Nokia Dental Expense Plan
For Active Employees

Plan Document and
Summary Plan Description

January 2025

This plan document and summary plan description replaces the prior plan document and summary plan description. This version, which is effective January 1, 2025, incorporates all changes included in each amendment to the Nokia Dental Expense Plan for Active Employees (formerly known as the Alcatel-Lucent Dental Expense Plan for Active Employees).

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Introduction

The Nokia Dental Expense Plan for Active Employees ("Plan") is designed to provide protection against the cost of dental care for you and your Eligible Dependents. This booklet--called a summary plan description ("SPD")--is intended to summarize the material terms of the Plan as in effect on January 1, 2025 and thereafter.

This booklet is also the official plan document for the Plan. It sets forth the terms of the Plan as of January 1, 2025 and thereafter.

Nokia of America Corporation (the Plan's sponsoring employer, sometimes referred to herein as the "Company") expects to continue the Plan but reserves the right to amend, modify, or terminate it, in whole or in part (including any Plan option or program), at any time by resolution of the Company's Board of Directors or its duly authorized delegate(s), with or without advance notice to Participants, for any reason, subject to applicable law. The Company also reserves the right to change the amount of required participant contributions under the Plan at any time, with or without advance notice to Participants.

> This document constitutes an amendment and restatement of the Plan with respect to the referenced Plan options and programs and replaces all prior communications regarding same.

Because of the many detailed provisions of the Plan, no one other than the personnel or entities identified in this document is authorized to advise you concerning your benefits or the terms of the Plan. Questions regarding your benefits should be addressed as indicated in this booklet (see Section P., "Important Contacts," for a list of Plan resources and how to contact them). Neither the Company, nor any Participating Company, nor the Plan is bound by statements made by unauthorized persons or entities. Moreover, in the event of a conflict between any information provided to you by an authorized source and information in this document, this document will control.

Section A. The Plan At-A-Glance

The Plan provides dental care for Eligible Employees and their enrolled Eligible Dependents. Coverage is subject to limitations, as described below and elsewhere in this document.

Below is a summary of the key features of the Plan. (Certain words and phrases used in the table below and elsewhere in this document have specific meaning under the Plan. These terms are printed in initial capital letters and are defined in Section B., "Terms You Should Know".)

Plan Features	Summary
Eligible Employee	You are an Eligible Employee if you satisfy the Plan's eligibility requirements, as provided in Section C of the Plan.
Participating Company	The following companies are Participating Companies: • Nokia of America Corporation • Nokia Federal Solutions LLC • Nokia Investment Management Corporation
Excluded Employee	An Excluded Employee is: (1) an individual who does not receive payment for services from a Participating Company's U.S. payroll, even if such individual is reclassified by a court or administrative agency as a common law employee of a Participating Company, (2) an employee who is employed by an independent company (such as an employment agency), (3) an employee whose services are rendered pursuant to a written agreement that excludes participation in the Company's benefit plans, (4) a Leased Employee, (5) a temporary employee (and any regular employee subclassified as a temporary employee), (6) a co-op student or an intern (and any trainee/student subclassified as an intern), (7) a trainee, (8) an International Assignee.

Plan Features	Summary
Participation and Enrollment	*Newly hired Eligible Employees* Newly hired Eligible Employees are automatically enrolled in the Plan as of their first day of employment and are assigned to the Enhanced Option. Employees who were not previously Eligible Employees but who become such (for example, they transfer employment from a Nokia Group company that is not a Participating Company to a Participating Company) are automatically assigned to the Enhanced Option under the Plan as of their first day of eligibility. Newly hired and newly Eligible Employees then have 31 days within which to change their Coverage Option (see "Coverage Options", below) and/or to add Eligible Dependents (see "Eligible Dependents", below). If they do not do so within this 31-day period, they may change their Coverage Option and add or drop Eligible Dependents during the Plan's Annual Open Enrollment Period (or earlier if they have a Qualified Status Change). Employees who are already enrolled in the Plan may change their Coverage Option and add or drop Eligible Dependents during the Plan's Annual Open Enrollment Period (or earlier if they have a Qualified Status Change).
Eligible Dependents	If you are eligible to participate in the Plan, you may also enroll your Eligible Dependents, defined as follows: • Your Spouse/Domestic or Civil Union Partner • Your Children (including your Spouse's Children, i.e., your stepchildren), up until the end of the month in which they turn age 26) • The Children of your Domestic or Civil Union Partner, provided they live with you, up until the end of the month in which they turn age 26 • Your Adult Disabled Children. Note: Each of the above terms has a specific definition. See Section B., "Terms You Should Know," for more detail regarding who is an Eligible Dependent under the Plan.

Plan Features	Summary
Coverage Options	The Plan offers the following coverage options: • Standard Option (a plan with a standard level of Coinsurance and Annual Deductibles) • Enhanced Option (a plan providing a higher level of coverage than the Standard option). These coverage options are described in more detail in Section E., "How the Dental Plan Works".
Coverage Categories	The following are the Coverage Categories for the Plan: • You only • You + your Spouse/Domestic or Civil Union Partner • You + your Children (including your Adult Disabled Children and, if applicable, the Children of your Domestic or Civil Union Partner) • You + your Family (i.e., your Spouse/Domestic or Civil Union Partner and your Children, including your Adult Disabled Children, and, if applicable, the Children of your Domestic or Civil Union Partner)
Cost of the Plan	You are required to contribute to the cost of coverage under the Plan for yourself and your enrolled Eligible Dependents. The cost of Plan coverage depends on the Coverage Option and Coverage Category (see above) you choose. In most instances, the cost of coverage is deducted from your paycheck on a pre-tax basis. (See Section D., "The Cost of Plan Coverage.") Information on the cost of coverage is available from the Nokia Benefits Resource Center (the NBRC) and through the Your Benefits Resources (YBR)™ website when you enroll in the Plan. For more information on how to contact the NBRC or how to log onto YBR, see Section P., "Important Contacts."
Other Plan Costs	Depending on the Plan option in which you enroll and whether you utilize an In-Network or Out-of-Network provider, you might also need to pay a Copay amount. Copays are described further in the Appendix, "Benefits at a Glance - Dental."

Plan Features	Summary
What's Covered	For a service or supply to be covered, it must be: • Performed or provided by a licensed Dentist, in accordance with broadly accepted standards of dental practice, • Incurred while the individual is a Participant, • Listed as a covered service and satisfy all the required conditions of services of the applicable options, and • Not specifically listed as excluded. Note: In some cases, there may be additional required criteria and conditions. Services and supplies meeting these criteria will be covered up to the Allowable Amount or the negotiated rate, if applicable.
Annual Open Enrollment Period	The Annual Open Enrollment Period is the period during which you can make selections regarding coverage for the upcoming Plan Year. You may add or cancel coverage for yourself, enroll or disenroll Eligible Dependents, and/or change your Coverage Option. Information about the Annual Open Enrollment Period, including information about any changes being made to the Plan, is communicated in the fall (usually between September and November).
Qualified Status Change	Eligible Employees may be able to change their coverage option and add or drop Eligible Dependents outside of the Plan's Annual Open Enrollment Period if they experience a Qualified Status Change. See "Changing Your Coverage During the Plan Year" in Section C., "Eligibility and Enrollment," for more information.
COBRA/ Continuation of Coverage	Eligible Employees (and their qualified beneficiaries) may be able to continue coverage under the Plan (for a period of time) if they would otherwise experience a loss of coverage due to a Qualifying Event (such as termination of employment). See Section k., "COBRA Continuation Coverage," for more information.
Claims Administrator	The third-party hired to process Claims for Benefits under the Plan. The current Claims Administrator is MetLife. See Section P., "Important Contacts," for information on how to contact the Claims Administrator.
Nokia Benefits Resource Center (NBRC)	The Nokia Benefits Resource Center (NBRC) is the service center for the Plan and your point-of-contact for information about, and transactions concerning, the Plan. The NBRC is also your point-of-contact during the Annual Open Enrollment for the Plan. See

Plan Features	Summary
	Section P., "Important Contacts," for information of how to contact the NBRC.
Your Benefits Resources (YBR)™	Your Benefits Resources (YBR)™ is your on-line access point for the Plan. See Section P., "Important Contacts," for information of how to access YBR. (Your Benefits Resources is a trademark of Alight Solutions LLC.)

Section B. Terms You Should Know

There are several words and phrases that have specific meaning under the Plan. This section explains those terms so you can better understand your benefits. These terms are capitalized when they appear in this document. Note, terms may be updated as set forth in Appendix 1.

Adult Disabled Child: With respect to an Eligible Employee, such Eligible Employee's Child who has attained age 26, provided such Child meets all of the following requirements:

- The Child was covered under the Plan as an Eligible Dependent immediately prior to attaining age 26 (note: for newly hired employees, a Child who has been continuously covered under another employer's group health plan since immediately before turning age 26 is treated as satisfying this requirement), and
- The Child, prior to attaining age 26 and thereafter was and remains--
  - Physically, mentally, or developmentally disabled, and
  - Incapable of self-support, and
  - Fully dependent on the Eligible Employee for support; and
- The Child is certified by the Claims Administrator for the Nokia Medical Expense Plan for Active Employees Plan as incapacitated due to disability (certification process must be started within 31 days of the end of the month in which the Child turns age 26).

Note: Adult Disabled Child coverage is available only with respect to the Child(ren) of an Eligible Employee (including stepchildren). It is not available with respect to the Child(ren) of a Domestic or Civil Union Partner.

Adverse Benefit Determination: A denial, reduction of or a failure to provide or make payment, in whole or in part, for a Benefit, including those based on a determination of eligibility, application of utilization review, or Medical Necessity.

Allowable Amount: The portion of a Provider's charge that is eligible for reimbursement either in full or in part. Any amount by which the Provider's charge exceeds the Allowable Amount is not reimbursable under the Plan.

Annual Deductible (or Deductible): The aggregate amount of covered charges each calendar year that the Participant must pay before the Plan begins to pay Benefits each calendar year. Whether an Annual Deductible applies, and the amount of the Annual Deductible, depends upon the Plan option you choose, the type of service or supply you receive, and whether care is received from an In-Network Provider or from an Out-of-Network Provider.

Annual Maximum: The maximum Benefit available from the Plan each calendar year for each Participant. Once the Annual Maximum Benefit has been paid, no other Benefits are available under any circumstances. You are responsible for all charges above the Annual Maximum Benefit.

Annual Open Enrollment: The period of time each year designated by the Company during which you can generally make changes to your benefits. Elections made during the Annual Open Enrollment period are effective as of the first day of the subsequent calendar year.

Benefits: Plan payments for covered services, subject to the terms and conditions of the Plan.

Beneficiary: with respect to a Participant, an Eligible Dependent who has been enrolled in and is Covered by the Plan.

Child (or Children): With respect to an Eligible Employee, such Eligible Employee's child(ren), up to the end of the month in which such child(ren) turn(s) age 26. For this purpose, child(ren) means:

- The Eligible Employee's biological child(ren)
- The Eligible Employee's stepchild(ren) (i.e., the biological child(ren) of the Eligible Employee's Spouse)
- The Eligible Employee's legally adopted child(ren), including child(ren) who are placed with the Eligible Employee for adoption
- The legally adopted child(ren) of the Eligible Employee's Spouse, including child(ren) who are placed with the Eligible Employee's Spouse for adoption
- Child(ren) for whom the Eligible Employee and/or the Eligible Employee's Spouse is (are) appointed as legal guardian as defined by a court order (this does not include wards of the state or foster child(ren); and
- Child(ren) for whom the Eligible Employee is required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

Child of a Domestic or Civil Union Partner: With respect to an Eligible Employee's Civil or Domestic Union Partner, such Domestic or Civil Union Partner's child(ren), up to the end of the month in which such child(ren) turn(s) age 26. For this purpose, child(ren) means:

- The Domestic or Civil Union Partner's biological child(ren), provided such child(ren) is (are) living with the Eligible Employee
- The Domestic or Civil Union Partner's legally adopted child(ren), including child(ren) placed with such partner for adoption, provided such child(ren) is (are) living with the Eligible Employee
- Child(ren) for whom the Domestic or Civil Union Partner is appointed as legal guardian as defined by a court order (this does not include wards of the state or foster child(ren)), provided such child(ren) is/are living with the Eligible Employee.

Civil Union Partner: See Domestic or Civil Union Partner.

Claim: A request for Benefits made by a Participant or his/her Authorized Representative in accordance with the procedures described in this document. It includes Prior Authorization requests; pre-service request for Benefits and appeals; urgent care request for Benefits and appeals; concurrent care request for Benefits and appeals; and post-services Claims.

Claims Administrator: The third-party hired to process Claims for Benefits under the Plan and to perform other administrative duties, herein. See Section P., "Important Contacts," for information of how to contact the Claims Administrator.

COBRA: An acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. This refers to federal legislation that governs the offer of temporary continued Plan coverage to participants who otherwise would lose coverage due to certain reasons, such as loss of employment.

Coinsurance: The cost-sharing method pursuant to which the Plan pays a percentage of Eligible Expenses (for example, 80 percent) and you pay a percentage (for example, 20 percent). Your Coinsurance is your share of the cost.

Company: Nokia of America Corporation, a Delaware corporation, or its successor(s).

Copayment (or Copay): A flat dollar amount (such as $10) that you are required to pay for a certain dental service (such as an office visit or supply).

Covered Person: Either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this document are references to a Covered Person.

Covered Dependent: With respect to an Eligible Employee who is enrolled in the Plan, each Eligible Dependent of such employee who is enrolled in the Plan.

Default Option: The Plan option to which you are assigned if you are an Eligible Employee and have not actively enrolled in the Plan or if your current option is eliminated and you do not actively select a new option. Eligible Employees working less than 20 hours per week are not assigned a Default Option; these Eligible Employees must actively enroll in the Plan to have coverage.

Dental Hygienist: A person who has been trained and licensed to remove calcareous deposits and stains from the surfaces of the teeth and to provide additional services and information on the prevention of oral disease under the direction of a Dentist.

Dentist: An individual duly licensed to practice dentistry by governmental authorities having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered. As used in the Plan, the term Dentist also includes a licensed physician authorized by his or her license to perform the particular dental service rendered.

Dependent: An individual who meets the eligibility requirements specified in the Plan. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

Domestic or Civil Union Partner: An individual, regardless of sex or gender, who, together and with respect to an Eligible Employee, meets the following criteria:

(A) If the Eligible Employee and the individual reside in a state or locality that maintains a registry of Domestic Partnerships or Civil Union Partnerships, comply with such state or local registration process.

(B) If the Eligible Employee and the individual do not reside in a state or locality that maintains a registry of Domestic Partnerships or Civil Union Partnerships, meet all of the following criteria (and so certify under penalty of perjury)--

- (i) They reside in the same household
- (ii) They are each age 18 or older
- (iii) They have the mental capacity sufficient to enter into a valid contract
- (iv) They are not related to each other by blood
- (v) They are not married to each other or to another person and are not the Domestic Partner or Civil Union Partner of another individual
- (vi) They consider themselves to have a close and committed personal relationship and have no other such relationship with any person
- (vii) They are responsible for each other's welfare and financial obligations, and
- (viii) They provide such other information as may be necessary for the Plan to determine whether the individual (or the Children of such individual) are Eligible Dependents under the Plan.

An Eligible Employee may not enroll more than one Domestic or Civil Union Partner in the Plan (and, if the Eligible Employee has a Spouse, may not enroll any Domestic or Civil Union Partner in the Plan).

Domestic or Civil Union Partnership: With respect to an Eligible Employee, the status of having a Domestic or Civil Union Partner.

Domestic Partner: See Domestic or Civil Union Partner.

Eligible Charge: A charge for dental services, subject to all of the terms, conditions, limitations, and exclusions for which the Plan, or Participant will pay.

Eligible Dependent: With respect to an Eligible Employee: the Eligible Employee's Spouse, Domestic or Civil Union Partner, as applicable; Child(ren); and Adult Disabled Child(ren). For Eligible Employees who have a Domestic or Civil Union Partner, Eligible Dependent also includes a Child of a Domestic or Civil Union Partner.

Eligible Employee: An individual employed by a Participating Company as a full- or part-time employee who is not an Excluded Employee.

Eligible Expenses: Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all Provider billings.

Employee Benefits Committee (EBC): The committee appointed by the Company to undertake certain administrative responsibilities with respect to the Plan. The EBC serves as the final review committee for all questions relating to eligibility to participate in the Plan and all other questions related to administration of the Plan, to the extent not delegated to the Claims Administrator or to the Nokia Benefits Review Team. Decisions by the EBC are conclusive and binding on all parties and not subject to further internal review.

ERISA: The Employee Retirement Income Security Act of 1974 as amended from time to time. The federal law that regulates retirement and employee welfare benefit plans maintained by employers.

Excluded Employee: Each of the following:

(1) an individual who does not receive payment for services from a Participating Company's U.S. payroll, even if such individual is reclassified by a court or administrative agency as a common law employee of a Participating Company
(2) an employee who is employed by an independent company (such as an employment agency)
(3) an employee whose services are rendered pursuant to a written agreement that excludes participation in the Company's benefit plans
(4) a Leased Employee
(5) a temporary employee (and any regular employee subclassified as a temporary employee)
(6) a co-op student or an intern (and any trainee/student subclassified as an intern)
(7) a trainee
(8) an International Assignee.

Explanation of Benefits (EOB): A statement that provides details about a Claim and explains what portion was paid to the Provider and what portion (if any) is the Participant's responsibility. The EOB is not a bill, it is a statement provided by the Claims Administrator to you, your Dentist, or another health care professional that explains the Benefits provided (if any); the Allowable Amounts; Copayments; any other reductions taken; the net amount paid by the Plan; and the reason(s) why the service or supply was not covered by the Plan.

FMLA: The Family and Medical Leave Act of 1993, as amended from time to time.

Incur/Incurred: The date a dental liability is created, usually the date on which treatment is received, services are rendered, or supplies or materials are purchased.

In-Network: The benefit choice that permits you to access the services of contracted Network Providers.

In-Network Provider: A dental services provider that has contracted with MetLife to provide dental services and supplies at a predetermined cost and is a part of the PDP Plus network.

International Assignee: Any of the following:

- An Employee who is classified as an Expatriate (Outbound Assignee) meaning the employee's home country is the United States, and the Expatriate is on a long-term international assignment for the Company outside of the United States, or
- An Employee who is classified as an Inpatriate (Inbound Assignee) meaning the employee's home country is outside of the United States, and the Inpatriate is on a long-term or short-term international assignment for the Company in the United States, or
- An Employee who is classified as on an International Professional Contract (IPC) meaning the employee does not have a designated home country and is on an international assignment for the Company in the United States.

Lifetime Maximum: The maximum Benefit available from the Plan in a lifetime for each Participant with respect to certain services. Once the lifetime maximum Benefit has been paid, no other Benefits are available under any circumstances with respect to those services. You are responsible for all charges above the lifetime maximum Benefit.

Network or Network Provider: This is a dental provider that is part of MetLife's PDP Plus network.

Network Benefits: The level of Benefits that are paid for Covered Health Services provided by Network Providers.

Nokia Benefits Resource Center: The resource to call to enroll, to make changes to your coverage or to ask questions about your Plan options. See the Section P., "Important Contacts," for information on how to contact the Nokia Benefits Resource Center.

Nokia Benefits Review Team: The team within the Nokia Benefits Resource Center assigned the responsibility to decide claims for eligibility to participate in the Plan.

Out-of-Network or Out-of-Network Provider: This is a dental provider that is not part of MetLife's PDP Plus network.

Participant: Each Eligible Employee and such Eligible Employee's Eligible Dependents who are enrolled in and covered under the Plan.

Participating Company: Each of the following:

- Nokia of America Corporation

- Nokia Federal Solutions LLC
- Nokia Investment Management Corporation.

Plan: The Nokia Dental Expense Plan for Active Employees, an employee welfare benefit plan (within the meaning of ERISA) maintained by the Company.

Plan Administrator: The Company or its designee.

Plan Sponsor: The Company.

Plan Year: The consecutive 12-month period commencing on January 1 and ending on December 31 (i.e., the calendar year).

PDP Plus: MetLife's Preferred Dentist Program (PDP) Plus is a network of participating Dentists who have agreed to accept negotiated fees for their services. You can choose any Provider, but when visiting a participating PDP Plus Dentist, you have the opportunity to lower your out-of-pocket expenses.

Provider: A dental professional, Dentist, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide dental services to you. The term "Provider" refers to an In-Network Provider unless otherwise specified.

Qualified Medical Child Support Order (QMCSO): A judgment, decree, or order issued by a court that requires coverage under the Plan for an Eligible Employee's Eligible Dependent and that has been determined by the Plan Administrator to be qualified under ERISA. You may obtain a copy of the Plan's QMCSO administrative procedures, free of charge, from the Nokia QMCSO Administrator. See Section P., "Important Contacts," for information on how to contact the Nokia QMCSO Administrator.

Qualified Status Change: A change in status with respect to an Eligible Employee or the Eligible Employee's Eligible Dependents that permits certain changes in coverage under the Plan. See "Changing Your Coverage During the Plan Year" in Section C., "Eligibility and Enrollment," for more information.

Spouse: A person of the same or opposite gender or sex who is lawfully married to an Eligible Employee. You may not have more than one Spouse under the Plan.

USERRA: An acronym for the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Section C. Eligibility and Enrollment

Who Is Eligible?

If you are an Eligible Employee, coverage under the Plan is available to you and to your Eligible Dependents. (Your Eligible Dependents must be covered under the same Plan option that you choose for yourself.)

Eligible Dependents who may be covered under the Plan are limited to:

- Your Spouse or Domestic or Civil Union Partner
- Your Child (through the end of the month in which such Child attains age 26)
- Your Adult Disabled Child
- The Child of your Domestic or Civil Union Partner (through the end of the month in which such Child attains age 26 and provided such Child lives with you).

Note: See Section B.,"Terms You Should Know," which sets forth the definitions for each type of "Eligible Dependent."

States sometimes pass laws that require employee benefit plans to provide Benefits and/or coverage to individuals who otherwise are not eligible. For example, a state might require an employer to provide coverage to an ex-spouse or a child who exceeds the Plan's age requirements and therefore is not eligible for Benefits under the Plan. The federal law known as ERISA supersedes state law. As a result, the Plan only covers the individuals described in this document. See "Dental Plan Contributions" later in this section for information on imputed income if you cover a Domestic or Civil Union Partner or a Domestic or Civil Union Partnership Child.

