Form 5500		•	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104			10-0110 10-0089
Department of the Treasury Internal Revenue Service		and 4065 of the Employee Retireme	employee benefit plans under sections 104 ent Income Security Act of 1974 (ERISA) and f the Internal Revenue Code (the Code).	2020		
Employ	artment of Labor ee Benefits Security Administration		ntries in accordance with ons to the Form 5500.	This	Form is Open to Pu	ıblic
Pension Ben	efit Guaranty Corporation				Inspection	
Part I	Annual Report Ide	entification Information				
For calendar	plan year 2020 or fisca	al plan year beginning 01/01/2020	and ending 12/31/20	20		
A This return	n/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking th participating employer information in accord			ns.)
		X a single-employer plan	a DFE (specify)			
B This return	n/report is:	the first return/report	the final return/report			
		an amended return/report	a short plan year return/report (less than 12 months)			
C If the plan	is a collectively-bargai	— ined plan, check here			•	
	г	X Form 5558	automatic extension	□ th	e DFVC program	
	c if filing under:				e DEVC program	
		special extension (enter description)				
		nation—enter all requested information	1			r
1a Name of NOKIA MED	•	N FOR MANAGEMENT EMPLOYEES		1b	Three-digit plan number (PN) ▶	502
				1c	Effective date of pla 10/01/1996	an
 Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 				2b Employer Identification Number (EIN) 22-3408857		
NOKIA OF AMERICA CORPORATION					2c Plan Sponsor's telephone number 908-723-9869	
600 MOUNTAIN AVENUE, ROOM 6D-401A MURRAY HILL, NJ 07974				2d Business code (see instructions) 334200		

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

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

SIGN	Filed with authorized/valid electronic signature.	07/19/2021	INGRID ORAV
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
HERE	Signature of DFE	Date	Enter name of individual signing as DFE
For Pap	erwork Reduction Act Notice, see the Instructions for Form 55	500.	Form 5500 (2020)

Form 5500 (2020) v. 200204

	Form 5500 (2020)	Page 2	
3a	Plan administrator's name and address \overline{X} