Nokia Dental Expense Plan For Retired Employees

Summary Plan Description – Management Retirees

January 2025

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Nokia Dental Expense Plan for Retired Employees
Management Retirees

Contents

Introduction

This is a summary of the benefits offered under the "management retiree" plan design of the Nokia Dental Expense Plan for Retired Employees ("Dental Plan" or the "Plan"), a component of the Nokia Retiree Welfare Benefits Plan. It is provided for informational purposes and is intended to comply with Department of Labor requirements for Summary Plan Descriptions (SPDs). More detailed information is provided in the official Dental Plan document.

This summary is based on Dental Plan provisions effective as of January 1, 2025 and replaces all previous SPDs and other descriptions of benefits provided under the Plan. If there is any conflict between the information in this SPD and the Dental Plan, the Dental plan document will govern. The Board of Directors of the Company (or its properly authorized designee) reserves the right to modify, suspend, amend or terminate the Dental Plan, in whole or in part, at any time, subject to the terms of any applicable bargaining agreement. Participants should make no assumptions about any possible future changes unless a formal announcement is made by the Company.

Questions regarding your benefits should be addressed as indicated in this document (see Section K. Important Contacts). Because of the many detailed provisions of the Dental Plan, no one is authorized to advise you as to your benefits, except as indicated in this SPD. Nokia cannot be bound by statements made by unauthorized personnel. In the event of a conflict between any verbal information provided to you by an authorized resource and information in the official Dental Plan document, the Dental Plan document will govern.

The Company expects to continue the Dental Plan but reserves the right to amend or terminate the Dental Plan, in whole or in part, at any time by the resolution of the Board of Directors or its properly authorized designee, subject to the terms of applicable collective bargaining agreements. In addition, the Company does not guarantee the continuation of any dental benefits during retirement, nor does it guarantee any specific level of benefits or contributions, subject to the terms of any applicable bargaining agreement.

Please note: Participation in the Dental Plan is neither an offer nor a guarantee of continued benefits during retirement.

Section A. Dental Plan Benefits At-a-Glance

The following charts are summaries of some key features of the Dental Plan. More details about these and other Plan provisions are included in the following sections of this SPD. (Certain words and phrase used in these tables and elsewhere in this SPD have specific meaning under the Plan. These terms are capitalized and are defined in Section J. "Terms to Know".

General Plan Information

Dental Plan Feature	Summary
Eligibility	You are eligible to participate in the Dental Plan if you are an Eligible Retiree as defined in Section J. "Terms to Know". You may also enroll your Eligible Dependents under the same coverage option that you choose for yourself.
Enrollment	When you retire or terminate employment as an eligible former employee, enrollment materials and information about your coverage options will be sent to you at your Preferred Address. Enrollment is NOT automatic. If you do not enroll promptly, you will not be able to enroll in dental coverage until the next annual open enrollment period (unless you have a qualified status change). Coverage for you and your Eligible Dependents begins as of your first day of your retirement, if you enroll by the deadline prescribed in your enrollment materials. Visit the Your Benefits Resources web site at https://digital.alight.com/nokia or contact the Nokia Benefits Resource Center at 1-888-232-4111 to enroll.
Cost	You pay the full cost of any dental coverage you elect for yourself and your Eligible Dependents.
Coverage Options	The coverage option available is the Preferred Provider Organization (PPO) option.
Informational Resources and Important Contacts	Questions regarding your enrollment and benefits should be addressed as indicated in this SPD (see Section K. "Important Contacts").

Dental Benefits Summary

This is a high level summary of coverage provisions. Please see "Appendix A" for more details on expenses Covered under the Plan. Note: You may also find additional information on your secure member website with the Dental Carrier (See Section K. Important Contacts).

For the services shown in the table below, where coverage is expressed as a percentage, it is a percentage of the provider's negotiated rate (for in-network services) and of the reasonable and customary (R&C) fee (for out-of-network services).

Feature	Plan Pays	
	In-Network	**Out-of-Network**
Annual Deductible	$50/individual $100/family Applies to basic and major services only	$75/individual $150/family Applies to diagnostic, preventive, basic and major services
Diagnostic and Preventive Care (for example: exams, cleanings and routine x-rays	100%	100%
Basic Services (for example: fillings)	60%	40%
Major Services (for example: crowns)	60%	40%
Orthodontia	60% up to a lifetime maximum of $1,500/individual	50% up to a lifetime maximum of $1,500/individual
Annual Maximum (in-network and out-of-network combined)	$1,250 (excluding orthodontia)	$1,000 (excluding orthodontia)

Section B. Joining the Dental Plan

Who Is Eligible

If you are an Eligible Retiree (see Section J. Terms to Know), coverage under the Dental Plan is available to you. As a participant in the Dental Plan, you may also enroll your Eligible Dependents for dental coverage under the same option you choose for yourself.

Enrollment/When Coverage Begins

When you retire or terminate employment, if you are an Eligible Retiree, enrollment materials and information about your coverage options will be sent to you at your Preferred Address. If you do not enroll promptly, you will not be able to enroll in dental coverage until the next annual open enrollment period (unless you have a qualified status change). Enroll by calling the Nokia Benefits Resource Center at 1-888-232-4111 or by logging on to the Your Benefits Resources™ web site at https://digital.alight.com/nokia (see Section K. Important Contacts). Any Eligible Dependent you cover must have the same coverage option you have.

Keeping Your Information Up to Date

If your email or mailing addresses change during the year, remember to update them on the Your Benefits Resources™ web site. Then follow the instructions to select which ones are preferred. This will ensure that you always receive all of your Nokia health and welfare benefit coverage information without delay.

Coverage Categories

There are three coverage categories in the Dental Plan:

Your Coverage Tier (as it appears on the Your Benefits Resources Web site)
Individual — Coverage for yourself
Two Person — Coverage for yourself and one Covered Dependent
Family — Coverage for yourself and two or more Covered Dependents

Nokia Families

Nokia retirees may only cover dependent(s) who are in the same plan design (for example, management or represented). The following chart explains who you can enroll as a dependent if both you and your Eligible Dependent are employed/retired with Nokia and a participant in a Nokia dental plan:

	You May Enroll the Following Dependent Employed/Retired with Nokia in Your Dental Plan option:		
If You Are A... ↓	**Active Employee**	**Management Retiree**	**Formerly Represented Retiree**
Management Retiree	Yes	Yes	No
Formerly Represented Retiree	No	No	Yes

If you have questions about whom you may cover and how to enroll, contact the Nokia Benefits Resource Center at 1-888-232-4111.

Changing Your Coverage During the Plan Year

Generally, once you enroll in the Plan, you cannot change your coverage election during the calendar year. However, you may be able to change your coverage election during the year in the following situation.

Qualified Status Changes

You may change your coverage under the Dental Plan during the 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 within 31 days of the event.

Provided you notify the Nokia Benefits Resource Center within the required timeframe, any coverage change due to a qualified status change takes effect on the date of the qualified status change.

A “qualified status change” is a change in eligibility for coverage under the Dental Plan or another employer’s plan due to one of the events listed in the following chart.

Qualified Status Change	Description
Change in Marital Status	Your marriage, divorce, legal separation, annulment or the death of your spouse.
Change in Domestic or Civil Union Partner Status	Termination of, a domestic or civil union partner relationship, including as a result of the death of your domestic or civil union partner.
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	A termination or commencement of employment by you or Eligible Dependents
Your Dependent Meets or No Longer Meets the Eligibility Requirements	An event that causes a dependent to meet or to no longer satisfy the Dental Plan's eligibility requirements, for example, a child reaches the maximum age for coverage.
Change in Place of Residence	A change in residence for you or an Eligible Dependent, which causes a gain or loss of eligibility for coverage.
Significant Cost or Coverage Changes	A significant change in the cost or coverage under the Dental Plan or another employer-sponsored plan in which one of your Eligible Dependents can participate.
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. If a dependent specified in the judgment, decree or court order does not meet the eligibility criteria of a Dependent as defined by the Plan, the Dependent is no longer eligible for coverage under the Dental Plan and must be removed from coverage immediately. The Dependent may be eligible for COBRA coverage and you and/or your Dependent will be sent information about the cost of this coverage after you notify the Nokia Benefits Resource Center at 1-888-232-4111 about the Dependent's status change.
Exhaustion of COBRA Continuation Coverage	You may be able to enroll in the Dental Plan during the year if COBRA coverage from another plan for you or Eligible Dependent is exhausted during the year. However, you must continue COBRA coverage for the full duration of the COBRA coverage period. If you do not exhaust the COBRA coverage, you will have to wait until annual open enrollment, even if the COBRA coverage ends mid-year due to, for example, a failure to pay premiums.

Qualified Status Change	Description
Enrolled Retiree Marries or Acquires a Child Through Birth, Legal Adoption or Placement With You for Legal Adoption	You may enroll your new spouse at the time of your marriage. In addition, you may enroll your child and non-enrolled spouse if you acquire a child through birth, legal adoption or placement with you for adoption. (See "Special Enrollment Period for Newborns, Newly Adopted Children and Children Newly Placed With You for Adoption" in Section B: Joining the Dental Plan).
Eligible **Non-Enrolled** Retiree Marries or Acquires a Child Through Birth, Legal Adoption or Placement With You for Legal Adoption	You may enroll yourself, your spouse and/or new child as of the date of your marriage, birth, legal adoption or placement with you for legal adoption. (See "Special Enrollment Period for Newborns, Newly Adopted Children and Children Newly Placed With You for Adoption" in Section B: Joining the Dental Plan)

Please note: Your election change under the Dental Plan 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 enroll the newly adopted child in the Dental Plan. You may not, however, cancel coverage for your spouse. As long as you enroll within the required timeframe, coverage will be retroactive to the date of the qualified status change.

Additionally, if your spouse's or Domestic Partner's employer's plan has a different enrollment period, this is not considered a qualified status change. For example, if one plan's annual enrollment period is in October and the other plan's annual enrollment period is in November, you may not make changes to your coverage under this Plan as a result of the different timing of the enrollment periods.

The Company also considers corresponding changes in Domestic Partnership Dependents as qualified status changes; however, a Domestic Partnership Dependent may only be Covered under the Dental Plan if he or she was Covered at some point during your active employment.

New Dependents/Spouse of a Non-Enrolled Retiree

If you're eligible but not enrolled, you may enroll an individual (spouse or child) who becomes your Eligible Dependent as a result of marriage, birth, adoption or placement for adoption. However, you (the non-enrolled retiree) also must be eligible to enroll and actually enroll at the same time.

Please Note: To enroll your domestic partner or civil union partner and your domestic partner's or civil union partner's dependent children, your domestic partner or civil union partner must have been Covered by you as a dependent under the Dental Plan at some time while you were an active employee.

How to Make Changes to Your Coverage During the Year

If you experience one of the events described in this section and need to change your coverage during the calendar year, you must report the event within the applicable timeframe online through the Your Benefits Resources Web site at https://digital.alight.com/nokia or by calling the Nokia Benefits Resource Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET). If you don't, you can't make a 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.

The Cost of Coverage

You pay the full cost of coverage you elect for yourself and your Eligible Dependents under the Dental Plan. You will be direct billed on a monthly basis. However, if you have a monthly pension payment, you can contact the Nokia Benefits Resource Center to request that monthly contributions, if any, be deducted from your monthly pension check.

During Annual Open Enrollment, you'll find cost information for all the available options on the Your Benefits Resources (YBR) Web site at https://digital.alight.com/nokia and on your personalized enrollment worksheet or confirmation of enrollment statement.

Deferring Coverage

You have the ability to defer healthcare coverage (medical and dental) upon retirement. You can defer your coverage as many times as you like and still re-enroll for coverage at a later date (provided you remain eligible for coverage under the terms of the Plan at the time you seek re-enrollment). While you can waive coverage at any time during the year, you can only re-enroll during a future annual open enrollment period or if you have a qualified status change. Note: if waiving coverage during the year, you may only waive coverage prospectively; you may not retroactively waive coverage.

Confirming Your Election

When changing your benefits online using the Your Benefits Resources Web site at https://digital.alight.com/nokia, be sure to print the "Completed Successfully" page, which will serve as your confirmation of enrollment statement. You will not receive a confirmation of enrollment statement in the mail.

If you change benefits through the Nokia Benefits Resource Center at 1-888-232-4111, you will receive a confirmation of enrollment statement in the mail.

Section C. How the Dental Plan Works

Understanding Your Coverage Under the PPO Option of the Dental Plan

The PPO Option of the Dental Plan usually pays the following ***for in-network*** coverage:

- 100% of negotiated charges for covered Type A expenses, such as routine oral exams;
- 60% of negotiated charges for Basic Services;
- 60% of negotiated charges for Major Services; and
- 60% of negotiated charges for Orthodontia.

See "Appendix A" for more coverage details.

Getting the Most From Your Coverage

To ensure you receive the maximum benefit under the PPO Option of the Dental Plan it is important to keep the following in mind when arranging dental care.

With the PPO option, you have the opportunity to manage your dental care costs. If you elect this coverage option, you can choose to receive In-Network or Out-of-Network services each time you go to a dentist. It is generally to your advantage to use In-Network dentists whenever possible because:

- You will receive the Plan's higher level of coverage when your care is provided by a Network Provider.
- In-Network dentists agree to accept a lower predetermined range of fees for covered services. As a result, even though the Plan pays benefits at the same coinsurance level for both In-Network and Out-of-Network care, your out-of-pocket costs are generally lower. This is because the Plan's coinsurance is based on the lower predetermined fee.
- You do not have to complete or submit any claim forms or other paperwork when you use In-Network Providers.

It is your responsibility to determine if your dentist is part of the network. Contact the Dental Carrier, as noted in Section K. "important Contacts", for an up-to-date list of dental PPO providers.

