Receivables (less allowance for doubtful accounts): 1b(1) 1b(2) 1b(1) (a) Deprive contributions. 1b(2) 1b(2) 1b(2) 1b(2) (b) End of Year 1b(2) 1c(1) 1c(1) 1c(1) 1c(1) 1c(1) 1c(1) 1c(1) 1c(2) 1c(1) 1c(2) 1c(1) 1c(2) 1c(1) 1c(2) 1c(3) 1c(2) 1c(3) 1c(4) 1c(3) 1c(4) 1c(3) 1c(4) 1c(3) 1c(4) 1c(4) 1c(4) 1c(4) 1c(4) 1c(4) 1c(4) 1c(4) <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>									
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b Receivables (less allowance for doubtful accounts): (1) Employer contributions. (2) Participant contributions. (3) Other (3) Other (1) Interest-bearing cash (include money market accounts & certificates of deposit). (1) Interest-bearing cash (include money market accounts & certificates of deposit). (1) Interest-bearing cash (include money market accounts & certificates of deposit). (2) U.S. Government securities (3) Corporate debt instruments (other than employer securities): (A) Preferred (B) All other (B) Common (A) Preferred (B) Common (C) Common (B) Common (C) Common (a) Preferred (b) Common (c) Common (c) Common (c) Common (c) Participant leans (c) Common (c) Common (c) Common <t< th=""><th>As:</th><th>sets</th><th></th><th>(a) B</th><th>eginning of</th><th>f Year</th><th></th><th>(b) End</th><th>of Year</th></t<>	As:	sets		(a) B	eginning of	f Year		(b) End	of Year
(1) Employer contributions 1b(1) (2) Participant contributions 1b(2) (3) Other 1b(3) 92235000 91727000 C General investments: 1b(3) 92235000 91727000 (1) Interest-bearing cash (include money market accounts & certificates of deposit) 1c(1) 1c(1) 1c(2) (2) U.S. Government securities 1c(1) 1c(2) 1c(3)(A) 1c(3)(A) (3) Corporate debt instruments (other than employer securities): 1c(3)(A) 1c(3)(B) 1c(3)(B) (4) Corporate stocks (other than employer securities): 1c(4)(A) 1c(4)(B) 1c(4)(B) (5) Partnership/joint venture interests 1c(6) 1c(6) 1c(7) (6) Real estate (other than opployer real property) 1c(6) 1c(7) 1c(8) (9) Value of interest in common/collective trusts 1c(9) 109306000 107506000 (10) Value of interest in master trust investment accounts 1c(11) 1c(12) 1c(13) (14) Value of interest in registered investment companies (e.g., mutual funds) 14/24 eof fundes held in insurance company general account (unallocated contracts) 1c(14) 35172000 325592000	a Total noninterest-bearing cash		1a						
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c General investments: 1 <th>(2) Participant contributions</th> <th></th> <td>1b(2)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	(2) Participant contributions		1b(2)						
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of deposit)									
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(12) Value of interest in 103-12 investment entities	(10) Value of interest in pooled sepa	arate accounts							
 (13) Value of interest in registered investment companies (e.g., mutual funds)	(11) Value of interest in master trust	investment accounts							
funds) funds) <t< th=""><th></th><th></th><th>1c(12)</th><th></th><th></th><th></th><th></th><th></th><th></th></t<>			1c(12)						
contracts)	funds)		1c(13)		1	1429600	0		29764000
(15) Other 1c(15)			1c(14)		35	5172000	0		325592000
	(15) Other		1c(15)						

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

(1) Employer securities		(a) Beginning of Year	(b) End of Year
	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	567557000	554589000
Liabilities			
g Benefit claims payable	1g	25100000	21800000
h Operating payables	1h	645000	694000
Acquisition indebtedness	1i		
Other liabilities	1j	18552000	8091000
k Total liabilities (add all amounts in lines 1g through1j)	1k	44297000	30585000
Net Assets			
Net assets (subtract line 1k from line 1f)	11	523260000	524004000

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	_ 2a(1)(A)	8835000	
(B) Participants	2a(1)(B)	117871000	
(C) Others (including rollovers)	2a(1)(C)	8034000	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	_ 2a(3)		134740000
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)	329000	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		329000
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	_ 2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	_ 2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0

