## Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110 1210-0089

2017

Administration		the instructions to the Form 5500.			1			
Pension Benefit Guaranty Corporation					This	Form is Open to Pu Inspection	ublic	
Part I	Annual Report Id	entification Information						
For caler		al plan year beginning 01/01/2017		and ending 12/31/20	17			
A This r	return/report is for:	a multiemployer plan		loyer plan (Filers checking the mployer information in accord			ns.)	
		X a single-employer plan	a DFE (specify	)				
<b>B</b> This r	eturn/report is:	the first return/report	the final return/	report				
		an amended return/report	a short plan ye	ar return/report (less than 12	months)			
C If the	plan is a collectively-barga	ined plan, check here				<b>×</b>		
<b>D</b> Chec	k box if filing under:	X Form 5558	automatic exten	sion	the	e DFVC program		
		special extension (enter description)	)					
Part II	Basic Plan Inforn	nation—enter all requested information	on					
	ne of plan RETIREE WELFARE BEN				1b	Three-digit plan number (PN) ▶	504	
					1c	1c Effective date of plan 10/01/1996		
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)					<b>2b</b> Employer Identification Number (EIN) 22-3408857		ntion	
NOKIA O	F AMERICA CORPORATI	ON			2c Plan Sponsor's telephone number 908-723-9869			
	INTAIN AVENUE, ROOM ( ' HILL, NJ 07974	6D-401A			2d Business code (see instructions) 334200		е	
Caution	A penalty for the late or	incomplete filing of this return/repor	t will be assessed u	unless reasonable cause is	establis	shed.		
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								
SIGN HERE	Filed with authorized/valid		10/08/2018	INGRID ORAV				
	Signature of plan admir	nistrator	Date	Enter name of individual sign	gning as	plan administrator		
SIGN HERE								
HERE	Signature of employer/p	olan sponsor	Date	Enter name of individual signing as employer or plan			onsor	

Date

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

SIGN HERE

Signature of DFE

Form 5500 (2017) v. 170203

Enter name of individual signing as DFE

	F. v. 5500 (0047)	D	2			
3a	Form 5500 (2017)  Plan administrator's name and address X Same as Plan Sponsor	Pa	age <b>2</b>	<b>3b</b> Administrat	or's EIN	
				3c Administration	or's telephone	
4	If the name and/or EIN of the plan sponsor or the plan name has changed sir enter the plan sponsor's name, EIN, the plan name and the plan number from			<b>4b</b> EIN 22-34	08857	
	Sponsor's name ALCATEL-LUCENT USA INC. Plan Name NOKIA RETIREE WELFARE BENEFITS PLAN			<b>4d</b> PN 504		
5	Total number of participants at the beginning of the plan year			5	86166	
6	Number of participants as of the end of the plan year unless otherwise stated <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).	l (welfare plan	s complete only lines 6a(1),			
a(	1) Total number of active participants at the beginning of the plan year			6a(1)	0	
<b>a</b> (2	2) Total number of active participants at the end of the plan year			6a(2)	0	
	Retired or separated participants receiving benefits			6b	82454	
	Other retired or separated participants entitled to future benefits			6c	0	
	Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> Deceased participants whose beneficiaries are receiving or are entitled to rec			6d 6e	82454	
f	Total. Add lines <b>6d</b> and <b>6e</b> .			6f		
g	Number of participants with account balances as of the end of the plan year (complete this item)			6g		
h	Number of participants who terminated employment during the plan year with less than 100% vested			6h		
7	Enter the total number of employers obligated to contribute to the plan (only r	multiemployer	plans complete this item)	. 7		
	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:  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					
	Plan funding arrangement (check all that apply)  (1)	(1) (2) (3) (4)	enefit arrangement (check all th  Insurance  Code section 412(e)(3)  X Trust  General assets of the s	insurance contra		
	Check all applicable boxes in 10a and 10b to indicate which schedules are at Pension Schedules		where indicated, enter the num  al Schedules	ber attached. (Se	ee instructions)	
а	(1) R (Retirement Plan Information)	(1)	H (Financial Infor	mation)		
		(2)	I (Financial Inform	•	an)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3)	X 26 A (Insurance Info		,	

(4)

(5)

(6)

C (Service Provider Information) **D** (DFE/Participating Plan Information)

**G** (Financial Transaction Schedules)

Purchase Plan Actuarial Information) - signed by the plan

**SB** (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

actuary

(3)

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)				
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)					
<b>11b</b> Is the	plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)				
11c Enter the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)					
Rece	ipt Confirmation Code				

Form 5500 (2017)

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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		parsaant to	ETTIOA 3000011 103(a)(2)	•			Inspection
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	ding 12/3	1/2017	
A Name of plan NOKIA RETIREE WELFA	ARE BENEFITS	PLAN			e-digit number (PN	l) <b>•</b>	504
C Plan sponsor's name a	as shown on line	2a of Form 5500		<b>D</b> Emplo	ver Identifica	ation Number	· (FIN)
NOKIA OF AMERICA CO		2 <u>2</u> 4 0 1 0 0000			3408857		(=)
		ning Insurance Contract.  Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or o	contract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
84-1011378	95434	092027	107	7	01/01/2017	,	12/31/2017
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, b	orokers, and	other persons in
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount o	of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker	r, or other person to who	m commiss	ions or fees	were paid	
							_
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	(a) Name a	nd address of the agent, broker	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd hase	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

P	art						
		If more than one contract covers the same of the information may be combined for reportion employees, the entire group of such individual.	ng purposes if such conti	acts are exp	perience-rated as a	unit. Where co	ontracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)		-			
	а	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insurance
	L			<u> </u>		ample, ment	
	e	Temporary disability (accident and sickness)	f Long-term disabilit		Supplemental un	employment	h Prescription drug
	İ	Stop loss (large deductible)	j 🔀 HMO contract	<b>k</b> [	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Ехр	erience-rated contracts:	ı		1		
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium rese	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))	ſ		I	9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)		T	
		(3) Incurred claims (add (1) and (2))					(
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or	·		1		_
		(A) Commissions	ŀ	9c(1)(A)			_
		(B) Administrative service or other fees	İ	9c(1)(B)			
		(C) Other specific acquisition costs	ľ	9c(1)(C)			_
		(D) Other expenses	İ	9c(1)(D)			_
		(E) Taxes		9c(1)(E)			_
		(F) Charges for risks or other contingencies (G) Other retention charges					_
			-			9c(1)(H)	
		(H) Total retention					
	٦.			_			
	d	Status of policyholder reserves at end of year: (1)	·				
		(2) Claim reserves					
	е	(3) Other reserves				` '	
10	_	onexperience-rated contracts:	i include amount entered	111111111111111111111111111111111111111	<i>j</i> .)		
10	a	Total premiums or subscription charges paid to ca	arrior			10a	55900
	_						33900
	b	If the carrier, service, or other organization incurred retention of the contract or policy, other than repo			•		
	Spe	ecify nature of costs.	rica iii i ait i, iiio 2 abov	o, roport am	ount:		
		•					
Р	art	IV Provision of Information					
11		d the insurance company fail to provide any inform	ation necessary to compl	ete Schedul	e A?	Yes	X No
		the answer to line 11 is "Yes," specify the information		cie ocneduli	о г.:		<u> </u>
1 4		the answer to line it is ites, specify the information	on not provided. 🔻				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		pursuant to t	ETTIOA 30011011 103(a)(2).			Inspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017	
A Name of plan NOKIA RETIREE WELFA	ARE BENEFITS	S PLAN		B Thre	e-digit number (PN)	504
C Plan sponsor's name as shown on line 2a of Form 5500  NOKIA OF AMERICA CORPORATION  D Employer Identification Number 22-3408857						er (EIN)
		rning Insurance Contract . Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
ALV EINI	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f) From	<b>(g)</b> To
13-1828429	55247	10093PD 000	49		01/01/2017	12/31/2017
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	tal commissions paid. Lis	st in line 3	the agents, brokers, and	other persons in
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount of fees paid	
3 Persons receiving com		ees. (Complete as many entries				
	<b>(a)</b> Name a	and address of the agent, broker,	, or other person to whon	n commiss	ions or fees were paid	
(b) Amount of sales ar	nd base	Fee	es and other commission	s paid		
commissions pa		(c) Amount	(	d) Purpos	e	(e) Organization code
	(a) Name a	and address of the agent, broker,	, or other person to whon	n commiss	ions or fees were paid	
(b) Amount of sales ar	nd base	Fee	es and other commission	s paid		
commissions pa		(c) Amount	(	d) Purpos	e	(e) Organization code
			5500			

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art	III	Welfare Benefit Contract Informal If more than one contract covers the same the information may be combined for report employees, the entire group of such individual to the contract of the c	group of employees of the ting purposes if such cont	racts are expe	erience-rated as a unit	t. Where c	ontracts cover indivi	
8	Ben	efit a	nd contract type (check all applicable boxes)	<u>_</u>		_		_	
	а	He	ealth (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insuranc	е
	е	Te	mporary disability (accident and sickness)	f Long-term disabilit	ty <b>g</b>	Supplemental unem	ployment	<b>h</b> Prescription	drug
	ιİ	Sto	op loss (large deductible)	j X HMO contract	k 🗌	PPO contract		I Indemnity co	ntract
	m		her (specify)	, .		I			
9	Ехр	erienc	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)		C
	b	Ben	efit charges (1) Claims paid		9b(1)				
			ncrease (decrease) in claim reserves				•		
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)		C
		(4) C	Claims charged				. 9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	on an accrual basis)					
		(	(A) Commissions						
			(B) Administrative service or other fees						
			(C) Other specific acquisition costs						
			(D) Other expenses						
			(E) Taxes						
			(F) Charges for risks or other contingencies.						
			(G) Other retention charges				0-/4\/!!	Λ.	
			(H) Total retention	_	_		9c(1)(H	)	
			Dividends or retroactive rate refunds. (These						
	d		us of policyholder reserves at end of year: (1	,			` '		
		` '	Claim reserves				9d(2)		
	_	` '	Other reserves				9d(3)		
10			dends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2).	.)	. 9e		
10	_		erience-rated contracts:				40-		200701
	а		al premiums or subscription charges paid to d				10a		203739
	_	rete	ntion of the contract or policy, other than rep				10b		
		rete ecify r	nature of costs.				10b		
Р	art	IV	Provision of Information						
11	Die	d the	insurance company fail to provide any inforn	nation necessary to compl	ete Schedule	A?	Yes	X No	
12	lf t	he ar	nswer to line 11 is "Yes," specify the informat	ion not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		F 4		-		inspection		
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017			
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	S PLAN			e-digit number (PN)	504		
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identification Numb	per (EIN)		
	NOKIA OF AMERICA CORPORATION 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 ca KEYSTONE HEALTH PLA								
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy of	or contract year		
<b>(b)</b> EIN	code	identification number	•	persons covered at end of policy or contract year		<b>(g)</b> To		
23-2399845	95199	509964	318		01/01/2017	12/31/2017		
	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						b		
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).				
	(a) Name a	and address of the agent, broke	er, or other person to whor	m commiss	ions or fees were paid			
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpose				
	(a) Name a	and address of the agent, broke	er, or other person to whor	m commiss	ions or fees were paid			
(b) Amount of sales and base Fees and other commissions paid								
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code		

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1				
(a) No.			aminaiana ar fana wara naid				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid				
4.1.		Fees and other commissions	paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code			
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid				
(-)		,					
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization			
commissions paid	(c) Amount	((	code				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
	<u> </u>						
(b) Amount of sales and base		Fees and other commissions p		(e) Organization			
commissions paid	(c) Amount	(1	d) Purpose	code			
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
		Fees and other commissions p	naid	(e)			
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code			
commissions paid		,		code			
(1)							
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
Fees and other commissions paid (e							
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code			

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art	III	Welfare Benefit Contract Informal If more than one contract covers the same the information may be combined for report employees, the entire group of such individual to the contract of the c	group of employees of the ting purposes if such cont	racts are expe	erience-rated as a unit	. Where c	ontracts cover indi	
8	Ben	efit a	nd contract type (check all applicable boxes)	_		_		_	
	а	He	ealth (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insura	nce
	е	Te	emporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Supplemental unem	ployment	<b>h</b> Prescriptio	n drug
	i İ	Sto	op loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity	contract
	m	_	ther (specify)	• 🗆	<u> </u>	I			
9	Ехр	eriend	ce-rated contracts:						
	а	Prem	iums: (1) Amount received		9a(1)				
		(2) lr	ncrease (decrease) in amount due but unpaid	b	9a(2)				
		(S) I	ncrease (decrease) in unearned premium res	serve	9a(3)				
		(4) E	arned ( <b>(1) + (2) - (3)</b> )				9a(4)		C
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) li	ncrease (decrease) in claim reserves		9b(2)				
		(S) I	ncurred claims (add (1) and (2))				9b(3)		C
		(4) C	Claims charged				9b(4)		
	C	Ren	nainder of premium: (1) Retention charges (c	n an accrual basis)					
			(A) Commissions						
			(B) Administrative service or other fees						
			(C) Other specific acquisition costs		- 4.3.4-3				
			(D) Other expenses						
			(E) Taxes						
			(F) Charges for risks or other contingencies.						
			(G) Other retention charges				0-/4\/11	1	
			(H) Total retention	_			9c(1)(H	)	
			Dividends or retroactive rate refunds. (These						
	d		us of policyholder reserves at end of year: (1				_ ` _		
		` '	Claim reserves				9d(2)		
		` '	Other reserves				9d(3)		
40			dends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2).	.)	. 9e		
10	_		erience-rated contracts:				40-		4000777
	а		al premiums or subscription charges paid to d				10a		1302777
		rete	ntion of the contract or policy, other than rep				10b		
		rete ecify r	nature of costs.				10b		
Р	art	IV	Provision of Information						
11	Di	d the	insurance company fail to provide any inform	nation necessary to comp	ete Schedule	A?	Yes	X No	
12	l If t	he ar	nswer to line 11 is "Yes," specify the informat	ion not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		F				mspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017	
A Name of plan		<b>B</b> Thre	e-digit			
NOKIA RETIREE WELFA	RE BENEFITS	S PLAN		plan	number (PN)	504
					,	
C Plan sponsor's name a	ıs shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identification Numbe	r (EIN)
NOKIA OF AMERICA CO	RPORATION			22-	3408857	
Part I Informat	ion Conce	rning Insurance Contra	ct Coverage, Fees,	and Con	nmissions Provide inf	ormation for each contract
on a separa	ate Schedule A	<ol> <li>Individual contracts grouped</li> </ol>	as a unit in Parts II and III	l can be re	ported on a single Sched	ule A.
1 Coverage Information:						
(a) Name of insurance ca	rrier					
GHC PUGET SOUND						
# N = N .	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year		(f) From	<b>(g)</b> To
04.0544770	05070	0000		•	04/04/0047	10/04/0047
91-0511770	95672	8800	78		01/01/2017	12/31/2017
•	·	<u> </u>				
Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. Li	st in line 3	the agents, brokers, and	other persons in
				4) T		
(a) Total amount of commissions paid (b) Total amount of fees paid						
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all p	persons).		
		and address of the agent, broke			sions or fees were paid	
			,			
(1) A		F	ees and other commission	ns naid		
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpose			(e) Organization code
commissions pa	iu	(C) Amount		(u) i dipos	<u>C</u>	(e) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to whor	n commiss	sions or fees were paid	
(b) Amount of sales and base Fees and other commissions paid						
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code
commissions pa		(4) /	<u> </u>		-	(a) organization todo

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1				
(a) No.			aminaiana ar fana wara naid				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid				
4.1.		Fees and other commissions	paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code			
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid				
(-)		,					
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization			
commissions paid	(c) Amount	((	code				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
	<u> </u>						
(b) Amount of sales and base		Fees and other commissions p		(e) Organization			
commissions paid	(c) Amount	(1	d) Purpose	code			
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
		Fees and other commissions p	naid	(e)			
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code			
commissions paid		,	<u>,                                      </u>	code			
(1)							
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
Fees and other commissions paid (e							
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code			

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art l	III Welfare Benefit Contract Informa	tion					
		If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	ng purposes if such contr	racts are exp	erience-rated as a uni	t. Where co	ontracts cover individual	
8	Bene	efit and contract type (check all applicable boxes)			<u> </u>			_
	аΓ	Health (other than dental or vision)	<b>b</b> Dental	сГ	Vision		<b>d</b> Life insurance	
	느			<u> </u>	<u></u>			
	e		f Long-term disabilit	· - =	Supplemental unem	pioyment	h Prescription drug	
	i	Stop loss (large deductible)	j X HMO contract	k_	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Expe	erience-rated contracts:	1					
	a F	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese	_	9a(3)		_		
	_	(4) Earned ((1) + (2) - (3))				. 9a(4)		<u>C</u>
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))				. 9b(3)		С
		(4) Claims charged				. 9b(4)		_
	С	Remainder of premium: (1) Retention charges (or		5 (1)(1)				
		(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	l-	9c(1)(D)				
		(E) Taxes		90(1)(E)				
		(F) Charges for risks or other contingencies (G) Other retention charges		9c(1)(G)				
		(H) Total retention	-			. 9c(1)(H)	1	
		(2) Dividends or retroactive rate refunds. (These					<i>)</i>	_
	٦			_				_
	d	Status of policyholder reserves at end of year: (1) (2) Claim reserves	·			`		_
		(3) Other reserves				. 9d(2) . 9d(3)		_
	е	Dividends or retroactive rate refunds due. (Do no						_
10		pnexperience-rated contracts:	t include amount entered	1 111 1111e 3C(2)	.)	., 36		
		Total premiums or subscription charges paid to ca	arrier			. 10a	3430	77
	_	If the carrier, service, or other organization incurre					0400	_
	D	retention of the contract or policy, other than repo	, ,		•	. 10b		
	Spe	ecify nature of costs.	, , , , , , , , , , , , , , , , , , , ,	-,				_
Pa	art I	IV Provision of Information						_
11	Dic	d the insurance company fail to provide any informa	ation necessary to compl	ete Schedule	A?	Yes	X No	
		he answer to line 11 is "Yes," specify the information		2.5 201104410				_
. 2	n u	no anower to line it is ites, specify the information	AT HOL PLOVIDED.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		pursuant to	ETTIOA SCOTIOTI TOS(a)(2)	•		Inspection	
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017		
A Name of plan NOKIA RETIREE WELFA	ARE BENEFITS	PLAN		B Thre	e-digit number (PN)	504	
C Plan sponsor's name a NOKIA OF AMERICA CO	RPORATION			22-	oyer Identification Numbe 3408857	· ,	
		rning Insurance Contrac  . Individual contracts grouped a					
Coverage Information:	ate Corredate 7	marviada contracto groupea c	as a drift in F dris it dria in	oun be re	ported on a single conec	auto 71.	
(a) Name of insurance ca UHC OF ARIZONA	rrier						
ALL FINE	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year	
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year		(f) From	<b>(g)</b> To	
94-3267522	95617	060408,060406	97		01/01/2017	12/31/2017	
descending order of the	amount paid. amount of commissions and formation (a) Name a	ees. (Complete as many entries and address of the agent, broker	as needed to report all p	(b) To	otal amount of fees paid	d other persons in	
commissions pa		(c) Amount		(d) Purpose		(e) Organization code	
	(a) Name a	and address of the agent, broker	, or other person to whor	n commiss	sions or fees were paid		
(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount		(d) Purpose		(e) Organization code	

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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Part III Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repo employees, the entire group of such indivi	e group of employees of the rting purposes if such contr	acts are exp	perience-rated as a u	nit. Where co	ontracts cover individual
8 Benefit and contract type (check all applicable boxes	)				
a Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
e Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental uner	mployment	h Prescription drug
i Stop loss (large deductible)	j X HMO contract	, J. k∫	_	, ,	I Indemnity contract
	, M Timo contract	., r	11 C contract		I Indemnity contract
m ☐ Other (specify) ▶					
O Evpariance rated contracts:					
9 Experience-rated contracts:		00/1)			_
a Premiums: (1) Amount received		9a(1) 9a(2)			_
(2) Increase (decrease) in amount due but unpa	To the second second second second second second second second second second second second second second second	9a(2)			
(3) Increase (decrease) in unearned premium re (4) Earned ((1) + (2) - (3))	_			9a(4)	
<b>b</b> Benefit charges (1) Claims paid	The state of the s	9b(1)		3a(4)	
(2) Increase (decrease) in claim reserves	T T	9b(1) 9b(2)			
(3) Incurred claims (add (1) and (2))	<u> </u>			9b(3)	
(4) Claims charged				9b(4)	
C Remainder of premium: (1) Retention charges (					
(A) Commissions	Γ	9c(1)(A)			
(B) Administrative service or other fees	T T	9c(1)(B)			_
(C) Other specific acquisition costs	<u> </u>	9c(1)(C)			_
(D) Other expenses	The state of the s	9c(1)(D)			
(E) Taxes	<u> </u>	9c(1)(E)			_
(F) Charges for risks or other contingencies	The state of the s	9c(1)(F)			
(G) Other retention charges		9c(1)(G)			_
(H) Total retention	-			9c(1)(H)	(
(2) Dividends or retroactive rate refunds. (Thes	e amounts were paid in	cash, or	credited.)		
<b>d</b> Status of policyholder reserves at end of year: (					
(2) Claim reserves	•			` '	
(3) Other reserves					
<b>e</b> Dividends or retroactive rate refunds due. (Do					
10 Nonexperience-rated contracts:			,	· ·	
<b>a</b> Total premiums or subscription charges paid to	carrier			10a	514294
<b>b</b> If the carrier, service, or other organization incu	rred any specific costs in co	nnection wi	th the acquisition or		
retention of the contract or policy, other than re	, ,		•	10b	
Specify nature of costs.					
Part IV Provision of Information					
11 Did the insurance company fail to provide any infor	mation necessary to comple	ete Schedul	e A?	Yes	X No
12 If the answer to line 11 is "Yes," specify the information					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017	inspection			
A Name of plan	·			_	e-digit				
NOKIA RETIREE WELFA	RE BENEFITS	SPLAN			number (PN)	504			
C Plan sponsor's name a	e chown on lin	o 20 of Form 5500		D Emple	oyer Identification Numb	or (EINI)			
NOKIA OF AMERICA CO		e 2a 01 F01111 5500		-	3408857	ei (Eiiv)			
	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:		<u> </u>							
(a) Name of insurance ca									
BLUE CROSS BLUE SHIE	LD								
	(c) NAIC	(d) Contract or	(e) Approximate no		Policy o	r contract year			
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To			
36-1236610	70670	H73523,B73523	21		01/01/2017	12/31/2017			
2 Insurance fee and com	mission informa	ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, an	d other persons in			
descending order of the	amount paid.		·			·			
(a) Total a	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 entrie	es as needed to report all	persons).					
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid				
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid					
commissions pai		(c) Amount		(d) Purpos	е	(e) Organization code			
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid				
(h) Amount of color or	nd book	F	ees and other commission	ns paid					
<b>(b)</b> Amount of sales ar commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code			
						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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Р	art						
		If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual.	ng purposes if such cont	racts are expe	erience-rated as a uni	it. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	y <b>g</b>	Supplemental unem	nlovment	h Prescription drug
	:		<u>=</u>	·	3	pioymoni	
	• [	☐ Stop loss (large deductible)	j X HMO contract	k_	PPO contract		I Indemnity contract
	m	Other (specify)					
_	F						
9	•	erience-rated contracts:		00(4)			_
	а	Premiums: (1) Amount received		9a(1) 9a(2)			_
		<ul><li>(2) Increase (decrease) in amount due but unpaid</li><li>(3) Increase (decrease) in unearned premium res</li></ul>		9a(2)			_
		(4) Earned ((1) + (2) - (3))		· · · · ·		. 9a(4)	0
	b	Benefit charges (1) Claims paid				. <sub>1</sub>	
	-	(2) Increase (decrease) in claim reserves		(-)			_
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)	0
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (or	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					
		(E) Taxes					_
		(F) Charges for risks or other contingencies		9c(1)(F)			_
		(G) Other retention charges				0-(4)(11)	
		(H) Total retention				. 9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These					
	d	Status of policyholder reserves at end of year: (1)					
		(2) Claim reserves				. 9d(2)	
	_	(3) Other reserves				. 9d(3) . 9e	_
10	e No	Dividends or retroactive rate refunds due. (Do no onexperience-rated contracts:	ot include amount entered	i in line 90(2)	.)	., 96	
	a	Total premiums or subscription charges paid to c	arrier			. 10a	430177
	b	If the carrier, service, or other organization incurr					430111
	D	retention of the contract or policy, other than repo			•	. 10b	
	Spe	ecify nature of costs.	, ,	., .,			
_	ort.	IV Provision of Information					
	art						
11		d the insurance company fail to provide any inform		ete Schedule	A?	Yes	X No
12	! If t	the answer to line 11 is "Yes," specify the information	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		F *** ********************************				mspection	
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017		
A Name of plan				B Three-digit			
NOKIA RETIREE WELFA	ARE BENEFITS	S PLAN		plan	number (PN)	504	
C Plan sponsor's name a		e 2a of Form 5500			oyer Identification Number	er (EIN)	
NOKIA OF AMERICA CO	RPORATION			22-	3408857		
Part I Informat	tion Conce	rning Insurance Contra	ct Coverage, Fees,	and Con	nmissions Provide in	formation for each contract	
	ate Scriedule A	A. Individual contracts grouped	as a unit in Parts II and I	i can be re	ported on a single sched	aule A.	
1 Coverage Information:							
(a) Name of insurance ca	rrior						
` '		05.0.04					
KAISER FOUNDATION HI	EALIH PLAN	JF S. CA					
		40.0	(e) Approximate no	umber of	Policy or	contract year	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a		(f) From	(g) To	
	0000	identification frameer	policy or contract	t year	(1) 1 10111	(9) 10	
94-1340523	00000	122636	346	6	01/01/2017	12/31/2017	
		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, and	other persons in	
descending order of the							
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).			
•		and address of the agent, broke			sions or fees were paid		
			,				
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code	
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid		
			and other committee:	no noid			
(b) Amount of sales ar			ees and other commissio	•		<del>-</del>	
commissions pa	ıa	(c) Amount		(d) Purpos	e	(e) Organization code	

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art	III	Welfare Benefit Contract Informalify more than one contract covers the same the information may be combined for report employees, the entire group of such individuals.	group of employees of the ting purposes if such conti	racts are expe	erience-rated as a unit	. Where co	ontracts cover individual
8	Bene	efit ar	nd contract type (check all applicable boxes)		•	<u> </u>		·
	а	_	alth (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insurance
	e	_	mporary disability (accident and sickness)	f Long-term disabilit		Supplemental unemp	alaymant	h Prescription drug
		=			· ~ \	İ	pioyinent	
	'	_	p loss (large deductible)	j X HMO contract	k∐	PPO contract		I Indemnity contract
	m	Otl	ner (specify)					
9	•		e-rated contracts:	!				
			ums: (1) Amount received		9a(1)			
			crease (decrease) in amount due but unpai					_
			crease (decrease) in unearned premium res				00(4)	(
			arned ( <b>(1) + (2) - (3)</b> ) efit charges (1) Claims paid				9a(4)	
			crease (decrease) in claim reservescurred claims (add (1) and (2))				9b(3)	(
			laims charged				9b(3) 9b(4)	
		` '	ainder of premium: (1) Retention charges (c				30(4)	
	Ū		A) Commissions		9c(1)(A)			
		,	B) Administrative service or other fees					
		,	C) Other specific acquisition costs		0 (4)(0)			_
		,	D) Other expenses		0 (4)(5)			
		(	E) Taxes		9c(1)(E)			
		(	F) Charges for risks or other contingencies.		9c(1)(F)			
		(	G) Other retention charges		9c(1)(G)			
			H) Total retention				9c(1)(H	)
		(2)	Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Stati	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement		
		(2) C	Claim reserves				9d(2)	
		(3) C	Other reserves				9d(3)	
			lends or retroactive rate refunds due. (Do n	ot include amount entered	d in line <b>9c(2)</b> .	)	. 9e	
10	) No	nexp	erience-rated contracts:					
	а	Tota	I premiums or subscription charges paid to o	arrier			10a	1082772
	b	reter	e carrier, service, or other organization incurnition of the contract or policy, other than rep				10b	
		cify n	ature of costs.					
Р	art I	V	Provision of Information			<u> </u>		
11	Dic	the i	nsurance company fail to provide any inforn	nation necessary to compl	ete Schedule	A?	Yes	X No
12	2 If th	he an	swer to line 11 is "Yes," specify the informat	ion not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		parodant to i	LINIOA 3000011 103(a)(2)	•		Inspection
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	iding 12/31/2017	
A Name of plan NOKIA RETIREE WELFARE BENEFITS PLAN				B Thre	e-digit number (PN)	504
C Plan sponsor's name as shown on line 2a of Form 5500  NOKIA OF AMERICA CORPORATION  D Employer Identification Number (Eleganor) 22-3408857						er (EIN)
		ning Insurance Contract. Individual contracts grouped a				
Coverage Information:	ato Corrodato 71	. marriadar contracto groupou a	io a anii ii i ano ii ana ii	0411 50 10	ported on a onigio cono.	2410 7 1.
(a) Name of insurance ca		DF CO				
<i>a</i> > <b>-</b> · · ·	(c) NAIC	(d) Contract or	etract or (e) Approximate nu		Policy or	contract year
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f) From	<b>(g)</b> To
84-0591617	95669	07368	333		01/01/2017	12/31/2017
descending order of the		ation. Enter the total fees and tot	tal commissions paid. Li		the agents, brokers, and	d other persons in
(1)				(-,	,	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).		
	(a) Name a	nd address of the agent, broker,	, or other person to whor	n commiss	ions or fees were paid	
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid		
commissions pai	id	(c) Amount		(d) Purpose	e	(e) Organization code
	(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 ar	nd base	Fee	es and other commissior	ns paid		
commissions pai		(c) Amount	(	(d) Purpos	e	(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1			
(a) No.			aminaiana ar fana wara naid			
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid			
Fees and other commissions paid						
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code		
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid			
(-)		,				
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization		
commissions paid	(c) Amount	(0	d) Purpose	code		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid			
	Г			1		
(b) Amount of sales and base		Fees and other commissions p		(e) Organization		
commissions paid	(c) Amount	((	d) Purpose	code		
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid			
		Fees and other commissions p	naid	(e)		
(b) Amount of sales and base	(c) Amount		d) Purpose	Organization		
commissions paid	(0)	,		code		
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid			
		Fees and other commissions	paid	(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 indivithis report.	idual contrac	cts with each carrier may	/ be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:				
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-						
a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation 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))	<u>.</u>		. 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)			
		\(\frac{1}{2} \)	( ./			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	Part III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such contr	acts are exp	perience-rated as a ur	nit. Where co	ontracts cover individual	
8	Benefit a	and contract type (check all applicable boxes)						
	а∏н	ealth (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance	
	е ∏ те	emporary disability (accident and sickness)	f Long-term disabilit	у <b>д</b> [	Supplemental uner	nployment	h Prescription drug	I
		top loss (large deductible)	j X HMO contract	, J k	=	. ,	I Indemnity contract	
	_		, Maria de la contract	•	11 0 dominant		i I Indominity contract	,,
	m∐o	ther (specify)						
^	<b>-</b>	an material and an attraction						
9	•	ce-rated contracts:	ſ	0-/4\	1			
		niums: (1) Amount received		9a(1)				
		ncrease (decrease) in amount due but unpaid	The state of the s	9a(2) 9a(3)				
		ncrease (decrease) in unearned premium res	-			02/4)		
		Earned ( <b>(1) + (2) - (3)</b> ) nefit charges (1) Claims paid	T T	9b(1)		9a(4)		
		ncrease (decrease) in claim reserves		9b(1)				
	` '	ncurred claims (add (1) and (2))	<u> </u>		1	9b(3)		
		Claims charged				9b(4)		
	` '	mainder of premium: (1) Retention charges (o				05(4)		
	• 1101	(A) Commissions	· · · · · · · · · · · · · · · · · · ·	9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs	ļ ·	9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes	ļ ·	9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)		(
	(2)	Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	<b>d</b> Sta	tus of policyholder reserves at end of year: (1	) Amount held to provide !	benefits afte	r retirement	` '		
	(2)	Claim reserves				9d(2)		
	(3)	Other reserves				- 1/->		
	<b>e</b> Divi	idends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2	<b>)</b> .)	9e		
10	<b>)</b> Nonexp	perience-rated contracts:						
	<b>a</b> Tota	al premiums or subscription charges paid to c	arrier			<u>10a</u>	1	252808
	<b>b</b> If th	ne carrier, service, or other organization incurr	ed any specific costs in co	onnection wi	ith the acquisition or			
	rete	ention of the contract or policy, other than repo	orted in Part I, line 2 above	e, report am	ount	10b		
	Specify i	nature of costs.						
F	Part IV	Provision of Information						
11	_	insurance company fail to provide any inform	ation necessary to comple	ete Schedul	e A?	Yes	X No	
		nswer to line 11 is "Yes," specify the informati						
		, , ,	•					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017	inspection
A Name of plan					e-digit	
NOKIA RETIREE WELFARE BENEFITS PLAN				plan	number (PN)	504
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identification Number	er (EIN)
NOKIA OF AMERICA CO				-	3408857	
		rning Insurance Contract. Individual contracts grouped				
1 Coverage Information:	ate ochedule /	marviduai contracts grouped	as a unit in r arts ir and ir	i can be ie	ported on a single oche	dule A.
1 Coverage information.						_
(a) Name of insurance ca						
KAISER FOUNDATION HE	EALTH PLAN I	NORTHWEST				
	(a) NIAIC	(d) Controlt or	(e) Approximate no	umber of	Policy or	r contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	t end of	(f) From	<b>(g)</b> To
93-0798039	95540	8384	policy or contract		01/01/2017	12/31/2017
	00010	0001			01/01/2011	12/01/2011
2 Insurance fee and com	mission inform	ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers, and	d other persons in
descending order of the		missions noid		(b) T	atal amount of food poid	
(a) 10tai a	amount of com	missions paid		(b) 10	otal amount of fees paid	
3 Dorono rocciving com	missions and f	ees. (Complete as many entrie	on an anadad to report all	norsons)		_
3 Persons receiving com		and address of the agent, broke			ions or fees were naid	
	(a) Hamo c	and address of the agent, broke	ir, or other percent to who		none of food word para	
			and other commission	no noid		
(b) Amount of sales ar commissions pai		(c) Amount	Fees and other commissions paid  (d) Purpose		(e) Organization code	
- Commissions par	u .	(b) / timount		(d) i dipos	<u> </u>	(c) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were paid	
(b) Amount of sales ar	nd hoos	F	ees and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code
				•		

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	Part II Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.							
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4				
		rent value of plan's interest under this contract in separate accounts at year e			5				
		tracts With Allocated Funds:			1 - 1				
·	a	State the basis of premium rates							
	b	Premiums paid to carrier			6b				
	С	Premiums due but unpaid at the end of the year			6c				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferred	d annuity						
		(3) definition of the other (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here					
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma							
-	а	Type of contract: (1) deposit administration (2) immedia							
	u			on gaarantoo					
		(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))	<u></u>		. 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)						
		\(\frac{1}{2} \)	( - /						
		•							
		(5) Total deductions			. 7e(5)	0			

0

ı	Page	4

P	art l	III Welfare Benefit Contract Informa	tion					
		If more than one contract covers the same g the information may be combined for reporting employees, the entire group of such individu	ng purposes if such conti	racts are exp	erience-rated as a uni	t. Where co	ontracts cover individual	
8	Bene	nefit and contract type (check all applicable boxes)		-	<u> </u>		·	_
	аΓ		<b>b</b> Dental	сГ	Vision		<b>d</b> Life insurance	
	느		봄	<u> </u>	<u>.</u>		븜	
	e	, (, , (, ,, ,, ,,	f Long-term disabilit	· - =	Supplemental unem	pioyment	h ☐ Prescription drug	
	i	Stop loss (large deductible)	j X HMO contract	k_	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Expe	erience-rated contracts:	-					
	a F	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese		9a(3)		1		
	_	(4) Earned ((1) + (2) - (3))				. 9a(4)		С
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))				. 9b(3)		C
		(4) Claims charged				. 9b(4)		_
	С	Remainder of premium: (1) Retention charges (or						
		(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		90(1)(E)				
		(F) Charges for risks or other contingencies (G) Other retention charges		9c(1)(G)				
		(H) Total retention	•			. 9c(1)(H)	1	
		(2) Dividends or retroactive rate refunds. (These					<i>)</i>	_
	٦			_				_
	d	Status of policyholder reserves at end of year: (1) (2) Claim reserves	·			•		_
		(3) Other reserves				9d(2) 9d(3)		_
	е	Dividends or retroactive rate refunds due. (Do no						
10		pnexperience-rated contracts:	i ilicidae alliodili elilerec	1 111 1111e 3C(2)	.)	., 36		
		Total premiums or subscription charges paid to ca	rrier			. 10a	2518	64
	_	If the carrier, service, or other organization incurre					2010	_
	D	retention of the contract or policy, other than repo	, .			10b		
	Spe	ecify nature of costs.	, =	-,			<b>"</b>	_
Pa	art I	IV Provision of Information						_
		d the insurance company fail to provide any informa	ation necessary to compl	ete Schedule	Α?	Yes	X No	_
		the answer to line 11 is "Yes," specify the information		oto concadio				
14	11 (1	the answer to line it is lies, specify the information	ii not provided. 🔻					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		pursuant to	E(10A, 3001011, 103(a)(2)	•		Inspection			
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	iding 12/31/2017				
A Name of plan NOKIA RETIREE WELFA	ARE BENEFITS	PLAN			e-digit number (PN)	504			
C Plan sponsor's name a NOKIA OF AMERICA CO		e 2a of Form 5500		-	oyer Identification Number 3408857	er (EIN)			
Part I Informat	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:		9 F			grand and an emigrand				
(a) Name of insurance ca		MIDATLANTIC							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a		Policy or	contract year			
<b>(b)</b> EIN	code	identification number	policy or contrac		(f) From	<b>(g)</b> To			
52-0954463	95639	2204	66	3	01/01/2017	12/31/2017			
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, brokers, and	d other persons in			
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid								
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s 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 ar	nd base	Fe	es and other commission	ns paid					
commissions pa		(c) Amount		(d) Purpose	e	(e) Organization code			
	(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 ar	nd base	Fe	es and other commission	ns paid					
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code			

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	Part II Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.							
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4				
		rent value of plan's interest under this contract in separate accounts at year e			5				
		tracts With Allocated Funds:			1 - 1				
·	a	State the basis of premium rates							
	b	Premiums paid to carrier			6b				
	С	Premiums due but unpaid at the end of the year			6c				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferred	d annuity						
		(3) definition of the other (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here					
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma							
-	а	Type of contract: (1) deposit administration (2) immedia							
	u			on gaarantoo					
		(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))	<u></u>		. 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)						
		\(\frac{1}{2} \)	( - /						
		•							
		(5) Total deductions			. 7e(5)	0			

0

ı	Page	4

F	Part	III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual.	group of employees of the ting purposes if such cont	racts are exp	erience-rated as a uni	it. Where co	ontracts cover indiv	
8	Ben	efit a	nd contract type (check all applicable boxes)						
	а	Не	ealth (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insuran	ce
	е	Te	mporary disability (accident and sickness)	f Long-term disability	ty <b>g</b>	Supplemental unem	plovment	h Prescription	ı drua
	ı İ	=	pp loss (large deductible)	j X HMO contract		PPO contract	1 -7	I ☐ Indemnity c	•
	· L			J M TIMO CONTIACT	·` L			I I Indemnity e	Jillaot
	m	_ 01	her (specify)						
0		vi o n	as rated contracts.						
J			ce-rated contracts: 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)		
	b	. ,	efit charges (1) Claims paid				., • • • • • •		
			ncrease (decrease) in claim reserves		• •				
			ncurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)		(
			claims charged				. 9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	n 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.		0.74\70\				
			(G) Other retention charges				<b>5</b> (4) (1)		
			(H) Total retention				. 9c(1)(H)	1	(
	_		Dividends or retroactive rate refunds. (These	<b>—</b>			<b>— `</b>		
	d		us of policyholder reserves at end of year: (1	•			• • •		
		` '	Claim reserves				. 9d(2)		
	_	` '	Other reserves						
11			dends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2)	).)	9e		
1	_		erience-rated contracts: Il premiums or subscription charges paid to c	corrior			. 10a		217420
	a						. Iva		217439
	b Sne	rete	e carrier, service, or other organization incuring the contract or policy, other than representative of costs.				. 10b		
		cify r	eature of costs.						
F	art l	V	Provision of Information						
1	<b>l</b> Dic	the	insurance company fail to provide any inform	ation necessary to compl	ete Schedule	e A?	Yes	X No	
12	2 If the	he ar	swer to line 11 is "Yes," specify the informat	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		F 4				mspection			
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017				
A Name of plan NOKIA RETIREE WELFARE BENEFITS PLAN				e-digit number (PN)	504				
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identification Numb	per (EIN)			
	NOKIA OF AMERICA CORPORATION 22-3408857								
Part I Information a separa	tion Conce ate Schedule A	rning Insurance Contrada. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	and Con	nmissions Provide i	nformation for each contract edule A.			
1 Coverage Information:									
(a) Name of insurance ca		OF GA							
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy of	or contract year			
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To			
58-1592076	96237	2081	49		01/01/2017	12/31/2017			
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. Li	st in line 3	the agents, brokers, an	nd other persons in			
(a) Total amount of commissions paid (b) Total amount of fees paid									
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).					
	(a) Name a	and address of the agent, broke	er, or other person to whor	n commiss	ions or fees were paid				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid					
commissions pa	id	(c) Amount		(d) Purpose	e	(e) Organization code			
	(a) Name	and address of the agent, broke	er, or other person to whor	n commiss	ions or fees were paid				
(b) Amount of sales ar	nd base	F	ees and other commissior	ns paid					
commissions pa		(c) Amount		(d) Purpose	е	(e) Organization code			
Continues para (c) Amount (a) Purpose (									

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	Part II Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.							
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4				
		rent value of plan's interest under this contract in separate accounts at year e			5				
		tracts With Allocated Funds:			1 - 1				
·	a	State the basis of premium rates							
	b	Premiums paid to carrier			6b				
	С	Premiums due but unpaid at the end of the year			6c				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferred	d annuity						
		(3) definition of the other (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here					
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma							
-	а	Type of contract: (1) deposit administration (2) immedia							
	u			on gaarantoo					
		(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))	<u></u>		. 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)						
		\(\frac{1}{2} \)	( - /						
		•							
		(5) Total deductions			. 7e(5)	0			

0

ı	Page	4

P	art	Welfare Benefit Contract Informati If more than one contract covers the same group the information may be combined for reporting employees, the entire group of such individual	oup of employees of the gurposes if such contra	acts are expe	erience-rated as a	unit. Where co	ontracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)					·
•	a [		Dental	с	Vision		<b>d</b> Life insurance
				<u>_</u>	<u>.</u>		
	е		Long-term disability	y <b>g</b> _	Supplemental un	employment	h Prescription drug
	i	Stop loss (large deductible)	X HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
		_					
9	Ехр	perience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reserve	ve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	C
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	C
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on a	an accrual basis)				
		(A) Commissions	<u> </u>	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs	<u> </u>	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		_			0
		(2) Dividends or retroactive rate refunds. (These ar	mounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) A	amount held to provide b	enefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е		include amount entered	in line 9c(2).	.)	9e	
10	No	Ionexperience-rated contracts:					
	а	Total premiums or subscription charges paid to car	rier			10a	264440
	b	retention of the contract or policy, other than report					
	Spe	retention of the contract or policy, other than reported					
P	art	IV Provision of Information					
11	Die	oid the insurance company fail to provide any informat	ion necessary to comple	ete Schedule	A?	Yes	X No
		the answer to line 11 is "Yes," specify the information					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		F		-		inspection			
For calendar plan year 20	17 or fiscal pla	in year beginning 01/01/2017		and en	ding 12/31/2017	<del>_</del>			
A Name of plan NOKIA RETIREE WELFA	RE BENEFIT	S PLAN			e-digit number (PN)	504			
C Plan sponsor's name a	s shown on lir	ne 2a of Form 5500		<b>D</b> Emplo	yer Identification Numb	per (EIN)			
NOKIA OF AMERICA CO					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 ca		OF HI							
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy of	or contract year			
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To			
94-1340523	60053	639	13	3	01/01/2017	12/31/2017			
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. Li	ist in line 3	the agents, brokers, ar	nd other persons in			
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount of fees paid	b			
3 Persons receiving com	missions and t	fees. (Complete as many entrie	es as needed to report all	persons).					
	(a) Name	and address of the agent, broke	er, or other person to whor	m commiss	ions or fees were paid				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid					
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code			
	(a) Name	and address of the agent, broke	er, or other person to whor	m commiss	ions or fees were paid				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid					
commissions pa		(c) Amount		(d) Purpos	е	(e) Organization code			

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the ng purposes if such contr	acts are ex	perience-rated as	a unit. Where co	entracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i [		j X HMO contract	, S k			I  Indemnity contract
	m	Other (specify)	, <u></u>				
	!						
9	Fxp	erience-rated contracts:					
Ī		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	•	9a(2)			
		(3) Increase (decrease) in unearned premium rese		9a(3)			
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	(
		(4) Claims charged				:-:	
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	(
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide I	benefits afte	er retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not	t include amount entered	in line 9c(2	<b>2)</b> .)	9e	
10	) No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			10a	6705
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	onnection w	ith the acquisition	or	
	_	retention of the contract or policy, other than report	rted in Part I, line 2 above	e, report am	nount	10b	
		ecify nature of costs.					
F	art	IV Provision of Information					
11	Die	d the insurance company fail to provide any informa	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the information	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017	inspection
A Name of plan B Three-						
NOKIA RETIREE WELFA	RE BENEFITS	SPLAN		plan	number (PN)	504
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identification Number	er (EIN)
NOKIA OF AMERICA CO				-	3408857	
		rning Insurance Contract. Individual contracts grouped				
1 Coverage Information:	ate concadie 7	marviduai contracto groupea	as a difficult ratio it and t	i can be re	ported on a single cone	adio 7t.
1 Coverage information.						
(a) Name of insurance ca						
KAISER FOUNDATION HE	EALTH PLAN (	OF N. CA				
	(a) NIAIC	(d) Contract or	(e) Approximate n	umber of	Policy or	r contract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To
94-1340523	00000	35147	539		01/01/2017	12/31/2017
•						
Insurance fee and community descending order of the	mission inform amount paid.	ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers, and	d other persons in
	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 entrie	es as needed to report all	persons).		
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were paid	
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid		
commissions pai		(c) Amount		(d) Purpos	е	(e) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were paid	
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid		
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

Р	art	Welfare Benefit Contract Information If more than one contract covers the same ground the information may be combined for reporting employees, the entire group of such individual	up of employees of the purposes if such contra	acts are expe	erience-rated as a u	unit. Where co	ontracts cover individual
8	Ben	enefit and contract type (check all applicable boxes)					•
•	a [		Dental	с	Vision		<b>d</b> Life insurance
			브		1		
	е		Long-term disability	⁄ g <u>⊔</u>	Supplemental une	employment	h Prescription drug
	i	Stop loss (large deductible)	X HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
		_					
9	Ехр	perience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reserv	e	9a(3)			
		(4) Earned ((1) + (2) - (3))	<u>.</u> .			9a(4)	C
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	C
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on a	n 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	<u> </u>	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	_				) (
		(2) Dividends or retroactive rate refunds. (These are	nounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Ar	mount held to provide b	enefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е		nclude amount entered	in line 9c(2).	.)	9e	
10	No	Ionexperience-rated contracts:				_	
	а	Total premiums or subscription charges paid to carri	er			10a	2445669
	b	retention of the contract or policy, other than reporte					
	Spe	retention of the contract or policy, other than reporte pecify nature of costs.	d in Part I, line 2 above	e, report amo	unt	<u>10b</u>	
Р	art	IV Provision of Information					
		Did the insurance company fail to provide any information	on necessary to comple	ete Schedule	A?	Yes	X No
		the answer to line 11 is "Yes," specify the information		Joniodule			
. 4		and another to line 11 to 100, specify the information	not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		paradant to	ETTIOA SCCIOTI 103(a)(z)	•			Inspection
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	iding 12/3	1/2017	
A Name of plan NOKIA RETIREE WELFA	ARE BENEFITS	PLAN			e-digit number (PN	J) •	504
C Plan sponsor's name a	as shown on line	2a of Form 5500		D Emplo	ver Identific	ation Number	(FIN)
NOKIA OF AMERICA CO		5 28 OF FORM 5500			3408857	ation Number	(LIIV)
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
a > =	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or o	contract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
22-0999690	55069	79-77087	1		01/01/2017	7	12/31/2017
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s 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 ar	nd base	Fe	es and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	(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 ar	nd base	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>,                                      </u>	code	
(1)					
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reporting employees, the entire group of such individu	roup of employees of the	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i [		j X HMO contract	, S k	=	1 1, 1, 1	I  Indemnity contract
	m	Other (specify)	, A rame community				
	••••						
9	Exp	erience-rated contracts:					
•		Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpaid	•	9a(2)			_
		(3) Increase (decrease) in unearned premium rese		9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	(
	b	Benefit charges (1) Claims paid	The state of the s	9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	(
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (or	an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	(
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide I	benefits afte	er retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2	2 <b>)</b> .)	9e	
10	) No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	arrier			10a	20476
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	onnection w	vith the acquisition	n or	
		retention of the contract or policy, other than repo- ecify nature of costs.	rted in Part I, line 2 above	e, report am	nount	10b	
P	art	IV Provision of Information					
11	Die	d the insurance company fail to provide any informa	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the information	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		parodantio	ETTIOA SCCIIOTI TOS(a)(2)				Inspection
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	iding 12/3	1/2017	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (PN	۷) 🕨	504
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		D Emplo	ver Identifica	ation Number	· (FIN)
NOKIA OF AMERICA CO		2 24 01 1 01111 0000			3408857	anon nambor	(=)
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca UHC OF CALIFORNIA	rrier						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or o	contract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
95-2931460	00000	142111	211		01/01/2017	7	12/31/2017
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, I	brokers, and	other persons in
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount o	of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
	ı						_
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpos	е		(e) Organization code
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
		-	•				
(h) Amount of colors	nd hoos	Fe	es and other commission	ns paid			
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>,                                      </u>	code	
(1)					
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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Р	art	t III Welfare Benefit Contract Informatic If more than one contract covers the same grouthe information may be combined for reporting employees, the entire group of such individual	up of employees of the purposes if such contra	acts are expe	erience-rated as a u	unit. Where co	ontracts cover individual
8	Ben	enefit and contract type (check all applicable boxes)					
•	а		Dental	сГ	Vision		<b>d</b> ☐ Life insurance
			브	<u> </u>			
	е		Long-term disability	⁄ g∐	Supplemental une	employment	h Prescription drug
	i	Stop loss (large deductible)	X HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Ехр	perience-rated contracts:	<u>_</u>				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reserv	e	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	C
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	C
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on a	n accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees	<u>-</u>	9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes	F	9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges				0 (4)(1)	
		(H) Total retention	_				)
		(2) Dividends or retroactive rate refunds. (These am	_				
	d	Status of policyholder reserves at end of year: (1) Ar	mount held to provide b	enefits after	retirement		
		(2) Claim reserves					
		(3) Other reserves				` '	
	е		clude amount entered	in line <b>9c(2)</b> .	.)	9e	
10	No	Nonexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carri	er			<u>10a</u>	938946
	b	retention of the contract or policy, other than reporte					
	Spe	retention of the contract or policy, other than reporte pecify nature of costs.	d in Part I, line 2 above	e, report amo	unt	106	
Р	art	t IV Provision of Information					
		Did the insurance company fail to provide any information	on necessary to comple	ete Schedule	A?	Yes	X No
		f the answer to line 11 is "Yes," specify the information		, o Goriodale	,		<u> </u>
14	ıı I	the answer to line 11 is 165, specify the information	not provided. 🔻				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

For calendar plan year 20	For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017					
A Name of plan				<b>B</b> Three-digit		
NOKIA RETIREE WELFA	RE BENEFITS	PLAN		plan	number (PN)	504
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Number	r (EIN)
NOKIA OF AMERICA CO	RPORATION			22-	-3408857	
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage, Fee	s, and Cor	nmissions Provide inf	formation for each contract
		. Individual contracts grouped				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
PARTNERS NATL HEALT	H PLANS OF N	IC INC.				
			(e) Approximate	number of	Policy or	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered policy or contri	d at end of	(f) From	<b>(g)</b> To
56-0894904	54631	*SEE BELOW		707	01/01/2017	12/31/2017
2 Insurance fee and communication descending order of the	mission informa amount paid.	ation. Enter the total fees and to	otal commissions paid.	List in line 3	the agents, brokers, and	other persons in
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report	all persons).		
	(a) Name a	nd address of the agent, broke	r, or other person to w	hom commiss	sions or fees were paid	
(b) Amount of sales ar			ees and other commiss			
commissions pai	id	(c) Amount		(d) Purpos	e	(e) Organization code
	(a) Name a	nd address of the agent, broke	r, or other person to w	hom commiss	sions or fees were paid	
	(4)		, p			
(b) Amount of color or	ad basa	Fe	ees and other commiss	sions paid		
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code
For Donomicont Dodicatio	n Act Notice of	and the Instructions for Form	FF00		Cala	adula A (Farm 5500) 2017

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>,                                      </u>	code	
(1)					
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	/ be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e		5		
		tracts With Allocated Funds:				
·	a	State the basis of premium rates				
	b	Premiums paid to carrier		6b		
	С	Premiums due but unpaid at the end of the year		. 6c		
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			ion gaaramoo		
		(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))	<u>.</u>		. 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)			
		\(\frac{1}{2} \)	( ./			
		•				
		(5) Total deductions			. 7e(5)	0

0

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Р	art	Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individua	roup of employees of the ng purposes if such contr	acts are expe	erience-rated as a ι	unit. Where co	ontracts cover individual
8	Ber	nefit and contract type (check all applicable boxes)		<u> </u>		<u> </u>	·
•	a		<b>b</b> Dental	с	Vision		<b>d</b> Life insurance
			브	<u> </u>	<u>.</u>		
	е		f Long-term disabilit	y <b>g</b>	Supplemental une	employment	h Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
		_					
9	Ехр	perience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid.		9a(2)			
		(3) Increase (decrease) in unearned premium rese	rve	9a(3)			
		(4) Earned ((1) + (2) - (3))	r			9a(4)	C
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)		1	
		(3) Incurred claims (add (1) and (2))				9b(3)	C
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees	•	9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses	ľ	9c(1)(D)			
		(E) Taxes	•	9c(1)(E)			_
		(F) Charges for risks or other contingencies		9c(1)(F)			_
		(G) Other retention charges				0-/4\/11	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
		(H) Total retention	_				)
		(2) Dividends or retroactive rate refunds. (These a	<b>—</b>				
	d		•				
		(2) Claim reserves					
	_	(3) Other reserves					
40	<u>e</u>		t include amount entered	in line 9c(2).	.)	9e	
10	_	lonexperience-rated contracts:				400	000404
	а	1 0 1					863191
	b	retention of the contract or policy, other than repor					
	Spe	ecify nature of costs.	ted in Fart I, into 2 above	s, report amo	OI II.		
Р	art	IV Provision of Information					
		oid the insurance company fail to provide any informa	ation necessary to comple	ete Schedule	Α?	Yes	X No
				ole Goriedule	Λ:		<u>r</u>
12	. IT	the answer to line 11 is "Yes," specify the information	n not provided. 🔻				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		F 31. 2 31. 31.				Inspection		
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017			
A Name of plan NOKIA RETIREE WELFA	DE RENEEITS	S DI AN		<b>B</b> Thre		504		
NONIA RETIRLE WEELA	INC DENETTIC	OT LAIN		plan	number (PN)	304		
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identification Numbe	r (EIN)		
NOKIA OF AMERICA CO	RPORATION			22-	3408857			
Part I Informat on a separa	t <b>ion Conce</b> l ate Schedule A	rning Insurance Contra Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	<b>and Con</b> I can be re	<b>nmissions</b> Provide int ported on a single Sched	formation for each contract lule A.		
1 Coverage Information:								
( ) N ( )								
(a) Name of insurance ca UHC OF OKLAHOMA	rrier							
UNC OF OKLAHOWA								
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	or contract year		
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To		
33-0115166	96903	008102	106	i	01/01/2017	12/31/2017		
2 Insurance fee and com	mission inform	ation. Enter the total fees and t	otal commissions paid. Li	st in line 3	the agents brokers and	other persons in		
descending order of the		ation. Enter the total lees and t	otal commissions paid. Li	50 117 11110 0	and agento, brokers, and	Curer persons in		
(a) Total a	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 entrie	es as needed to report all	persons).				
		and address of the agent, broke			ions or fees were paid			
			ees and other commission	ns naid				
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purpose			(e) Organization code		
commissions par		(o) / imodite	'	( <b>a)</b> 1 dipoo	<u> </u>	(b) Organization code		
	(a) Name a	and address of the agent, broke	er, or other person to whor	m commiss	ions or fees were paid			
	, ,	<u> </u>						
(b) Amount of color and bose Fees and other commissions paid								
<b>(b)</b> Amount of sales and base		(c) Amount		is paid (d) Purposi	•	(e) Organization code		
commissions pai	u	(C) Amount	'	(w) i diposi	<u> </u>	(e) Organization code		

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1				
(a) No.			aminaiana ar fana wara naid				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid				
Fees and other commissions paid							
(b) Amount of sales and base commissions paid	(b) Amount of sales and base commissions paid (c) Amount (d) Purpose						
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid				
(-)		,					
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization			
commissions paid	(c) Amount	(0	d) Purpose	code			
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
	Г			1			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization			
commissions paid	(c) Amount	((	d) Purpose	code			
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
		Fees and other commissions p	naid	(e)			
(b) Amount of sales and base	(c) Amount		d) Purpose	Organization			
commissions paid	(0)	,		code			
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
Fees and other commissions paid							
(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 indivithis report.	idual contrac	cts with each carrier may	/ be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e		5		
		tracts With Allocated Funds:				
·	a	State the basis of premium rates				
	b	Premiums paid to carrier		6b		
	С	Premiums due but unpaid at the end of the year		. 6c		
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			ion gaaramoo		
		(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))	<u>.</u>		. 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)			
		\(\frac{1}{2} \)	( ./			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art							
		If more than one contract covers the same of the information may be combined for reportion employees, the entire group of such individual.	ing purposes if such conti	racts are exp	erience-rated as a un	it. Where co	ontracts cover individual	
8	Ben	nefit and contract type (check all applicable boxes)	-					
	а	Health (other than dental or vision)	<b>b</b> Dental	сГ	Vision		<b>d</b> Life insurance	
	L	블	<b>=</b>	L	<u></u>	n la venant		
	e	Temporary disability (accident and sickness)	f Long-term disabilit	`		ipioyment	h Prescription drug	
	Ī	Stop loss (large deductible)	j X HMO contract	k L	PPO contract		I Indemnity contract	
	m	Other (specify)						
	_							
9	Expe	perience-rated contracts:	ı					
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium res	erve	9a(3)		1		
		(4) Earned ((1) + (2) - (3))				9a(4)	(	
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves				1		
		(3) Incurred claims (add (1) and (2))				9b(3)	C	
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (or	n an accrual basis)		T			
		(A) Commissions	ŀ	9c(1)(A)			_	
		(B) Administrative service or other fees	ŀ	9c(1)(B)			_	
		(C) Other specific acquisition costs	ľ	9c(1)(C)			_	
		(D) Other expenses	l	9c(1)(D)				
		(E) Taxes					_	
		(F) Charges for risks or other contingencies					_	
		(G) Other retention charges	•			0o(1)(H)		
		(H) Total retention	_					
		(2) Dividends or retroactive rate refunds. (These	_					
	d		•					
		(2) Claim reserves				9d(2)		
	_	(3) Other reserves				9d(3)		
10	<u>e</u>	Dividends or retroactive rate refunds due. (Do no	include amount entered	in line 9c(2)	<b>]</b> .)	9e		
10	_	onexperience-rated contracts:  Total premiums or subscription charges paid to ca	orrior			10a	46740	
	a					<u>10a</u>	467194	
	b	If the carrier, service, or other organization incurred retention of the contract or policy, other than repo				10b		
	Spe	ecify nature of costs.	itted iii i ait i, iiile 2 abovi	e, report and	Juin	100		
	•	,						
P	art	IV Provision of Information						
			ation noosees to see !	oto Coba de la	. Д.	Yes	X No	
11		id the insurance company fail to provide any inform		ete Schedule	e A ?	169	<u> </u>	
12	12 If the answer to line 11 is "Yes," specify the information not provided.							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2017

This Form is Open to Public

		pursuant to i	ERISA Section 103(a)(2)				Inspection
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	iding 12/31/	2017	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (PN)	•	504
				·	, ,		
C Plan sponsor's name as shown on line 2a of Form 5500  NOKIA OF AMERICA CORPORATION  D Employer Identification Number (EIN) 22-3408857						(EIN)	
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide inform							
•	ate Schedule A	. Individual contracts grouped a	is a unit in Parts II and II	I can be re	ported on a sir	ngle Schedu	lle A.
1 Coverage Information:							
(a) Name of insurance ca HUMANA HEALTH PLANS							
	(c) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or c	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f) F	rom	<b>(g)</b> To
61-1013183	95885	*SEE BELOW	289	)	01/01/2017		12/31/2017
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	tal commissions paid. L	ist in line 3	the agents, br	okers, and o	other persons in
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount of	fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	, or other person to who	m commiss	ions or fees w	ere paid	
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
	(a) Name a	nd address of the agent, broker,	, or other person to who	m commiss	ions or fees w	ere paid	
(b) Amount of sales and base		Fee	es and other commission	ner commissions paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
For Donomicals Dodinatio	n Act Natice	see the Instructions for Form	EEOO			Caba	dula A (Form FEOO) 2017