Out-of-Network Care

You can receive Out-of-Network care at any time. If you do:

- Your out-of-pocket costs are (in most cases) higher;
- You are required to pay amounts in excess of reasonable and customary (R&C) charges; and
- You must file your own claims.

Alternate Procedures

Often, there are several ways to treat a particular dental problem. 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 professionally accepted dental standards. In such instances, the PPO option 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 PPO option would pay for the less expensive treatment — namely, the filling.

You may avoid such unnecessary charges by discussing treatment choices with your dentist prior to beginning work or by having your dentist file a predetermination of benefits as described below.

Predetermination of Benefits

If you need dental work costing over $200, you should determine before treatment begins what is Covered and how much PPO option will pay. This procedure is called "Predetermination of Benefits." Here is how predetermination works:

- If you don't have a claim form, get one from the Dental Carrier (see Section K. Important Contacts) and give it to your dentist.
- Your dentist outlines the treatment plan and fees on the claim form and sends it to the Dental Carrier.
- The Dental Carrier determines the amount the PPO Option will pay and informs you and your dentist.

If after reviewing the predetermination, you and your dentist decide to change the treatment plan, the Dental Carrier will adjust its payment accordingly. If there is a major change in the treatment plan, your dentist should submit a revised plan.

If you do not request Predetermination of Benefits for claims over $200,

The Dental Carrier will pay the claim based on the information it has about your case. If it is determined that a less expensive treatment was possible, you may receive a

lower benefit than you expected. Predetermination of Benefits could help you avoid expensive surprises.

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.

Emergency Care

The Plan pays benefits at the Network level of coverage even if the services and supplies were not provided by a Network Provider up to the dental emergency maximum. The care must be a covered service or supply. You must submit a claim to the Dental Carrier describing the care given. Additional dental care to treat your dental emergency will be covered at the appropriate level.

Services Covered Under the PPO Option

See "Appendix A" for a list of the most common services covered under the PPO option.

Services Not Covered Under the Dental Plan

See "Appendix C" for a list of expenses not covered under the Dental Plan. Please note that the omission of any dental service or supply from the listing of non-covered expenses will not automatically qualify the service or supply as a covered expense. The service or supply must otherwise meet the requirements as listed in the section, "Eligible Expenses Under the PPO Option."

Coverage for Dental Work Completed After Termination of Coverage

Your dental coverage may end while you or your Covered Dependent is in the middle of treatment. The Plan does not cover dental services that are given after coverage terminates. However, ordered inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures, fixed partial dentures (bridges) and root canals will be covered when ordered, if the item is installed or delivered no later than 30 days after coverage terminates.

"Ordered" means:

- *For a denture*: The impressions from which the denture will be made were taken.
- *For a root canal*: The pulp chamber was opened.
- *For any other item*: The teeth which will serve as retainers or supports, or the teeth which are being restored must have been fully prepared to receive the item and impressions have been taken from which the item will be prepared.

Section D. When Coverage Ends

When Retiree Coverage Ends

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

- You die;
- Your coverage is canceled;
- You stop making any required contributions; or
- The Dental Plan is terminated.

When your coverage ends, you may be able to continue coverage (see Section E. COBRA Continuation of Coverage).

When Dependent Coverage Ends

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

- If your coverage ends, your Covered dependent's(s') coverage will end on the same day.
- If your Covered Dependent(s) cease to be eligible, coverage will end on the last day of the month in which the event occurs.

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Section E. COBRA Continuation Coverage

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to offer "qualified beneficiaries" (certain employees and the Covered Dependents of both active and retired employees) the opportunity to continue their group dental coverage at their own expense for a limited period of time if they lose coverage due to a qualifying event. The Dental Plan also provides COBRA-like rights to participants' Domestic Partners.

Please note: If you or your Covered Dependents are eligible for any other continuing healthcare coverage offered by the Company, that coverage will run concurrently with your COBRA continuation coverage period.

Also note that it is your or your qualified beneficiary's responsibility to notify the Nokia Benefits Resource Center at 1-888-232-4111 of a qualifying event other than your termination of employment (such as your divorce or the marriage of a Dependent) that makes you or a Dependent eligible for COBRA continuation coverage. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

You or your qualified beneficiary must notify the Nokia Benefits Resource Center within 31 days of the qualifying 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.

If This Qualifying Event Occurs…	**COBRA Continuation Coverage Can Last for…**
• Your divorce or legal separation; • Termination of your domestic or civil union partnership; • Your death; or • A child's loss of eligibility under the Dental Plan	Your Covered Dependents may elect COBRA continuation coverage for up to 36 months from the date of the qualifying event.

Covering a Newborn or Newly Adopted Dependent

If your qualified beneficiary, while enrolled in COBRA continuation coverage, has a baby, legally adopts a child or a child is placed for legal adoption during the COBRA continuation coverage, the child will be a "qualified beneficiary" and eligible for COBRA continuation coverage.

A parent or legal guardian can make COBRA elections on behalf of a minor child.

How Much COBRA Continuation Coverage Costs

Generally, the qualified beneficiary pays the full cost of COBRA continuation coverage, plus a two percent administrative fee.

Electing COBRA Continuation Coverage

It is your or your qualified beneficiary's responsibility to notify the Nokia Benefits Resource Center at 1-888-232-4111 within 31 days of the qualifying event. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m. ET.

Complete details about COBRA continuation coverage, including information about election and cost, will then be sent to the preferred address of the qualified beneficiary.

Section F. 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 K., "Important Contacts".

Types of Claims

The Dental Plan contemplates two types of claims:

- Eligibility claims; and
- Benefits claims.

Eligibility Claims

An eligibility claim is a claim by you or your dependent concerning your or his or her right to participate in the Dental Plan. For example, you may believe an error was made during an Annual Open Enrollment that resulted in your being assigned incorrect coverage, or you may believe you or a dependent incurred 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 you or your dependent has 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 Dental Plan.

There is only one type of eligibility claim, and it generally will be handled within the time frame described below.

Benefits Claims

A benefits claim is exactly what it sounds like — it is a claim for benefits under the terms of the Dental Plan. Post-Service Claims are claims where you or a Covered Dependent has already received dental care and is seeking payment for that claim.

Eligibility Claims

If you have an eligibility claim, contact the Nokia Benefits Resource Center at 1-888-232-4111. If appropriate, a representative will provide you with an eligibility claim form, called a Claim Initiation Form ("CIF"). Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

On the CIF, you will be asked to set forth the nature of the claim (for example, failure to include someone as a Covered Dependent, failure to permit a mid-year change in elections, or incorrect coverage option), 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.

Where to Send Your Claim Form

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

Nokia Benefits Review Team
Dept 07544
P.O. Box 299107
Lewisville, TX 75029-9107

If your eligibility claim is coupled with a claim for benefits, send the benefits claim form to the Dental Carrier but also include a copy of it with your eligibility claim submitted to the Benefits Review Team.