			(a	a) Amc	ount			(b) Total
	(6) Net investment gain (loss) from common/collective trusts	2b(6)						8021000
	(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)						
(Net investment gain (loss) from registered investment companies (e.g., mutual funds) 	2b(10)						
С	Other income	. 2c						20170000
d	Total income. Add all income amounts in column (b) and enter total	- 2d						163260000
	Expenses							
е	Benefit payment and payments to provide benefits:	·						
	(1) Directly to participants or beneficiaries, including direct rollovers	. 2e(1)			9048	6000		
	(2) To insurance carriers for the provision of benefits	. 2e(2)			6100	6000		
	(3) Other	2e(3)						
	(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)						151492000
f	Corrective distributions (see instructions)	<u>0</u> 4						
g	Certain deemed distributions of participant loans (see instructions)							
-	Interest expense							
i	Administrative expenses: (1) Professional fees				1102	4000		
	(2) Contract administrator fees	2:(2)						
	(3) Investment advisory and management fees	0:(0)					-	
	(4) Other	0:(4)						
	(4) Outer administrative expenses. Add lines 2i(1) through (4)	0:(5)						11024000
i	Total expenses. Add all expense amounts in column (b) and enter total							162516000
,	Net Income and Reconciliation							
k	Net income (loss). Subtract line 2j from line 2d	2k						744000
I.	Transfers of assets:							
	(1) To this plan							
	(2) From this plan	. 2l(2)						
Pa	rt III Accountant's Opinion							
	Complete lines 3a through 3c if the opinion of an independent qualified public attached.	accountant is	s attached to	o this F	Form 5	500. Co	omplete line 3	d if an opinion is not
a 1	The attached opinion of an independent qualified public accountant for this pla	·	tructions):					
	(1) 🛛 Unqualified (2) 🗌 Qualified (3) 🗌 Disclaimer (4)	Adverse						
b	Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.10	3-8 and/or 1	03-12(d)?				Yes	X No
CE	Enter the name and EIN of the accountant (or accounting firm) below:							
	(1) Name: PRICEWATERHOUSECOOPERS LLP		(2) EIN:	13-40	08324			
d ٦	The opinion of an independent qualified public accountant is not attached be (1) This form is filed for a CCT, PSA, or MTIA. (2) It will be atta		ext Form 55	500 pur	rsuant	to 29 C	CFR 2520.104	-50.
Pa	rt IV Compliance Questions							
4	CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete		lines 4a, 4e	e, 4f, 4	g, 4h, 4	4k, 4m,	, 4n, or 5.	
	During the plan year:	.с што т т.		Г	Yes	No		Amount
-		to the day of						
а	Was there a failure to transmit to the plan any participant contributions with period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any	prior year fai						
	fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction	Program.)		4a		Х		
b	Were any loans by the plan or fixed income obligations due the plan in defa							
	close of the plan year or classified during the year as uncollectible? Disrega secured by participant's account balance. (Attach Schedule G (Form 5500)							
	checked.)			4b		Х		

Page **4-** 1

			N/		_	
~	Were any leases to which the plan was a party in default or classified during the year as		Yes	No	Amo	unt
С	uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X		
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	X			12000000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X		
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X		
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X		
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)		Х			
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and					
	see instructions for format requirements.)	4j	Х			
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X		
Ι	Has the plan failed to provide any benefit when due under the plan?	41		Х		
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m				
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n				
ο	Defined Benefit Plan or Money Purchase Pension Plan Only: Were any distributions made during the plan year to an employee who attained age 62 and had not separated from service?	40				
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?					
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	Yes	No	Amou	unt:	
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), id transferred. (See instructions.)	entify t	he plan	(s) to w	hich assets or liabi	lities were
	5b(1) Name of plan(s)				5b(2) EIN(s)	5b(3) PN(s)
lf	the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA sec "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan		21.)?	🗌 Y		Not determined e instructions.)
Part	V Trust Information			<u> </u>		
6a N	ame of trust			61	b Trust's EIN	
6c N	ame of trustee or custodian 6d Trustee	's or o	ustodia	n's tele	phone number	

FINANCIAL STATEMENTS AND SUPPLEMENTAL SCHEDULES

Nokia Retiree Welfare Benefits Plan (formerly, Alcatel-Lucent Retiree Welfare Benefits Plan) Years Ended December 31, 2016 and 2015 With Report of Independent Auditors

Financial Statements and Supplemental Schedules

December 31, 2016 and 2015

Contents

Report of Independent Auditors	1
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Statements of Benefit Obligations and Net Assets Available for Benefits Statement of Changes in Benefit Obligations and Net Assets Available for Benefits Notes to Financial Statements	4
Supplemental Schedules	
Schedule H, Line 4i – Schedule of Assets (Held at End of Year) Schedule H, Line 4j – Schedule of Reportable Transactions	



Report of Independent Auditors

To the Administrator of Nokia Retiree Welfare Benefits Plan

We have audited the accompanying financial statements of Nokia Retiree Welfare Benefits Plan (formerly Alcatel-Lucent Retiree Welfare Benefits Plan) (the "Plan"), which comprise the statement of benefit obligations and net assets available for benefits as of December 31, 2016, and the related statement of changes in benefit obligations and net assets available for benefits for the year then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of the Plan as of December 31, 2016, and the changes in its financial status for the year then ended in accordance with accounting principles generally accepted in the United States of America.

PricewaterhouseCoopers LLP, PricewaterhouseCoopers Center, 300 Madison Avenue, New York, NY 10017 T: (646) 471 3000, F: (813) 286 6000, www.pwc.com/us



Other Matter

2015 Financial Statements

The financial statements of the Plan as of December 31, 2015 and for the year then ended, prior to the revision to correct an error as described in Note 2, were audited by other auditors whose report dated October 5, 2016 expressed an unmodified opinion on those financial statements.

We also have audited the adjustment to revise the statement of benefit obligations and net assets available for benefits as of December 31, 2015 to correct an error, as described in Note 2. In our opinion, such adjustment is appropriate and has been properly applied. We were not engaged to audit, review, or apply any procedures to the 2015 financial statements of the Plan other than with respect to the adjustment and, accordingly, we do not express an opinion or any other form of assurance on the 2015 financial statements taken as a whole.

Supplementary Information

Our audit of the Plan's financial statements as of and for the year ended December 31, 2016 was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of assets (held at end of year) as of December 31, 2016 and the schedule of reportable transactions for the year ended December 31, 2016 are presented for the purpose of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. Such information is the responsibility of the Plan's management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Tricewate house Coopers LLP

October 13, 2017

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

		31	
		2016	2015
Benefit obligations			
Accumulated postretirement benefit obligation:			
Current retirees	\$	3,173,800 \$	3,466,700
Medical claims payable and liability for claims incurred			
but not reported		21,800	25,100
Other participants fully eligible for benefits		5,700	6,400
Other participants not yet fully eligible for benefits		52,900	56,000
Total benefit obligations		3,254,200	3,554,200
Assets			
Group life insurance policies		325,592	351,720
Net assets held in Lucent Technologies Inc. Master Pension Trust		,	,
Restricted for 401(h) account		189,050	213,415
Restricted for applicable life insurance account		1	-
Common/collective trusts		107,506	109,306
Registered investment company		29,764	14,296
Rebates receivable		57,762	56,258
Refund receivable		33,955	35,976
Interest receivable		10	1
Total assets		743,640	780,972
Liabilities			
Due to Sponsor, net		8,091	18,552
Accrued administrative expenses		694	645
Total liabilities		8,785	19,197
Net assets available for benefits		734,855	761,775
Excess of benefit obligations over net assets		,	,
available for benefits	\$	2,519,345 \$	2,792,425

See accompanying notes.

Statement of Changes in Benefit Obligations and Net Assets Available for Benefits (In Thousands)

Year Ended December 31, 2016

Net decrease in benefit obligations Increase (decrease) during the period attributable to:	
Benefits reclassified to amounts currently payable	\$ (258,300)
Change in actuarial assumptions and experience	(209,300)
Interest due to the passage of time	126,300
Change in discount rate	41,300
Net decrease in benefit obligations	(300,000)
Net change in net assets available for benefits	
Additions to Plan assets available for benefits attributable to:	
Sponsor contributions	8,835
Participant contributions	117,871
Other contributions	8,034
Income from insurance policies	20,170
Net appreciation in fair value of investments	8,021
Interest income	329
Net increase in applicable life insurance account	1
Total additions	 163,261
	105,201
Deductions from Plan assets available for benefits attributable to:	
Payments for benefits	154,792
Net decrease in 401(h) account	24,365
Administrative expenses	11,024
Total deductions	 190,181
Net decrease in net assets available for benefits	 (26,920)
Decrease in excess of benefit obligations over net assets available for benefits	(273,080)
Excess of benefit obligations over net assets available for benefits: Beginning of year End of year	\$ 2,792,425 2,519,345

See accompanying notes.

Notes to Financial Statements (In Thousands)

December 31, 2016

1. Plan Description

The following description of the Nokia Retiree Welfare Benefits Plan (the Plan) provides only general information. Prior to January 1, 2017, the Plan was named the Alcatel-Lucent Retiree Welfare Benefits Plan. Participants should refer to the Plan document, and the plan documents and the summary plan descriptions of each of the component plans, for a more complete description of the Plan's provisions.

General

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

On January 7, 2016, Nokia, a Finnish corporation headquartered in Espoo (Helsinki), Finland, acquired a controlling interest in Alcatel Lucent, the (indirect) parent company of the Company. On November 2, 2016, Nokia acquired a 100% interest in Alcatel Lucent. Notwithstanding this change in the identity of the Company's ultimate parent, the Company continues to be the sponsoring employer and administrator of the Plan.

Effective January 1, 2017, eligible retired employees of Nokia Solutions and Networks US LLC became participants of the Retiree Medical Plan and the Retiree Dental Plan.

Notes to Financial Statements (continued) (In Thousands)

1. Plan Description (continued)

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

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

Benefits

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

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

During 2016, the Plan paid \$15,765 in HMO premiums, \$33,952 in MAPPO premiums, \$1,877 in DMO premiums and \$9,412 in dental PPO premiums to insurance carriers, which are included in payments for benefits. The Plan received refunds of certain of these premiums. See Note 2 for additional information.

Section 420 Maintenance of Cost Obligation

Section 420 of the Internal Revenue Code of 1986, as amended (the Code) permits employers to transfer "excess pension assets" (as defined in Section 420 of the Code) from a defined benefit pension plan to a "health benefits account" within the plan and to use the assets in such account to

Notes to Financial Statements (continued) (In Thousands)

1. Plan Description (continued)

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

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

Contributions

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

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

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

Notes to Financial Statements (continued) (In Thousands)

1. Plan Description (continued)

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

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

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

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

Effective January 1, 2015, post-March 1, 1990 management retirees paid non-subsidized contribution rates for access to coverage. Effective January 1, 2017, medical coverage was eliminated for post-March 1, 1990 non-Medicare eligible management retirees and their dependents.

Effective January 1, 2016, post-March 1, 1990 non-represented occupational retirees paid nonsubsidized contribution rates for access to coverage. Effective January 1, 2017, medical coverage was eliminated for post-March 1, 1990 non-Medicare eligible non-represented occupational retirees and their dependents.

Pursuant to a December 2004 collective bargaining agreement between the Sponsor and the Unions, the Lucent Supplemental Healthcare Benefits Trust for Formerly Represented Retirees (SHBT) was established for the exclusive purpose of paying a portion of the retiree healthcare

Notes to Financial Statements (continued) (In Thousands)

1. Plan Description (continued)

benefits that eligible participants and their beneficiaries who are covered by the agreement would otherwise be required to absorb through premiums and other payments. The SHBT provides reimbursement to the Sponsor for a portion of the participants' medical and/or dental expenses. This reimbursement is recorded as Other contributions on the Statement of Changes in Net Assets Available for Benefits.

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

Administrative Expenses

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

Other

At December 31, 2016 and 2015, the Plan's benefit obligations exceeded its net assets available for benefits. However, management expects that the Plan's net assets available for benefits and future Sponsor contributions will be sufficient to fund obligations as they become due.

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

2. Summary of Significant Accounting Policies

Basis of Presentation

The financial statements of the Plan have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP).

Notes to Financial Statements (continued) (In Thousands)

2. Summary of Significant Accounting Policies (continued)

Valuation of Investments and Income and Expense Recognition

The Plan invests in common/collective trusts and a registered investment company. Investments in common/collective trusts are valued at fair value based on the common/collective trusts' net asset values on the last business day of the Plan year as determined by the trusts' managers. There are currently no redemption restrictions on the common/collective trusts. Investments in the registered investment company are valued at fair value based on the fund's net asset value on the last business day of the Plan year as determined by the fund's net asset value on the last business day of the Plan year as determined by the fund's manager. See Note 3 for additional information.

Purchases and sales of investments are recorded on a trade-date basis. Interest income and administrative expenses are recorded on an accrual basis. Dividend income is recorded on investments held as of the ex-dividend dates. The net appreciation in fair value of investments consists of the realized gains and losses on the sales of securities and the unrealized appreciation (depreciation) of investments.

Valuation of Group Life Insurance Policies

The Plan has prepaid premiums for life insurance policies with an insurance company. The prepaid premiums are invested by the insurance company at the Plan's direction in equity, fixed income and international separate accounts and a general account, all of which are valued by the insurance company. The underlying investments in the separate accounts are valued at fair value generally using readily available market values. If there is no readily available market value for any asset in the separate accounts, the insurance company determines, at its discretion and in accordance with any applicable laws and regulations, the value to be used as such asset's market value. The Plan is allocated a portion of the earnings from these investments. The general account's interest crediting rate is currently based upon the six-month U.S. Treasury Bill plus 0.25% basis points. The policies are valued by the insurance company based on the fair value of the underlying assets in the separate accounts and the general account balance.