Enrolling in the Plan

What you need to do to enroll in coverage under the Plan differs depending on whether you are:

- A newly hired (or newly eligible) employee
- Changing your existing coverage during an Annual Open Enrollment Period, or
- Changing your existing coverage during the year due to a Qualified Status Change (see "Changing Your Coverage During the Plan Year" later in this section).

Declining Coverage

You may decline coverage under the Plan. However, if you do, you will have to wait until the next Annual Open Enrollment Period if you want to enroll in the Plan--unless you have a Qualified Status Change. See "Changing Your Coverage During the Plan Year" later in this section.

Plan Options and Coverage Categories

The Plan offers different coverage options (plan design) and coverage categories (who is covered). Depending on the plan option and coverage category you choose, your cost of services covered under the Plan, and the amount of contributions required for such coverage, will differ.

The following coverage options are available under the Plan:

- Standard Option (with a standard level of Coinsurance, and Annual Deductibles)
- Enhanced Option (providing a higher level of coverage than the Standard option).

To see the difference between the level of coverage offered under the Standard Option and the Enhanced Option, see the Appendix, "Benefits at a Glance - Dental". Depending on the option you choose, the cost of dental services for you and your covered Eligible Dependents will differ.

You may select from one of the following coverage categories when enrolling yourself and your Eligible Dependents in the Plan:

- You only
- You + your Spouse/Domestic or Civil Union Partner
- You + your Children (including your Adult Disabled Children and, if applicable, the Children of your Domestic or Civil Union Partner)
- You + your Family (i.e., your Spouse/Domestic or Civil Union Partner and your Children, including your Adult Disabled Children, and, if applicable, the Children of your Domestic or Civil Union Partner).

Newly Hired Employees

If you are a full-time or a part-time Eligible Employee regularly scheduled to work 20 or more hours a week, you are assigned individual coverage under the Plan as of your first day of work. You may add Eligible Dependents to your coverage provided you do so within 31 days of the date you're notified of your eligibility to enroll.

If you are scheduled to work less than 20 hours a week, you must actively enroll.

If you enroll your Eligible Dependents in the Plan, you must enroll them in the same Plan option that you choose for yourself. If you enroll your Eligible Dependents at the same time you enroll yourself, coverage for those Eligible Dependents begins the same day your coverage begins.

You generally will receive an e-mail from the Nokia Benefits Resource Center pointing you to the Your Benefits Resources (YBR) website for more information about your coverage options, including the cost, how to enroll yourself and your Eligible Dependents, and the date by which you must make your elections (generally, within 31 days after you receive your enrollment information).

If You Don't Enroll (New Hires)

As a new hire, if you do not make any elections by the required date, here is what happens:

- If you are a regular full-time or a regular part-time Eligible Employee scheduled to work 20 or more hours a week, you alone will continue to have coverage under a dental coverage option. You may not add any Eligible Dependents until the next Annual Open Enrollment Period, unless you have a Qualified Status Change (see "Changing Your Coverage During the Plan Year" later in this section).
- If you are scheduled to work fewer than 20 hours per week, you will not be assigned a dental coverage option. This means you and your Eligible Dependents cannot enroll in the Plan until the following Plan Year. You must wait until the next Annual Open Enrollment Period to enroll, unless you have a Qualified Status Change (see "Changing Your Coverage During the Plan Year" later in this section).

Note: Your Eligible Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse/Domestic or Civil Union Partner are both Eligible Employees, you may each be enrolled separately (as a covered Eligible Employee) or one of you may be covered as the Eligible Dependent of the other person, but not both. If you and your Spouse/Domestic or Civil Union Partner enroll separately, either parent (but not both) may enroll any Eligible Dependent Child.

Annual Open Enrollment Period

During Annual Open Enrollment each year, you will have the opportunity to select the coverage that best meets your needs for the coming year. This means that you may "add" or "cancel" coverage for yourself and your Eligible Dependents and/or change coverage options. Annual open enrollment is held once a year, usually in the fall. Elections made during annual open enrollment take effect on the first day of the next calendar year.

Before annual open enrollment, you will receive enrollment materials that will include information about the coverage options available to you under the Plan in the upcoming year. In most cases, if you are currently enrolled in the Plan and do not make any changes to your coverage, your current coverage elections will remain in effect unless a particular Plan option is being discontinued or replaced by another option.

If your Plan option is being discontinued and you do not select another Plan option, you will be enrolled in the Default Option.

Changing Your Coverage During the Plan Year

You may change your coverage under the Plan during the Plan Year **only** if you have a Qualified Status Change. In order to be able to make a change during the year, Qualified Status Changes must be reported through YBR or to the Nokia Benefits Resource Center within 31 days of the event.

A Qualified Status Change is an event that causes someone to become eligible for, or to no longer be eligible for, coverage under the Plan or another employer's plan. These events are listed in the table below.

Please note: Your election change under the Plan during the year must be due to and consistent with the type of Qualified Status Change that has occurred. For example, if you legally adopt a Child, you may enroll the newly adopted Child in the Plan. You may not, however, cancel coverage for your Spouse.

Qualified Status Change	Description
Change in Marital Status	Your marriage, divorce, legal separation, the annulment of your marriage, or the death of your Spouse.
Change in Domestic or Civil Union Partner Status	The entering into of, or termination of, a Domestic or Civil Union Partner relationship.
Change in the Number of Eligible Dependents	The birth, death, legal adoption, or placement for legal adoption of one of your Eligible Dependents.
Change in Employment Status, Work Schedule, or Worksite That Causes a Change in Eligibility	You or Eligible Dependent: • Becomes employed or loses employment • Experiences a change in worksite, or • Reduces or increases hours of employment, including a switch between part-time and full-time employment or the start of, or a return from, a leave of absence. Note: Without a corresponding change in your or your Eligible Dependent's eligibility under the Plan, the above changes will not permit a mid-year change under the Plan.
Your Eligible Dependent Meets or No Longer Meets the Plan's Eligibility Requirements	An event that causes a Dependent to meet or to no longer meet the Plan's eligibility requirements, for example, your Child reaches the maximum age for coverage.

Qualified Status Change	Description
Change in Place of Residence	A change in residence for you or an Eligible Dependent that causes a gain or loss of eligibility for coverage.
Significant Cost or Coverage Changes	A significant change in the cost or coverage under the Plan (for example, if costs significantly increase mid-year, you may be eligible to drop coverage) or a significant change in cost or coverage under another employer's group health plan in which one of your Eligible Dependents participates. (For example, if costs significantly increase under your Spouse's plan mid-year, your Spouse may be able to disenroll from the other employer's plan and enroll in the Plan.)
Court-Ordered Coverage	A change in your responsibility to provide healthcare coverage for a Dependent Child as stipulated in a judgment, decree or court order resulting from a divorce, legal separation, annulment or change in legal custody (for example, a Qualified Medical Child Support Order). Documentation must be submitted.

Note: The fact that another employer's plan has a different enrollment period than the Plan is not considered a Qualified Status Change under the Plan. For example, if one plan's annual open enrollment period is in October and the other plan's annual open enrollment period is in November, you may not make changes to your coverage under the Plan as a result of the different timing of the enrollment periods.

The Company also considers corresponding changes in Domestic or Civil Union Partners and Domestic or Civil Union Partnership Dependents as Qualified Status Changes.

Special Enrollment Rights

The Plan provides "special enrollment rights" for both Eligible Employees and their Eligible Dependents in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and also the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA). Special enrollment rights refer to the ability to enroll for coverage under the Plan outside the Plan's normal enrollment periods (e.g., when first becoming eligible for coverage or during an Annual Open Enrollment Period) in certain limited circumstances, provided timely notice is provided to the Plan, as described below.

Under HIPAA, if you declined coverage under the Plan (either when you first became eligible for coverage or during a subsequent Annual Open Enrollment Period) because you had other health insurance or other group health plan coverage (for example, coverage available under a Spouse's plan), you may be able to enroll yourself and your Eligible Dependents in this Plan if you (or any

of your Eligible Dependent(s)) lose eligibility for that other coverage or if, in the case of an employer-sponsored group health plan, the other employer stops contributing toward your or your dependents' other coverage. However, you must request enrollment in the Plan within 31 days plan after your or your Eligible Dependent's(s') other coverage ends (or within 31 days after the other employer stops contributing toward that other coverage).

Also under HIPAA, if you "gain" a new Dependent during the Plan Year as a result of marriage, entering into a Domestic or Civil Union Partnership, or the birth, adoption, or placement for adoption of a Child, you may be able to enroll yourself and your Eligible Dependents (both "new" Eligible Dependents and existing but unenrolled Eligible Dependents) in the Plan. However, you must request enrollment within 31 days after the event, i.e., the marriage, entering into such Domestic or Civil Union Partnership, birth, adoption, or placement for adoption.

If you timely request enrollment in the Plan due to a special enrollment event as described above, coverage will be effective as follows:

- If the event is the birth, adoption or placement for adoption of a Child, coverage will be effective as of the date of birth, adoption or placement for adoption
- For all other events, coverage will be effective on the day first of the month following the month in which your request for enrollment is received.

In addition to the foregoing special enrollment rights under HIPAA, the Plan provides for special enrollment rights under CHIPRA. If you or your Eligible Dependent is eligible for but not enrolled in coverage under the Plan, you are eligible to enroll in the Plan outside of the Plan's Annual Enrollment Period if you meet either of the following conditions and you request enrollment with the Plan no later than the deadline described below:

- You or your Eligible Dependent loses eligibility for Medicaid or State Children's Health Insurance Program (CHIP) coverage
- You or your Eligible Dependent becomes eligible for premium assistance with respect to coverage under the Plan, due to coverage with Medicaid or CHIP.

In order to enroll in the Plan for any of those circumstances, you must request enrollment within 60 days of the event.

If you timely request enrollment in the Plan due to a CHIPRA special enrollment event as described above, coverage will be effective on the first day of the month following the month in which your request for enrollment is received.

For more information about your special enrollment rights under these laws, please contact the Nokia Benefits Resource Center.

Section D. The Cost of Plan Coverage

Employee Contributions for Eligible Employees

The Plan is "self-insured" by the Company, meaning the Company is responsible for the cost of providing Benefits due under the Plan as well as the cost of administering the Plan. You are required to contribute toward this cost. The amount you pay depends on the plan option you choose (e.g., Standard vs. Enhanced) and the coverage category (e.g., you, you plus spouse, etc.). You are provided with information regarding the amount of contribution that you are required to pay at the time of enrollment. You can also find cost information for all the available options on the YBR website.

In most instances, your contributions are deducted from your paycheck on a pre-tax basis (that is, before taxes are deducted from your pay).

Tax Treatment of Coverage for Domestic and Civil Union Partners and Their Children

Most Eligible Dependents under the Plan are considered to be "Tax Dependents" of the Eligible Employee, meaning that covering such dependents under the Plan does not result in additional taxable income to the employee under state or federal tax law. You are not taxed on the value of your Plan Benefits for Tax Dependents.

Nokia assumes all Covered Dependents are Tax Dependents, with the exception of Domestic or Civil Union Partners and their Children. If you are eligible to cover a Domestic or Civil Union Partner or a Child of your Domestic or Civil Union Partner (or some other person who is not a Tax Dependent), Nokia is required to report income for you that reflects the value of the coverage (minus any after-tax contributions) for tax reporting purposes. This is known as imputed income. Your Form W-2 will include the value of coverage for any Eligible Dependent who is not a Tax Dependent, and this additional taxable income is subject to both income tax and FICA withholding.

For more information about the tax implications of coverage for a Domestic or Civil Union Partner or Domestic or Civil Union Dependent under the Plan, please consult with your personal tax advisor. Neither the Company nor the Plan provides personal tax advice.

Cost of COBRA Coverage

"COBRA" coverage is continuation coverage that is available under the Plan in certain circumstances. See Section K., "COBRA Continuation Coverage," for more information. There is a difference between the contributions required for active employee coverage and coverage as

COBRA continuant. Please contact the Nokia Benefits Resource Center or visit the YBR website or refer to your COBRA Enrollment Notice for details on the current cost of your coverage. See Section P., "Important Contacts," for more information on how to contact the Nokia Benefits Resource Center.

Section E. How the Dental Plan Works

Understanding Your Options Under the Dental Plan

The Plan offers two types of coverage options:

- The Enhanced Option; and
- The Standard Option.

The options vary by the level of covered services and how much you pay out of your pocket.

The details pertaining to your Plan options, including Coinsurance, Deductibles, and Annual Maximum can be found in the Appendix to this document.

MetLife's Preferred Dentist Program (PDP) Plus

When you visit a general Dentist or a specialist who is in the Network, your out-of-pocket costs are usually lower. That is because participating PDP Plus Dentists have agreed to accept negotiated fees for covered services that are usually 35 percent to 50 percent less than the average charges in the same community[1] and both the Enhanced and Standard Plan Options offer more generous coverage for covered services performed by PDP Plus Providers. Lower fees can help you cut your final costs and stretch your Annual Maximum.

In particular, the cost of specialty care like implants, root canals and crowns can really add up. That is why it is good to know the Network is there to help you manage your out-of-pocket costs. You can view your potential savings on In-Network vs. Out-of-Network fees by using the MetLife's Dental Dental Cost Estimator[2] tool located at www.metlife.com/mybenefits. (To sign in, use the company/group name "US-Nokia" and follow the onscreen prompts using your MetLife MyBenefits credentials.)

[1] Based on internal analysis by MetLife. Negotiated fees refer to the fees that In-Network Dentists have agreed to accept as payment in full for covered services rendered by them, subject to any Copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

[2] This tool does not provide the payment information used by MetLife when processing your claims. Prior to receiving services, pretreatment estimates through your dentist will provide the most accurate fee and payment information. MetLife Online Services capabilities may vary by product and may not be available to all customers. Please contact your MetLife representative for more information.

Taking Advantage of the PDP Plus Network

To take advantage of the PDP Plus network you must be enrolled in the Plan. Visit the MetLife website, or call MetLife, to find a Dentist who participates. You and your Covered Dependents can select the same or different Dentists, and you do not have to select a primary Dentist in the PDP Plus to take advantage of its features. Just let your Dentist know that you participate in the MetLife PDP Plus when you schedule your appointment.

The most up-to-date Provider listings are available on the MetLife website. If you are already enrolled, visit www.metlife.com/mybenefits, enter the organization name "US-Nokia", then log in using your MetLife user credentials and password. If you are not yet enrolled, you may visit www.metlife.com, select "Find a Dentist", then select the network "PDP Plus". If you have questions about participating PDP Plus Dentists in your area, you may also contact MetLife. See Section P. "Important Contacts" for information on how to contact MetLife.If you visit a Dentist who is not in the PDP Plus, your Dentist will need to complete and submit a claim form. Claim forms are available from MetLife. Or, ask your Dentist to apply to join the PDP Plus. Your Dentist can visit www.metdental.com or call 1-877-MET-DDS9. (Note that this website and phone number are for dental professionals only.)

Getting the Most from Your Coverage

In addition to using the MetLife PDP Plus, you can ensure that you receive the maximum Benefit under the Plan by keeping the following in mind when arranging dental care.

Alternate Procedures

Often, there are several ways to treat a particular dental condition. For example, suppose in repairing your tooth, the Dentist has the option of using a filling or a crown, and that either treatment meets with generally accepted dental standards. In such instances, the Plan will cover only the less expensive treatment — in this case, the filling. So it is important to discuss the choices for treating your problem with your Dentist before work begins. If your Dentist used a crown instead, you would be responsible for the charges above what the Plan would pay for the less expensive treatment — namely, the filling.

You can avoid such unnecessary charges and surprises by discussing treatment choices with your Dentist prior to beginning work and by having your Dentist file a predetermination of Benefits as described below.

Predetermination of Benefits

If you need dental work costing over $300, you should determine before treatment begins what is covered and how much the Plan will pay. This procedure is called "predetermination of Benefits." Here is how predetermination works:

- Your Dentist outlines the treatment plan and fees on the claim form, and sends it to MetLife; then

- MetLife determines the amount the Plan will pay and informs you and your Dentist.

If after reviewing the predetermination, you and your Dentist decide to change the treatment plan, MetLife will adjust its payment accordingly. If there is a major change in the treatment plan, your Dentist should submit a revised plan. In addition, if your predetermination is issued in one calendar year, but your service is provided in another calendar year, it is recommended your Dentist submit a revised plan in the calendar year in which the service will be provided for an updated predetermination.

If you have a treatment plan approved and then your coverage ends before the start of treatment or services being rendered, subsequent Benefits are generally not payable. But see, "*Short Extension of Coverage to Complete Certain Treatments" in Section I., "When Coverage Ends."*

Section F. What's Covered

The Services covered under the Plan are set forth in the Appendix, "Benefits at a Glance - Dental".

Section G. What's Not Covered

The following services are not covered under the Plan:

- Services that are not Dentally Necessary, or those that do not meet generally accepted standards of care for treating the particular dental condition, as determined by the Claims Administrator
- Services for which you would not be required to pay in the absence of dental coverage
- Services that are neither performed nor prescribed by a Dentist, except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist, and which are for:
    - Scaling and polishing of teeth, or
    - Fluoride treatments
- Diagnosis and treatment of temporomandibular joint disorder (TMJ)
- Work done for appearance (cosmetic or aesthetic purposes), including personalization or characterization of Dentures
    - Porcelain facings on Crowns and Pontics posterior to the second bicuspid shall always be considered cosmetic and subject to clinical review which may result in an alternate benefit being applied
- Biopsies of hard or soft oral tissue
- Fees in excess of PDP Plus negotiated fees for PDP Plus Providers
- Fees in excess of reasonable and customary (R&C) charges for non-PDP Plus Providers
- Replacement of broken, missing, lost or stolen appliances
    - In the event that a broken, missing, lost, or stolen prosthetic device is replaced at the individual's expense, the rebasing, relining, or repair of such a duplicate prosthetic device is a covered expense
- Work furnished or payable by the armed forces of any government or by any civil unit of any government
- Treatment resulting from declared or undeclared war, insurrection, participation in a riot or service in the armed forces of any government
- Appliances, restorations, or procedures to alter vertical dimensions or restore occlusion, or for the purpose of splinting or correcting attrition or abrasion
- Services payable under workers' compensation or similar laws
- Charges for dental services if benefits for all or any part of the expenses for such services are provided under the Nokia Medical Expense Plan for Management Employees or other Company-provided health plan
- Work done while not covered under the Plan
- Extra/duplicate sets of dentures or other appliances
- Work that is otherwise free of charge

- Charges for broken appointments
- Charges for completing or filing claim forms
- Educational training programs, dietary instructions, and plaque control programs
- Treatment resulting from or caused by the negligent or wrongful act of a third party
- Periodontal splinting
- General anesthesia or conscious intravenous sedation, unless in conjunction with extensive covered and eligible procedures, or considered medically necessary based on the patient's condition.
- Local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide, when charged separately by the Dentist
- Drugs or their administration
- Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss
- Experimental and investigational procedures, as determined by the Claims Administrator, and
- Full mouth debridement
- Local chemotherapeutic agents

Section H. Coordination of Benefits (COB); Subrogation, Overpayment and Reimbursement

Coordination of Benefits

What Is Coordination of Benefits?

The Plan has a Coordination of Benefits ("COB") provision. This feature is designed to prevent duplicate Benefit payments when you or your Covered Dependents participate in more than one group health plan.

When Does Coordination of Benefits Apply?

The COB provision applies when you or your Covered Dependents have dental coverage in addition to that provided under the Plan, such as under:

- Another employer's plan
- A group-sponsored insurance or prepayment plan, or
- A government-sponsored plan.

When Does Coordination of Benefits Not Apply?

The COB provision does not apply:

- To benefits under any personal policy (except no-fault or other state-mandated automobile insurance); and
- To two related people, both of whom are Eligible Employees and/or dependents of Eligible Employees, due to the following two rules:
  - One person cannot receive Plan Benefits as both an Eligible Employee and as an Eligible Dependent of an Eligible Employee, and
  - One person cannot receive Plan Benefits as an Eligible Dependent of more than one Eligible Employee or retiree of a Participating Company.

Which Plan Pays Benefits First?

Under the COB feature, one plan is primary and determines its Benefits first. The other plan(s) is secondary and determines what Benefits, if any, it may pay after the primary plan determines its Benefits.

If the Plan through Nokia is primary, it pays its Benefits without regard to the secondary plan. When the Plan is secondary, it calculates what it would have paid if it was the primary plan. The

Nokia Plan then pays the remaining Eligible Charges not paid by the primary plan up to the amount the Nokia Plan would have paid if it was the primary plan. You can receive up to 100 percent (but not more) of the Allowable Amount under the highest paying plan.

To claim Benefits, submit your Claim to the primary plan first. After that plan determines its Benefits, submit a completed claim form to the secondary plan along with a copy of the original bill and a copy of the Explanation of Benefits statement you received from the primary plan.

How the Claims Administrator Determines Which Plan Is Primary

This Plan uses the following rules to determine which plan is primary and which plan(s) is (are) secondary:

- If the other plan(s) does not have a COB feature, that plan(s) is considered primary and the Plan is considered secondary.
- If your Spouse or Domestic or Civil Union Partner is employed by a company other than Nokia, and he or she is covered under his or her employer's plan, that plan is primary, and the Plan is secondary (i.e., the Spouse or Domestic or Civil Union Partner as a Covered Dependent under the Plan).
- For Dependent Children, determination of the primary and secondary plan(s) follows these rules in this sequence:
  - The Plan uses the "birthday rule." The plan covering the parent whose birthday (month and day) comes first in the year is the primary plan for the Child(ren), and the plan covering the other parent is the secondary plan for the Child(ren).
  - If both parents have the same birthday, the plan that has covered one parent longer is the primary plan for the Child(ren), while the plan that has covered the other parent for a shorter period of time is the secondary plan, and
  - If one parent's plan follows the male-female rule and one parent's plan (such as this Plan) follows the birthday rule, the male-female rule applies to the extent permitted by law.
- If the parents of the covered Child(ren) are divorced or legally separated, the Claims Administrator will determine whether there is a court decree or a QMCSO establishing financial responsibility for dental expenses.
  - If there is such a decree or QMCSO, the plan covering the parent who has the responsibility to provide coverage pursuant to such decree of QMCSO will be the primary plan
  - If there is no such decree or QMCSO, the plan that covers the parent with custody will be the primary plan; the other parent's plan will be secondary
  - If there is no such decree or QMCSO and the parent with custody remarries, that parent's plan remains primary; the stepparent's plan is secondary, and the non-custodial parent's plan is tertiary (third-in order), and
  - If payment responsibilities are still unresolved, the plan that has covered the patient for the longest time is the primary plan.