When You Can Expect To Receive a Decision

When you file an eligibility claim, the Nokia 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 Nokia 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 Nokia 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 Nokia 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 Nokia 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 Nokia Benefits Review Team then receives that information on, for example, Day 30 of your 45-day response time, the time within which the Nokia 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'll 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 Dental 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;
- 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 benefits claim; and
- An explanation of the Dental Plan's claim review procedures, applicable time limits and your rights. If your claim is denied and your appeal is also denied, you have the right to bring a civil action in federal court under ERISA Section 502(a).

Appeal Procedures and Deadline

If your initial eligibility claim is denied by the Nokia Benefits Review Team, you or your authorized representative may appeal the denial under the Dental Plan's administrative review procedures. The Dental Plan contemplates a single, mandatory appeals process with respect to eligibility claims.

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.

You must file your appeal within 180 days from the date on the claim denial letter. During the 180-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 to the Employee Benefits Committee.

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 to or considered by the Nokia Benefits Review Team in connection with the initial claim decision. Your appeal will be reviewed "de novo," which means you get to "start fresh" with your claim on appeal. In reviewing your appeal, the Employee

Benefits Committee will not place deference upon the original decision. 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.

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 decision on appeal within 60 days after receipt of your appeal.

What You'll Be Told If Your Eligibility Claim Is Denied on Appeal

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 specific Dental Plan provisions on which the denial is based;
- A statement about the claimant's right to bring an action under section 502(a) of the Employee Retirement Income Security Act (ERISA).

Other Voluntary Options

There is no independent, voluntary third-party appeal review process for eligibility claims. If the Employee Benefits Committee denies your eligibility claim on appeal, you have the right to bring a civil action in federal court under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). This option is available to you only after you have exhausted all of the administrative remedies available to you through the Dental Plan's claims and appeals process as described in this section.

Benefits Claims

You or your dental provider are required to send the Dental Carrier a claim in writing. You can request a claim form from the Dental Carrier. The Dental Carrier will review that claim for payment to the dental provider or to you as appropriate. You must send Dental Carrier notice and proof as soon as reasonably possible. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 15 months after the deadline.

Claim Determinations

Post-Service Claims

The Dental Carrier will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. The Dental Carrier may determine that due to matters beyond its control

an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if the Dental Carrier notifies you within the first 30 calendar day period. If this extension is needed because the Dental Carrier needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information.

You will have 45 calendar days, from the date of the notice, to provide the Dental Carrier with the required information.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider, you must write the Dental Carrier (see Section K. "Important Contacts" for where to write.) You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. The Dental Carrier will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

You may submit an appeal if the Dental Carrier gives notice of an adverse benefit determination. This Plan provides for one level of appeal. It will also provide an option to request an external review of the adverse benefit Determination. You have 180 calendar days with respect to dental benefit claims following the receipt of notice of an adverse benefit determination to request your level one appeal. Your appeal may be submitted in writing and should include:

- Your name;
- Your employer's name;
- A copy of the Dental Carrier's notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

Send in your appeal to the address shown on the Notice of Adverse Benefit Determination, or you may call in your appeal using the toll-free number listed on such notice.

The Dental Carrier shall issue a decision within 30 calendar days of receipt of the request for an appeal. The Dental Carrier may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if the Dental Carrier notifies you within the first 30

calendar day period. If this extension is needed because the Dental Carrier needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide the Dental Carrier with the required information.

Voluntary Second Level Appeal

If you disagree with the first level appeal decision, you can choose to use a voluntary second level appeal or an external review, if the situation is eligible for external review. If you appeal a second time, you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

The second level appeal will be reviewed by a panel of healthcare professionals with appropriate expertise and who were not involved in the appeal.

External Review

The Dental Carrier may deny coverage because it determines that the proposed or rendered care is not appropriate or a service or supply is considered experimental or investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with the Dental Carrier's decision. An external review is a review by people in an organization outside of the Dental Carrier who has expertise in the problem or questions involved. This is sometimes called an Independent Review Organization. To request an external review, the following requirements must be met:

- You have exhausted the applicable internal appeal processes and have received a final notice of coverage denial by the Dental Carrier; and
- Your claim was denied because the Dental Carrier determined that the care was not necessary or was experimental or investigational; and

If upon the final level of review, the Plan upholds the coverage denial and it is determined that you are eligible for external review, you will be informed in writing of the steps necessary to request an external review including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to the Dental Carrier within 4 months of the date you received the final coverage denial letter. You also must include a copy of the final denial letter and all other pertinent information that supports your request.

You will be notified of the decision of the Independent Review Organization usually within 45 calendar days of the Dental Carrier's receipt of your request form and all necessary information.

The Dental Carrier will abide by the decision of the independent dentist reviewer, except where the Dental Carrier can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the Independent Review Organization to the Dental Carrier. The Dental Carrier is responsible for all costs associated with the services of the Independent Review Organization.

For more information about the External Review process, call the Dental Carrier (see section K. “Important Contacts”).

Section G. How Coordination of Benefits Works

What Coordination of Benefits Is

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

When the Coordination of Benefits Provision Applies

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

- A group-sponsored insurance or prepayment plan; or
- A government-sponsored plan.

When the Coordination of Benefits Provision Does Not Apply

The COB provision described in this section 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 employees, retirees and/or Dependents of employees of the Company or a Participating Company, due to the following rules:
    - One person cannot receive Dental Plan benefits as both an Eligible Employee and a dependent of an Eligible Employee of the Company or a Participating Company; and
    - One person cannot receive Dental Plan benefits as an Eligible Dependent of more than one Eligible Employee or retiree of the Company or a Participating Company.
    - One person cannot receive Dental Plan benefits as both an Eligible Retiree of the Company or a Participating Company and as an Eligible Dependent of such an Eligible Employee or Eligible Retiree; and

- One person cannot receive Dental Plan benefits as both an Eligible Dependent of more than one Eligible Employee or Eligible Retiree of the Company or 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 Dental Plan through Nokia is primary, it pays its benefits without regard to the secondary plan.
- When the Dental Plan through Nokia is secondary, it coordinates benefits with the primary plan. The Dental Carrier calculates what it would have paid if it was the primary plan. The Dental Plan then pays the remaining eligible charges not paid by the primary plan up to the amount the Dental 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 (EOB) statement you received from the primary plan.

How the Dental Carrier Determines Which Plan Is Primary

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

- If the other plan(s) does not have a COB feature, that plan(s) is considered primary and the Dental Plan through Nokia is considered secondary.
- If you are actively employed by a company other than Nokia, and you are eligible for coverage with your new employer, that plan is primary, and the Dental Plan through Nokia is secondary.
- If your spouse/domestic partner/civil union partner is employed by a company other than Nokia, and he or she is eligible for coverage under his or her employer's plan, that plan is primary, and the Dental Plan through Nokia is secondary.
- If you are retired from another company, in addition to being retired from Nokia, the company that first owed you a retiree dental benefit pays before the company that owed you a retiree dental benefit second, regardless of your eligibility for Medicare.

- For Dependent children, determination of the primary and secondary plan(s) follows these rules in this sequence:
    - The Dental 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 children, and the plan covering the other parent is the secondary plan for the children.
    - If both parents have the same birthday, the plan that has Covered one parent longer is the primary plan for the children, while the plan that has Covered the other parent for a shorter period of time is the secondary plan; or
    - If one parent's plan follows the male-female rule and one parent's plan includes the birthday rule, the male-female rule applies to the extent permitted by law.
- If the parents of Dependent children are divorced or legally separated, the Dental Carrier will determine whether there is a court decree or a Qualified Medical Child Support Order (QMCSO) establishing financial responsibility for medical 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 noncustodial parent's plan is tertiary; or
    - If payment responsibilities are still unresolved, the plan that has Covered the patient for the longest time is the primary plan.

When both parents have coverage through the Company or a Participating Company, either parent (but not both) may choose to cover the child(ren). Claims for the child(ren) are submitted to the plan of the parent covering the child(ren). The other parent's plan is not secondary because it does not cover the child(ren). So expenses that are not paid by the primary plan cannot be submitted to the Dental Plan by the second parent.

Section H. Overpayments and Subrogation

Obligation to Refund

If the Dental Plan pays for benefits in violation of the terms of the Dental Plan (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. You or your Covered Dependents are responsible for any improper or excess payments the Dental Plan made to you, your Covered Dependents, Providers or any other person or organization.

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.

If you or your Covered Dependents, or any other person or organization, do not promptly refund the full amount, the Dental Plan 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 so that the Dental Plan can recoup the full amount of the improper or excess payment, as applicable.

Right of Recovery and Subrogation

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, your spouse/domestic partner/civil union partner, or your Eligible Dependents, including Domestic Partnership 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 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.
    - Any other payments from any source designed or intended to compensate a participant for injuries sustained as a result of negligence or alleged negligence of a third party.

- You and your Dependents are required to fully cooperate and perform all actions necessary to secure the Dental Plan's right of recovery and subrogation, including:
    - Permitting the Plan to enforce 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
    - Refraining from assigning any rights to recover dental care expenses from any party whose negligence gives rise to liability for damages.

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.

The right of recovery and subrogation may not be applicable in some states.

Section I. Events Affecting Coverage

If a Dependent Loses Eligibility

See “When Dependent Coverage Ends” in Section D. When Coverage Ends and also Section E. COBRA Continuation of Coverage.

If You Die

Your enrolled dependents have the option of continuing coverage under COBRA for up to 36 months if they make required contributions (see Section E. COBRA Continuation Coverage.)

Section J. Terms to Know

Several words and phrases have specific meanings under the Dental Plan. This section explains these terms so you can better understand your benefits.

Annual Deductible: The amount of eligible expenses you may be required to pay each Plan Year before the Plan will pay benefits for Covered expenses. Whether a Deductible applies, and the amount of the Deductible, depends upon the type of service or supply you receive.

Annual Maximum: The maximum benefit available from the Dental 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 in which you can generally make changes in your benefits for reasons other than a Qualified Status Change.

Class I Dependents:

Note: For individuals who retired before March 1, 1990, the rules set forth below apply regardless of your or your dependent's Medicare eligibility. For all other retirees, the rules set forth below apply only to your Medicare-eligible dependents. Non-Medicare eligible dependents are not eligible for coverage.

- Your spouse, including common-law spouse, regardless of gender or sex.†
- Your domestic or civil union partner, regardless of gender or sex‡ , provided that you and your partner satisfy (A) or (B) below, as applicable:
  A. Comply with any state or local registration process (if you and your partner live in a state or locality that maintains a registry for domestic or civil union partnerships); or
  B. Meet all of the following requirements (if you and your partner live in a state or locality that does not maintain a registry for domestic or civil union partnerships):
     - Reside in the same household
     - Are 18 years of age or older
     - Have the mental capacity sufficient to enter into a valid contract
     - Are unrelated by blood
     - Are not married to another person and are not the domestic or civil union partner of another person

  - Consider one another to have a close and committed personal relationship and have no other such relationship with any person
  - Are responsible for each other's welfare and financial obligations, and
  - Provide such other information or documents as the plan(s) may require to confirm that the relationship meets the above criteria.

Please note that retirees are not permitted to enroll new same- or opposite-sex domestic or civil union partners in coverage unless the partner was previously enrolled in coverage and then was dropped from coverage.

- Your unmarried child(ren), up to the end of the month in which such child(ren) turn(s) age 20 (or to the end of the month in which such child(ren) turn(s) age 24, if such child(ren) is (are) continuously enrolled as a full-time student). For purposes of the plans, your child(ren) means:
  1. Your biological child(ren)
  2. Your stepchild(ren) (i.e., the biological child(ren) of your spouse)
  3. Your legally adopted child(ren), including child(ren) who are placed with you for adoption
  4. The legally adopted child(ren) of your spouse, including child(ren) who are placed with your spouse for adoption
  5. Child(ren) for whom you and/or your 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))
  6. Child(ren) for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO)
  7. The biological child(ren) of your domestic or civil union partner, provided such child(ren) is (are) living with you
  8. The legally adopted child(ren) of your domestic or civil union partner, including child(ren) placed with such partner for adoption, provided such child(ren) is (are) living with you, and
  9. Child(ren) for whom your 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 you.

- Your unmarried child(ren) (as defined in "1." through "6.," above), beyond age 20 (or beyond age 24, if such child(ren) is (are) continuously enrolled as a full-time student), provided such child(ren) meet(s) all of the following requirements:
  - The child(ren) was (were) covered under the applicable plan as an eligible dependent immediately prior to attaining the age limit noted above, and
  - The child(ren), prior to attaining such age limit and thereafter was and is—
    - Physically, mentally, or developmentally disabled, and
    - Incapable of self-support, and

    - Fully dependent on you for support; and
  - The child(ren) is (are) certified by the medical plan's claims administrator as incapacitated due to disability (certification process must be started no later than 31 days after the end of the month in which the child(ren) reached the age limit noted above).

As noted: This coverage applies only with respect to your child(ren) and/or your spouse's child(ren) (as defined in "1." through "6.," above). It is not available with respect to the child(ren) of your domestic or civil union partner (as defined in "7." through "9.," above).

† For purposes of the plans, you may not enroll more than one spouse.

‡ For purposes of the plans, you may not enroll more than one domestic or civil union partner (and you may not enroll a domestic or civil union partner if you have a spouse).

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

Coinsurance: The percentage of a covered service's charge for which you are required to pay under the Plan.

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

Covered: Generally, means "eligible" under the terms of the Dental Plan. "Covered" is often used to modify other terms. A "Covered person" is one who has benefits available under the Dental Plan. A "Covered Provider" is one who is (or which is) eligible to provide services and receive payment because of participation in a particular Network.

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

Deductible: The amount of eligible expenses you may be required to pay each Plan Year before the Plan will pay benefits for Covered expenses. Whether a Deductible applies, and the amount of the Deductible, depends upon the type of service or supply you receive, and whether care is received In-Network or Out-of-Network.