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

Notes to Financial Statements (continued) (In Thousands)

2. Summary of Significant Accounting Policies (continued)

New Accounting Pronouncements

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

In February 2017, the FASB issued ASU No. 2017-06, Plan Accounting: Defined Benefit Pension Plans (Topic 960), Defined Contribution Pension Plans (Topic 962), Health and Welfare Benefit Plans (Topic 965): Employee Benefit Plan Master Trust Reporting. ASU No. 2017-06 requires the Plan's interest in the master trust and the change in that interest to be presented in separate line items in the statement of net assets available for benefits and the statement of changes in net assets available for benefits, respectively; it also requires disclosure of: the total master trust investment amounts by general type and the dollar amount of the Plan's interest in each general type of investment, the master trust's other assets and liabilities and the dollar amount of the Plan's interest in each balance, and the net appreciation/(depreciation) in the fair value of the investments of the master trust and investment income exclusive of such net appreciation/(depreciation); additionally, it requires a description of the basis used to allocate net assets and total investment income to the Plan, including the Plan's percentage interest in the master trust as of the date of each statement of net assets available for benefits presented; lastly, it removes investment disclosures about 401(h) account assets to be provided in health and welfare benefit plan financial statements. ASU No. 2017-06 is effective for fiscal years beginning after December 15, 2018, with early application permitted. Plan management is currently evaluating the impact on the Plan of adopting ASU No. 2017-06.

Notes to Financial Statements (continued) (In Thousands)

2. Summary of Significant Accounting Policies (continued)

Accumulated Postretirement Benefit Obligation (APBO)

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

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

For purposes of determining the actuarial present value of accumulated plan benefits as of December 31, 2016, a 7.0% post-65 medical, 7.4% pre-65 medical and 11.5% pre- and post-65 prescription drug annual rate of increase in the per capita cost of covered benefits were assumed for 2017. These rates were assumed to decline gradually after 2017 to 5.0% by the year 2028 and then remain constant.

For purposes of determining the actuarial present value of accumulated plan benefits as of December 31, 2015, a 5% post-65 medical, 5.5% pre-65 medical and 11.5% pre- and post-65 prescription drug annual rate of increase in the per capita cost of covered benefits were assumed for 2016. These rates were assumed to decline gradually after 2016 to 5.0% by the year 2028 and then remain constant. These assumptions could greatly affect the amounts reported. To illustrate, increasing the assumed trend rate by 1% in each year could increase the APBO by \$60,300 and \$82,800 at December 31, 2016 and 2015, respectively.

Notes to Financial Statements (continued) (In Thousands)

2. Summary of Significant Accounting Policies (continued)

For dental care benefits, the rate is 3.5% for 2017 and beyond. For 2016, the rate was 3.5%. These assumptions could greatly affect the amounts reported. To illustrate, increasing the assumed trend rate by 1% in each year could increase the APBO by \$2,300 and \$2,700 at December 31, 2016 and 2015, respectively.

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

The following summarizes other significant actuarial assumptions used in the valuations as of December 31, 2016 and 2015, respectively:

Weighted-average discount rate: Mortality:	 3.60% (2016), 3.69% (2015) 2016: Society of Actuaries RP-2014 amounts – weighted, white collar for management retirees and blue collar for occupational retirees with MP-2016 generational projection scale 2015: Society of Actuaries RP-2014 amounts – weighted, white collar for management retirees and blue collar for occupational retirees with MP-2015 generational projection scale
Weighted average rate of compensation increase:	2.17% (2016), 2.24% (2015)

Notes to Financial Statements (continued) (In Thousands)

2. Summary of Significant Accounting Policies (continued)

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

In March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the Act) were enacted. The primary focus of the Act is to significantly reform health care in the U.S. The Plan has included the estimated effect of the Act in the valuation of its postretirement benefit obligation as of December 31, 2016 and 2015. The Plan continues to evaluate the various provisions of the Act.

Medicare Subsidy

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

Claims Incurred But Not Reported

Plan obligations at December 31, 2016 and 2015 for incurred but not reported claims are estimated by the Plan's actuary in accordance with accepted actuarial principles based on claims data provided by the Plan's third-party administrator. These amounts are paid by the Plan only if claims are submitted and approved for payment.

Use of Estimates

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

Notes to Financial Statements (continued) (In Thousands)

2. Summary of Significant Accounting Policies (continued)

Risks and Uncertainties

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

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

Payment of Benefits

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

Rebates and Refunds

Rebates and refunds are recorded when earned from the provider and netted with payments for benefits in the accompanying statement of changes in benefit obligations and net assets available for benefits. The Plan utilizes a pharmacy benefit manager which periodically issues rebates to the Plan based on the Plan's actual utilization pattern of specific drugs. The Plan also periodically receives premium refunds from the provider administering the MAPPO plan based on the ratio of revenues received to medical costs incurred. Rebates and refunds due as of the financial statement date have been reported as a receivable, with the offset being netted against payments for benefits. Rebates and refunds totaling \$118,361 have been netted with payments for benefits in the accompanying statement of changes in benefit obligations and net assets available for benefits for the year ended December 31, 2016.

Notes to Financial Statements (continued) (In Thousands)

2. Summary of Significant Accounting Policies (continued)

Due to Sponsor, Net

The Sponsor traditionally makes benefit payments on behalf of the Plan, net of participant contributions, and may opt to receive subsequent reimbursement from the Plan. As a result of timing, a liability has been reported on the statements of benefit obligations and net assets available for benefits as due to sponsor relating to such benefit payments made by the Sponsor that are not yet reimbursed by the Plan as of December 31, 2016 and 2015. Such reimbursements may be made subsequent to the Plan's year-end.

Revision of Previously Issued Financial Statements

The accompanying statement of benefit obligations and net assets available for benefits as of December 31, 2015 has been revised to correct an error in the Plan's postretirement benefit obligation. The previously issued financial statements included an estimate for certain individuals who were not eligible to receive life insurance benefits under the Plan. Management has concluded that this error is not material to the previously issued 2015 financial statements.

The impact of this revision is as follows (amounts in thousands):

	s previously issued ecember 31, 2015	As revised ecember 31, 2015
Accumulated postretirement benefit obligation:		
Current retirees	\$ 3,506,300	\$ 3,466,700
Other participants not yet fully eligible for benefits	\$ 57,000	\$ 56,000
Total benefit obligations	\$ 3,594,800	\$ 3,554,200
Excess of benefit obligations over net assets		
available for benefits	\$ 2,833,025	\$ 2,792,425

Notes to Financial Statements (continued) (In Thousands)

3. Investments

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

Fair Value Measurements

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

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

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

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

Notes to Financial Statements (continued) (In Thousands)

3. Investments (continued)

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value, as of December 31, 2016 and 2015. Assets are classified in their entirety based upon the lowest level of input that is significant to the fair value measurement.

	Assets at Fair Value as of December 31, 2016							
	Level 1*		Level 2* 1		Level 3**		Total	
	(In Thor				ousands)			
Group life insurance policies	\$	- \$	_	\$	325,592	\$	325,592	
Net assets held in Lucent Technologies Inc. Master								
Pension Trust – Restricted for 401(h) account		_	188,880		_		188,880	
Common/collective trusts		_	107,506		_		107,506	
Registered investment company		29,764	_		_		29,764	
Total assets at fair value	\$	29,764 \$	296,386	\$	325,592	\$	651,742	

*There were no transfers between Level 1 and Level 2 during the year ended December 31, 2016.

**There were no transfers in or out of Level 3 during the year ended December 31, 2016.

	Assets at Fair Value as of December 31, 2015						
	Lev	/el 1* 1	Level 2*	Ι	Level 3**		Total
	(In Tho			ousa	nds)		
Group life insurance policies	\$	- \$	_	\$	351,720	\$	351,720
Net assets held in Lucent Technologies Inc. Master							
Pension Trust – Restricted for 401(h) account		-	213,415		-		213,415
Common/collective trusts		_	109,306		-		109,306
Registered investment company		14,296	_		_		14,296
Total assets at fair value	\$	14,296 \$	322,721	\$	351,720	\$	688,737

*There were no transfers between Level 1 and Level 2 during the year ended December 31, 2015. **There were no transfers in or out of Level 3 during the year ended December 31, 2015.

Notes to Financial Statements (continued) (In Thousands)

3. Investments (continued)

The table below sets forth a summary of changes in the fair value of the Level 3 assets held by the Plan for the year ended December 31, 2016.