Right of Recovery and Subrogation

If all or some of the expenses under the Dental Plan are not payable (improper payments), or if all or some of the payments made exceed the benefits payable under the Dental Plan (excess payments), then those improper or excess payments must be refunded to the Dental Plan.

If the refund is due from another person or organization, you or your Covered Dependents must assist the Dental Plan in obtaining the refund when requested. You or your Covered Dependents are still responsible for any improper or excess payments made to you or your Covered Dependents or to providers under the Dental Plan.

Failure by you or your Covered Dependents, or any other person or organization that was improperly or excessively paid, to promptly refund the full amount may reduce the amount of any future benefits that are payable to or on behalf of you or your Covered Dependents under the Dental Plan.

The Dental Plan provides covered benefits to you and your Covered Dependents that are not provided by any third party. So, benefits provided under the Dental Plan as a result of any illness or injury that gives rise to a claim by you or your Covered Dependents against a third party (as the result of or attributable to the negligent or wrongful acts or omission of such third party) are excluded and are not covered under the plan. If such benefits have been paid by the Dental Plan:

- The Dental Plan shall be entitled to all of your and your Covered Dependents' rights of recovery against such third party to the extent of the reasonable value of the benefits provided under the Dental Plan.

- You and your Covered Dependents agree to reimburse the Dental Plan for the reasonable value of all benefits received under the Dental Plan out of any actual recoveries you or your Covered Dependents received from any third party (other than the participant's family members).

- The Dental Plan's subrogation and reimbursement rights apply to any recoveries that may be received or actually are received by you or your Covered Dependents, including, but not limited to, the following:

  - Any payments as a result of a settlement, judgment or otherwise, made by or on behalf of a third party or his or her insurance company or made under an uninsured or underinsured motorist coverage.

  - Any payments from any source designed or intended to compensate your or your Covered Dependents for injuries sustained as the result of negligence or alleged negligence of a third party.

  - Any payments under workers' compensation, no-fault or other state mandated motor vehicle insurance.

- Any payments made as a result of coverage under any automobile, school or homeowners' insurance policy.

You and your Covered Dependents are required to fully cooperate and perform all actions necessary to secure the Dental Plan's right of recovery and subrogation, including granting a lien on any monies recovered from a third party, refraining from taking any action or negotiating any agreement with any third party that may prejudice the Dental Plan's rights, and from assigning any rights to recover dental care expenses from any tort-feasor or other person or entity to any other party. You or your Covered Dependents shall not incur any expenses on behalf of the Dental Plan in pursuit of the Dental Plan's rights. No court costs or attorney's fees may be deducted from the Dental Plan's recovery without the advance express written consent of the Dental Plan.

In the event that you or your Covered Dependents fail or refuse to honor these terms, the Dental Plan will be entitled to recover any cost incurred in enforcing these terms and conditions.

Section I. When Coverage Ends

When Employee Coverage Ends

Your coverage under the Plan ends on the last day of the month in which any of the following events occurs:

- Your employment with a Participating Company terminates or you otherwise cease to be an Eligible Employee
- You do not make a required contribution toward coverage under the Plan
- You request that your coverage be canceled, or you decline coverage, when permitted
- The company you work for ceases to be a Participating Company, or
- The Plan is terminated.

When your coverage ends, you may be able to continue coverage under certain circumstances. See Section K., "COBRA Continuation Coverage," for more information.

When Dependent Coverage Ends

Your Eligible Dependent's(s') coverage under the Plan will end as follows:

- If your coverage ends, your Eligible Dependent's(s') coverage will end on the same day.
- If your Eligible Dependent Child attains age 26, such Child's coverage will end on the last day of the month in which the Eligible Dependent Child reaches age 26.

***Please note**: If your Dependent Child is an Adult Disabled Child within the meaning of the Plan, he or she may be able to continue his or her coverage regardless of age. This coverage is not automatic. The Claims Administrator must certify that the Child is eligible for coverage. To apply for coverage, contact the Claims Administrator and notify the Nokia Benefits Resource Center of your intention to seek this coverage.*

If your Eligible Dependent's coverage ends for any other reason, coverage for the Dependent will end on the last day of the month in which the event occurs.

- If you and your Spouse divorce, your Spouse's coverage will end on the last day of the month in which the divorce becomes final.

- If your Domestic or Civil Union Partnership ends (or you and your Domestic or Civil Union Partner no longer satisfy the Plan's eligibility criteria for Domestic or Civil Union Partnership), your Domestic or Civil Union Partner's coverage, and coverage for any enrolled Child(ren) of your Domestic or Civil Union Partner, will end on the last day of the month in which the Domestic or Civil Union Partnership ends (or in which the eligibility criteria are no longer satisfied).

Short Extension of Coverage to Complete Certain Treatments

In general, no Benefits will be paid under the Plan for covered dental services or supplies received after coverage ends, except for:

- **Dentures or bridgework**, if the final impressions were taken and the abutment teeth fully prepared before coverage ended and the device is delivered and installed within the next two months following the coverage end date
- **A crown**, if the Dentist prepared the tooth and took the final impression before coverage ended and installs the crown within the next two months following the coverage end date. or
- **Root canal therapy**, if the pulp cap was opened into the chamber before coverage ended and the treatment is completed within the next two months following the coverage end date.

Section J. Employment-Related Events

If You Terminate Employment

Your coverage under the Plan ends on the last day of the month in which your employment ends. You may, however, be eligible for coverage under the group healthcare plan that the Company maintains for retired employees, provided you meet the eligibility criteria of that plan. The benefits provided by the group healthcare plan for retired employees may differ from the Benefits provided for active Eligible Employees under this Plan. This Plan and the plan for retired employees are subject to amendment, modification, or termination by the Company at any time, including before or during your retirement.

When coverage under this Plan ends, you may be eligible to continue coverage for yourself and your eligible Covered Dependents under COBRA. For more information, see Section K., "COBRA Continuation Coverage."

If You Transfer Employment to Another Nokia Group Company

If you transfer employment to another Nokia Group company, whether your coverage will continue depends on whether the other company is also a Participating Company with respect to this Plan. If you transfer employment to a Participating Company, your participation in the Plan will not be affected. If, however. you transfer employment to a non-Participating Company, you will be treated as having had a termination of employment for purposes of the Plan and will no longer have coverage under the Plan. However, you may be eligible to continue coverage for yourself and your eligible Covered Dependents through COBRA. For more information, see Section K., "COBRA Continuation Coverage."

If You Leave Nokia and Are Later Rehired by a Participating Company or If You Transfer Employment to Another Nokia Group Company and You Later Transfer Back to a Participating Company

If you leave Nokia and are later rehired by a Participating Company (after a break in service), you will be treated as a new-hire for purposes of the Plan; you will automatically be enrolled in coverage under the Plan as of your first day of active employment upon your return. For more information, see Section C., "Eligibility and Enrollment."

If You Become Disabled

If you are absent due to a disability, but still employed with a Participating Company, then your coverage under the Plan continues (provided you are still an Eligible Employee).

If You Take an Approved Leave of Absence

If you take an approved leave of absence--including, but not limited to, absence due to disability, leave under FMLA, and qualified military leave under USERRA--you can continue Plan coverage for yourself and your Covered Dependents. In some instances, you might have to pay the full cost of Plan coverage.

State and Local Leave Laws

To the extent continued Plan coverage is required by state and/or local leave laws and is not otherwise preempted by federal law, the Plan will comply.

Section K. COBRA Continuation Coverage

Overview

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to offer "qualified beneficiaries" (certain covered employees and certain of their covered dependents) the opportunity to continue their group health benefit coverage at their own expense for a limited period of time if they lose coverage due to a "qualifying event".

Note: Domestic or Civil Union Partners and their Children are not typically eligible for continuation coverage under federal law, as they do not meet the definition of "qualified beneficiary" under COBRA. However, the Plan provides COBRA-like rights to covered Domestic or Civil Union Partners and to the Child(ren) of Domestic or Civil Union Partners as outlined in this section of the SPD. While not legally applicable in all cases, references herein to "COBRA" and to "qualified beneficiary" includes, respectively, "COBRA-like" coverage and Domestic or Civil Union Partners and the Child(ren) of Domestic or Civil Union Partners.

Qualifying Events

In order to become eligible for continuation coverage under the Plan's COBRA continuation of coverage provisions, you (or your Covered Dependents) must face a loss of Plan coverage due to a "qualifying event". The following constitute qualifying events under the Plan:

- Termination of your employment for any reason (other than for gross misconduct)
- A reduction in your work hours
- Your divorce or legal separation from your Spouse or the termination of your Domestic or Civil Union Partnership
- A Child's loss of eligibility under the terms of the Plan (e.g., your Child turns age 26)
- Your death.

The qualifying event is deemed to occur on the date that coverage under the Plan would be lost due to the occurrence of the event. For example, because coverage under the Plan continues until the end of the month in which you experience an involuntary termination of employment, this qualifying event is considered to occur on the first day of the following month.

Notice Requirement

It is your or your qualified beneficiary's responsibility to notify the Nokia Benefits Resource Center of a qualifying event (other than your termination of employment, reduction in hours of employment, or death, or your Covered Dependent Child turns age 26) that makes you or your

Covered Dependent(s) eligible for COBRA continuation coverage. The deadline for providing such notice is 60 days from the end of the calendar month in which the qualifying event occurs. For example, if you become legally separated from your Spouse on May 15, your Spouse and covered dependents (or you on their behalf) will have until July 31 (60 days from the first day of the month immediately following the month in which this event occurs) to notify the Nokia Benefits Resource Center of this event.

The individual eligible for COBRA continuation coverage must respond by the date on the notice of COBRA rights to be eligible for COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouses/Domestic or Civil Union Partners, and parents may elect COBRA continuation coverage on behalf of their Children.

Maximum Period of Continuation Coverage

The table below shows the maximum period of continuation coverage available under the Plan's COBRA continuation-of-coverage provisions:

If This Qualifying Event Occurs…	**COBRA Continuation Coverage Can Last for…**
• Termination of your employment for any reason other than gross misconduct; or • A reduction in your work hours.	Up to 18 months (for you and your Covered Dependents)
• Your divorce or legal separation • Termination of your Domestic or Civil Union Partnership	Up to 36 months (for your Covered Dependents)
• Your death	Up to 36 months (for your Covered Dependents).
• Your Child's loss of eligibility under the Plan	Up to 36 months (for your covered Child)
• You or your Covered Dependent becoming disabled at any time during the first 60 days of the COBRA continuation coverage period and such disability lasting at least until the end of the initial 18-month period of COBRA continuation coverage.	The continuation-of-coverage period may be extended from 18 months to up to 29 months (for the disabled qualified beneficiary). To be eligible for the additional period of coverage, the disabled person must call the Nokia Benefits Resource Center before the end of the initial 18-month period and within 60 days of receiving notice of disability from the Social Security Administration.

If This Qualifying Event Occurs…	COBRA Continuation Coverage Can Last for…
	The individual must also notify the Nokia Benefits Resource Center within 30 days after the Social Security Administration determines that he or she is no longer disabled.

How COBRA Continuation Coverage Is Affected by Multiple Qualifying Events

A qualified beneficiary (other than you--the Eligible Employee) may be eligible for an additional period of COBRA continuation coverage, not to exceed a total of 36 months from the initial qualifying event, if there is a second qualifying event because of your death, the divorce or legal separation of you and your Spouse, the termination of your Domestic or Civil Union Partnership, or your Child losing eligibility under the Plan. The second event can be a second qualifying event only if it would have caused a loss of coverage under the Plan in the absence of the first qualifying event.

For example, suppose you terminate employment on December 31, 2024, and you are eligible to continue coverage for up to 18 months (i.e., until June 30, 2026). Your Child, who is a Covered Dependent on December 31, 2024, reaches age 26 (a second qualifying event) on December 31, 2025. Your Child is then eligible for up to an additional 18 months of COBRA continuation coverage from the date of the original qualifying event. In this case, your Child is eligible to continue coverage through December 31, 2027, which is 36 months from December 31, 2024, the date of your termination of employment (the original qualifying event).

To be eligible for extended coverage after a second qualifying event, you or your qualified beneficiary must notify the Nokia Benefits Resource Center within 60 days of the date of the second qualifying event.

Adding a Newborn or Newly Adopted Dependent During a Period of Continuation Coverage

If, while you are enrolled in COBRA continuation coverage, you have a baby, legally adopt a Child or a Child is placed with you for legal adoption and the Child meets the Plan's rules for being an Eligible Dependent, the Child will be a considered a "qualified beneficiary" and will be eligible for COBRA continuation coverage. The maximum coverage period for such a Child will be the remainder of the maximum coverage period for that qualifying event.

Electing COBRA Continuation Coverage

Complete details about COBRA continuation coverage, including information about election and cost, are automatically sent to your preferred address if you (the employee):

- Terminate employment with a Participating Company,
- Experience a reduction in work hours,
- Die, or

- If your Covered Dependent Child turns age 26.

For certain qualifying events, information regarding COBRA coverage is not automatically sent. It is your or your qualified beneficiary's responsibility to notify the Nokia Benefits Resource Center of the occurrence of the following qualifying events:

- Divorce from a Spouse
- Legal separation from a Spouse
- Termination of a Domestic or Civil Union Partnership, or
- A Child no longer satisfying the Plan's eligibility criteria, other than turning age 26.

You and/or your qualified beneficiaries must notify the Nokia Benefits Resource Center within 60 days of the occurrence of the qualifying event.

What Does COBRA Coverage Cost?

COBRA participants must pay monthly contributions for coverage.

Generally, monthly contributions are based on the full cost per Covered Person, set at the beginning of the year, plus two percent for administrative costs. Covered Dependents making separate elections must contribute at the same rate as the former employee. If your COBRA continuation coverage is extended to 29 months due to a qualifying disability, you may be required to pay the full cost of COBRA continuation coverage plus a 50 percent administrative fee for each month beyond 18 months.

Where the initial qualifying event is the employee's death, Covered Dependents electing COBRA continuation coverage pay the active-employee rate for the first six months of continuation coverage and the regular COBRA rate, as described above, thereafter. (The active-employee rate only applies where the initial qualifying event is due to death and does not apply where the death occurs later, i.e., during a previously elected COBRA continuation period.)

Payment is due at enrollment, but there is a 45-day grace period from the date you (or your Covered Dependents) elect coverage to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s).

Ongoing monthly payments are due on the 10th of each month, but there is a 45-day grace period (for example, the June payment is due June 10th, but will be accepted if postmarked up to 45 days after that).

Termination of COBRA Continuation Coverage Before the End of the Maximum Period of Continuation Coverage

COBRA continuation coverage will end before the end of the maximum continuation period if one of the following occurs:

- You or your Covered Dependent does not make timely premium payments or contributions as required

- The Company stops providing dental Benefits to its employees, or
- You or any of your Covered Dependents become covered under another group healthcare plan not offered by a Nokia Group Company.

Continuation coverage also may be terminated for any reason where the Plan would terminate coverage of a participant or Beneficiary not receiving continuation coverage (for example, in the case of fraud).

Section L. Claims and Appeals

The Plan maintains claims and appeals procedures designed to afford you a fair and timely review of any Claim you might have relating to the Plan. Generally, you are legally required to pursue all your claim and appeal rights on a timely basis before seeking any other legal recourse, including litigation.

For information regarding how to contact parties referenced in this section, see Section P., "Important Contacts".

Overview

Disagreements about eligibility to participate in the Plan (or in one of the Plan's programs) or about Benefits provided under the Plan can and do arise. To resolve these disagreements, the Plan provides for a formal claims and appeals process.

Note: You must exhaust the claim and appeal procedures as described in this document before filing any legal action (whether in state or federal court) regarding your Plan dispute.

The Plan has separate claims and appeals procedures depending on whether you have:

- An eligibility claim; or
- A Benefit Claim.

An eligibility claim is a claim by you (or your dependent) concerning the right to participate in the Plan. For example, you may believe an error was made during Annual Open Enrollment that resulted in your (or your dependent) being assigned incorrect coverage, or you may believe you (or your dependent) experienced a Qualified Status Change that entitles you (or your dependent) to make a change in Plan coverage during the year, but you are being told to wait until the next Annual Open Enrollment to make the change. Another example of an eligibility claim is a claim to be included as a Participant in the Plan (e.g., there is a disagreement regarding your employment status that affects your eligibility for Plan coverage). Eligibility claims do not address whether a particular treatment or benefit is covered under the Plan.

In contrast to eligibility claims, Benefit Claims concern the question of coverage under the Plan. Such Claims can include, for example, whether a procedure or course of treatment is covered under the terms of the Plan, the amount of co-insurance or co-pays payable under the Plan with respect to a particular service, or the extent to which Plan limits or other restrictions apply to the service at issue.

The claim and appeal procedures for eligibility claims and for Benefit Claims are described separately below. (References to "you" refer to any claimant, including the authorized representative of any claimant.)

In addition, there are four **categories** of Claims for Benefits under the Plan, each with slightly different claims and appeals rules. The primary difference is the time frame within which claims and appeals must be determined.

- ***Post-service:*** A Claim for reimbursement of services already received. This is the most common type of Claim.

- ***Pre-service:*** A Claim for a Benefit for which prior authorization is required by the Plan.

- ***Urgent care:*** A Claim for dental care or treatment that, if the longer time frames for non-urgent care were applied, the delay: (1) could seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or (2) in the opinion of a Dentist with knowledge of the claimant's dental condition, would subject the claimant to severe pain that could not be managed without the care or treatment that is the subject of the claim.

- ***Concurrent care:*** A claim for ongoing treatment over a period of time or a number of treatments.

Decision-Making Authority

The authority to adjudicate claims and appeals has been assigned to different entities—for eligibility claims, to the Nokia Benefits Review Team (the "NBRT") and then to the Nokia Employee Benefits Committee (the "EBC"); for Benefit claims, to the relevant Claims Administrator. Each of these entities (NBRT, EBC, and a Claims Administrator) is a fiduciary under ERISA and is required to review and decide your claim in accordance with the Plan's terms (the documents and instruments governing the Plan) and these procedures. In this regard, the Plan grants to each of these entities (as applicable) sole and complete discretionary authority to determine conclusively for all parties, and in accordance with such documents and instruments, any and all questions arising from administration of the Plan and interpretation of all Plan provisions, determination of all questions relating to participation in the Plan and eligibility for Plan Benefits, determination of all relevant facts, determination of the amount and type of Benefits payable under the Plan, and construction of all Plan terms. In the case of an appeal, the EBC's and the Claims Administrator's decisions are final and binding on all parties to the full extent permitted under applicable law, unless the claimant later proves that the decision was an abuse of administrator discretion.

Eligibility Claims and Appeals Procedure

In instances where you are required to file a claim form (as opposed to the automatic submission with some benefit-related claims), you should submit claims within 60 days of the date the service is provided. If it's not reasonably possible to submit a claim within this time frame, an

extension of up to 12 months from the date of service will be allowed. However, no Benefits will be paid for claims submitted more than 12 months after the date of service.

Submitting an Eligibility Claim

If you have an eligibility claim, contact the Nokia Benefits Resource Center and request an eligibility claim form ("Claim Initiation Form" or "CIF"). Your eligibility claim is not filed until you complete and mail your CIF, including any supporting documentation to:

Claims and Appeals Management
Dept 07544
PO Box 299107
Lewisville, TX 75029-9107

If your eligibility claim is coupled with a claim for Benefits, follow the Benefits Claims Administrator's process, but also include a copy of the Benefits claim information with your CIF. You should indicate on your CIF whether the Benefits claim is a post-service claim, pre-service claim, an urgent (pre-service) claim, or a concurrent care claim.

When You Can Expect to Receive a Decision with Respect to Your Eligibility Claim

Since the vast majority of eligibility claims are post-service, you will receive a response within 30 days from the date that your CIF is received. The NBRT may extend the period for making the claim decision by 15 days if it determines that an extension is necessary and notifies you, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision. If your eligibility claim is being submitted in conjunction with a Benefit claim, see the timing applicable to your "type" of claim or appeal in the ***Benefits Claims and Appeals Procedure*** section of this document.

Special Rule: If you do not provide sufficient information to allow the NBRT to make a decision with respect to your eligibility claim, you will be notified of the need for the information. You will have at least 45 days from receipt of the notice to provide the specified information. In such an instance, the NBRT's deadline for rendering a decision is suspended from the date on which it sends notice of the need for necessary information until the date on which you provide the information. For example, if the NBRT notifies you on Day 10 of the initial 30-day review period that additional information is required, you will have 45 days from your receipt of the notice to provide the necessary information. If the NBRT then receives that information on, for example, Day 30 of your 45-day response time, the time within which the NBRT is required to decide your claim picks up as if it were Day 11 of its initial 30-day review period.

What You Will Be Told if Your Eligibility Claim Is Denied

If your claim is **denied**, in whole or in part, your written denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.

- Any additional material or information you may need to submit to complete the claim and an explanation as to why it is necessary.
- Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request).
- A description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following your appeal.

Eligibility Appeals Procedure and Deadline to Submit Your Appeal

If your eligibility claim is denied and you wish to have it re-reviewed, you must file an appeal. You must file your appeal within **180 days** from the date on the claim denial letter. To file an appeal, you must write to:

Nokia
Employee Benefits Committee ("EBC")
600–700 Mountain Avenue
Room 6C-402A
Murray Hill, NJ 07974

You should include a copy of your initial claim denial notification, the reason(s) for the appeal, and relevant documentation with your appeal request.

You may request access, free of charge, to all documents relating to your appeal. Your appeal will be reviewed "de novo," which means you get to "start fresh" to establish the merits of your claim and the EBC will not place deference upon the original decision. The EBC is a fiduciary who is not the individual who made the initial decision and who is not the subordinate of the initial reviewer.

When You Can Expect to Receive a Decision with Respect to Your Eligibility Appeal

You will be notified of the decision by the EBC within 60 days after receipt of your appeal.