Dental Carrier: The dental insurance provider for the Plan. See Section K, "Important Contacts", for information on how to contact the Dental Carrier.

Dental Plan: Nokia Dental Expense Plan for Retired Employees

Eligible Dependents: Your eligible Class I dependents.

Eligible Retiree: This is a Medicare eligible, former management employee or former non-represented occupational employee who, at the time of termination or retirement from a participating company, is:

- At least 50 years old with at least 15 years of service; or
- At least 55 years old with at least 10 years of service

Further, you are also eligible to participate in this Plan if you:

- Retired from AG Communication Systems Corp. before January 1, 2004 and, at the time of your retirement, were entitled to receive retiree medical benefits under the terms of AG Communication Systems Corp.'s retiree medical plans; or
- Are a former represented occupational employee who, when actively employed by a Participating Company, was represented for collective bargaining purposes by the Merrimack Valley Guards (RGA), the Merrimack Valley Powerhouse (NCFO) or Bell Laboratories (LPU) and who, at the time of your termination from employment, are:
    - At least 50 years old with at least 15 years of service; or
    - At least 55 years old with at least 10 years of service.
- If you retired from Alcatel USA before January 1, 2008, and were eligible to participate in the retiree medical programs of Alcatel USA, Inc. as of December 31, 2009, you are eligible to participate in this plan.

Further, coverage is not available if:

- You are not eligible for Medicare, even if upon termination of employment, you met one of the age and service requirements described above. However, when you become eligible for Medicare, you may be eligible for coverage at that time, or
- You do not have a U.S. or U.S. territory address, as your address of record, on file with the Nokia Benefits Resource Center.

For individuals who retired before March 1, 1990, the rules set forth above apply regardless of your Medicare eligibility

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 Dental Carrier 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, and all applicable regulations.

In-Network Provider: This is a dental provider that has contracted with the Dental Carrier to provide dental services and supplies at a predetermined cost.

Lifetime Maximum: The maximum benefit available from the Dental Plan in a lifetime for each Participant. Once the Lifetime Maximum benefit has been paid, no other benefits are available under any circumstances. You are responsible for all charges above the Lifetime Maximum benefit.

Necessary: A service or supply furnished by a dentist is Necessary if the Dental Carrier (see Section K. Important Contacts) determines that it is appropriate for the diagnosis, and/or the care or the treatment of the disease or injury involved.

Network: The providers in a given area who have signed a contract to participate with the Dental Carrier and offer services to members enrolled with that Dental Carrier at a contract rate. A "Network Provider" means a provider who participates in the Network.

Nokia Benefits Resource Center: The resource to call to enroll, to make changes to your coverage or to ask questions about your Dental Plan. Call 1-888-232-4111 or 1-212-444-0994 (if calling from outside of the United States, Puerto Rico or Canada). If you are hearing or speech impaired, please use a Relay Service when calling a representative**.** Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET). You can also obtain information by visiting the Your Benefits Resources Web site at https://digital.alight.com/nokia.

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 Provider: This is a dental provider that has not contracted with the Dental Carrier to provide dental services and supplies at a predetermined cost.

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

Participating Company/Companies: A company or companies that participate in the Dental Plan. As of January 1, 2025, these are:

- Nokia of America Corporation
- Nokia Federal Solutions, LLC
- Nokia Investment Management Corporation
- Predecessors and affiliates of the foregoing that adopted the Plan for the benefit of their eligible employees and retired employees.

Plan: The Nokia Dental Expense Plan for Retired Employees, a component plan of the Nokia Retiree Welfare Benefits Plan.

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

Preferred Address: The address on file with the Nokia Benefits Resource Center.

Preferred Provider Organization (PPO): A Network of providers under the Dental PPO option offered in many areas of the country. When you are covered under the PPO option and you elect to receive dental care from providers in the PPO Network, charges are generally lower and guaranteed to be within the allowable amount.

Qualified Medical Child Support Order (QMCSO): a judgment, decree or order issued by a court that requires coverage under the Plan for an Eligible Retiree'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 K. "Important Contacts**"** for information on how to contact the Nokia QMCSO Administrator.

Qualified Status Change: a change in status with respect to an Eligible Retiree or the Eligible Retiree's Eligible Dependent that permits certain changes in coverage under the Plan. See "Changing Your Coverage During the Plan Year" in Section B. "Joining the Dental Plan" for more information.

Reasonable and customary (R&C): The fee determined by the Dental Carrier to be reasonable and customary on the basis of:

- The fees a dentist usually charges most patients for a similar service, and
- The range of fees charged by dentists with similar training and experience for the same or similar services within the geographic region.

The Your Benefits Resources Web site (YBR): a Web-based resource located at https://digital.alight.com/nokia where you can learn more about your healthcare benefits, access your benefit options and costs and enroll for your benefits online.

Section K. Important Contacts

Here is a list of important contacts for the Plan:

Contact/Service Provided	Address/Phone/Online
Dental Carrier (Aetna)-- Download or request claim forms, check the status of your claim, request a list of In-Network dentists and obtain other general information on the PPO Option coverage.	*Online* Through the Aetna website at: www.aetna.com 24 hours a day, seven days a week. *By Phone* Call Aetna Dental Customer Service at 1-800-220-5470. *By Mail* Aetna P.O. Box 14066 Lexington, KY 40512
Your Benefits Resources (YBR)™ Website • View your current coverage • Review and compare your healthcare options and contribution costs • Enroll in coverage • Make changes to your coverage • Learn more about Nokia's benefits • Review, add or change your dependent's information on file • Understand how a Qualified Status Change may affect your benefits	You can access YBR at https://digital.alight.com/nokia, 24 hours a day, seven days a week. (Your Benefits Resources is a trademark of Alight Solutions LLC.)

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 Qualified Status Change 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.
Nokia BenefitAnswers Plus Website • 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 • Find carrier contact information during the year	www.benefitanswersplus.com
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.

Section L. Other Important Information About Your Benefits

Qualified Medical Child Support Order Benefit Payments

Benefit payments under the Dental Plan will be made according to the terms of a Qualified Medical Child Support Order (QMCSO). If the Plan Administrator determines that a medical Child support order qualifies, benefit payments from the Dental Plan may be made according to the qualified order to the Child or Children named in the order, or to the custodial parent or legal guardian, where appropriate, or healthcare Providers (if benefits have been properly assigned by the Child or Children or by the custodial parent or legal guardian).

Dental Plan Funding and Payment of Benefits

Nokia pays certain administrative costs associated with providing benefits under the Nokia Dental Plan unless borne by participants.

Plan Documents

This summary plan description (SPD) is designed to describe the Dental Plan in easy-to-understand terms. However, it is the Dental Plan documents and contracts that determine your rights and the rights of your Eligible Dependents under the Plan. In all instances, even if the SPD and Dental Plan are in conflict, the terms of the Dental Plan documents govern.