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		<b>(e)</b> Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,		code	
(1)					
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the ng purposes if such contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	ı İ		j X HMO contract	k		. ,	I Indemnity contract
	m	Other (specify)	, <u></u>	1			
	••••						
9	Exp	erience-rated contracts:					
•		Premiums: (1) Amount received		9a(1)			
	_	(2) Increase (decrease) in amount due but unpaid	•	9a(2)			
		(3) Increase (decrease) in unearned premium rese		9a(3)			_
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)		1 7	
		(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )			1	9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees	•	9c(1)(B)			
		(C) Other specific acquisition costs	•	9c(1)(C)			_
		(D) Other expenses		9c(1)(D)			
		(E) Taxes	•	9c(1)(E)			
		(F) Charges for risks or other contingencies	•	9c(1)(F)			_
		(G) Other retention charges	1	9c(1)(G)			
		(H) Total retention	<del>-</del>			9c(1)(H)	(
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)		
	d	Status of policyholder reserves at end of year: (1)	<b>—</b>				
	<u> </u>	(2) Claim reserves	•			, , ,	
		(3) Other reserves					
	е	Dividends or retroactive rate refunds due. (Do not					
10		pnexperience-rated contracts:			<b>-</b> /		
	а	Total premiums or subscription charges paid to ca	rrier			10a	628150
	b	If the carrier, service, or other organization incurre					
		retention of the contract or policy, other than report					
	Spe	ecify nature of costs.					
_		N Draviaion of Information					
	art						
11		d the insurance company fail to provide any informa		ete Schedu	le A?	Yes	X No
12	2 If t	the answer to line 11 is "Yes," specify the information	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

		pursuant to E	RISA section 103(a)(2)	).			Inspection		
For calendar plan year 20°	17 or fiscal plan	year beginning 01/01/2017		and en	ding 12/3	1/2017			
A Name of plan NOKIA RETIREE WELFARE BENEFITS PLAN					e-digit number (PN	N) <b>•</b>	504		
C Plan sponsor's name as shown on line 2a of Form 5500 NOKIA OF AMERICA CORPORATION  D Employer Identification Number (EIN) 22-3408857						EIN)			
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance car METROPOLITAN LIFE INS		MPANY							
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			Policy or co	ntract year		
(b) EIN	code	identification number	policy or contrac		(f)	From	<b>(g)</b> To		
13-5581829	65978	95083-G	81643	3	01/01/2017	7	12/31/2017		
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 a	amount of comm			<b>(b)</b> To	otal amount	of fees paid	710007		
		180000					719297		
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	were paid			
AON CONSULTING			NETWORK PLACE GO, IL 60673-1298						
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid					
commissions pai		(c) Amount		(d) Purpos			(e) Organization code		
	180000		OMIN FEES SUPPLEM ONETARY COMPENS		MPENSATI	ON NON-	3		
	(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 ar	nd base	Fee	s and other commission	ns paid					
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code		
Fan Damamuanlı Danluştia	n Act Nation	see the Instructions for Form F	E00			Calaa	I.I. A (Farm FEOO) 2017		

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		<b>(e)</b> Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>,                                      </u>	code	
(1)					
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

Pa	пe	4

P	art	If more than one contract covers the same go the information may be combined for reporting the combine	group of employees of the ng purposes if such contr	acts are exp	perience-rated as a	a unit. Where co	entracts cover individual
		employees, the entire group of such individu	ial contracts with each cal	rrier may be	treated as a unit f	or purposes of the	nis report.
8	Bene	efit and contract type (check all applicable boxes)	. 🗖	_	7		. 🗖
	а	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		<b>d</b> X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	y <b>g</b>	Supplemental u	nemployment	<b>h</b> Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)	- <b>L</b>	_	_		
	L						
9	Expe	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)		42988816	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium rese	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	42988816
	b	Benefit charges (1) Claims paid		9b(1)		85787600	
		(2) Increase (decrease) in claim reserves	_	9b(2)		450607	
		(3) Incurred claims (add (1) and (2))				• • •	86238207
		(4) Claims charged				9b(4)	86238207
	С	Remainder of premium: (1) Retention charges (or	·	0 (4)(4)	Ī		_
		(A) Commissions	F	9c(1)(A)		180000	
		(B) Administrative service or other fees	F	9c(1)(B) 9c(1)(C)			_
		(C) Other specific acquisition costs	_	9c(1)(D)		4047047	_
		(D) Other expenses(E) Taxes	F	9c(1)(E)		1847947	
		(F) Charges for risks or other contingencies	F	9c(1)(F)		1191692 529184	
		(G) Other retention charges	-	9c(1)(G)		172371	
		(H) Total retention	_		<u> </u>		
		(2) Dividends or retroactive rate refunds. (These					560645
	d	Status of policyholder reserves at end of year: (1)	_				264148585
	-	(2) Claim reserves	·				22203844
		(3) Other reserves				- 1/2	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2)	<b>)</b> .)		
10	<b>)</b> No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	arrier			10a	
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	onnection wi	th the acquisition of	or	
	0	retention of the contract or policy, other than repo	rted in Part I, line 2 above	e, report amo	ount	10b	
	Spe	cify nature of costs.					
Р	art I	IV Provision of Information					
11		d the insurance company fail to provide any informa	ation necessary to comple	ete Schedule	e A?	Yes	X No
		he answer to line 11 is "Yes," specify the information		2.5 001100011		<u></u>	<u></u>
			st providod.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		pursuant to	ETTION 3000011 103(a)(2)	•		Inspection			
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	iding 12/31/2017				
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (PN)	504			
C Plan sponsor's name as shown on line 2a of Form 5500  NOKIA OF AMERICA CORPORATION				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 ca AETNA HEALTH PLANS	rrier								
/L\	(c) NAIC	(d) Contract or	(e) Approximate no		Policy or	contract year			
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To			
52-1270921	95287	*SEE BELOW	118	3	01/01/2017	12/31/2017			
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers, and	other persons in			
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount of fees paid				
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).					
	(a) Name a	nd address of the agent, broker	r, or other person to who	m commiss	ions or fees were paid				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid					
commissions pa	id	(c) Amount		(d) Purpos	е	(e) Organization code			
	(a) Name a	nd address of the agent, broker	r, or other person to who	m commiss	ions or fees were paid				
(b) Amount of sales ar	nd hase	Fe	es and other commission	ns paid					
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code			
			5500						

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		<b>(e)</b> Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>,                                      </u>	code	
(1)					
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

P	art l	III Welfare Benefit Contract Informa	tion				
		If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	ng purposes if such conti	acts are expe	erience-rated as a uni	t. Where co	ontracts cover individual
8	Bene	efit and contract type (check all applicable boxes)			<u> </u>		
	аΓ	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insurance
	_ 			<u> </u>	<u></u>		
	e		f Long-term disabilit		Supplemental unem	pioyment	h Prescription drug
	i L	Stop loss (large deductible)	j X HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Ехре	erience-rated contracts:	,				
	a i	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium rese		9a(3)		1	
	_	(4) Earned ((1) + (2) - (3))				. 9a(4)	C
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves				1	
		(3) Incurred claims (add (1) and (2))				. 9b(3)	0
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (or	Ī				
		(A) Commissions	l	9c(1)(A)			_
		(B) Administrative service or other fees	ŀ	9c(1)(B)			
		(C) Other specific acquisition costs	ľ	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		9c(1)(G)			
		(H) Total retention	·			. 9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These					,
	٦			_			
	d	Status of policyholder reserves at end of year: (1) (2) Claim reserves	·			•	
		(3) Other reserves				9d(2) 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no					
10		pnexperience-rated contracts:	include amount entered	111 11110 30(2)	.)	., 36	
		Total premiums or subscription charges paid to ca	arrier			. 10a	607317
	_	If the carrier, service, or other organization incurre					007017
	D	retention of the contract or policy, other than repo			•	10b	
	Spe	ecify nature of costs.	, =	-,			
Pa	art I	IV Provision of Information					
11	Dic	d the insurance company fail to provide any informa	ation necessary to compl	ete Schedule	А?	Yes	X No
		the answer to line 11 is "Yes," specify the information					<u>  </u>
. 2	n u	no anower to line it is ites, specify the infolliation	an not provided. 🔻				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		F				inspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017	
A Name of plan NOKIA RETIREE WELFA	ARE BENEFITS	S PLAN		<b>B</b> Thre	-	504
NORWALL WEEL	INC BENEFIN	ST EMV	-	plan	number (PN)	004
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identification Number	er (EIN)
NOKIA OF AMERICA CO	RPORATION			22-	3408857	
Part I Information a separa	t <b>ion Conce</b> l ate Schedule <i>F</i>	rning Insurance Contra  A. Individual contracts grouped	ct Coverage, Fees, a as a unit in Parts II and III	ind Con can be re	<b>nmissions</b> Provide in ported on a single Scheo	formation for each contract dule A.
1 Coverage Information:						
(a) Name of insurance ca	rrier					
	1	<u> </u>	(e) Approximate nui	mbor of	Policy or	contract year
<b>(b)</b> EIN	(c) NAIC	(d) Contract or identification number	persons covered at			
	code	identification number	policy or contract	year	(f) From	<b>(g)</b> To
36-1236610	70670	H73525,B73524	17		01/01/2017	12/31/2017
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. Lis	t in line 3	the agents, brokers, and	d other persons in
(a) Total a	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 entrie	es as needed to report all p	ersons).		
		and address of the agent, broke			sions or fees were paid	
(b) Amount of sales ar	nd base	F	ees and other commission	•		
commissions pa	id	(c) Amount		d) Purpos	e	(e) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to whom	commiss	sions or fees were paid	
	(4)	and addition of the agent, prom	5., c. cc. percent to inner.		morro di rece mere para	
(b) Amount of color and	ad boos	F	ees and other commission	s paid		
(b) Amount of sales ar commissions pa		(c) Amount		d) Purpos	e	(e) Organization code
- 1 -		, ,	,			,, ,

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

Р	art	t III Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individua	roup of employees of the ng purposes if such contr	acts are expe	erience-rated as a u	unit. Where co	ontracts cover individual
8	Ber	enefit and contract type (check all applicable boxes)					
•	а		<b>b</b> Dental	с	Vision		<b>d</b> Life insurance
			<u> </u>	<u>_</u>	<u>.</u>		
	е		f Long-term disabilit	y <b>g</b> _	Supplemental une	employment	h Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Ехр	perience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid.		9a(2)			
		(3) Increase (decrease) in unearned premium rese	rve	9a(3)		1	
		(4) Earned ((1) + (2) - (3))	r			9a(4)	C
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	C
		(4) Claims charged				9b(4)	
	C	Remainder of premium: (1) Retention charges (on	an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			_
		(E) Taxes	•	9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			_
		(G) Other retention charges				0 (4)(1)	
		(H) Total retention	_				)
		(2) Dividends or retroactive rate refunds. (These a					
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide I	penefits after	retirement		
		(2) Claim reserves					
		(3) Other reserves				` '	
4.0	е		include amount entered	in line <b>9c(2)</b> .	.)	9e	
10	No	Nonexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			<u>10a</u>	279142
	b	retention of the contract or policy, other than repor					
	Spe	retention of the contract or policy, other than repor	ted in Part I, line 2 above	e, report amo	unt.	100	
Р	art	t IV Provision of Information					
11	Di	Did the insurance company fail to provide any informa	tion necessary to comple	ete Schedule	A?	Yes	X No
		f the answer to line 11 is "Yes," specify the informatio		-			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		pursuant to	ENIOR Section 105(a)(z)	•			Inspection			
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	nding 12/31/201	7				
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (PN)	•	504			
C Plan sponsor's name a		e 2a of Form 5500			oyer Identification	Number (	(EIN)			
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.									
1 Coverage Information:										
(a) Name of insurance ca AETNA LIFE INSURANCE										
41 N = 1 N 1	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or co	ontract year			
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f) From	1	<b>(g)</b> To			
06-6033492	60054	0700140-RET	21049	)	01/01/2017		12/31/2017			
2 Insurance fee and coming descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents, broke	rs, and o	ther persons in			
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount of fee	s paid				
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).						
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	sions or fees were	paid				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid						
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code			
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	sions or fees were	paid				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid						
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code			

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

Р	art	III Welfare Benefit Contract Informa	ation				
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ing purposes if such cont	racts are expe	erience-rated as a uni	t. Where co	ntracts cover individual
8	Ber	nefit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> X Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	y <b>g</b>	Supplemental unem	nlovment	h Prescription drug
	:			·	<u>-</u>	ploymont	
	• !	Stop loss (large deductible)	j  HMO contract	k_	PPO contract		I Indemnity contract
	m	Other (specify)					
_	_						
9	•	erience-rated contracts:		0-(4)			_
	а	Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpaid		9a(2)			-
		(3) Increase (decrease) in unearned premium res				02/4)	0
	b	(4) Earned ((1) + (2) - (3))				.  9a(4)	0
		(2) Increase (decrease) in claim reserves		(-)			_
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)	0
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o					
		(A) Commissions	,	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes					
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				. 9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These					
	d	Status of policyholder reserves at end of year: (1					
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves				. 9d(3)	_
40	е .	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2)	.)	9e	
10	_	onexperience-rated contracts:				100	0500504
	a	Total premiums or subscription charges paid to c				. 10a	9588591
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo	, ,		•	. 10b	
	Spe	ecify nature of costs.	•	, I			
D	art	IV Provision of Information					
						Voc	V No
11		d the insurance company fail to provide any inform	•	ete Schedule	e A?	Yes	X No
12	! If t	the answer to line 11 is "Yes," specify the informati	ion not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		pursuant to	LINIOA 30011011 103(a)(2)	•		Inspection
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	iding 12/31/2017	
A Name of plan NOKIA RETIREE WELFA	ARE BENEFITS	PLAN			e-digit number (PN)	504
C Plan sponsor's name a	as shown on line	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Numbe	er (EIN)
NOKIA OF AMERICA CORPORATION				22-	3408857	
Part I Information a separa	t <b>ion Concer</b> ate Schedule A	ning Insurance Contrac . Individual contracts grouped a	t Coverage, Fees, as a unit in Parts II and II	and Con I can be re	<b>nmissions</b> Provide in ported on a single Sched	formation for each contract dule A.
1 Coverage Information:						
(a) Name of insurance ca						
/L. \ _	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f) From	<b>(g)</b> To
61-1103898	95270	*SEE BELOW	76	5	01/01/2017	12/31/2017
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, brokers, and	other persons in
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).		
<u> </u>		nd address of the agent, broker			ions or fees were paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid		
commissions pa	id	(c) Amount		(d) Purpose	e	(e) Organization code
	(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 ar	nd base	Fe	es and other commission	ns paid		
commissions pa		(c) Amount		(d) Purpos	е	(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

Р	art	t III Welfare Benefit Contract Informat If more than one contract covers the same gr the information may be combined for reportin employees, the entire group of such individua	oup of employees of the g purposes if such contra	acts are expe	erience-rated as a ur	nit. Where co	ontracts cover individual
8	Ber	enefit and contract type (check all applicable boxes)		· ·		<u> </u>	·
•	a		<b>b</b> Dental	с	Vision		<b>d</b> Life insurance
		<u>'</u>	브	<u> </u>			
	е		f Long-term disability	⁄ g <u></u>	Supplemental uner	nployment	h Prescription drug
	i	Stop loss (large deductible)	X HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
		_					
9	Ехр	perience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reser	rve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	C
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)		•	
		(3) Incurred claims (add (1) and (2))				9b(3)	C
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)				
		(A) Commissions	<u> </u>	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs	<u> </u>	9c(1)(C)			
		(D) Other expenses	<u> </u>	9c(1)(D)			
		(E) Taxes	l l	9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	_				) (
		(2) Dividends or retroactive rate refunds. (These a	mounts were paid in	cash, or	credited.)	··· 9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide b	enefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е		include amount entered	in line 9c(2).	)	9e	
10	No	Nonexperience-rated contracts:					
	а	Total premiums or subscription charges paid to car	rier			<u>10a</u>	61821
	b	retention of the contract or policy, other than report				10b	
		retention of the contract or policy, other than report pecify nature of costs.				<u>10b</u>	
Р	art	t IV Provision of Information					
		Did the insurance company fail to provide any information	tion necessary to comple	ete Schedule	А?	Yes	X No
		f the answer to line 11 is "Yes," specify the information					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		F 31. 3 3 3 1 1 1				inspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	S PLAN		B Thre	e-digit number (PN)	504
				pian	Thember (114)	
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Number	er (EIN)
NOKIA OF AMERICA CO					3408857	(,
		rning Insurance Contra  A. Individual contracts grouped				
1 Coverage Information:						
(a) Name of insurance ca AETNA HEALTH PLANS	rrier					
	(c) NAIC	(d) Contract or	(e) Approximate nu	mber of	Policy or	contract year
<b>(b)</b> EIN	code	(d) Contract or identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To
23-2169745	95109	*SEE BELOW	110		01/01/2017	12/31/2017
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. Li	st in line 3	the agents, brokers, and	d other persons in
(a) Total a	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 entrie	es as needed to report all	persons).		
<u> </u>		and address of the agent, broke			sions or fees were paid	
(b) Amount of sales ar			ees and other commission	•		<del>-</del>
commissions paid (c) Amount (d) Purpose			(e) Organization code			
	(a) Name a	and address of the agent, broke	er, or other person to whor	n commiss	sions or fees were paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid		
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(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))	<u></u>		. 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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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Р	Part III Welfare Benefit Contract Information						
		If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual.	ing purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ntracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unem	nlovment	h Prescription drug
	:		<u></u>	·	<u>-</u>	ploymont	
	• [	☐ Stop loss (large deductible)	j X HMO contract	k_	PPO contract		I Indemnity contract
	m	Other (specify)					
_	_						
9	•	erience-rated contracts:		0-(4)			_
	а	Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpaid					-
		(3) Increase (decrease) in unearned premium res				02/4)	0
	b	(4) Earned ((1) + (2) - (3))				.  9a(4)	
	D	(2) Increase (decrease) in claim reserves		(-)			_
		(3) Incurred claims (add (1) and (2))	· ·			. 9b(3)	0
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or					
		(A) Commissions	,	9c(1)(A)			
		(B) Administrative service or other fees		- (1)(-)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes					
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				. 9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These					
	d	Status of policyholder reserves at end of year: (1)					
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves				. 9d(3)	
40	<u>e</u>	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)	9e	
IU	_	onexperience-rated contracts:	orrior			. 10a	F20.400
	a	Total premiums or subscription charges paid to c				. <u> </u>	530400
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo			•	. 10b	
	Spe	ecify nature of costs.	ntod in r dit i, into 2 dbov	o, roport arric	,		
_		N/ Duradalan of lafarrantian					
Р	art						
11		d the insurance company fail to provide any inform		ete Schedule	e A?	Yes	X No
12	lf t	he answer to line 11 is "Yes," specify the information	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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OMB No. 1210-0110

2017

		pursuant to i	ETTIOA SCOTIOTI TOS(a)(2)	•		Inspection
For calendar plan year 20	17 or fiscal plar	n year beginning 01/01/2017		and en	iding 12/31/2017	
A Name of plan NOKIA RETIREE WELFA	ARE BENEFITS	PLAN		B Thre	e-digit number (PN)	504
C Plan sponsor's name a NOKIA OF AMERICA CO	RPORATION			22-	oyer Identification Number 3408857	` '
		rning Insurance Contract. Individual contracts grouped a				
Coverage Information:	ate ochequie A	marviduai contracto grouped a	is a driit iii i arts ii arid iii	r can be re	ported on a single cone	duic A.
(a) Name of insurance ca HORIZON BCBS OF NJ	rrier					
(1.) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f) From	<b>(g)</b> To
22-2651245	95529	67-77087	152		01/01/2017	12/31/2017
descending order of the	amount paid. amount of communications and fe (a) Name a	ees. (Complete as many entries and address of the agent, broker,	s as needed to report all p , or other person to whor	(b) To	otal amount of fees paid	(e) Organization code
	(a) Name a	and address of the agent, broker,	, or other person to whor	n commiss	ions or fees were paid	
(b) Amount of sales ar	nd base	Fee	es and other commissior	ns paid		
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code
			5500			

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	/ be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:				
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			ion gaaramoo		
		(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))	<u>.</u>		. 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)			
		\(\frac{1}{2} \)				
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

F	Part	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for report employees, the entire group of such individu	group of employees of the ing purposes if such conti	acts are ex	perience-rated as	s a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v <b>a</b>	Supplemental	unemplovment	h Prescription drug
	i İ	Stop loss (large deductible)	j X HMO contract	k			I  Indemnity contract
	m	Other (specify)	,				
9	Fxne	erience-rated contracts:					
Ī		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	ŀ	9a(2)			
		(3) Increase (decrease) in unearned premium res		9a(3)			_
		(4) Earned ((1) + (2) - (3))				9a(4)	(
	b	Benefit charges (1) Claims paid	ſ	9b(1)		, , ,	
		(2) Increase (decrease) in claim reserves	ľ	9b(2)			
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (o					
		(A) Commissions	·	9c(1)(A)			
		(B) Administrative service or other fees	ľ	9c(1)(B)			
		(C) Other specific acquisition costs	ŀ	9c(1)(C)			_
		(D) Other expenses		9c(1)(D)			
		(E) Taxes	l	9c(1)(E)			
		(F) Charges for risks or other contingencies	ŀ	9c(1)(F)			_
		(G) Other retention charges		9c(1)(G)			_
		(H) Total retention				9c(1)(H)	(
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)		
	d	Status of policyholder reserves at end of year: (1			1		
	-	(2) Claim reserves	•			` ` `	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do no					
1(	) No	nexperience-rated contracts:		,	,,	•	
	а	Total premiums or subscription charges paid to c	arrier			10a	1131596
	b	If the carrier, service, or other organization incurr					
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.					
P	art	V Provision of Information					
11	Die	d the insurance company fail to provide any inform	ation necessary to compl	ete Schedu	le A?	Yes	X No
12		he answer to line 11 is "Yes," specify the informati					
		, -p,					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		F 4		-		mspection			
For calendar plan year 20	17 or fiscal pla	in year beginning 01/01/2017		and en	nding 12/31/2017				
A Name of plan NOKIA RETIREE WELFA	RE BENEFIT	S PLAN			e-digit number (PN)	504			
C Plan sponsor's name a	s shown on lir	ne 2a of Form 5500		<b>D</b> Emplo	oyer Identification Numb	per (EIN)			
NOKIA OF AMERICA CO				•	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 ca SIERRA HEALTH AND LIF		CE COMPANY, INC.							
	(c) NAIC	(d) Contract or	(e) Approximate nu	ımber of	Policy of	or contract year			
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To			
94-0734860	71420	H2001	75383	1	01/01/2017	12/31/2017			
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, brokers, an	d other persons in			
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount of fees paid	1			
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).					
	(a) Name	and address of the agent, broke	er, or other person to whor	m commiss	sions or fees were paid				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid					
commissions paid		(c) Amount	(d) Purpose		(e) Organization code				
	(a) Name	and address of the agent, broke	er, or other person to whor	n commiss	sions or fees were paid				
(b) Amount of sales and base Fees and other commissions paid									
commissions pai		(c) Amount	(d) Purpose			(e) Organization code			

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1			
(a) No.			aminaiana ar fana wara naid			
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid			
Fees and other commissions paid (e)						
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code		
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid			
(-)		,				
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization		
commissions paid	(c) Amount	(0	d) Purpose	code		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid			
	Г			1		
(b) Amount of sales and base		Fees and other commissions p		(e) Organization		
commissions paid	(c) Amount	((	d) Purpose	code		
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid			
		Fees and other commissions p	naid	(e)		
(b) Amount of sales and base	(c) Amount		d) Purpose	Organization		
commissions paid	(0)	,		code		
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid			
		Fees and other commissions	paid	(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 indivithis report.	idual contrac	cts with each carrier may	/ be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:				
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			ion gaaramoo		
		(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))	<u>.</u>		. 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)			
		\(\frac{1}{2} \)				
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

F	art	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reporti employees, the entire group of such individu	group of employees of the ng purposes if such contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v <b>a</b>	Supplemental	unemplovment	h Prescription drug
	i İ	Stop loss (large deductible)	j  HMO contract	_	X PPO contract		I  Indemnity contract
	m	Other (specify)	,				
	•••						
9	Exp	erience-rated contracts:					
-		Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpaid	•	9a(2)			_
		(3) Increase (decrease) in unearned premium rese		9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))	•			9b(3)	(
		(4) Claims charged				:-:	
	С	Remainder of premium: (1) Retention charges (or	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	<del>-</del>			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide I	penefits afte	er retirement		
		(2) Claim reserves	·			` ` `	
		(3) Other reserves				- 1/25	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2	2 <b>)</b> .)		
10	) No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	arrier			10a	20460368
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	onnection w	rith the acquisition	or	
		retention of the contract or policy, other than repo					
		cify nature of costs.					
F	art	IV Provision of Information					
11	l Di	d the insurance company fail to provide any inform	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the information	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Service Provider Information** 

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2017

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017	and ending 12/31/2017
A Name of plan	<b>B</b> Three-digit
NOKIA RETIREE WELFARE BENEFITS PLAN	plan number (PN) 504
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
NOKIA OF AMERICA CORPORATION	22-3408857
	22 6 1888881
Part I Service Provider Information (see instructions)	
You must complete this Part, in accordance with the instructions, to report the inform or more in total compensation (i.e., money or anything else of monetary value) in corplan during the plan year. If a person received <b>only</b> eligible indirect compensation for answer line 1 but are not required to include that person when completing the remains	nnection with services rendered to the plan or the person's position with the or which the plan received the required disclosures, you are required to
1 Information on Persons Receiving Only Eligible Indirect Comp	ensation
a Check "Yes" or "No" to indicate whether you are excluding a person from the remaind	
indirect compensation for which the plan received the required disclosures (see instru	uctions for definitions and conditions)
<b>L</b>	
<b>b</b> If you answered line 1a "Yes," enter the name and EIN or address of each person perceived only eligible indirect compensation. Complete as many entries as needed (see the compensation).	
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
THE DREYFUS CORPORATION	
13-5673135	
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
METLIFE	
13-5881829	
10 0001020	
(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

Schedule C (Form 5500) 2017	Page <b>2-</b> 1
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract	no provided you disclosures on eligible indirect compensation
( <b>b</b> ) Enter name and EIN or address of person where	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the control of th	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the control of th	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation

	Schedule C (Form 550	00) 2017		Page <b>3 -</b> 1		
answered	l "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ich person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN or	address (see instructions)		
36-223579	SSOCIATES LLC					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	NONE	2574163	Yes No 🗵	Yes No		Yes No
	•	(	a) Enter name and EIN or	address (see instructions)		
EXPRESS 22-346174	SCRIPTS, INC					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	NONE	1780724	Yes No 🗵	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
ALIGHT S	OLUTIONS LLC	<u> </u>	•	· · · · · · · · · · · · · · · · · · ·		
82-106123	33					

(f)
Did indirect compensation

include eligible indirect

compensation, for which the plan received the required

disclosures?

Yes No

(g) Enter total indirect

compensation received by

service provider excluding

eligible indirect

answered "Yes" to element (f). If none, enter -0-.

compensation for which you estimated amount?

**(h)** Did the service

provider give you a

formula instead of

an amount or

Yes No

(c) Relationship to employer, employee

organization, or

person known to be

a party-in-interest

NONE

(d) Enter direct

compensation paid by the plan. If none, enter -0-.

587349

**(e)** Did service provider

receive indirect compensation? (sources other than plan or plan

sponsor)

Yes No X

(b) Service

Code(s)

13 50

Page 3 -	2	
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answered	d "Yes" to line 1a abov	e, complete as many	entries as needed to list ea	r Indirect Compensation the person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
-		(	(a) Enter name and EIN or	r address (see instructions)		
AON CON	SULTING, INC.					
22-223226	64					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 16 38 50	NONE	451107	Yes No X	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
36-273957	IEALTHCARE					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	NONE	269479	Yes No 🛚	Yes No		Yes No
			(a) Enter name and EIN or	address (see instructions)		
TRUVEN H	HEALTH ANALYTICS					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	143890	Yes No X	Yes No		Yes No

age <b>3</b> -	3	
----------------	---	--

2	. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you
	answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation
	(i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

PRICEWATERHOUSE COOPERS LLC

#### 13-4008324

(b) Service Code(s)	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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
10 50	NONE	107575	Yes No 🗵	Yes No		Yes No
	(a) Enter name and EIN or address (see instructions)					

#### **GRAPHIC PARTNERS**

#### 36-4074726

(b) Service Code(s)	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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
38 50	NONE	46200	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)	<b>(f)</b>	(g)	(h)
Service	Relationship to	Enter direct	Did service provider	Did indirect compensation	Enter total indirect	Did the service
Code(s)	employer, employee	compensation paid		include eligible indirect	compensation received by	
	organization, or	by the plan. If none,		compensation, for which the	service provider excluding	formula instead of
	person known to be	enter -0	other than plan or plan	plan received the required	eligible indirect	an amount or
	a party-in-interest		sponsor)	disclosures?	compensation for which you	
					answered "Yes" to element	
					(f). If none, enter -0	
21 24 28 50	NONE	28401			0	
51			Yes X No	Yes X No		Yes No X

4	
	4

-						
answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation in person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and EIN or	r address (see instructions)		
CANDID L						
13-357431	19					
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36 50	NONE	25238	Yes No 🛚	Yes No		Yes No
		(	a) Enter name and FIN or	address (see instructions)	•	
13-516038				(n)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 21 25 49 50 62	TRUSTEE	23000	Yes 🛛 No 🗌	Yes 🛛 No 🗌	0	Yes X No
		(	a) Enter name and EIN or	address (see instructions)		
UNIVERSA 22-238166	AL MAILING SERVICE	<b>=</b>				
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
38 50	NONE	21515	Yes No X	Yes No		Yes No

Page <b>3</b> -	5	

answered	"Yes" to line 1a above	e, complete as many e	entries as needed to list ea	ch person receiving, directly or ne plan or their position with the		otal compensation
		(	a) Enter name and EIN or	address (see instructions)		
NOKIA INV	ESTMENT MNGMT (	CORP.				
22-364652	4					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
1 50	AFFILIATE	15208	Yes No X	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
TAX SAVE						
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
3 50	NONE	6934	Yes No X	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No No	Yes No		Yes No

Page	4	-	I
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### Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compen or provides contract administrator, consulting, custodial, investment advisory, investment ma questions for (a) each source from whom the service provider received \$1,000 or more in ind provider gave you a formula used to determine the indirect compensation instead of an amount many entries as needed to report the required information for each source.	nagement, broker, or recordkeepinç lirect 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	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	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	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

Page **5 -** 1

D( II	t II   Carving Dravidare Who Eail at Defuse to Dravida Information				
this Schedule.		h service provide	r who failed or refused to provide the information necessary to complete		
(a) Enter name and El	N 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 El	N 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 El	N 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 El	N 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 El	N 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 El	N 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		

Schedule C (Form 5500) 2017

Pa	art III Termination Information on Accountants and Enrolled Actuaries (see in	structions)
	(complete as many entries as needed)	•
а	Name:	<b>b</b> EIN:
C	Position:	
d	Address:	A Tolonhono:
u	Audicoo.	e Telephone:
Ex	planation:	
		h = w.
а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	<b>e</b> Telephone:
Fy	planation:	
^	processor or or	
а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	e Telephone:
_	Addioos.	Total phone.
EX	planation:	
а	Name:	<b>b</b> EIN:
C	Position:	
d		O Talanhana.
u	Address:	e Telephone:
Ex	planation:	
_	Name	b EIN:
<u>a</u>	Name:	U EIIV.
C	Position:	
d	Address:	<b>e</b> Telephone:
Ex	planation:	

### **SCHEDULE D** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### **DFE/Participating Plan 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

2017

This Form is Open to Public Inspection.

	<u> </u>	0.1/0.1/0.0.	1 1 10001
For calendar plan year 2017 or fiscal p	olan year beginning	01/01/2017 an	d ending 12/31/2017
A Name of plan			<b>B</b> Three-digit
NOKIA RETIREE WELFARE BENEFI	TS PLAN		plan number (PN) 504
C Plan or DFE sponsor's name as she	own on line 2a of Form	n 5500	D Employer Identification Number (EIN)
NOKIA OF AMERICA CORPORATIO			22-3408857
			22 0400007
Dout I Information on inter	acta in MTIAs. CC	To DCAs and 102 12 IEs (to be se	mulated by plane and DEEs)
		Ts, PSAs, and 103-12 IEs (to be co	impleted by plans and DFES)
		to report all interests in DFEs)	
a Name of MTIA, CCT, PSA, or 103-	12 IE: BLACKROCK	EQUITY INDEX FUND	
<b>b</b> Name of sponsor of entity listed in	(a): BLACKROCK	(INSTITUTIONAL TRUST CO. N.A.	
	d Catitu	• Pollor value of interest in MTIA CCT I	OCA or
C EIN-PN 94-3167617-001	d Entity C	e Dollar value of interest in MTIA, CCT, F 103-12 IE at end of year (see instruction)	
	code	103-12 IL at end of year (see instruction	0113)
a Name of MTIA, CCT, PSA, or 103-	12 IE: BLACKROCK	CEAFE EQUITY INDEX FUND	
	DI VCKBOCK	ZINSTITUTIONAL TRUST CO N A	
<b>b</b> Name of sponsor of entity listed in	(a):	(INSTITUTIONAL TRUST CO. N.A.	
	·		•••
C EIN-PN 94-6581674-001	<b>d</b> Entity C	Dollar value of interest in MTIA, CCT, F	
	code	103-12 IE at end of year (see instruction	ins)
a Name of MTIA, CCT, PSA, or 103-	12 IE: BLACKROCK	U.S. DEBT INDEX FUND	
		(INOTITUTIONAL TRUICT OO NI A	
<b>b</b> Name of sponsor of entity listed in	(a):	(INSTITUTIONAL TRUST CO. N.A.	
	1 -		
C EIN-PN 94-3138366-001	<b>d</b> Entity C	e Dollar value of interest in MTIA, CCT, F	
	code	103-12 IE at end of year (see instruction	ns)
a Name of MTIA, CCT, PSA, or 103-	12 IF:		
<b>b</b> Name of sponsor of entity listed in	(a):		
	. ,	T	
C EIN-PN	<b>d</b> Entity	e Dollar value of interest in MTIA, CCT, F	·
	code	103-12 IE at end of year (see instruction	ons)
a Name of MTIA, CCT, PSA, or 103-	12 IF·		
a Name of Willia, COT, 1 CA, of 103	12 1L.		
<b>b</b> Name of sponsor of entity listed in	(a):		
	(~).		
C EIN-PN	<b>d</b> Entity	e Dollar value of interest in MTIA, CCT, F	PSA, or
C EIN-FIN	code	103-12 IE at end of year (see instruction	ons)
3 Name of MTIA CCT DCA cr 400	10 IE:		
a Name of MTIA, CCT, PSA, or 103-	12 IE:		
<b>b</b> Name of sponsor of entity listed in	(2):		
• Name of sponsor of entity listed III	(a).		
• FINI DAI	<b>d</b> Entity	e Dollar value of interest in MTIA, CCT, F	PSA, or
C EIN-PN	code	103-12 IE at end of year (see instruction	
A N. CATIA COT TO	40.15		
a Name of MTIA, CCT, PSA, or 103-	12 IE:		
h Name of anonese of autitudical de-	(a):		
<b>b</b> Name of sponsor of entity listed in	(a):		
	<b>d</b> Entity	e Dollar value of interest in MTIA, CCT, F	PSA or
C EIN-PN	code	103-12 IE at end of year (see instruction	·

Page	2	-
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Schedule D (Form 5500) 2017

a Name of MTIA, CCT, PSA, or 103-	12 IE:				
<b>b</b> Name of sponsor of entity listed in	Name of sponsor of entity listed in (a):				
C EIN-PN	<b>d</b> 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>b</b> Name of sponsor of entity listed in	(a):				
C EIN-PN	<b>d</b> 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>b</b> Name of sponsor of entity listed in	(a):				
C EIN-PN	<b>d</b> 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>b</b> Name of sponsor of entity listed in	(a):				
C EIN-PN	<b>d</b> 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>b</b> Name of sponsor of entity listed in	(a):				
C EIN-PN	<b>d</b> 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>b</b> Name of sponsor of entity listed in	(a):				
C EIN-PN	<b>d</b> 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>b</b> Name of sponsor of entity listed in	(a):				
C EIN-PN	<b>d</b> 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>b</b> Name of sponsor of entity listed in	(a):				
C EIN-PN	<b>d</b> 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>b</b> Name of sponsor of entity listed in	(a):				
C EIN-PN	<b>d</b> 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>b</b> Name of sponsor of entity listed in	(a):				
C EIN-PN	<b>d</b> Entity code	Dollar value of interest in MTIA, CCT, PSA, or     103-12 IE at end of year (see instructions)			

P	Part II	Information on Participating Plans (to be completed by DFEs) (Complete as many entries as needed to report all participating plans)	
а	Plan na		
b	Name o		C EIN-PN
а	Plan na	ne	
b	Name o		C EIN-PN
a	Plan na		
b	Name o		C EIN-PN
	Plan na		
	Name o		C EIN-PN
	plan spo	nsor	
	Plan na		
_ 	Name o		C EIN-PN
а	Plan na	ne	
b	Name o		C EIN-PN
а	Plan na	ne	
b	Name o		C EIN-PN
а	Plan na	ne	
b	Name o		C EIN-PN
а	Plan na	ne	
b	Name o		C EIN-PN
а	Plan na	ne	
b	Name o		C EIN-PN
а	Plan na	ne	
b	Name o		C EIN-PN
а	Plan na	ne	
b	Name o		C EIN-PN

### **SCHEDULE H** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### **Financial Information**

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2017

This Form is Open to Public

Pension Benefit Guaranty Corporation						Inspection	n
For calendar plan year 2017 or fiscal pla	n year beginning 01/01/2017		and endi	ing 12/31/	2017		
A Name of plan NOKIA RETIREE WELFARE BENEFITS	S PLAN		В	Three-di	git nber (PN)	•	504
				pian nun	iber (PN)	,	004
C Plan sponsor's name as shown on lir NOKIA OF AMERICA CORPORATION			D		Identification 408857	on Number (E	EIN)
Part I Asset and Liability S	tatement						
the value of the plan's interest in a collines 1c(9) through 1c(14). Do not en benefit at a future date. <b>Round off a</b>	illities at the beginning and end of the plan ommingled fund containing the assets of mater the value of that portion of an insurance mounts to the nearest dollar. MTIAs, Co salso do not complete lines 1d and 1e. See	nore than one se contract wh CTs, PSAs, a	plan on a line nich guarantee and 103-12 IEs	-by-line bas s, during thi	is unless th s plan year,	ne value is rep , to pay a spe	oortable on ecific dollar
Ass	sets		(a) Begir	ning of Yea	ır	<b>(b)</b> End (	of Year
a Total noninterest-bearing cash		1a					
<b>b</b> Receivables (less allowance for double	btful accounts):						
(1) Employer contributions		1b(1)					
(O) Death in a star and all setting		1h/2\					

a Total noninterest-bearing cash	1a		
<b>b</b> Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	91727000	70454000
<b>C</b> General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	107506000	123912000
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	29764000	48903000
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	325592000	320665000
(15) Other	1c(15)		

1d	Employer-related investments:		(a) Beginning of Year	(b) End of Year
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
е	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	554589000	563934000
	Liabilities			
g	Benefit claims payable	1g	21800000	16800000
h	Operating payables	1h	694000	627000
i	Acquisition indebtedness	1i		
j	Other liabilities	1j	8091000	17618000
k	Total liabilities (add all amounts in lines 1g through1j)	1k	30585000	35045000
	Net Assets			
ı	Net assets (subtract line 1k from line 1f)	11	524004000	528889000

#### Part II Income and Expense Statement

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

Income	•	(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from	n: <b>(A)</b> Employers	<b>A)</b> 1033000	
(B) Participants	2a(1)(	<b>B)</b> 99801000	
(C) Others (including rollovers)	2a(1)(	C) 17747000	
(2) Noncash contributions	2a(2	)	
(3) Total contributions. Add lines 2a(1)(	(A), (B), (C), and line 2a(2)2a(3		118581000
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (includin certificates of deposit)	g money market accounts and 2b(1)(	A)	
(B) U.S. Government securities	2b(1)(	В)	
(C) Corporate debt instruments	2b(1)(	C)	
(D) Loans (other than to participan	ts)2b(1)(	D)	
(E) Participant loans	2b(1)(	E)	
(F) Other	2b(1)(	<b>F)</b> 806000	
(G) Total interest. Add lines 2b(1)(	A) through (F)	G)	806000
(2) Dividends: (A) Preferred stock	2b(2)(	A)	
(B) Common stock	2b(2)(	В)	
(C) Registered investment compar	ny shares (e.g. mutual funds)2b(2)(	C)	
(D) Total dividends. Add lines 2b(2	2)(A), (B), and (C) 2b(2)(	D)	0
(3) Rents	2b(3		
(4) Net gain (loss) on sale of assets: (A	A) Aggregate proceeds	A)	
(B) Aggregate carrying amount (se	ee instructions)	В)	
(C) Subtract line 2b(4)(B) from line	2b(4)(A) and enter result	C)	0
(5) Unrealized appreciation (depreciation)	of assets: (A) Real estate	A)	
(B) Other	2b(5)(	В)	
(C) Total unrealized appreciation of Add lines 2b(5)(A) and (B)	of assets. 2b(5)(	C)	0

			ſ						
			(;	a) Amo	unt			(b)	Total
	(6) Net investment gain (loss) from common/collective trusts	2b(6)							18976000
	(7) Net investment gain (loss) from pooled separate accounts	2b(7)							
	(8) Net investment gain (loss) from master trust investment accounts	2b(8)							
	(9) Net investment gain (loss) from 103-12 investment entities	2b(9)							
	(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)							
С	Other income	2c							43384000
d	Total income. Add all <b>income</b> amounts in column (b) and enter total	2d							181747000
	Expenses								
е	Benefit payment and payments to provide benefits:								
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)			12207	9000			
	(2) To insurance carriers for the provision of benefits	2e(2)			4455	2000			
	(3) Other	2e(3)							
	(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)							166631000
f	Corrective distributions (see instructions)	2f							
g									
	Interest expense	-							
i	Administrative expenses: (1) Professional fees	2i(1)			1023	1000			
	(2) Contract administrator fees	21/2							
	(3) Investment advisory and management fees	0:(0)							
	(4) Other	2:/4)							
	(5) Total administrative expenses. Add lines 2i(1) through (4)	0:(5)							10231000
i	Total expenses. Add all <b>expense</b> amounts in column (b) and enter total								176862000
•	Net Income and Reconciliation	···							
k	Net income (loss). Subtract line 2j from line 2d	2k							4885000
ī	Transfers of assets:								
	(1) To this plan	2l(1)							
	(2) From this plan	2l(2)							
_									
	art III Accountant's Opinion								
	Complete lines 3a through 3c if the opinion of an independent qualified public attached.	c accountant	is attached to	o this F	orm 5	500. Co	mplete	e line 3d if a	an opinion is not
a	The attached opinion of an independent qualified public accountant for this p	lan is (see in:	structions):						
	(1) Unqualified (2) Qualified (3) Disclaimer (4	Adverse							
b	Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.1	03-8 and/or 1	03-12(d)?					Yes	X No
С	Enter the name and EIN of the accountant (or accounting firm) below:								
	(1) Name: PRICEWATERHOUSECOOPERS LLP		<b>(2)</b> EIN	13-40	08324				
ď	The opinion of an independent qualified public accountant is <b>not attached</b> be (1) This form is filed for a CCT, PSA, or MTIA. (2) It will be att	ecause: ached to the	next Form 55	500 pui	rsuant	to 29 C	FR 252	20.104-50.	
Pa	art IV Compliance Questions								
4	CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do		e lines 4a, 4e	e, 4f, 4	g, 4h, 4	4k, 4m,	4n, or	5.	
	103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not comple During the plan year:	ete iine 41.		Г	Yes	No		Λm	ount
а	Was there a failure to transmit to the plan any participant contributions with	hin the time			163	140		Aill	Zuit
u	period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any		ilures until						
	fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction	n Program.)		4a		X			
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? Disreg secured by participant's account balance. (Attach Schedule G (Form 5500								
	checked.)		· · <del>-</del>	4b		X			

Page	4-

Schedule H (Form 5500) 2017

			Yes	No	Amou	ınt
С	Were any leases to which the plan was a party in default or classified during the year as			.,		
	uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		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			X		
	checked.)	4d		^		
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.)	4i	X			
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	X			
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X		
ı	Has the plan failed to provide any benefit when due under the plan?	41		X		
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m				
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n				
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?	S X	No			
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ide transferred. (See instructions.)	ntify t	he plan	(s) to v	vhich assets or liabili	ties were
	5b(1) Name of plan(s)				<b>5b(2)</b> EIN(s)	<b>5b(3)</b> PN(s)
	f the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section for the PBGC promium filing for this plan).			∐ ١		ot determined

## FINANCIAL STATEMENTS AND SUPPLEMENTAL SCHEDULES

Nokia Retiree Welfare Benefits Plan Years Ended December 31, 2017 and 2016 With Report of Independent Auditors

# Financial Statements and Supplemental Schedules

December 31, 2017 and 2016

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#### **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 (the "Plan"), which comprise the statements of benefit obligations and net assets available for benefits as of December 31, 2017 and 2016 and the related statement of changes in benefit obligations and net assets available for benefits for the year ended December 31, 2017, 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 audits. We conducted our audits 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, 2017 and 2016, and the changes in its financial status for the year ended December 31, 2017 in accordance with accounting principles generally accepted in the United States of America.



#### Other Matter

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets (held at end of year) as of December 31, 2017 and reportable transactions for the year ended December 31, 2017 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 audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements 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.

September 28, 2018

Kricusaterhouse Coopers US

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

	December 31		
	2017	2016	
Benefit obligations		_	
Accumulated postretirement benefit obligation:			
Current retirees	\$ 3,035,700 \$	3,173,800	
Medical claims payable and liability for claims incurred			
but not reported	16,800	21,800	
Other participants fully eligible for benefits	6,500	5,700	
Other participants not yet fully eligible for benefits	 53,600	52,900	
Total benefit obligations	3,112,600	3,254,200	
Assets			
Group life insurance policies	320,665	325,592	
Net assets held in Lucent Technologies Inc. Master Pension Trust			
Restricted for 401(h) account	213,202	189,050	
Restricted for applicable life insurance account	2	1	
Common/collective trusts	123,912	107,506	
Registered investment company	48,903	29,764	
Rebates receivable	50,459	57,762	
Refund receivable	19,946	33,955	
Interest receivable	49	10	
Total assets	777,138	743,640	
Liabilities			
Due to Sponsor, net	17,618	8,091	
Accrued administrative expenses	627	694	
Total liabilities	18,245	8,785	
Net assets available for benefits	758,893	734,855	
Excess of benefit obligations over net assets	,	<u> </u>	
available for benefits	\$ 2,353,707 \$	2,519,345	

See accompanying notes.

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

Year Ended December 31, 2017

Net decrease in benefit obligations	
Increase (decrease) during the period attributable to:	
Benefits reclassified to amounts currently payable	\$ (234,600)
Change in actuarial assumptions and experience	(138,300)
Interest due to the passage of time	112,800
Change in discount rate	118,500
Net decrease in benefit obligations	(141,600)
Net change in net assets available for benefits	
Additions to Plan assets available for benefits attributable to:	
Sponsor contributions	1,033
Participant contributions	99,801
Other contributions	17,747
Income from insurance policies	43,384
Net increase in 401(h) account	24,152
Net appreciation in fair value of investments	18,976
Interest income	806
Net increase in applicable life insurance account	1
Total additions	 205,900
Deductions from Plan assets available for benefits attributable to:	
Payments for benefits, net	171,631
Administrative expenses	10,231
Total deductions	181,862
Net increase in net assets available for benefits	 24,038
Decrease in excess of benefit obligations over net assets available for benefits	(165,638)
Excess of benefit obligations over net assets available for benefits:	
Beginning of year	2,519,345
End of year	\$ 2,353,707
•	 · · ·

See accompanying notes.

## Notes to Financial Statements (In Thousands)

December 31, 2017

#### 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 (the Retiree Medical Plan), the Nokia Dental Expense Plan for Retired Employees (the Retiree Dental Plan) and the Nokia 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, the Company and the Plan Administrator), and its domestic subsidiaries. Effective January 1, 2018, the Company was renamed Nokia of America Corporation. 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).

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.

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.