Please Note: *If your eligibility appeal is coupled with a non-urgent pre-service Benefits appeal, urgent pre-service Benefits appeal, or concurrent care Benefits appeal, as the case may be, an effort will be made to decide your eligibility appeal within the time frames applicable to the Benefits Claim.*

What You Will Be Told if Your Eligibility Appeal Is Denied
If your eligibility claim is denied on appeal, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial
- The Plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim

- Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request)
- A statement about your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) and a statement about voluntary alternative dispute resolution options

The decision on your appeal is final. As a result, the EBC will not review your matter again, unless new facts are presented. Upon denial by the EBC, you have the right to bring a civil action in federal court. This option is available to you only after you have exhausted all the administrative remedies available to you through the Plan's claims and appeals process as described in this section.

Benefits Claims and Appeals Procedure
The following is a summary of the Benefits claims and appeals procedure.

The Claims Administrator (MetLife) must comply with this process or you must verify that the process has been exhausted. If you believe that the Claims Administrator/fiduciary has violated this process, you may write to the Plan Administrator.

Submitting a Benefit Claim

To file a Benefit Claim:

- If you need a claim form, call your Claims Administrator to request a claim form. You may also be able to print out a claim form at the applicable Claims Administrator website. Contact information for the Claims Administrator appears in Section P., "Important Contacts".
- Follow the instructions printed on the form.
- Attach a copy of the Provider's itemized bill.
- Submit the completed form and attachments to the address printed on the form.

Your Claim will be evaluated to determine if any Benefits will be paid. You'll receive an Explanation of Benefits statement. If Benefits are payable, a check will be sent to you, or to your Provider if he or she agreed to accept payment directly from the Claims Administrator. If your Claim is denied, you will be advised of the reasons for the denial and may appeal the decision.

When You Can Expect to Receive a Decision with Respect to Your Benefit Claim

You will be notified of the Claims Administrator's decision within the following time frames following the receipt of your Claim:

- ***Post-service Claim*:** Within 30 days (an additional 15-day extension may apply)
- ***Pre-Service Claim*:** Within 15 days (an additional 15-day extension may apply)

- ***Urgent care claim:*** Within 72 hours

- ***Concurrent care Claim:*** A time period in advance of the reduction or termination of coverage to allow appeal and obtain a response to that appeal before coverage is reduced or terminated. If the concurrent care Claim also is an urgent care claim, within 24 hours if it's in advance of reduction or termination of coverage; otherwise, within 72 hours

Note: You will be notified within the original time frame if an extension of time applies.

Special Rules:

Failure to Follow Procedures: If your Claim is misdirected or you otherwise do not follow the Benefit Claim procedures, you will be notified of this failure and provided the proper procedure for filing the Claim as soon as possible, but within 5 days of the Claims Administrator's receipt of your claim for a pre-service Claim or within 24 hours for an urgent care claim.

Incomplete Claim: If you fail to provide sufficient information with your Claim, the Claim may be decided based on the information provided. Alternatively, the Claims Administrator may notify you that additional information is needed, and you will have the following time frames to respond:

- ***Post-service Claim***: 45 days. Claims Administrator will then respond within the time frame remaining for the initial Claim.

- ***Pre-Service Claim***: 45 days. Claims Administrator will then respond within the time frame remaining for the initial Claim.

- ***Urgent care Claim:*** Within 48 hours. Claims Administrator will then respond within 48 hours.

- ***Concurrent care Claim:*** N/A – Claim will be decided based on the information provided.

What You Will Be Told if Your Benefit Claim Is Denied

If your Claim is denied, in whole or in part, the Claims Administrator will notify you in writing, except for urgent care (in which case, you will be notified by telephone, which will be followed by a written denial notice within three days, and you will receive a description of the expedited appeals process applicable to urgent care claims). Your written denial notice will contain:

- The specific reason(s) for the denial.

- The Plan provisions on which the denial was based.

- Any additional material or information you may need to submit to complete the Claim and an explanation as to why it is necessary.

- Any internal procedures or protocols or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request).
- A description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following your appeal.

If the Claims Administrator relies on new evidence to deny your Claim, you will be notified in advance, free of charge, with the rationale so that you can respond in advance of the final internal Adverse Benefit Determination. You have a right to review your Claim file.

Benefit Appeal Procedure and Deadline to Submit Your Appeal

If your Benefit Claim is denied and you wish to have it re-reviewed, you must file an appeal. Your appeal must be filed with the party outlined in your Claim denial letter within **180 days** from the date of the letter. You should include a copy of your initial Claim denial notification, the reason(s) for the appeal, and relevant documentation with your appeal request.

You may request access, free of charge, to all documents relating to your appeal. Your appeal will be reviewed "de novo," which means you get to "start fresh" to establish the merits of your Claim and the Claims Administrator will not place deference upon the original decision.

The Claims Administrator (MetLife) reviewing your appeal is a fiduciary and the individual/committee who reviews your appeal at the Claims Administrator will not be the individual who made the initial decision and will not be the subordinate of the individual/committee who reviewed your Claim. In addition, if your appeal involves a dental judgment, the Claims Administrator will consult with a dental care professional who has appropriate relevant experience and such individual will be independent of any health care professional who reviewed your Claim. You are entitled to learn the identity of such an expert, upon request.

When You Can Expect to Receive a Decision with Respect to Your Benefit Appeal

You will be notified of the Appeals Administrator's decision within the following time frames following the receipt of your Claim:

- ***Post-service Claim***: Within 60 days (or 30 days if Appeals Administrator offers 2 levels of mandatory appeal)
- ***Pre-Service Claim***: Within 30 days (or 15-days if Appeals Administrator offers 2 levels of mandatory appeal)
- ***Urgent care Claim:*** Within 72 hours

- ***Concurrent care Claim:*** Before a reduction or termination of benefits would occur. If the concurrent care Claim also is an urgent care claim then, within 24 hours if it's in advance of reduction or termination of coverage; otherwise, within 72 hours

What You Will Be Told if Your Benefit Appeal Is Denied

If your appeal is denied in whole or in part, your denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your Benefit Claim upon request.
- Any internal procedures or protocols or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request).
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA.
- Information pertaining to your right to an external review (and if applicable, any second level of internal appeal).
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

Section M. Your Rights Under ERISA

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA, as described below.

Your Right to Receive Information About the Plan and About Your Benefits under the Plan

Under ERISA, all Plan Participants have the right:

- To examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan and a copy of the latest Annual Return/Report (the Form 5500) filed by the Plan Administrator with the U.S. Department of Labor. The Plan's Annual Return/Report (Form 5500) is also available at the Public Disclosure Room, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C.

- To obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan and copies of the latest Annual Return/Report (Form 5500) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for such copies.

Your Right to Prudent Actions by the Plan's Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Participants and Beneficiaries. No one, including the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your Claim for a Benefit under the Plan is denied or ignored, in whole or in part, you have a right to know the reasons for the denial, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time limits.

Under ERISA, there are steps you can take to enforce the above rights. For example, if you request a copy of Plan documents or the latest Annual Return/Report (Form 5500) from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials to you and also to pay you up to $110 a day until you receive the materials (unless the materials were not

sent because of reasons beyond the control of the Plan Administrator). If you have a Claim for Benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that the Plan's fiduciaries misuse the money belonging to the Plan, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement of your ERISA rights or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by going to www.dol.gov/EBSA or calling the publications hotline of the Employee Benefits Security Administration at (866) 444-EBSA (3272).

Section N. Other Information About the Plan

This Document, which is the Official Plan Document, is Controlling

This document serves as both the official plan document of the Plan and also as the Plan's Summary Plan Description (SPD).

Because of the many detailed provisions of the Plan, no one other than the personnel or entities identified is this document (see Section P., "Important Contacts") is authorized to advise you concerning the terms of the Plan. Questions regarding your benefits or the Plan should be addressed as indicated in this document. Neither the Company, any Participating Company, nor the Plan is bound by statements made by unauthorized persons or entities. Moreover, in the event of a conflict between any information provided to you by an authorized resource and this document, this document will control.

The Company Has the Right to Modify, Suspend, or Terminate the Plan

The Company expects to continue the Plan. However, the Company has expressly reserved the right to modify, suspend, change or terminate the Plan at any time and for any reason.

The Plan is Not a Contract of Employment

Your participation in the Plan, and your right to amounts contributed to and earned under your Plan account, do not create a contract of employment, which is generally considered to be "at will."

Plan Funding and Payment of Benefits

The Claims and expenses of the Plan are paid by the [Claims Administrator]. Funding for Plan payments is derived from employer and employee contributions.

Your Plan Benefits and Rights Are Not Assignable

Benefits payable under the Plan are not subject to assignment or alienation, nor may any Participant assign any cause of action relating to such Benefits, nor any other rights with respect to the Plan, to any other person or entity, including any dental provider. Any such purported assignment or alienation shall be null and void. Notwithstanding the foregoing:

- in accordance with Section 609(b) of ERISA, payments for Benefits with respect to a Participant under the Plan will be made in accordance with any assignment of rights made

by or on behalf of such Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act; and

- the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan.

Authority of Plan Administrator and Claims Administrators

The Plan Administrator has the full discretionary authority and power to control and manage all aspects of the Plan, to determine eligibility for Plan Benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Plan as the Plan Administrator may deem appropriate in accordance with the terms of the Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Plan, including the discretionary authority to interpret and construe the terms of the Plan, to direct disbursements, and to determine eligibility for Plan Benefits.

The Plan Administrator has delegated its responsibility to review claims relating to eligibility to participate in the Plan to the Nokia Benefits Review Team. The Plan Administrator has delegated its responsibility to review appeals of denied claims relating to eligibility to participate in the Plan to the Employee Benefits Committee. The Plan Administrator has delegated its responsibility to review all other claims and appeals relating to Benefits under the Plan to the Claims Administrators. Each Claims Administrator has the full discretionary authority and power to control and manage all aspects of the Plan with respect to which they have been delegated responsibility, including the discretionary power and control to determine eligibility for Plan Benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Plan as they may deem appropriate in accordance with the terms of the Plan and all applicable laws. See also “Decision-Making Authority” in Section L., “Claims and Appeals.”

Section O. Administrative Information

Plan Name	The official name of the Plan is the Nokia Dental Expense Plan for Active Employees.
Plan Sponsor Name and Address	The Plan Sponsor of the Plan is Nokia of America Corporation. The address of the Plan Sponsor is: Nokia Room 6D-401A 600-700 Mountain Avenue Murray Hill, NJ 07974 USA
Plan Administrator Name and Address	The Plan is administered by Nokia of America Corporation. The address of the Plan Administrator is: Nokia Plan Administrator Room 6D-401A 600-700 Mountain Avenue Murray Hill, NJ 07974 USA The Plan Administrator has retained MetLife to act as a third-party administrator (contract administrator) responsible for administering Claims and paying Benefits under the terms of the Plan. For contact information for the Claims Administrator, see Section P., "Important Contacts". In addition, the Plan Administrator has retained Alight Solutions LLC (using the name the Nokia Benefits Resource Center (NBRC)) as third-party administrator responsible for eligibility and enrollment under the terms of the Plan. For contact information for each of these third-party administrators, see Section P., "Important Contacts."
Type of Administration	The Plan is administered by the Plan Sponsor.
Type of Plan	The Plan is considered an "employee welfare benefit plan" within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Plan Records and Plan Year	The Plan and all its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Agent for Service of Legal Process	The Nokia Legal & Compliance organization is the agent for service of legal process. Service of legal papers, including service of subpoenas, may be served directly to: Nokia Legal & Compliance Room 6D-401A 600-700 Mountain Avenue Murray Hill, NJ 07974 USA
Employer Identification Number	The Employer Identification Number assigned by the IRS to the Plan Sponsor is 22-3408857.
Plan Number	The Plan Number assigned by the Plan Sponsor to the Plan is 505.
Plan Trustee	None. Plan Benefits are paid from the general assets of the Company.