Dental Plan May Be Amended or Terminated

The company expects to continue the Dental Plan, but reserves the right to amend or terminate the Dental Plan, in whole or in part, at any time by the resolution of the Board of Directors, subject to the terms of any applicable collective bargaining agreements. In addition, the company doesn't guarantee the continuation of any dental benefits during retirement nor does it guarantee any specific level of benefits or contributions.

Plan Administrator and Dental Carrier

The Plan Administrator and the Dental Carrier have the full discretionary authority and power to control and manage all aspects of the Dental Plan, to

determine eligibility for Dental Plan benefits, to interpret and construe the terms and provisions of the Dental Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Dental Plan as they may deem appropriate in accordance with the terms of the Dental Plan, applicable collective bargaining agreements and all applicable laws.

Plan Sponsor

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

Administrative Information

Plan Name	Nokia Dental Expense Plan for Retired Employees, a component of the Nokia Retiree Welfare Benefits Plan
Plan Sponsor	Nokia of America Corporation
Type of Administration	This Dental Plan is administered by Aetna as named in the Dental Carrier section below. Enrollment and eligibility under the Dental Plan are administered by the Nokia Benefits Resource Center.
Dental Carrier	The Dental Carrier is Aetna. Benefit claims and appeals should be submitted to: Aetna P.O. Box 14066 Lexington, KY 40512-4094
Eligibility Claims Administrator	Nokia Benefits Review Team Dept 07544 P.O. Box 299107 Lewisville, TX 75029-9107
Plan Administrator	Dental Plan Administrator Nokia Room 6D-401A 600-700 Mountain Avenue Murray Hill, NJ 07974
Agent for Service of Legal Process	The agent for service of any legal process regarding benefit claims is the Dental Carrier. The agent for service of any other legal process is the Plan Administrator.

Plan Records and Plan Year	The Dental Plan and all its records are maintained on a calendar-year basis, beginning on January 1 and ending on December 31 of each year.
Type of Plan	The Dental Plan is considered a "employee welfare plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Plan Number	The Plan Number is 504.
Employer Identification Number	The Employer Identification Number is 22-3408857.

Section M. Your Legal Rights

Your Rights Under ERISA

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). These rights are described in this section.

ERISA provides that all Dental Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Dental Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Dental Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Dental Plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Dental Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue healthcare coverage for yourself, your spouse, or your Dependents if there is a loss of coverage under the Dental Plan as a result of a "qualifying event." You, your spouse or your Dependents will have to pay for this coverage. Review this SPD and the Plan document about the rules governing your COBRA Continuation Coverage rights.
- Receive, free of charge, a Certificate of Creditable Coverage from the Dental Plan when you, your spouse or your Dependents lose coverage under the Dental Plan or become entitled to elect COBRA Continuation Coverage under the Dental Plan, or when you, your spouse or your Dependents' COBRA Continuation Coverage ends, if you request it before losing coverage (or up to 24 months after losing coverage).

Please note: Without evidence of creditable coverage, if you enroll in another plan, you, your spouse and your Dependents may be subject to a Pre-Existing Condition exclusion for 12 months (18 months for late enrollees) after enrolling in the other plan.

In addition to establishing rights for Plan participants, ERISA imposes certain duties on the people responsible for the operation of a Dental Plan. The people who operate the Dental Plan, called "fiduciaries," have a duty to do so prudently and in the interest of all participants and beneficiaries.

No one, including the Company, may fire you or otherwise discriminate against you in any way to keep you from obtaining a welfare benefit or exercising your ERISA rights.

If your claim for a welfare benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Dental Plan documents or the latest annual report from the Dental Plan 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 and 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, you may also file suit in federal court if you disagree with the Dental Plan's decision or lack thereof concerning the qualified status of a medical Child support order.

If it should happen that Dental Plan fiduciaries misuse the Dental Plan's money, 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 questions about the Dental Plan, you should contact the Plan Administrator or the Nokia Benefits Resource Center at 1-888-232-4111. Representatives are available Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern Time (ET).

If you have any questions about this statement 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, United States Department of Labor, listed in your telephone directory, or write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
United States 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 calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272 or by logging on to the internet at http://www.dol.gov/ebsa.

Appendix A: Eligible Covered Expenses Under the PPO Option

Please Note: This section includes a high-level summary of common procedures covered by the Plan and does not list all covered services. Please contact the Dental Carrier for more information or visit your secure member website with the Dental Carrier (See Section K. Important Contacts).

General Features

General Feature	Plan Pays	
	In-Network	Out-of-Network
Annual Deductible	$50 /individual $100/family Applies to basic and major services only	$75/individual $150/family Applies to diagnostic, preventive, basic and major services
Annual Maximum*	$1,250	$1,000
Lifetime Orthodontic Maximum Benefit	$1,500 per individual (in-network and out-of-network combined)	
Dental Emergency Maximum	$75	$75

***Please Note**: The Annual Maximum benefit applies to In-Network and Out-of-Network covered dental expenses combined. However, when your covered expenses totaling $1,000 have been applied to your Annual Maximum, the Plan will no longer pay benefits for further Out-of-Network expense that your or your dependent incur.

Preventive — Type A Services

Preventive — Type A Services	Plan Pays	
	In-Network ***(no deductible)***	**Out-of-Network** ***(after deductible)***
Visits and Exams:		
• Office visit for oral examination (limited to two visits a year)	100%	100%
• Prophylaxis treatment (cleaning) (limited to two treatments a year) - Adult - Child	 100% 100%	 100% 100%
• Topical application of fluoride (limited to four courses of sodium treatments per year, or one course of stannous or acid phosphate treatment a year)	100%	100%
X-Rays and Pathology:		
• Bitewing X-rays (limited to twice a year)	100%	100%
• Complete X-ray series, including bitewings or panoramic film (limited to once every three years)	100%	100%
• Vertical bitewing X-ray (limited to one set every three years)	100%	100%

Basic Restorative Care – Type B Services

Basic Restorative Care — Type B Services	Plan Pays	
	In-Network ***(after deductible)***	**Out-of-Network** ***(after deductible)***
Visits and Exams:		
• Professional visits after hours (payments will be made on the basis of services rendered or visit, whichever is greater)	60%	40%
• Emergency palliative treatment, per visit	60%	40%
X-Rays and Pathology:		
• Periapical X-rays (single films up to 13)	60%	40%
• Intra-oral, occlusal view, maxillary or mandibular	60%	40%
• Extra-oral upper or lower jaw	60%	40%
• Biopsy and histopathologic examination of oral tissue	60%	40%
• Diagnostic casts	60%	40%

Basic Restorative Care — Type B Services	Plan Pays	
	In-Network ***(after deductible)***	**Out-of-Network** ***(after deductible)***
Endodontics:		
• Pulp capping	60%	40%
• Pulpotomy	60%	40%
• Root canal therapy (including necessary X-rays) -Anterior -Bicuspid -Molar	60%	40%
• Apexification/recalcification	60%	40%
• Apicoectomy	60%	40%
Restoration and Repairs:		
• Amalgam restoration	60%	40%
• Resin restoration (other than for molars)	60%	40%
• Pin Retention	60%	40%
• Sedative fillings	60%	40%
• Prefabricated stainless steel crowns	60%	40%
• Prefabricated resin crowns (excluding temporary crowns)	60%	40%
• Recementing inlays, crowns, bridges	60%	40%
• Full and partial dental repairs -Broken dentures, no teeth involved -Repair cast framework -Replacing missing or broken teeth, each tooth	60%	40%
• Space maintainers (includes all adjustments within six months after installation for dependent children to age 19) -Fixed (unilateral or bilateral) -Removable (unilateral or bilateral) -Removable inhibiting appliance to correct thumbsucking -Fixed or cemented inhibiting appliance to correct thumbsucking	60%	40%
• Occlusal guard (for bruxism only)	60%	40%

Basic Restorative Care — Type B Services	Plan Pays	
	In-Network ***(after deductible)***	**Out-of-Network** ***(after deductible)***
Periodontics:		
• Gingivectomy — per quadrant	60%	40%
• Gingivectomy — one to three teeth per quadrant	60%	40%
• Gingival flap procedures, including root planing — per quadrant	60%	40%
• Gingival flap procedures, including root planing — one to three teeth per quadrant	60%	40%
• Occlusal adjustment (other than with an appliance or by restoration)	60%	40%
• Osseous surgery (including flap entry and closure) — per quadrant	60%	40%
• Osseous surgery (including flap entry and closure) — one to three teeth per quadrant	60%	40%
• Root planing and scaling per quadrant (limited to four separate quadrants a year)	60%	40%
• Root planing and scaling — one to three teeth per quadrant (limited to once per site every year)	60%	40%
• Periodontal maintenance procedures following active therapy (limited to two per year)	60%	40%
Intravenous Sedation and General Anesthesia:		
When medically necessary and provided in conjunction with a covered surgical procedure	60%	40%

Basic Restorative Care — Type B Services	Plan Pays	
	In-Network ***(after deductible)***	**Out-of-Network** ***(after deductible)***
Oral Surgery:		
• Extractions, erupted tooth or exposed root	60%	40%
• Surgical removal of erupted tooth	60%	40%
• Surgical removal of impacted tooth	60%	40%
• Excision of hyperplastic tissue per arch	60%	40%
• Excision of pericoronal gingiva	60%	40%
• Incision and drainage of abscess	60%	40%
• Crown exposure to aid eruption	60%	40%
• Removal of foreign body from soft tissue	60%	40%
• Suture of soft tissue injury	60%	40%
• Removal of odontogenic cyst or tumor	60%	40%
• Closure of oral fistula of maxillary sinus	60%	40%
• Removal of foreign body from bone	60%	40%
• Sequestrectomy for osteomyelitis or bone abcess, superficial	60%	40%
• Frenectomy	60%	40%
• Transplantation of tooth or tooth bud	60%	40%
• Alveolectomy in conjunction with extractions — per quadrant	60%	40%
• Alveolectomy not in conjunction with extractions — per quadrant	60%	40%
• Removal of exostosis	60%	40%
• Sialolithotomy; removal of salivary calculus	60%	40%
• Closure of salivary fistula	60%	40%

Major Restorative Care – Type C Services

Major Restorative Care — Type C Services	Plan Pays	
	In-Network ***(after deductible)***	**Out-of-Network** ***(after deductible)***
Restorations:		
Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only as treatment for decay or acute traumatic injury, and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. Coverage is limited to 1 per tooth every 5 years.		
• Inlays/Onlays	60%	40%
• Labial veneers -Laminate — chairside -Resin laminate — laboratory -Porcelain laminate — laboratory	60%	40%
• Crowns	60%	40%
• Post and core	60%	40%
Prosthodontics:		
The first installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 5 years old. Replacement of existing bridges or dentures is limited to 1 every 5 years.		
• Bridge abutments	60%	40%
• Pontics	60%	40%
• Removable bridge (unilateral)	60%	40%
• Dentures and Partials (includes relines, rebases and adjustments within six months after installation) -Complete (upper or lower) -Partial -Stress breakers (per unit) -Interim partial dentures (Stay plates); anterior only -Adding teeth to an existing partial denture -Full and partial denture repairs -Relining/rebasing dentures (include adjustments within six months after installation)	60%	40%

Orthodontia

Orthodontia	Plan Pays	
	In-Network ***(after deductible)***	**Out-of-Network** ***(after deductible)***
• Comprehensive Orthodontic Treatment	60%	50%
• Post Treatment Stabilization	60%	50%

Cleft Lip and Cleft Palate Rule

Coverage for the treatment of a cleft lip or cleft palate is provided as follows:

- Dental-related oral surgery of a cleft lip or cleft palate for a child under age 18 is covered as a Type B Service.
- If coverage for orthodontic treatment is not otherwise specified, orthodontic treatment of a cleft lip or cleft palate for a child under 18 is covered as an orthodontic expense.

Appendix B: Services/Charges Not Covered Under the PPO Option

Please Note: This section includes a high-level summary of services/charges not covered under the PPO Option; it does not list all exclusions. Please contact the Dental Carrier for more information or visit your secure member website with the Dental Carrier (See Section K. Important Contacts).

The following services and charges are not covered under the PPO option:

- Acupuncture, acupressure and acupuncture therapy;
- Asynchronous dental treatment;
- Work done for appearance (cosmetic purposes);
- Fees in excess of negotiated or reasonable and customary charges;
- Replacement of lost or stolen appliances;
- 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, abrasion or erosion;
- Services payable under workers' compensation or similar laws;
- Services covered by any other company-provided health plan;
- Work done while not covered under the Dental Plan, except for certain services as explained in this summary plan description (SPD) under "*Coverage for Dental Work Completed After Termination of Coverage*" in Section C. How the Dental Plan Works;
- Replacement of teeth removed before coverage is effective;
- Extra sets of dentures or other appliances;
- Work that is otherwise free of charge;
- Services or supplies not necessary for proper dental care, as determined by the Dental Carrier;

- Charges for broken appointments;
- Charges for completing or filing claim forms;
- Educational training programs, dietary instructions, plaque control programs;
- Routine dental exams and other preventive services and supplies, except as specifically provided in "Appendix A";
- Implantology;
- Except as covered in "Appendix A", treatment of any jaw joint disorder other than temporomandibular joint disorder (TMJ) treatment and treatments to alter bite or the alignment or operation of the jaw, other than TMJ treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment;
- Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium);
- Treatment resulting from or caused by the negligent or wrongful act of a third party;
- General anesthesia and intravenous sedation, except specifically covered and only when done in connection with another necessary covered service or supply;
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth;
- Surgical removal of impacted wisdom teeth only for orthodontic reasons;
- Drugs or their administration;
- Experimental and investigational drugs, devices, treatments or procedures, as determined by the Dental Carrier; or
- Any services or supplies not specifically defined as Covered dental expenses in the Plan.

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.

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