## Notes to Financial Statements (continued) (In Thousands)

#### 1. Plan description (continued)

#### **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 2017, the Plan paid \$14,502 in HMO premiums, \$20,462 in MAPPO premiums, \$1,684 in DMO premiums and \$7,904 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 maintaining an overfunded defined benefit pension plan to transfer excess pension assets (as defined in Section 420) from the pension plan to a health benefits account, a retiree life insurance account, or both, established within the pension plan and to use the assets in such accounts to pay for applicable health benefits or applicable life insurance benefits (each as defined in Section 420) for retired employees (and, with respect to health benefits, their spouses and dependents). Under current law, no such transfers may be made after December 31, 2025.

A transfer of excess pension assets under Section 420 imposes certain "maintenance of cost" obligations on the group health plan or arrangement and group term life insurance plan under which the applicable health benefit and applicable life insurance benefits, as the case may be, are provided.

## Notes to Financial Statements (continued) (In Thousands)

#### 1. Plan description (continued)

#### **Contributions**

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

Participant contributions are made primarily through pension 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.

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 Retired age 65 and over – family coverage	\$ 4,225 8,600 2,000 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 retired after May 31, 1998.

## Notes to Financial Statements (continued) (In Thousands)

#### 1. Plan description (continued)

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 non-subsidized 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 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.

## Notes to Financial Statements (continued) (In Thousands)

#### 1. Plan description (continued)

#### Other

At December 31, 2017 and 2016, 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).

#### 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 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.

Notes to Financial Statements (continued)
(In Thousands)

#### 2. Summary of significant accounting policies (continued)

#### Valuation of group life insurance policies

The Plan has prepaid premiums for life insurance policies with an insurance company. The prepaid premiums are invested by the insurance company at the Plan's direction in equity, fixed income and international separate accounts and general accounts, 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.

#### **Recently adopted accounting standards**

Accounting Standards Update (ASU) No. 2015-7 - Fair Value Measurement (Topic 820) - Disclosures for Investments in Certain Entitles that Calculate Net Asset Value per Share (or its Equivalent). The amendments in this update remove the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the net asset value per share practical expedient. The amendments also remove the requirement to make certain disclosures for all investments that are eligible to be measured at fair value using the net asset value per share practical expedient. Rather, those disclosures are limited to investments for which the entity has elected to measure the fair value using that practical expedient. For the Plan, the amendments in this update are effective for fiscal years beginning after December 15, 2016. A reporting entity should apply the amendments retrospectively to all periods presented. Accordingly, information reported as of December 31, 2016 has been modified to reflect these changes.

## Notes to Financial Statements (continued) (In Thousands)

#### 2. Summary of significant accounting policies (continued)

#### **New accounting pronouncements**

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.

#### 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.

## Notes to Financial Statements (continued) (In Thousands)

#### 2. Summary of significant accounting policies (continued)

For purposes of determining the actuarial present value of accumulated plan benefits for medical as of December 31, 2017, a 6.8% post-65 medical, 7.1% 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 2018. These rates were assumed to decline gradually after 2018 to 5.0% by the year 2028 and then remain constant.

For purposes of determining the actuarial present value of accumulated plan benefits for medical 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.

These assumptions could greatly affect the amounts reported. To illustrate, increasing the assumed trend rate by 1% in each year could increase the APBO for medical benefits by \$45,900 and \$60,300 at December 31, 2017 and 2016, respectively.

For purposes of determining the actuarial present value of accumulated plan benefits for dental as of December 31, 2017, a rate of 3.5% was assumed for 2018 and beyond. For purposes of determining the actuarial present value of accumulated plan benefits for dental as of December 31, 2016, a rate of 3.5% was assumed for 2017 and beyond. These assumptions could greatly affect the amounts reported. To illustrate, increasing the assumed trend rate by 1% in each year could increase the APBO for dental benefits by \$1,900 and \$2,300 at December 31, 2017 and 2016, 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.

### Notes to Financial Statements (continued) (In Thousands)

#### 2. Summary of significant accounting policies (continued)

The following summarizes other significant actuarial assumptions used in the valuations as of December 31, 2017 and 2016, respectively:

Weighted-average discount rate: 3.22% (2017), 3.60% (2016)

Mortality: 2017: Society of Actuaries RP-2014 amounts –

weighted, white collar for management retirees and blue collar for occupational retirees with MP-2017

generational projection scale

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

Weighted average rate of

compensation increase: 2.18% (2017), 2.17% (2016)

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 was 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, 2017 and 2016. The Plan continues to evaluate the various provisions of the Act.

The Bipartisan Budget Act of 2018 was signed by the President on February 9, 2018. The impact of this legislation was reflected in the present value of accumulated plan benefits as of December 31, 2017.

#### **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. Therefore, 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.

### Notes to Financial Statements (continued) (In Thousands)

#### 2. Summary of significant accounting policies (continued)

#### Claims incurred but not reported

Plan obligations at December 31, 2017 and 2016 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 and are reported on the Statements of Benefit Obligations and Net Assets Available for Benefits. These amounts are paid by the Plan only if claims are submitted and approved for payment.

#### Use of estimates

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

#### Risks and uncertainties

Plan contributions and the actuarial present value of the Plan's 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.

## Notes to Financial Statements (continued) (In Thousands)

#### 2. Summary of significant accounting policies (continued)

#### Payments for benefits, net

Benefits are recorded when paid and are presented net of rebates and refunds. 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 \$111,588 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, 2017.

#### 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, 2017 and 2016. Such reimbursements may be made subsequent to the Plan's year-end.

## Notes to Financial Statements (continued) (In Thousands)

#### 3. Investments

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

#### 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, 2017 and 2016. 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, 2017								
	Level 1*	Level 2*	Level	1 3**	Total				
		(In Th	ousands)						
Registered investment company	\$ 48,90	3 \$ -	\$	- \$	48,903				
Total assets at fair value	48,90	<del>-</del>		-	48,903				
Assets measured at NAV <sup>1</sup>				_	657,525				
Total assets	\$ 48,90	<b>)3</b> \$ -	\$	- \$	706,428				

<sup>\*</sup> There were no transfers between Level 1 and Level 2 during the year ended December 31, 2017.

	Assets at Fair Value as of December 31, 2016								
	Lev	vel 1*	Level 2*	Level 3	<b>}</b> **	Total			
			(In The	ousands)					
Registered investment company	\$	29,764 \$	S –	\$	- \$	29,764			
Total assets at fair value		29,764	_		_	29,764			
Assets measured at NAV <sup>1</sup>		_	_		_	621,978			
Total assets	\$	29,764 \$	· –	\$	- \$	651,742			

<sup>\*</sup> There were no transfers between Level 1 and Level 2 during the year ended December 31, 2016.

<sup>\*\*</sup> There were no transfers in or out of Level 3 during the year ended December 31, 2017.

Assets measured at NAV represents investments fair valued using NAV as a practical expedient. These investments are not leveled on the fair value hierarchy table.

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

<sup>&</sup>lt;sup>1</sup> Assets measured at NAV represents investments fair valued using NAV as a practical expedient. These investments are not leveled on the fair value hierarchy table.

## Notes to Financial Statements (continued) (In Thousands)

#### 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. 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.

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, 2017 and 2016 and the related changes in net assets available for benefits for the year ended December 31, 2017.

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

	December 31				
	 2017		2016		
Accrued interest receivable	\$ 254	\$	170		
JPMCB Liquidity Fund	 212,948		188,880		
Net assets available for benefits	\$ 213,202	\$	189,050		

Changes in net assets available for benefits for the year ended December 31, 2017:

Transfer from Pension Plan	\$ 140,000
Interest income	1,708
Administrative expenses	(7,366)
Benefit payments	(110,190)
Net increase in 401(h) account	\$ 24,152

## Notes to Financial Statements (continued) (In Thousands)

#### 4. Section 420 transfers (continued)

The following tables present the components of the net assets available for applicable life insurance benefits under Code section 420 as of December 31, 2017 and 2016 and the related changes in net assets available for benefits for the year ended December 31, 2017.

Net assets restricted for applicable life insurance account as of:

	December 31			
	201	7	2016	
Accrued interest receivable	<u> </u>	2 \$	1	

Changes in net assets available for benefits for the year ended December 31, 2017:

Transfer from Pension Plan	\$ 39,999
Interest income	2
Benefit payments	(40,000)
Net increase in applicable life insurance account	\$ 1

#### 5. Tax status

The Plan was originally funded by means of a trust established effective as of October 1, 1996 known as the Lucent Technologies Inc. Postretirement Life Insurance Benefits Trust (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.

## Notes to Financial Statements (continued) (In Thousands)

#### **5.** Tax status (continued)

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, 2017, 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 2014.

#### 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 the Company, provides fiduciary services to the Plan. Effective March 1, 2018, ALIMCO was renamed Nokia Investment Management Corporation (NIMCO). NIMCO charges the Plan only for the costs that are incurred for providing such services to the Plan. For the year ended December 31, 2017, the Plan incurred fiduciary service fees of \$15, which are included in administrative expenses on the Statement of Changes in Benefit Obligations and Net Assets Available for Benefits. At December 31, 2017 and 2016, the Plan had a payable due to NIMCO of \$5 and \$3, respectively, which is included in accrued administrative expenses on the Statements of Benefit Obligations and Net Assets Available for Benefits.

Certain Plan investments are managed by affiliates of the trustee, Bank of New York Mellon. At December 31, 2017 and 2016, the Plan held \$48.9 million and \$29.8 million, respectively, of the Dreyfus Treasury and Agency Cash Management Fund, which is a fund that is related to the trustee.

## Notes to Financial Statements (continued) (In Thousands)

#### 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, 2017 and 2016:

2017	2016
\$ <b>758,893</b> \$	734,855
(16,800)	(21,800)
(213,202)	(189,050)
(2)	(1)
\$ 528,889 \$	524,004
\$	\$ 758,893 \$ (16,800) (213,202) (2)

The following is a reconciliation of total additions per the financial statements to the Form 5500 for the year ended December 31, 2017:

Total additions per the financial statements	\$ 205,900
Less:	
Net increase in 401(h) account	(24,152)
Net increase in applicable life insurance account	(1)
Total income per Form 5500	\$ 181,747

The following is a reconciliation of payments for benefits per the financial statements to the Form 5500 for the year ended December 31, 2017:

Total payments for benefits per the financial statements	\$ 171,631
Add: Medical claims payable and liability for claims incurred but not	
reported at December 31, 2017	16,800
Less: Medical claims payable and liability for claims incurred but not	
reported at December 31, 2016	(21,800)
Total payments for benefits per Form 5500	\$ 166,631

## Notes to Financial Statements (continued) (In Thousands)

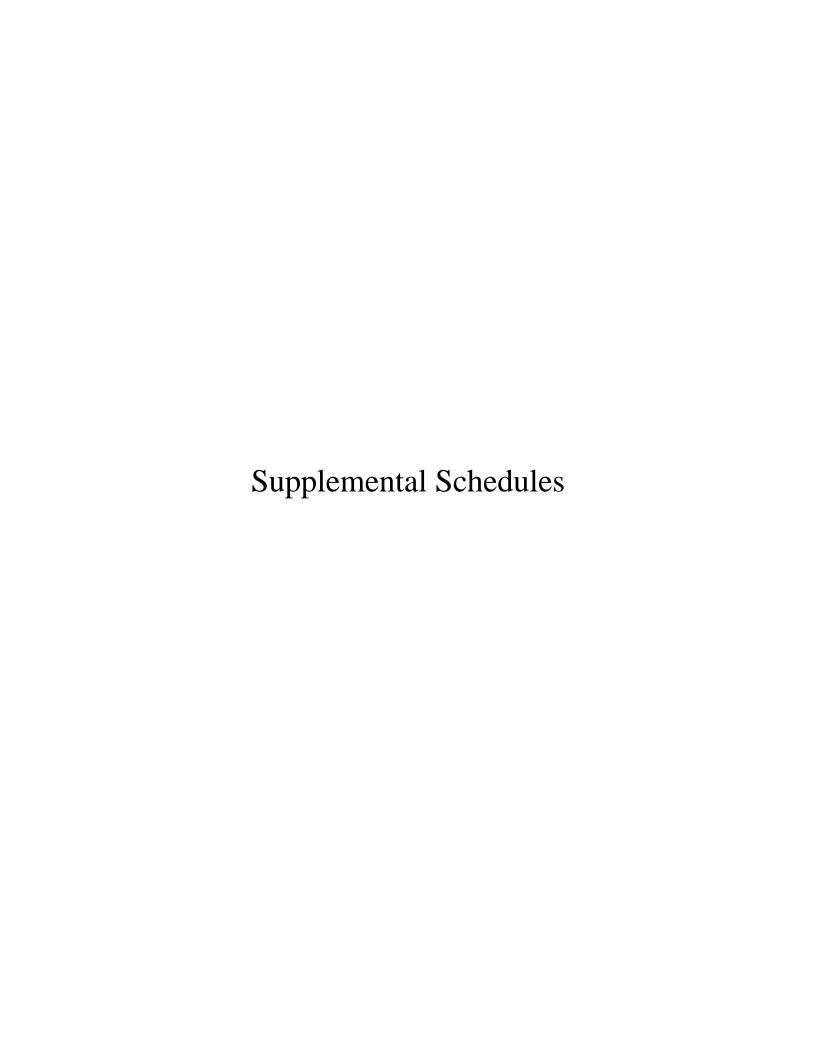
#### 7. Reconciliation of financial statements to Form 5500 (continued)

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 September 28, 2018, the date the financial statements were available to be issued. There were no material subsequent events that occurred between January 1, 2018 through September 28, 2018.



#### EIN #22-3408857 Plan #504

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

#### December 31, 2017

**(b)** Identity of Issue, Borrower, **(d)** (c) **(e) Lessor or Similar Party Description of Investment** Current Value Cost BlackRock Equity Index Fund B Lendable 31,791,747 \$ 70,538,548 U.S. Debt Index Fund B BlackRock 25,606,702 29,079,834 BlackRock 16,095,191 EAFE Equity Index Fund B 24,294,002 Dreyfus Treasury & Agency Cash Management Fund\* 48,903,193 48,903,193 MetLife Insurance Policy 95083-G 95,233,767 97,577,154 MetLife Insurance Policy 190374-G 188,985,619 223,088,248 406,616,219 \$ 493,480,979

<sup>\*</sup> Represents party-in-interest

### EIN #22-3408857 Plan #504

### Schedule H, Line 4j – Schedule of Reportable Transactions

Year Ended December 31, 2017

#### Single transactions in excess of 5%

		(a) Identity of		(c)	( <b>d</b> )	(g)	(i)	
Transaction	1	Party	<b>(b)</b>	Purchase	Selling	Cost of	Net Ga	in
Code	Shares	Involved	Description of Asset	Price*	Price*	Asset	or (Los	ss)
В	28,449,230	Dreyfus	Treasury & Agency Cash Management Fund	\$ 28,449,230 \$	- \$	_	\$	_
S	28,449,230	Dreyfus	Treasury & Agency Cash Management Fund	_	28,449,230	28,449,230		_

#### Series of transactions in excess of 5%

		(a)					
		Identity of		(c)	<b>(d)</b>	<b>(g)</b>	<b>(i)</b>
		Party	<b>(b)</b>	Purchase	Selling	Cost of	<b>Net Gain</b>
Count	Shares	Involved	<b>Description of Asset</b>	Price*	Price*	Asset	or (Loss)
163	166,084,979	Dreyfus	Treasury & Agency Cash Management Fund	\$ 166,084,979 \$	_	\$ -	\$ -
75	146,945,409	Dreyfus	Treasury & Agency Cash Management Fund	_	146,945,409	146,945,409	-

There were no category (ii) or (iv) reportable transactions during the year ended December 31, 2017.

B = Bought, S = Sold

<sup>\*</sup> At market

Plan Name	okia Retiree Welfare Benefits Plan			
Plan Sponsor EIN	22-3408857			
ERISA Plan No.	504			
Plan Year End	12/31/2017			

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

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

Plan Name	kia Retiree Welfare Benefits Plan			
Plan Sponsor EIN	22-3408857			
ERISA Plan No.	504			
Plan Year End	12/31/2017			

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

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