Nokia Flexible Spending Account Plans

Plan Document and Summary Plan Description

January 2025 (Updated February 2025)

This plan document and summary plan description (bearing the cover-page legend “January 2025 (Updated February 2025)”) replaces the prior plan document and summary plan description (bearing the cover page legend “January 2025”). This version reflects the restoration of Nokia Investment Management Corporation as a “Participating Company” in the plans.

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Introduction

Nokia's benefit programs can be an important part of your financial security. The Nokia Flexible Spending Account Plans allow you to set aside Pre-Tax dollars from your pay to cover certain healthcare and dependent care expenses. There are two separate Flexible Spending Account plans:

- The Nokia Health Care Reimbursement Account Plan, which provides for a *Health Care Flexible Spending Account (**HFSA**)*. The HFSA may be used to pay for eligible healthcare expenses for yourself, your Spouse, and Eligible Healthcare Dependents.

- The Nokia Child/Elder Care Reimbursement Account Plan, which provides for a *Dependent Care Flexible Spending Account (**DFSA**)*. The DFSA may be used to pay for eligible dependent care expenses for your eligible dependent while you work, or if you are married, that allow both you and your Spouse to work, or your Spouse to look for work or attend school full time.

You may elect to participate in one Plan, both Plans, or neither Plan.

This document serves as the official plan document of the Plans and also as the Plans' Summary Plan Description (SPD). It sets forth the terms of the Plans as of January 1,2025.

The Company expects to continue the Plans but reserves the right to amend, modify, or terminate either or both of them, in whole or in part, at any time by resolution of the Company's Board of Directors or its duly authorized delegate(s).

This document constitutes an amendment and restatement of the Plans and replaces all prior communications regarding the Plans.

Section A: The Plans At-A-Glance

Here is a summary of the key features of the Plans. (Certain words and phrases used in the table below and elsewhere in this SPD have specific meaning under the Plans. These terms are printed in initial capital letters and are defined in the "Terms You Should Know" section of this SPD.)

Plan Features	Summary
Eligibility and Participation	You are eligible to participate in the Plans if you are an Eligible Employee. Participation is not automatic. You must enroll in the Plans in order to make contributions. (You may enroll in the Nokia Health Care Reimbursement Account Plan, the Nokia Child/Elder Care Reimbursement Account Plan, or both.) You will remain a Participant in the Plan in which you enroll until your account in that Plan is fully distributed or forfeited, in accordance with the rules of the Plan.
Eligible Employee	You are an Eligible Employee if you are employed by a Participating Company and are not an Excluded Employee.
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) an intern (and any trainee/student subclassified as an intern), (7) a co-op student, or (8) a trainee (other than an International Graduate Trainee).

Plan Features	Summary
Enrollment	You must affirmatively enroll in a Plan in order to participate. Enrollment is not automatic. Also, your salary reduction contribution elections do *not* automatically continue from one year to the next. To continue to participate in either or both of the Plans after your initial enrollment, you must re-enroll each year during the Annual Open Enrollment period.
Minimum Contribution	The minimum amount that you may contribute to either Plan is $100.
Maximum Contribution	The maximum amount you may contribute to the Plans is as follows: HFSA-- • 2025: $3,200 DFSA-- • 2025: $5,000. **Note:** For both the HFSA and the DFSA, your maximum contribution could be lower than what is shown above based on the results of certain "nondiscrimination" testing (applicable to Highly Compensated Employees). For the DFSA, your maximum contribution could also be lower than what is shown above based upon your Spouse's income and your tax-filing status. See Section D: Your Health Care Flexible Spending Account, and Section E: Your Dependent Care Flexible Spending Account, for more information.
What the HFSA Covers	The HFSA may be used to pay eligible healthcare expenses of yourself, your Spouse, and your Eligible Healthcare Dependents. Eligible healthcare expenses are limited to expenses that: • Are for services that are medically necessary, • Are not reimbursed by Nokia or any other employer plan, • Would be considered tax-deductible by the IRS (notwithstanding the fact that such expenses are to be paid or reimbursed from the HFSA). Amounts paid for personal protective equipment, such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19, are also considered to be eligible healthcare expenses under the HFSA.

Plan Features	Summary
	See Section D: Your Heath Care Flexile Spending Account for more information.
What the DFSA Covers	The DFSA may be used to pay eligible dependent-care expenses of a Qualifying Individual. Examples of eligible dependent-care expenses are: • Fees for day care, babysitting and housekeepers whose duties include dependent care, • Fees for before- and after-school care programs to allow you to work or, if you are married, to allow you and your Spouse to work or to allow you to work and your Spouse to look for work or to attend school full-time. See Section E: Your Dependent Care Flexible Spending Account for more information.
Forfeiture of Unused Account Balances	Any balance in either the HFSA or DFSA that is not used for expenses incurred during the Plan Year are forfeited. Unused balances **cannot** be transferred between the HFSA and DFSA or vice versa. Notwithstanding the foregoing, if you are participating in the HFSA on December 31 of a Plan Year, any unused amounts as of December 31 can be applied to expenses incurred through March 15 of the following Plan Year. This period, January 1 through March 15, is referred to as the "Grace Period." There is no "Grace Period" for the DFSA.
Flexible Spending Accounts Contact	For additional information about the Flexible Spending Account(s), log on to www.benefitanswersplus.com, or contact Alight Smart-Choice Accounts™ (Smart-Choice) at digital.alight.com/nokia or 1-888-232-4111.

Section B: Terms You Should Know

There are several words and phrases that have specific meanings under one or both of the Flexible Spending Account plans. This section explains those terms so you can better understand your benefits. These terms are printed in initial capital letters when they appear to let you know they are defined here.

Alight Smart-Choice Accounts™ (Smart-Choice): a web-based resource located online and accessed through the Your Benefits Resources™* website. Smart-Choice serves as Claims Administrator and recordkeeper for the Plans, answers questions about eligible and ineligible healthcare and dependent care expenses, processes requests for reimbursement from your flexible spending account(s), and handles claims with respect to such account(s).

Annual Open Enrollment: the period 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 Plan Year. If you want to continue participating in the HFSA and/or the DFSA for any year after the year of your initial enrollment, you *must re-enroll each Plan Year* during Annual Open Enrollment. Your elections do *not* automatically continue from one year to the next.

Children: your biological children, stepchildren, legally adopted children, children lawfully placed with you for adoption, and foster children placed with you by an authorized placement agency or by judgment, decree, or other order of any court or competent jurisdiction.

Claims Administrator: the entity appointed by the Company to process claims for benefits under the Plans. Subject to the review and oversight by the Plan Administrator, the Claims Administrator has discretionary authority to determine, in accordance with the documents and instruments governing the Plan, 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 facts, determination of the amount payable under and extent of other benefits provided under the Plan, and construction of all Plan terms. Decisions of the Plan Administrator are subject to oversight and review by the Employee Benefits Committee. The Claims Administrator may employ others to carry out or render advice with respect to its responsibilities under the Plan, including discretionary authority to interpret and construe the terms of the Plan, to direct disbursements and to determine eligibility for Plan benefits.

COBRA: the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. This refers to federal legislation that governs the offer of temporary continued healthcare coverage to

* Your Benefits Resources is a trademark of Alight Solutions LLC.

participants who otherwise would lose coverage due to certain reasons, such as a loss of employment. COBRA coverage is available only with respect to the HFSA.

Code: the Internal Revenue Code of 1986, as amended, and regulations promulgated thereunder.

Company: Nokia of America Corporation, a Delaware corporation, and any successor entity.

Dependent Care Center: a facility that provides adult or child care for more than six individuals (other than individuals who reside at the facility) and receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether the facility is operated for a profit).