Balance, beginning of year	\$ 351,720
Purchases	40,000
Realized gains	_
Unrealized gains*	20,437
Settlements	(86,565)
Balance, end of year	\$ 325,592

*The unrealized gains on Level 3 assets are included in income from insurance policies in the statement of changes in benefit obligations and net assets available for benefits. This amount also represents net changes in unrealized appreciation/ (depreciation) on Level 3 assets still held as of December 31, 2016.

The Plan's valuation technique and the inputs used to value its Level 3 securities at December 31, 2016 and 2015 are based on net asset value as practical expedient.

4. Section 420 Transfers

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

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

Notes to Financial Statements (continued) (In Thousands)

4. Section 420 Transfers (continued)

The following tables present the components of the net assets available for retiree healthcare obligations funded under Code section 401(h) as of December 31, 2016 and 2015 and the related changes in net assets available for benefits for the year ended December 31, 2016.

Net assets restricted for 401(h) account as of:

	December 31			
		2016	2015	
Accrued interest receivable	\$	170 \$	59	
JPMCB Liquidity Fund		188,880	213,356	
Net assets available for benefits	\$	189,050 \$	213,415	

Changes in net assets available for benefits for the year ended December 31, 2016:

Transfer from Pension Plan	\$ 150,000
Interest income	921
Administrative expenses	(8,054)
Benefit payments	 (167,232)
Net decrease in 401(h) account	\$ (24,365)

The following tables present the components of the net assets available for applicable life insurance benefits under Code section 420 as of December 31, 2016 and 2015 and the related changes in net assets available for benefits for the year ended December 31, 2016.

Net assets restricted for applicable life insurance account as of:

	December 31		
	2016	6	2015
Accrued interest receivable	\$	1 \$	—

Changes in net assets available for benefits for the year ended December 31, 2016:

Transfer from Pension Plan	\$ 40,000
Interest income	1
Benefit payments	(40,000)
Net increase in applicable life insurance account	\$ 1

Notes to Financial Statements (continued) (In Thousands)

5. Tax Status

The Plan was originally funded by means of a trust established effective as of October 1, 1996 known as the Lucent Technologies Inc. Postretirement Life Insurance Benefits Trust (Life Insurance Benefits Trust). The Life Insurance Benefits Trust obtained a recognition of exemption letter from the Internal Revenue Service (IRS) dated November 25, 1998. The Life Insurance Benefits Trust was amended and restated in 2002, and its tax-exempt status was confirmed by a private letter ruling issued by the IRS on October 10, 2002. Pursuant to the private letter ruling, a further trust was established – the Nonrepresented Trust, and certain life insurance assets associated with the Life Insurance Trust were transferred to the Nonrepresented Trust. The Life Insurance Trust was also renamed the Represented Trust. The Represented Trust and the Nonrepresented Trust were each further amended in 2004. The IRS confirmed the tax-exempt status of both the Represented Trust and the Nonrepresented Trust by a private letter ruling issued September 8, 2004. The Nonrepresented Trust also obtained a recognition of exemption letter from the IRS dated May 24, 2011.

The Plan, the Represented Trust and the Nonrepresented Trust are required to operate in conformity with the Code to maintain their tax-exempt status. The Plan Administrator believes the Plan is being operated in compliance with the applicable requirements of the Code and, therefore, believes the related trusts are tax exempt. Accordingly, no provision for income taxes has been made.

Accounting principles generally accepted in the United States require the Plan Administrator to evaluate uncertain tax positions taken by the Plan. The financial statement effects of a tax position are recognized when the position is more likely than not, based on the technical merits, to be sustained upon examination by the IRS. The Plan Administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2016, there are no uncertain tax positions taken or expected to be taken. The Plan has recognized no interest or penalties related to uncertain tax positions. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Plan Administrator believes it is no longer subject to income tax examinations for years prior to 2013.

Notes to Financial Statements (continued) (In Thousands)

6. Party-In-Interest and Related-Party Transactions

As described in Note 1, the Plan pays certain investment and administrative expenses of the Plan to various service providers, which are parties-in-interest under the provisions of ERISA. The payment of these expenses meets the requirements of one or more prohibited transaction exemptions under ERISA.

Alcatel-Lucent Investment Management Corporation (ALIMCO), a wholly owned subsidiary of Alcatel-Lucent USA Inc. provides fiduciary services to the Plan. ALIMCO charges the Plan only for the costs that are incurred for providing such services to the Plan. For the year ended December 31, 2016, the Plan incurred fiduciary service fees of \$13, which are included in administrative expenses on the statement of changes in benefit obligations and net assets available for benefits. At December 31, 2016 and 2015, the Plan had a payable due to ALIMCO of \$3 and \$4, respectively, which is included in accrued administrative expenses on the statement of benefit obligations and net assets available for benefits.