Section P. Important Contacts

Here is a list of important contacts for the Plan:

Contract/Service Provided	Address
Claims Administrator (MetLife)-- Access or obtain Preferred Dentist Program (PDP) Plus directories, download or request claim forms; and obtain other general information on the MetLife PDP Plus.	*Online* Through the MetLife website at: www.metlife.com/mybenefits, 24 hours a day, seven days a week. (To sign in, use the organization name "US-Nokia" and follow the onscreen prompts.) *By Phone* Call MetLife Dental Customer Service at 1-888-262-4876. The TDD number is 1-888-638-4863. *By Mail* MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 *For Dental Professionals Only* Your Dentist can apply to join the PDP Plus network by visiting www.metdental.com or calling 1-877-MET-DDS9.

Plan Administrator Administers the Plan; adjudicates eligibility claims; oversees third-party service-providers, responsible for certain disclosure to Participants regarding the Plan.	Plan Administrator Nokia 600-700 Mountain Avenue Room 6D-401A Murray Hill, NJ 07974 USA
Nokia Benefits Resource Center (NBRC) Call center where you can: • Enroll in coverage • Make changes to your coverage • Review, add or change your dependent's information on file • Understand how a Life Event may affect your benefits • Get answers to your questions regarding eligibility and enrollment in the Plan	1-888-232-4111 (domestic) 1-212-444-0994 (if calling from outside the U.S., Puerto Rico or Canada) Representatives are available between 9:00 a.m. and 5:00 p.m., Eastern Time (ET), Monday through Friday. If you are hearing or speech impaired, please use a Relay Service when calling a representative. The mailing address of the NBRC is: Nokia Benefits Resource Center Dept. 07544 P.O. Box 64116 The Woodlands, TX 77387-4116 USA Overnight mail should be sent to: Nokia Benefits Resource Center Dept. 07544 8770 New Trails Drive The Woodlands, TX 77381 USA
Nokia BenefitAnswers Plus Website where you can: • See benefits news and updates • View plan-related documents such as Summary Plan Descriptions (SPDs), Summaries of Material Modifications (SMMs), and Summary Annual Reports • View enrollment materials	https://www.benefitanswersplus.com/

Nokia Benefits Review Team • The team within the Nokia Benefits Resource Center assigned the responsibility to decide claims for eligibility to participate in the Plan	Claims and Appeals Management Dept 07544 PO Box 299107 Lewisville, TX 75029-9107
Nokia Employee Benefits Committee Serves as final review committee for Plan eligibility appeals.	Employee Benefits Committee Nokia 600-700 Mountain Avenue Room 6C-402A Murray Hill, NJ 07974 USA
Nokia Legal & Compliance Organization Authorized agent for service of process of all legal papers for the Plan, the Severance Plan Administrator, and the Nokia Employee Benefits Committee. Also authorized agent for service of subpoenas.	Legal & Compliance Organization Nokia 600-700 Mountain Avenue Room 6D-401A Murray Hill, NJ 07974 USA
Nokia QMCSO Administrator • Handles matters relating to Qualified Medical Child Support Orders ("QMCSOs") for the Plan	Send all draft or court-certified orders to: Nokia Qualified Order Team P.O. Box 1542 Lincolnshire, IL 60069-1542 USA You can also fax documents and inquiries to: 1 (847) 442-0899. For information or if you have questions: visit the Qualified Order Center website at www.QOcenter.com, email your questions to QOcenter@alight.com, or contact the Nokia Benefits Resource Center.
Your Benefits Resources (YBR)™ Website where you can: • View your current coverage • Review and compare your healthcare options and contribution costs • Enroll in coverage • Make changes to your coverage • Learn more about your Nokia benefits • Review, add or change your dependent's information on file	You can access YBR at https://digital.alight.com/nokia, 24 hours a day, seven days a week.

• Understand how a Life Event may affect your benefits (Your Benefits Resources is a trademark of Alight Solutions LLC.)	

Appendix

Appendix 1

Benefits at a Glance - Dental

Dental

Note:

This section includes a high-level summary of common procedures covered by these options and does not list all covered services. Additional frequency limits, requirements and exclusions may apply.

For more information about your dental coverage, contact MetLife at www.metlife.com/mybenefits or call 1-888-262-4876.

	MetLife Enhanced Dental		MetLife Standard Dental	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Network	You can use any dental provider you choose. However, your out-of-pocket costs will be less if you use MetLife Preferred Dentist Program (PDP) Plus network providers because: • PDP Plus network providers offer lower negotiated fees, and • Both dental options offer more generous coverage for PDP Plus network providers. If you use an out-of-network provider, your out-of-pocket costs will be based on reasonable and customary (R&C) charges, and your coverage will be lower.			
Annual deductible (applies to basic and major services only; in- and out-of-network combined)[1]	$0	$50 per individual; maximum of $100 per family	$50 per individual; maximum of $100 per family	$100 per individual; maximum of $200 per family
Annual maximum benefit (per individual; in- and out-of-network combined)[2]	$2,250	$1,750	$1,500	$1,000
Diagnostic/preventive care				
Oral exam (up to two preventive exams and up to two problem-focused exams per year)	Plan pays 100%	Plan pays 90%; not subject to deductible	Plan pays 100%; not subject to deductible	Plan pays 90%; not subject to deductible
Cleaning and scaling of teeth (two per year)	Plan pays 100%	Plan pays 90%; not subject to deductible	Plan pays 100%; not subject to deductible	Plan pays 90%; not subject to deductible
Space maintainers for dependent children (up to, but not including, age 19)	Plan pays 100%	Plan pays 90%; not subject to deductible	Plan pays 100%; not subject to deductible	Plan pays 90%; not subject to deductible
Fluoride treatment	Plan pays 100% (limited to four times per calendar year); no age limit	Plan pays 90%; not subject to deductible (limited to four times per calendar year); no age limit	Plan pays 100% for children up to, but not including, age 19; limited to twice per calendar year; not subject to deductible	Plan pays 90% for children up to, but not including, age 19; limited to twice per calendar year; not subject to deductible

[1] The in-network and out-of-network deductibles are shared. This means that, when you receive a covered dental service that is subject to the deductible from an in-network **or** out-of-network provider, the amount you pay toward the deductible will count toward **both** the in-network **and** out-of-network deductible.

[2] The in-network and out-of-network annual maximums are shared. This means that the amount the plan pays for a covered in-network **or** out-of-network dental service will count toward **both** the maximum in-network **and** out-of-network benefit the plan will pay for all covered dental services for the plan year.

	MetLife Enhanced Dental		MetLife Standard Dental	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Diagnostic/preventive care (continued)				
X-ray services — full-mouth and panoramic (panorex)	Plan pays 100% (limited to once every 60 months)	Plan pays 90%; not subject to deductible (limited to once every 60 months)	Plan pays 100%; not subject to deductible (limited to once every 60 months)	Plan pays 90%; not subject to deductible (limited to once every 60 months)
Bitewing X-ray (limited to once per year for adults; two times per year for children up to, but not including, age 19)	Plan pays 100%	Plan pays 90%; not subject to deductible	Plan pays 100%; not subject to deductible	Plan pays 90%; not subject to deductible
Sealants for permanent molars	Plan pays 100% for children up to, but not including, age 19; limited to once in 60 months	Plan pays 90% for children up to, but not including, age 19; limited to once in 60 months; not subject to deductible	Plan pays 100% for children up to, but not including, age 19; limited to once in 60 months; not subject to deductible	Plan pays 90% for children up to, but not including, age 19; limited to once in 60 months; not subject to deductible
Restorative services				
Anesthesia	Plan pays 80%	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 40% after deductible
Extractions — nonsurgical	Plan pays 80%	Plan pays 70% after deductible	Plan pays 80% after deductible	Plan pays 70% after deductible
Extractions — surgical	Plan pays 80%	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 40% after deductible
Fillings (composite resin and amalgam)	Plan pays 80%	Plan pays 70% after deductible	Plan pays 80% after deductible	Plan pays 70% after deductible
Inlays/onlays (limited to once every seven years)	Plan pays 80%	Plan pays 70% after deductible	Plan pays 80% after deductible	Plan pays 70% after deductible
Crowns to restore tooth structure (limited to once every seven years)	Plan pays 80%	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 40% after deductible
Periodontal scaling/planing	Plan pays 80% (limited to once per quadrant every 24 months)	Plan pays 70% after deductible (limited to once per quadrant every 24 months)	Plan pays 80% after deductible (limited to once per quadrant every 24 months)	Plan pays 70% after deductible (limited to once per quadrant every 24 months)
Periodontal surgery	Plan pays 80% (limited to once per unique area every 36 months)	Plan pays 70% after deductible (limited to once per unique area every 36 months)	Plan pays 50% after deductible (limited to once per unique area every 36 months)	Plan pays 40% after deductible (limited to once per unique area every 36 months)
Bridges (limited to once every seven years)	Plan pays 80%	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 40% after deductible
Implants (limited to once every seven years)	Plan pays 80%	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 40% after deductible

	MetLife Enhanced Dental		MetLife Standard Dental	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Restorative services (continued)				
Root canals	Plan pays 80%	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 40% after deductible
Dentures (limited to once every seven years)	Plan pays 80%	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 40% after deductible
Removal of wisdom teeth — nonsurgical	Plan pays 80%	Plan pays 70% after deductible	Plan pays 80% after deductible; not subject to calendar-year maximum	Plan pays 70% after deductible; not subject to calendar-year maximum
Removal of wisdom teeth — surgical	Plan pays 80%	Plan pays 70% after deductible	Plan pays 50% after deductible; not subject to calendar-year maximum	Plan pays 40% after deductible; not subject to calendar-year maximum
Oral surgery (except for surgical extractions and surgical removal of wisdom teeth)	Plan pays 80%	Plan pays 70% after deductible	Plan pays 80% after deductible; not subject to calendar-year maximum	Plan pays 70% after deductible; not subject to calendar-year maximum
Orthodontia	Plan pays 50% up to lifetime maximum of $2,000/individual (in- and out-of-network combined)		Plan pays 50% up to lifetime maximum of $1,500/individual (in- and out-of-network combined)	
Bruxism (appliance replacement)	Plan pays 80% (limited to once every 24 months)	Plan pays 70% after deductible (limited to once every 24 months)	Not covered	

About Nokia

At Nokia, we create technology that helps the world act together.

As a B2B technology innovation leader, we are pioneering networks that sense, think and act by leveraging our work across mobile, fixed and cloud networks. In addition, we create value with intellectual property and long-term research, led by the award-winning Nokia Bell Labs.

Service providers, enterprises and partners worldwide trust Nokia to deliver secure, reliable and sustainable networks today – and work with us to create the digital services and applications of the future.