DFSA: Dependent Care Flexible Spending Account. Money in this account may be used to pay for eligible dependent care expenses that allow you to work, or, if you are married, that allow both you and your Spouse to work, or your Spouse to look for work or to attend school full time.

Eligible Employee: a regular, active full-time or part-time employee who works for a Participating Company who is not an Excluded Employee.

Eligible Healthcare Dependents: each of the following:

- Your Children through the end of the month in which they attain age 26;
- Your Children who are age 26 or older, provided that:
    - Immediately prior to attaining age 26, they were enrolled in the Nokia Medical Expense Plan for Active Employees (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),
    - Immediately prior to attaining age 26 and thereafter, they are:
        - Incapable of self-support;
        - Physically or mentally handicapped, developmentally disabled, or mentally ill; and
        - Fully dependent on you for support; and
    - They are certified as eligible by the claims administrator for the medical plan option under which they are covered (you must start the certification process within 31 days of the end of the month in which they attain age 26); or
- Anyone else you claim as a dependent on your federal income tax return.

From time to time, the Plan Administrator may ask you to verify your healthcare dependents' eligibility. Verification will include documentation requirements.

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 the administration of the Plan. Decisions by the EBC are conclusive and binding on all parties and not subject to further internal review. The EBC has sole and complete discretionary authority to determine conclusively for all parties, and in accordance with the terms of the documents or instruments governing the Plan, 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 facts, determination of the amount payable under and extent of other benefits provided under the Plan, and construction of all Plan terms.

ERISA: the Employee Retirement Income Security Act of 1974, as amended, and regulations promulgated thereunder.

Excluded Employee: Any 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, (6) an intern, (7) a co-op student, (8) a trainee (other than an International Graduate Trainee) or (9) an International Assignee.

Grace Period: with respect to a Plan Year, the period from January 1 to March 15th of the immediately following Plan Year, provided you were a Participant in the Plan on December 31 of such Plan Year. The Grace Period applies only with respect to the HFSA.

HFSA: Health Care Flexible Spending Account. Money in this account may be used to pay for eligible healthcare expenses for yourself, your Spouse, and your Eligible Healthcare Dependents.

Highly Compensated Employee: For purposes of the HFSA, you are considered to be a highly compensated employee if: (i) you are one of the 5 highest paid officers of the Nokia Group; (ii) you are a shareholder owning more than 10% in value of the stock of Nokia Corporation; or (iii) you are among the top 25% of paid employees of the Nokia Group. Please contact the Nokia Benefits Resource Center to obtain more information if you believe that you may be a Highly Compensated Employee. For purposes of the DFSA, you are considered by the Plan to be a highly compensated employee if: (a) you are a 5% owner of Nokia Corporation during the Plan Year or the preceding Plan Year; or (b) your total annual pay exceeds a certain annual threshold ($155,000 for 2024; amount for 2025 not available at time of publication) and you are among the top 20% of paid employees of the Nokia Group.

International Assignee: an employee who is classified by the Company or other Nokia Group company as a long-term international assignee or who is on international assignment pursuant to an International Professional Contract (IPC).

IRS: the US Internal Revenue Service.

Leased Employee: an individual as described in Section 414(n) of the Code.

Nokia Benefits Resource Center (NBRC): the resource to call to enroll, to make changes to your coverage or to ask questions about your Flexible Spending Account Plan(s). See Section M: Important Contacts, for contact information for the NBRC.

Nokia Group: the Company and each entity required to be aggregated with the Company under Sections 414(b), (c), (m) or (o) of the Code, i.e., all companies (parents, subsidiaries, and affiliates) that are under "common control" with the Company, plus the Company. Effectively, this means all "Nokia group" entities.

Participant: an Eligible Employee who has enrolled in the Plan.

Participating Company/Companies: a company that participates in the Plan. The following companies are Participating Companies:

- Nokia of America Corporation
- Nokia Federal Solutions LLC
- Nokia Investment Management Corporation.

Plan: each of the Nokia Health Care Reimbursement Account Plan and the Nokia Child/Elder Care Reimbursement Account Plan.

Plan Year: a 12-month period beginning on January 1 and ending on December 31.

Plan Administrator: the Company, acting through and by the individual occupying the position of Plan Administrator or his or her successor. The Plan Administrator has discretionary authority to determine, in accordance with the documents and instruments governing the Plan, 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 facts, determination of the amount payable under and extent of other benefits provided under the Plan, and construction of all Plan terms. Decisions of the Plan Administrator are subject to oversight and review by the Employee Benefits Committee. The Plan Administrator may 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 discretionary authority to interpret and construe the terms of the Plan, to direct disbursements and to determine eligibility for Plan benefits.

Pre-Tax: contributions you make to your HFSA and/or your DFSA on a before-tax basis before federal, Social Security (FICA) and most state and local taxes are withheld.

Qualified Medical Child Support Order (QMCSO): a judgment, decree, or order issued by a court of competent jurisdiction that requires coverage for a Participant's child and that has been determined by the Plan Administrator (or its delegate) to meet certain requirements under ERISA. The Plan has written procedures that it uses to process QMCSOs. For a copy of these procedures, or for other questions regarding QMCSOs, contact the Nokia Benefits Resource Center (see Section O: Important Contacts).

Qualifying Individual:

- Your Children, brothers, sisters, stepbrothers, stepsisters, or any of their descendants under age 13 who:
    - Live with you for more than half of the Plan Year; and
    - Have not been able to provide over one-half of their own support for the Plan Year.
- Your older Children, Spouse and/or dependent of any age who:
    - Is mentally or physically incapable of self-care;
    - Lives with you for more than half of the Plan Year; and
    - Has not been able to provide over one-half of his or her own support for the Plan Year.

Spouse: a person of the same or opposite sex who is lawfully married to a Participant. The term Spouse does not include individuals (whether of the same or opposite sex) who have entered into a registered domestic partnership, a civil union, or other similar formal relationships recognized under state or other law that is not denominated as "marriage." You may not have more than one Spouse under the Plan.

Your Benefits Resources™ (YBR): a web-based resource located online at digital.alight.com/nokia where you can learn more about all of the healthcare benefits and where you can enroll for your benefits.

Section C: Joining the Plans

Who Is Eligible?

If you are a full-time or part-time employee of a Participating Company and are not an Excluded Employee, you are eligible to enroll in the Flexible Spending Accounts as of your first day of employment.

Enrolling in the Plans

If you are newly eligible for participation in the Plans (e.g., you are a newly hired employee or you newly transferred to a Participating Company from a Nokia Group company that is not a Participating Company), you will be provided with instructions on how to obtain enrollment information. The information provided will include details about the Plans, how to enroll, and the date by which you must make your contribution elections.

To enroll, go to the Your Benefits Resources™ website or call the Nokia Benefits Resource Center (NBRC). (See Section M: Important Contacts, for the web address and contact information for the NBRC.) You may enroll in the HFSA, the DFSA, or both the HFSA and DFSA. When you enroll, you must indicate the amount you want to contribute (salary reduction contributions).

If you enroll by the date specified in your enrollment information, your participation will begin retroactive to the first day of your employment. Your salary reduction contributions will begin as soon as administratively possible. If you do not enroll within 31 days, you may not elect to participate until the next Annual Open Enrollment--unless you have a "qualified status" change during the Plan Year (see "Changing Your Contribution Election During the Year," later in this Section C).

Annual Open Enrollment is held once a year, usually in the fall. During Annual Open Enrollment, you will have an opportunity to select the benefits that best meet your needs for the coming year. Elections made during Annual Open Enrollment are effective on the first day of the following Plan Year.

Note: Your salary reduction contribution elections do not automatically continue from one Plan Year to the next. If you want to continue participation in one or both of the Plans after your initial enrollment, you must re-enroll during each subsequent Annual Open Enrollment. You will receive information about the Annual Open Enrollment period and the enrollment procedures in advance of the Annual Open Enrollment period.

How Much You Can Contribute

The minimum amount you may contribute to each Plan for each Plan Year is $100.

The maximum amount you may contribute depends on the type of account. For the HFSA, the maximum amount you may contribute for 2025 is $3,200. For the DFSA, the maximum amount that you may contribute for 2025 is $5,000.

Note: The above maximums can vary under certain circumstances. For both the HFSA and the DFSA, if you are a Highly Compensation Employee, your maximum contribution amount could be lower, depending on the results of certain required "nondiscrimination" testing under the Code. You will be notified if this applies to you. For the DFSA, your maximum contribution could be also lower than the maximum noted above depending on your Spouse's income and your tax-filing status. See "Other Rules Applicable to the DFSA--Limit on Maximum Contributions to Your DFSA" in Section E: Your Dependent Care Flexible Spending Account, for more information.

Even if your enrollment is effective after January 1 of a Plan Year (for example, you enroll mid-year after experiencing a qualified status change), you can still set aside up to the maximum annual amount allowed for each account. Your contributions will be deducted from your pay in installments based on the number of pay periods remaining in that Plan Year.

The Importance of Carefully Estimating Your Expenses

It is important to carefully estimate your expenses before you decide how much you want to contribute to the HFSA and/or the DFSA during the Plan Year. You should be able to get a good idea of what your expenses might be by looking at your expenses over the last couple of years. Also consider any healthcare expenses (medical, dental, vision or hearing) and/or changes to your dependent care needs that you expect may occur during the coming Plan Year.

You might want to be conservative in your estimate since any balance that is not used by the claim deadline is forfeited. See "Other Rules Applicable to the HFSA--Forfeiture of Unused Funds" in "Section D: Your Health Care Flexible Spending Account, and "Other Rules Applicable to the DFSA--Forfeiture of Unused Funds" in Section E: Your Dependent Care Flexible Spending Account, for more information.

Effect of Contributions on Other Benefits

Your contributions to the Flexible Spending Account(s) do not affect pay-related benefits, such as savings plan, pension, disability and group life insurance.

If You and Your Spouse Both Work for Nokia

If you and your Spouse work for Nokia and are eligible to enroll in the Flexible Spending Accounts, here's what happens:

- Each of you may have your own HFSA. Each of you may contribute up to the Plan Year maximum to your HFSA.

- Each of you may have your own DFSA. However, your combined total annual contribution will be subject to IRS limitations (see "Other Rules Applicable to the DFSA—Limit on Maximum Contributions to Your DFSA" in Section E: Your Dependent Care Flexible Spending Account, for more information.

Changing Your Contribution Election During the Year

Generally, once you enroll in the Plans, you cannot change your HFSA or DFSA contribution election during the Plan Year. However, you may be able to change your contribution election during the year if you experience a "qualified status change," as described below.

A "qualified status change" is a change in eligibility for coverage under the Plans or under another employer's plan due to one of the events listed in the following tables. Your election change during the year must correspond with the type of qualified status change that has occurred. For example, if you legally adopt a child, you may *increase* the amount you are contributing to one or both of the Plans. However, you may not cancel your election to contribute.

Qualified Status Changes for the HFSA	
Change	**Description**
Change in Marital Status	Your marriage, divorce, legal separation, or the annulment of your marriage or the death of your Spouse.
Change in the Number of Eligible Healthcare Dependents	The birth, death, legal adoption, or placement for legal adoption of one of your Eligible Healthcare Dependents.
Change in Employment Status, Work Schedule or Worksite That Affects Eligibility for Coverage Under an Employer-Sponsored Group Health Plan	You, your Spouse, or other Eligible Healthcare Dependent becomes employed (and eligible for health insurance coverage through an employer) or loses employment (and health insurance coverage).
Your Dependent Meets or No Longer Meets the Eligibility Requirements	An event that causes a dependent to meet or to no longer satisfy the definition of Eligible Healthcare Dependent. For example, your child turns age 26.

Qualified Status Changes for the HFSA	
Change	**Description**
Court-Ordered Coverage	A change in your responsibility to provide healthcare coverage for an Eligible Healthcare 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). **Note:** If a dependent specified in the judgment, decree or court order does not meet the eligibility criteria of an Eligible Healthcare Dependent, the dependent's expenses are not eligible for reimbursement from your HFSA. The dependent may be eligible for COBRA coverage and you or your dependent(s) will be sent information about the cost of this coverage after you notify the Nokia Benefits Resource Center.

Qualified Status Changes for the DFSA	
Change	**Description**
Change in the Number of Qualifying Individuals	The birth, death, legal adoption, or placement for legal adoption with you of a Qualifying Individual.
Change in Employment Status for Your Spouse	Your Spouse's employment begins or ends or changes from part-time to full-time (or vice versa).
Your Qualifying Individual Meets or No Longer Meets the Eligibility Requirements	Your dependent ceases to satisfy the requirements to be a Qualifying Individual. For example, your child turns age 13.
Change of Dependent Care Providers	You decide to enroll your Qualifying Individual child in a program with a different provider.
Significant Cost or Coverage Changes	Applies only if a dependent care provider who is not a relative imposes a significant cost change, or if coverage is significantly curtailed or eliminated.

Deadline for Reporting Qualified Status Changes

If you experience one of the events described above and need to change your HFSA or DFSA election during the Plan Year, you must report the event to the Nokia Benefits Resource Center within **31 days** of its occurrence, either online through the Your Benefits Resources™ website or by calling the Nokia Benefits Resource Center. (See Section M: Important Contacts, for the web address and contact information for the Nokia Benefits Resource Center.)

If you timely report the status-change event, any election to start or increase your HFSA or DFSA contribution election due to the qualified status change will take effect as of the date of the qualified status change. If you timely report the status-change event, any election to end or decrease your HFSA or DFSA contribution election due to the qualified status change will take effect as of the first day of the following month.

If you do not report the event within the 31-day reporting period, you will not be able to make a contribution election coverage change until the next Annual Open Enrollment, unless you once again meet one of the conditions for a qualified status change during the year.

Election Change Limits

You may not increase your election to more than what the Plan maximum will allow. Also, you may not reduce your election to less than the greatest of your current year-to-date contributions, current year-to-date reimbursements, or current available balance.

Any increases to your HFSA or DFSA elections during the Plan Year can only be used for services incurred on or after the increase date. Any services incurred prior to the effective date of the election change are not eligible for reimbursement under the new election balance even if the previous balance has been depleted.

Account Statements

Online account statements are available for your Flexible Spending Accounts. You can check the balance of your HFSA and DFSA anytime by visiting the Your Benefits Resources (YBR)™ website or calling the Nokia Benefits Resource Center. (See Section M: Important Contacts, for the web address and contact information for the Nokia Benefits Resource Center.) You can also view your available balance(s) on the Smart-Choice mobile app. For more information, visit the FAQs on the Learn About tab of the Smart-Choice website.

Section D: Your Health Care Flexible Spending Account

Individuals Whose Expenses May Be Covered by the HFSA

Your HFSA can be used to pay for eligible healthcare expenses for yourself, your Spouse, and your Eligible Healthcare Dependents.

Note: From time to time, the Plan Administrator may ask you to verify your healthcare dependent's eligibility. Verification will include documentation requirements.

Eligible Healthcare Expenses

To be an eligible healthcare expense, the expense must be:

- For services that are medically necessary;
- Not reimbursed by Nokia or any another employer's medical, dental or vision plans (including your Spouse's or Eligible Healthcare Dependents' plans); and
- Be considered tax deductible medical expenses by the IRS (notwithstanding the fact that such expenses are to be paid or reimbursed from the HFSA).

Listed below are examples of the most common expenses that you pay for out-of-pocket and that may qualify for reimbursement under the HFSA. A complete list of eligible expenses may be obtained by visiting the YBR Web site or calling the Nokia Benefits Resource Center. (See Section M: Important Contacts, for the web address and contact information for the Nokia Benefits Resource Center.)

- Copayments, deductibles (if applicable), and out-of-pocket costs not covered under the medical and dental plans;
- Vision costs not covered under Added Benefits or other insurance;
- Copayments, deductibles (if applicable), and out-of-pocket costs not covered under the prescription drug program including those for prescribed over-the-counter medications;
- Over the counter (OTC) medications/drugs without a prescription;
- Amounts paid for personal protective equipment, such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19;
- Menstrual care products; and

- Insulin (whether or not prescribed).

Ineligible Healthcare Expenses

Not all healthcare expenses are eligible for reimbursement under the HFSA. Some examples of healthcare expenses that are not eligible for reimbursement under your HFSA include:

- Cosmetic surgery or procedures to improve appearance;
- Cosmetics, toothpaste, and other toiletries;
- Custodial care in an institution;
- Dependent care expenses (these may be eligible for reimbursement under the DFSA);
- Fees for an exercise, athletic or health club membership unless there is a special medical reason for the membership;
- Insurance premiums paid for any health coverage (including Medicare Part B premiums);
- Marriage and family counseling; and
- Vitamins taken for general health improvement.

Using the HFSA Debit Card (Alight Smart-Choice Card™)

The HFSA debit card (Alight Smart-Choice Card™) provides a convenient method to pay for out-of-pocket eligible health care expenses for you, your Spouse, and your Eligible Health Care Dependents. If you enroll in the HFSA, you will automatically be issued a Smart-Choice Card, free of charge. By signing or using the Smart-Choice Card, you agree to the terms of the "Benefits Card Cardholder Agreement" you received with the Smart-Choice Card. You can request additional cards, at no charge, through the Smart-Choice website or by calling the Nokia Benefits Resource Center.

Your Smart-Choice Card will have a stored value equal to your HFSA election for the Plan Year, less any previous reimbursements for that Plan Year and the Grace Period following that Plan Year. As you use your Smart-Choice Card, your eligible expenses are deducted automatically from your HFSA.

Each time you use your Smart-Choice Card, you are deemed to be making the following certifications: (1) that the expense is an eligible healthcare expense; (2) that the expense has not already been reimbursed; (3) that the expense will not be submitted for reimbursement from another source; and (4) that sufficient documentation for any expense paid using the Smart-Choice Card will be retained.

Where the Smart-Choice Card Can Be Used

The IRS has stringent regulations regarding appropriate use of the Smart-Choice Card, as far as where the card can be used and when follow-up documentation is required.

NOTE: Use of the card **DOES NOT** necessarily eliminate all of the claim substantiation paperwork; you may be required to submit documentation to substantiate your charges. Per IRS regulations, the Smart-Choice Card can be used at the following locations:

- Health care providers (e.g., physicians, dentists, hospitals, vision care offices) that have a health care merchant category code ("MCC"). Every merchant that accepts credit cards has an MCC, which is a general category that is assigned when the merchant applies for the right to accept credit cards.

- Retail stores (e.g., pharmacies and drug stores) that have implemented the Inventory Information Approval System ("IIAS"). The IIAS restricts purchases with the Smart-Choice Card to eligible expenses. Stated simply, when you use the debit card, the payment card processor's or participating merchant's system collects information about the potential purchase, compares the information collected about the item with a list of eligible health care expenses, and generally approves the purchase through use of the card if the item is on the list. If the potential purchase is not on the list, you will not be able to use the Smart-Choice Card to make the purchase. You will have to pay with a separate form of payment and submit a claim for reimbursement.

- Retail stores with the MCC for drugstores and pharmacies if, on a store location-by-location basis, 90% of the store's gross receipts during the prior taxable year consisted of items that qualify as eligible health care expenses.

You need to keep your receipts from your services or purchases to provide documentation that may be required after you have used your Smart-Choice Card to verify it was used for eligible health care expenses.

When the Smart-Choice Card Will Be Deactivated

Your Smart-Choice Card will be deactivated upon the occurrence of one of the following events:

- Your employment with the Company or a Participating Company is terminated;

- You go on a leave of absence;

- You use, or attempt to use, the Smart-Choice Card to purchase an ineligible healthcare expense;

- When Smart-Choice is notified that your Smart-Choice Card has been lost or stolen;

- Subject to the termination or suspension conditions described in the "Benefits Card Cardholder Agreement;" or

- When card transactions remain unsubstantiated, after reasonable written notice to you.

While the Smart-Choice Card is deactivated, you will have to submit any claims for reimbursement as described in Section G: Requests for Reimbursement.

To notify Smart-Choice of a lost or stolen debit card, or if you need more information regarding the Smart-Choice Card, visit the YBR web site or call the Nokia Benefits Resource Center. (See Section M: Important Contacts, for the web address and contact information for the Nokia Benefits Resource Center.)

Other Rules Applicable to the HFSA

Forfeiture of Unused Funds

Federal law requires that any funds left in your account(s) (HFSA or DFSA) after the deadline for filing claims must be forfeited. The deadline for filing claims is May 15 of the Plan Year following the Plan Year for which you made your election. Any amounts left in your account(s) after May 15 will be forfeited.

Balances Can Not Be Transferred Between HFSA and DFSA

If you elect to participate in the HFSA and the DFSA, your salary reduction contributions to each account are kept separately. Because of the special tax advantage offered by these accounts, IRS rules do not allow you to transfer balances from one Flexible Spending Account to another. Your HFSA balance may only be used for eligible healthcare expenses and your DFSA balance may only be used for eligible dependent care expenses.

HFSA Reimbursement Restrictions

The money contributed to your HFSA can only be used for eligible expenses incurred during the same Plan Year (and, if you were participating in the HFSA on December 31 of a Plan Year, during the Grace Period, which is the period January 1 through March 15th of the immediately following Plan Year) in which you elected to contribute to the HFSA. However, you may submit claims for expenses incurred during a Plan Year (and, if you were participating in the HFSA on December 31, those expenses incurred during the immediately following Grace Period) up to the May 15 of the following Plan Year.

When an Expense Is Incurred

Any healthcare or dependent care expense is considered "incurred" on the date the service or treatment is provided, not on the day you pay for it.

If a healthcare service or treatment extends beyond December 31, only expenses incurred

during the Plan Year for which an HFSA election is made (or during the Grace Period, if you are participating in the HFSA on December 31 of the Plan Year) are eligible for reimbursement.

Non-deductibility of Expenses

You cannot claim expenses reimbursed through your HFSA as a deduction on your federal income tax return.

Nondiscrimination Rules

The HFSA must meet certain nondiscrimination standards. If these requirements are not satisfied, Highly Compensated Employees may not be able to make the maximum contribution. You will be notified if this applies to you.

Section E: Your Dependent Care Flexible Spending Account

The DFSA allows you to use Pre-Tax dollars to pay for dependent care expenses for your eligible dependent while you are at work. If you're married, you and your Spouse must both be working, or your Spouse must be a full-time student (i.e., enrolled for 5 or more months during the Plan Year in the number of course hours required to be a full-time student at an educational institution that has a regular faculty curriculum and enrolled student body at a place where its educational activities are regularly carried on) or looking for work or incapable of self-care.

Individuals Whose Expenses May Be Covered by the DFSA

Only expenses relating to a Qualifying Individual may be covered by the DFSA.

Eligible Dependent Care Expenses

If you want to determine if a particular expense is covered, visit the YBR web site or call the Nokia Benefits Resource Center. (See Section M: Important Contacts, for the web address and contact information for the Nokia Benefits Resource Center.)

Some examples of dependent care expenses that may be eligible for reimbursement under your DFSA include:

- Fees for preschool, nursery school, or similar programs for children below the level of kindergarten;
- Fees for Dependent Care Centers (i.e., child care or adult care centers that comply with any state and local laws or regulations), including those Dependent Care Centers which provide day camp or similar programs (day camps can include those camps which specialize in a particular activity, such as soccer day camp);
- What you pay baby-sitters inside or outside your home;
- Costs of housekeepers whose duties include child or elder care;
- The amount you pay relatives who care for your Qualifying Individuals, as long as you do not claim the caregivers as dependents on your income tax return (payments to your Children who provide such care may be made only if that child is at least age 19 by the end of the Plan Year);
- Fees for people who care for an elderly or incapacitated Qualifying Individual; and

- Fees for before-school and after-school day care programs, for children in kindergarten or higher grades, provided the fees are itemized separately from any tuition expenses.

Ineligible Dependent Care Expenses

Not all dependent care expenses are eligible for reimbursement under the DFSA. Some examples of dependent care expenses that are not eligible for reimbursement under your DFSA include:

- Expenses for food, clothing, diapers, education, or lodging of a Qualifying Individual (unless the expenses are incidental to and cannot be easily separated from the cost of the dependent care);
- Fees for schooling in kindergarten or higher grades (including summer school or tutoring programs);
- Expenses for transportation between your house and the Dependent Care Center or to pick up a baby-sitter, unless the transportation is provided by the Dependent Care Center;
- Expenses for which you use the Federal Dependent Care Tax Credit;
- Nursing home expenses;
- Amounts you pay to the Qualifying Individual's parent for care provided to the Qualifying Individual;
- Expenses for overnight summer camps; and
- Healthcare expenses (these may be eligible for reimbursement under the HFSA).

Effect of DFSA Payments on Federal Dependent Care Tax Credit

The IRS makes available a Federal Dependent Care Tax Credit for dependent care expenses. You file for the tax credit on your annual tax return. However, you cannot claim the same expenses under the Federal Dependent Care Tax Credit as you do under the DFSA. In addition, the amount you elect to contribute to a DFSA for a Plan Year will reduce the amount of the dependent care tax credit available to you for that year.

Eligibility for the Federal Dependent Care Tax Credit, which depends on your income, could impact whether the DFSA or the Federal Dependent Care Tax Credit is more beneficial to you. You will need to decide whether participation in a DFSA or the Federal Dependent Care Tax Credit is more beneficial, and you may want to consult a financial or tax advisor to help with this determination.

Other Rules Applicable to the DFSA

Forfeiture of Unused Funds

Federal law requires that any funds left in your account(s) (HFSA or DFSA) after the deadline for filing claims must be forfeited. The deadline for filing claims is May 15 of the Plan Year following the Plan Year for which you made your election. Any amounts left in your account(s) after May 15 will be forfeited.

Balances Can Not Be Transferred Between DFSA and the HFSA

If you elect to participate in the DFSA and also the HFSA, your salary reduction contributions to each account are kept separately. Because of the special tax advantage offered by these accounts, IRS rules do not allow you to transfer balances from one account to another. Your DFSA balance may only be used for eligible dependent care expenses, and your HFSA balance may only be used for eligible healthcare expenses.

DFSA Reimbursement Restrictions

The money contributed to your DFSA can only be used for eligible expenses incurred during the same Plan Year in which you elected to contribute to the DFSA. Unlike the HFSA, the DFSA does not offer a Grace Period. However, you may submit claims for expenses incurred during a Plan Year up to May 15 of the following Plan Year.

When an Expense Is Incurred

Any dependent care expense is considered "incurred" on the date the service or treatment is provided, not on the day you pay for it.

Limit on Maximum Contributions to Your DFSA

- If you're married, you and your Spouse may both participate in a DFSA. However, the following limits apply:
    - If you file a joint federal income tax return, your combined total annual contribution cannot exceed $5,000.
    - If you file separate returns, each of you may contribute up to $2,500.
    - The annual amount you contribute to your DFSA cannot be more than your income or your Spouse's income, whichever is lower. For example, if you earn $30,000 a year and your Spouse earns $4,500, the maximum your family can set aside for eligible dependent care expenses is $4,500.
    - If your Spouse is a full-time student (i.e., enrolled for 5 or more months during the Plan Year in the number of course hours required to be a full-time student at an educational institution that has a regular faculty, curriculum, and enrolled student

body at a place where its educational activities are regularly carried on), or if he or she is disabled and has no income, the IRS assumes your Spouse's income is $250 a month ($3,000 a year) if you claim expenses for one Qualifying Individual, and $500 a month ($6,000 a year) if you claim expenses for two or more Qualifying Individuals.

- If you're single or divorced, you may contribute the full $5,000 each year.

Section F: Requests for Reimbursement

Requests for Reimbursement from the HFSA

One of the advantages of using the Smart-Choice Card is that, in many instances, your Smart-Choice Card purchases are deemed automatically substantiated at the point-of-sale, and you don't need to submit any claim forms to request reimbursement from your HFSA. However, even if you use your Smart-Choice Card, keep your original itemized receipt or invoice from the provider and/or Explanation of Benefits ("EOB"). You may be asked to substantiate your claim at a later date. (For more information on the Smart-Choice Card, see "Using the HFSA Debit (Smart-Choice) Card" in Section D: Your Health Care Flexile Spending Account.)

You **do** need to submit a claim form to receive benefits if the Smart-Choice Card purchase is not automatically deemed substantiated at the point-of-sale or if you do not use the Smart-Choice Card. To request reimbursement from your HFSA in such circumstances, follow these steps:

Step 1: Log on to the YBR website at digital.alight.com/nokia and select the link to your HFSA. Once in your Smart-Choice Account--

- Select "Submit Health Care Claim" via the drop-down menu on the Health Care tab or under "Take Action" on the main homepage.
- Choose how you want to send your itemized receipts or EOBs by checking "Upload" or "Fax or mail."
- Follow the prompts to enter your claim online. If you have chosen to submit your claim by fax or mail, be sure to print the claim form (cover sheet) and sign and date it.

Step 2: Submit your completed form (if required) and itemized receipt or EOB by the date indicated.

- *Online:* Follow the onscreen instructions to upload an electronic copy or photo of your itemized receipt or EOB.
- *Fax:* 1-855-673-6719
- *Mail:*
  Alight Smart-Choice Accounts
  P.O. Box 64009
  The Woodlands, TX 77387-4009

To process a request for reimbursement from your HFSA, you need to include an EOB from your healthcare carrier or a copy of your itemized receipt for the expense. Eligible receipts must contain:

- Date of service;
- Name of service provider;
- Name of patient;
- Name of drug, product, or service; and
- Amount paid.

Handwritten receipts should include the service provider's signature. For prescription drugs, remember to submit the receipt that the pharmacist has attached to the prescription, not the cash register receipt. For faster processing, fax your signed and completed claim form and supporting documentation to Smart-Choice Accounts. Your claim will be processed as soon as possible.

If you've lost a receipt, contact your doctor or pharmacy to request a copy or call your health plan for an Explanation of Benefits (EOB). If you don't provide the necessary information, the processing of your claim may be delayed or your account may be placed into an overpayment status. Visit the Smart-Choice Accounts website for more documentation requirements.

For over-the-counter medicine, you'll also need to submit a prescription from an authorized health care provider that includes:

- Name of patient;
- Date;
- Name and address of provider;
- Name of specific product prescribed;
- Dosage; and
- Provider's signature.

If you have medical insurance, proof of any amount paid by other coverage, such as an EOB, is the preferred documentation.

You can also use the Smart-Choice Mobile app to manage your HFSA. Just download the Smart-Choice Mobile app to your smart phone or mobile device, look up your employer name and after you have registered, enter your benefits log-in information. For more information, see the "Download the Smart-Choice Mobile App" on the Smart-Choice Accounts home page.

Requests for Reimbursement from the DFSA

To request reimbursement from your DFSA:

Step 1: Log on to the YBR website at digital.alight.com/nokia and select the link to your DFSA. Once in your Smart-Choice Account--

- Select "Create Dependent Care Claim" via the drop-down menu on the Dependent Care tab or under "Take Action" on the main homepage.
- Choose how you want to send your itemized receipts or EOBs by checking "Upload" or "Fax or mail."
- Follow the prompts to enter your claim online. If you have chosen to submit your claim by fax or mail, be sure to print the claim form (cover sheet) and sign and date it.

Step 2: Submit your completed form (if required) and itemized receipt or invoice from the provider and/or EOB by the date indicated.

- *Online:* Follow the onscreen instructions to upload an electronic copy or photo of your itemized receipt or EOB.
- *Fax:* 1-855-673-6719
- *Mail:*
  Alight Smart-Choice Accounts
  P.O. Box 64009
  The Woodlands, TX 77387-4009

Your itemized bill or receipt from the provider should show:

- Dates of service;
- Name of service provider;
- Name of dependent receiving services; and
- Amount paid.

Your plan requires that you send Smart-Choice Accounts itemized receipts or other documentation to prove that your expenses are eligible under the plan. A simpler alternative that can be completed using either the website or the Smart-Choice mobile app is for you to get your dependent care provider to sign the Provider Certification section of your claim form. This way, you don't need to submit additional receipts or documentation.

Submit the provider-signed claim via the website by following these three steps:

1. Enter your claim information on this website.

2. Print the claim form and have your provider sign and date it.

3. Upload the form (after photographing or scanning it) or send a copy by fax or mail.

For provider certification on the go, use your Smart-Choice mobile app by using the E-Signature feature. Just download the Smart-Choice Mobile app to your smart phone or mobile device, look up your employer name and after you have registered, enter your benefits log-in information. For more information, see the "Download the Smart-Choice Mobile App" on the Smart-Choice Accounts home page.

Payment of Reimbursement Requests

If your request for reimbursement is approved and you have elected direct deposit, payment/reimbursement will be made by direct deposit to the bank account of your choice. If you have not elected direct deposit, you will receive a check in the amount of any payment/reimbursement due.

Plans' Right to Recover Improper Payments and Overpayments

If the HFSA or DFSA is used to reimburse ineligible expenses (you received an improper payment), or if all or some of the payments made exceed the benefits payable under your account(s) (you received excess payments), then those improper or excess payments must be refunded. If you do not refund the improper or excess payment, you are responsible for paying any state or federal income taxes or employment taxes that would have been withheld by the Company or Participating Company had such amounts been paid to you as taxable cash compensation, as well as interest and penalties on such amounts. You might also be responsible for any penalties or interest payable by the Company or a Participating Company due to your receipt of the improper or excess payment.

If the improper or excess payment involved the use of the HFSA debit card, your HFSA debit card will be deactivated until the amount of the improper or excess payment is recovered. While the HFSA debit card is deactivated, you will have to make claims for reimbursement as described above under "Requests for Reimbursement from the HFSA."

The Plan Administrator will ask you to refund the improper or excess payment. If you do not refund the improper or excess payment, the Company or a Participating Company reserves the right to withhold that amount from your pay. The Plan Administrator may also attempt to recoup the improper or excess payment by applying a claims substitution or offset to a later claim you submit for reimbursement within the same Plan Year (or the immediately following Grace Period) of the improper or excess payment. (For example, if you received an improper payment of $200 and you later submit a valid claim for $250 during the Plan Year (or immediately following Grace Period), you would receive reimbursement of only $50. As a last resort, the Company or

a Participating Company will treat the improper or excess payment as business indebtedness. As a result, you might have to include in income up to the entire amount of your HFSA election for the year of the improper or excess payment. You would have to pay taxes, and possibly interest and penalties, on that amount.

Section G: When Participation Ends

Rules Applicable to Both Plans

Your election to participate in the Flexible Spending Accounts for a Plan Year will remain in effect through December 31st of that Plan Year only. However, your participation and eligibility to make Pre-Tax contributions can also end upon the occurrence of any of the following events even if such events occur prior to December 31st of the Plan Year:

- Your employment with a Participating Company is terminated for any reason;
- You become eligible for long-term disability benefits under the Nokia Long-Term Disability Plan;
- You take a leave of absence (other than a Family and Medical Leave Act (FMLA) leave) of more than 30 days (see "If You Take a Leave of Absence" in Section L. Events Affecting Participation);
- The company for which you work ceases to be a Participating Company; or
- The Flexible Spending Account Plan(s) is terminated.

What Happens When Your HFSA Participation Ends

Your HFSA debit card is automatically cancelled when you cease to participate in the HFSA.

However, you may be eligible to continue to contribute to your HFSA for a limited period of time. Your future contributions will be in after-tax dollars. If you elect to continue your participation, you may submit claims for eligible expenses incurred for as long as you participate in the HFSA. For more information, see below under "Continuing Your HFSA Coverage Through COBRA."

You have until the annual claim filing deadline (May 15th of the year following the Plan Year for which you made your election) to submit claims for the reimbursement of eligible expenses incurred prior to the last day of the month in which your participation terminated. After the May 15th claim filing deadline, you forfeit any balance remaining in your HFSA.

What Happens When Your DFSA Participation Ends

You can continue to submit claims until May 15 of the following Plan Year for eligible dependent care expenses incurred at any time during that Plan Year. After the annual May 15th claim filing deadline, you forfeit any balance remaining in your DFSA.

You cannot continue to make DFSA contributions after you leave the payroll.

Continuing Your HFSA Coverage through COBRA

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to offer "qualified beneficiaries" (enrolled Eligible Employees, their Spouses, and their Eligible Healthcare Dependents) the opportunity to continue their group health coverage (including participation in the HFSA) *at their own expense* for a limited period of time if they lose coverage due to a qualifying event.

You may, under certain circumstances, be eligible to continue your participation in the HFSA by making after-tax payments. HFSA continuation is available only if you have unclaimed money which exceeds the cost of HFSA continuation coverage for the remainder of the Plan Year remaining in your account when the qualifying event occurs. So, if you already claimed all the money you had contributed to your account, you would not be eligible to continue participation under COBRA.

Coverage may be extended until December 31 of the Plan Year in which the qualifying event occurs. If you have COBRA continuation coverage as of December 31, your coverage will be extended to March 15 of the following Plan Year.

You pay the full cost for COBRA continuation coverage (for the HFSA, this would be the amount of the after-tax contributions you elect to make to your HFSA), plus an administrative fee. For information on the cost of COBRA coverage, call the NBRC at 1-888-232-4111.

COBRA coverage is <u>not</u> available for the DFSA.

Here is a summary of the COBRA coverage available under the HFSA:

Event	**Continuation Coverage Available**
• Termination of your employment for any reason other than gross misconduct, or • A reduction in your work hours.	You and/or your Spouse or Eligible Healthcare Dependents (or a dependent newly acquired by marriage, birth or adoption during the **COBRA** coverage period) may continue coverage through December 31 of that Plan Year (March 15th of the following Plan Year if covered under COBRA as of December 31).
• Disability of you, your Spouse, or an Eligible Healthcare Dependent as defined under the Social Security Act at the time of the qualifying event.	The disabled person and other qualified beneficiaries (or a dependent newly acquired by marriage, birth, or adoption during the **COBRA** coverage period) may extend continued coverage through December 31 of

Event	Continuation Coverage Available
	that Plan Year (March 15th of the following Plan Year if covered under COBRA as of December 31).
• Your divorce or legal separation, • Your death, • Your entitlement to benefits under Medicare, or • Your Spouse's or Eligible Healthcare Dependent's loss of eligibility under the Plan.	Your Spouse or Eligible Healthcare Dependents may continue coverage through December 31 of that Plan Year (March 15th of the following Plan Year if covered under COBRA as of December 31).

Complete details about COBRA continuation coverage, including information about election and cost, is automatically sent to your home if you (the Nokia employee) lose coverage due to a COBRA qualifying event. If your Spouse or Eligible Healthcare Dependent loses coverage due to a COBRA qualifying event other than your termination or reduction in hours, information isn't sent automatically. If your Spouse or Eligible Healthcare Dependent wants to continue coverage under COBRA, you, your Spouse, or your Eligible Healthcare Dependent must notify the Nokia Benefits Resource Center within 60 days of the date the event occurs.

Additional Considerations

If your participation ends during the Plan Year, you cannot withdraw the cash remaining in your Flexible Spending Account(s).

If you die, your dependents, estate or representative also has until the May 15 annual claim filing deadline to submit claims for the reimbursement of eligible expenses incurred prior to the date of your death.

Section H: Claims and Appeals

The Plan contemplates two types of claims:

- Benefits claims; and
- Eligibility claims.

A benefits claim is a claim relating to the benefits provided under the Plans, e.g., a claim for reimbursement of an expense under the HFSA or the DFSA.

An eligibility claim is a claim concerning your right to participate in the Plans. For example, you may believe an error was made during an Annual Open Enrollment that resulted in your being incorrectly excluded from participation in the Plans.

Appeals from adverse decisions regarding claims--whether a benefits claim or an eligibility claim--are to be made to the Nokia Employee Benefits Committee.

Benefits Claims

Deadlines for Requesting Reimbursements

All claims for reimbursement must be submitted no later than May 15 of the year following the year for which you made your salary reduction election under the Plan(s).

In instances where you are required to file a claim form in connection with a benefits claim, you must submit a fully documented claim no later than May 15 of the year following the year for which you made your election. If additional documentation required to substantiate a claim is submitted after the May 15th deadline, the claim will be denied for not meeting the May 15th deadline date. Any money remaining in your account(s) after that date is forfeited. No benefits will be paid for claims submitted after this May 15th annual claim filing deadline.

Your claim will be evaluated to determine if any benefits will be paid. If benefits are payable, a check will be sent to you or, if you elected direct deposit, will be made directly to your designated bank account. If your claim is denied, you will be advised of the reasons for the denial and you may appeal the decision (see, respectively, “What You Will Be Told If Your Claim Is Denied” and “Appeals” later in this section).

When You Can Expect To Receive a Decision

When you file a benefits claim, Smart-Choice reviews the claim and makes a decision to either approve or deny the claim. The time frames within which you can expect to be advised of that decision are described below.

Generally, you will be notified of Smart-Choice's decision within 30 days after Smart-Choice's receipt of your claim. Smart-Choice 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.

What You Will Be Told If Your Claim Is Denied

If your benefits claim is denied, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial;
- The specific Plan provisions on which the denial is based;
- A description of any additional material or information needed and an explanation of why it is necessary;

Eligibility Claims

If you have an eligibility claim, contact the Nokia Benefits Resource Center. If appropriate, a representative will provide you with a claim form, called a Claim Initiation Form ("CIF").

On the CIF, you will be asked to set forth the nature of the claim (for example, failure to permit a mid-year change in elections), all pertinent facts and the reasons why you believe you are entitled to the relief you are requesting. Also, include with your CIF any documentation supporting your claim.

All claims relating to eligibility must be sent to the NRBC within six (6) months of the date on which the claim arises.

Where to Send Your Claim Form

Mail your completed CIF and any enclosures to the following address:

Nokia Benefits Review Team
P.O. Box 1407
Lincolnshire, IL 60069-1407

If your eligibility claim is coupled with a claim for benefits, send the benefits claim form to the following address:

Alight Smart-Choice Accounts
P.O. Box 64009
The Woodlands, TX 77387-4009

Be sure to include with your benefits claim a **copy** of your CIF (eligibility claim that you submitted to the Benefits Review Team). Be sure also to note in your eligibility claim (submitted to the Benefits Review Team) that you are also submitting a benefits claim to Smart-Choice.

When You Can Expect To Receive a Decision

When you file an eligibility claim, the Benefits Review Team reviews the claim and makes a decision to either approve or deny the claim. Generally, you will be notified of the Benefits Review Team's decision within 30 days after its receipt of your claim. The Benefits Review Team 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 you do not provide sufficient information to allow the Benefits Review Team 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 Benefit Review Team'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 Benefits Review Team 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 Benefits Review Team then receives that information on, for example, Day 30 of your 45-day response time, the time within which the Benefits Review Team 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 eligibility claim is denied, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial;
- The specific Plan provisions on which the denial is based;
- A description of any additional material or information needed and an explanation of why it is necessary;

- If an internal rule, guideline or protocol was relied upon in connection with the denial of your benefits claim on appeal, a copy of the actual rule, guideline or protocol, or a statement that the rule, guideline or protocol was used and that you can request a copy free of charge; and

- An explanation of the Plan's claim review procedures, applicable time limits and your appeal rights.

Appeals

If your initial claim (whether a claim for benefits or a claim relating to Plan eligibility) is denied, you or your authorized representative may appeal that denial under the Plan's administrative review procedures. Responsibility for conducting the review of a denied benefits claim is with the Employee Benefits Committee, and the Employee Benefits Committee's determination is final and binding.

Your appeal must be in writing and should be addressed to:

Nokia
Employee Benefits Committee
600-700 Mountain Avenue
Room 6C-402A
Murray Hill, New Jersey 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.

All appeals must be sent to the Employee Benefits Committee within sixty (60) days of the date shown on your claim denial letter.

During this 60-day period, you or your authorized representative will be given reasonable access to all documents and information relevant to the claim and you may request copies free of charge. You can also submit written comments, documents, records and other information relating to the appeal.

Review of your appeal will take into account all comments, documents, records and other information relating to the appeal, without regard to whether the information was submitted or considered in the initial claim decision. Your appeal will be reviewed "de novo." That means you get to "start fresh" to establish the merits of your claim. Your appeal will be reviewed by an appropriate named fiduciary who is not the individual who made the initial decision, who is not subordinate to the initial reviewer, and who will give a full and fair review of the claim and the denial. In reviewing your appeal, the reviewer will not place deference upon the original decision.

When You Can Expect To Receive a Decision on Appeal

The Employee Benefits Committee will review your appeal, and you will be notified of the appeal decision within 60 days after receipt of your appeal. If special circumstances cause the Employee Benefits Committee to need additional time to make a decision, a representative of the Committee will notify you in writing within the initial 60-day review period and explain why such additional time is needed. An additional 60 days—for a total of 120 days—may be taken if the Employee Benefits Committee sends this notice.

What You Will Be Told If Your Appeal Is Denied

If your appeal is denied, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial;
- The specific Plan provisions on which the denial is based;
- A statement that the claimant is 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;
- If an internal rule, guideline or protocol was relied upon in connection with the denial of your claim on appeal, a copy of the actual rule, guideline or protocol, or a statement that the rule, guideline or protocol was used and that you can request a copy free of charge; and
- A statement about the claimant's right to bring an action under section 502(a) of ERISA.