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

7. Reconciliation of Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 as of December 31, 2016 and 2015:

	 2016	2015
Net assets available for benefits per the financial statements	\$ 734,855 \$	761,775
Less:		
Medical claims payable and claims incurred but not reported	(21,800)	(25,100)
Net assets held in Pension Plan – 401(h) account	(189,050)	(213,415)
Net assets held in Pension Plan – applicable life insurance account	 (1)	-
Net assets available for benefits per Form 5500	\$ 524,004 \$	523,260

Notes to Financial Statements (continued) (In Thousands)

7. Reconciliation of Financial Statements to Form 5500 (continued)

The following is a reconciliation of total deductions per the financial statements to the Form 5500 for the year ended December 31, 2016:

Total deductions per the financial statements	\$ 190,181
Add: Medical claims payable and liability for claims incurred	
but not reported at December 31, 2016	21,800
Less:	
Medical claims payable and liability for claims incurred	
but not reported at December 31, 2015	(25,100)
Net decrease in 401(h) account	 (24,365)
Total expenses per Form 5500	\$ 162,516

The following is a reconciliation of payments for benefits per the financial statements to the Form 5500 for the year ended December 31, 2016:

Total payments for benefits per the financial statements	\$ 154,792
Add: Medical claims payable and liability for claims incurred but not	
reported at December 31, 2016	21,800
Less: Medical claims payable and liability for claims incurred but not	
reported at December 31, 2015	 (25,100)
Total payments for benefits per Form 5500	\$ 151,492

Claims that have been processed and approved for payment at year-end but not paid and claims incurred but not reported are not considered liabilities under U.S. GAAP and, therefore, are not presented as liabilities or claims paid in the accompanying financial statements, but are recorded on the Form 5500 as a liability.

The net assets and related activity of the 401(h) account and applicable life insurance account included in the financial statements are not included in the Form 5500 because the assets are held by the Master Pension Trust.

8. Subsequent Events

Management has evaluated subsequent events through October 13, 2017, the date the financial statements were available to be issued. There were no material subsequent events that occurred between January 1, 2017 through October 13, 2017.

Supplemental Schedules

EIN #22-3408857 Plan #504

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

December 31, 2016

(b) Identity of Issue, Borrower, Lessor or Similar Party	, (c) Description of Investment	(d) Cost C	(e) Current Value
BlackRock	Equity Index Fund B Lendable	\$ 33,085,055 \$	60,245,951
BlackRock	U.S. Debt Index Fund B	24,199,388	26,667,230
BlackRock	EAFE Equity Index Fund B	17,078,033	20,592,785
Dreyfus	Treasury & Agency Cash Management Fund*	 29,763,624	29,763,624
		\$ 104,126,100 \$	137,269,590

* Represents party-in-interest

EIN #22-3408857 Plan #504

Schedule H, Line 4j – Schedule of Reportable Transactions

Year Ended December 31, 2016

Series of transactions in excess of 5%

		(a)		(c)	(d)	(g)	(i)
		Identity of	(b)	Purchase	Selling	Cost of	Net Gain
Count	Shares	Party Involved	Description of Asset	Price*	Price*	Asset	or (Loss)
163	144,545,673	Dreyfus	Treasury & Agency Cash Management Fund	\$ 144,545,673 \$	_	\$ -	\$ -
64	129,077,969	Dreyfus	Treasury & Agency Cash Management Fund	-	129,077,969	129,077,969	_

There were no category (i), (ii) or (iv) reportable transactions during the year ended December 31, 2016.

* At market

Plan Name	NOKIA RETIREE WELFARE BENEFITS PLAN
Plan Sponsor EIN	22-3408857
ERISA Plan No.	504
Plan Year End	12/31/2016

The required attachment noted below is included within the Accountant's Opinion attachment to the

Form 5500 Schedule H, Part III, which consists of the entire Audit report issued by the Plan's

Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line Item	Description
SCHEDULE H	LINE 4j	TRANSACTIONS IN EXCESS OF 5%

Plan Name	NOKIA RETIREE WELFARE BENEFITS PLAN
Plan Sponsor EIN	22-3408857
ERISA Plan No.	504
Plan Year End	12/31/2016

The required attachment noted below is included within the Accountant's Opinion attachment to the

Form 5500 Schedule H, Part III, which consists of the entire Audit report issued by the Plan's

Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line Item	Description
SCHEDULE H	LINE 4I	ASSETS HELD (AT END OF YEAR)