Further Review

If the Employee Benefits Committee denies your appeal, you have the right to bring a civil action in federal court under Section 502(a) of ERISA. This option is available to you only after you have exhausted all of the administrative remedies available to you through the Plan's claims and appeals process as described in this section.

Section I: Events Affecting Participation

If You Terminate Your Employment

Your eligibility to make Pre-Tax contributions to the Health Care Flexible Spending Account (HFSA) and/or the Dependent Care Flexible Spending Account (DFSA) ends if your employment with a Participating Company ends for any reason.

However, your participation in the Plan might not end at that time. For more information, see Section H. When Participation Ends.

If You Become Disabled

Your participation in the HFSA and DFSA may be affected if you become disabled. The duration of your disability and the disability benefit plan under which you are receiving benefits determines the effect it will have on your participation.

If you become disabled and receive benefits under the Nokia Short-Term Disability Plan (the "STD Plan"), your participation in the HFSA and/or the DFSA may continue for as long as you continue to receive disability benefits under the STD Plan.

If you receive benefits under the Nokia Long-Term Disability Plan (the "LTD Plan"), your eligibility to make Pre-Tax contributions to HFSA and/or the DFSA will cease, and your eligibility to participate will be governed by the rules contained in Section G. When Participation Ends.

If You Take an Approved Leave of Absence

If you're participating in the HFSA and/or the DFSA during an approved leave of absence (other than a New Child Leave of Absence or a Family and Medical Leave Act (FMLA) leave) that begins and ends during the same Plan Year, your contributions will stop during your leave. When you return to work, your contributions will automatically resume. You cannot make up the missed contributions.

If you're on an approved leave of absence (other than an FMLA leave) during the next Annual Open Enrollment, you cannot enroll at that time. However, if you return to active employment during the next Plan Year, you can enroll within 31 days of your return to work. Your enrollment will be effective no later than the first day of the second month after enrollment.

Section J: Your Rights Under ERISA

As a Participant in the Plan(s), 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 Savings 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) for the Health Care Reimbursement Account Plan 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 pension 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. If it should happen that the Plan's fiduciaries misused 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 K: 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 "Important Contacts" at the end of this SPD) 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 SPD. 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 by resolution of the Company's Board of Directors or its duly authorized delegate(s).

The Plan is Not a Contract of Employment

Neither the Plan nor this document constitutes a contract of employment. Neither the Plan nor this document is intended to create, and neither shall be construed to create, any contractual employment rights, either express or implied, between you and Nokia, the Company, or any other Participating Company. The employment relationship between each Participating Company and the employees covered by the Plan is "at-will." This means that employees have the right to quit their employment at any time and for any reason, and each Participating Company has the right to terminate any respective employee's employment, with or without cause, at any time for any reason.

Plan Rights and Plan Benefits Are Not Assignable and Are Inalienable

An Eligible Employee's rights under the Plan are personal, and the Eligible Employee may not assign or transfer any of those rights or any benefits due him or her under the Plan to any other person or entity.

Alienation of any benefits under the Plan will not be permitted or recognized except as otherwise required by applicable law. The benefits provided under the Plan are not subject to sale, anticipation, alienation, attachment, garnishment, levy, execution or any other form of

transfer. Generally, state and local laws will not be recognized unless permitted by or under applicable federal law, such as ERISA.

Plan Funding and Payment of Benefits

The source of funding for the HFSA and DFSA is your elected payroll deductions. The general operating assets of the Company pay the cost of administering the Plan. Any amounts left in any Flexible Spending Account after all claims are paid (through May 15 of the next Plan Year) are considered forfeited balances.

New Jersey Law Applies, to the Extent Not Preempted by Federal Law

The Plans shall be construed, administered, and governed according to the laws of the State of New Jersey (determined without regard to conflicts of law provisions), except to the extent preempted by federal law, which shall in that case control.

Section L: Administrative Information

Plan Names	The official plan names are: • the Nokia Health Care Reimbursement Account Plan, and • the Nokia Child/Elder Care Reimbursement Account Plan. The plans are sometimes collectively referred to as the Nokia Flexible Spending Account Plans.
Plan Sponsor Name and Address	The Plan Sponsor of the Plans is Nokia of America Corporation. The address of the Plan Sponsor is: Nokia 600-700 Mountain Avenue Room 6D-401A Murray Hill, NJ 07974 USA
Plan Administrator Name and Address	The Plans are administered by Nokia of America Corporation. The address of the Plan Administrator is: Nokia 600-700 Mountain Avenue Room 6D-401A Murray Hill, NJ 07974
Claims Administrator Name and Address	The Claims Administrator for the Plans is Smart-Choice. The address of the Claims Administrator is: Alight Smart-Choice Accounts P.O. Box 64009 The Woodlands, TX 77387-4009
Type of Administration	The Plan is administered by the Plan Sponsor. Administration and claims for benefits are administered by the Claims Administrator.
Type of Plan	The Nokia Health Care Reimbursement Account Plan is an "employee welfare benefit plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

	The Nokia Child/Elder Care Reimbursement Account Plan is not governed by ERISA but is administered as if it were.
Plan Records and Plan Year	The Plans and all of their records are kept on a calendar-year basis, beginning January 1 and ending 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 Organization Room 6D-401A 600-700 Mountain Avenue Murray Hill, NJ 07974 USA
Employer Identification Number	The Employer Identification Number for the Plan Sponsor is 22-3408857.
Plan Numbers	The Plan Numbers for the Plans are: • Nokia Health Care Reimbursement Account Plan: 518 • Nokia Child/Elder Care Reimbursement Account Plan: none.
Plan Trustee	None. Plan benefits are paid from the general assets of the Company or Participating Company.

Section M: Important Contacts

Here is a list of important contacts for the Plans:

Contact/Service Provided	Address
Smart-Choice— Serves as Claims Administrator and recordkeeper for the Plans, answers questions about eligible and ineligible healthcare and dependent care expenses, processes requests for reimbursement from your flexible spending account(s), and handles benefits claims with respect to such account(s).	Online at digital.alight.com/nokia By phone through the Nokia Benefits Resource Center (see below). Or by mail at: Alight Smart-Choice Accounts P.O. Box 64009 The Woodlands, TX 77387-4009
Nokia Benefits Resource Center— Service center for the Plans; processes Plan-related transactions such as contribution elections and contribution-election changes due to qualified status changes; also handles eligibility claims with respect to the Plans.	Online through the Your Benefits Resources (YBR)™ website at digital.alight.com/nokia, 24 hours a day, seven days a week. By phone through the Nokia Benefits Resource Center, from 9:00 a.m. to 5:00 p.m., Eastern Time, Monday through Friday. Call 1-888-232-4111. (Outside the United States, call 1-212-444-0994 collect on Business Days from 9:00 a.m. to 5:00 p.m., Eastern Time, to speak with a representative.)
Nokia BenefitsAnswers Plus Website— Provides information about the Flexible Spending Accounts, allows you to obtain electronic copies of your enrollment materials during Annual Open Enrollment	www.benefitanswersplus.com

Contact/Service Provided	**Address**
Nokia Employee Benefits Committee— Serves as final review committee for Plan benefit 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 Plan Administrator— Administers the Plan; adjudicates claims for benefits; responsible for certain disclosure to Participants regarding the Plan.	Plan Administrator Nokia 600-700 Mountain Avenue Room 6D-401A Murray Hill, NJ 07974 USA
Domestic Relations Matters Group— Handles matters relating to Qualified Medical Child Support Orders (QMCSOs)	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.

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.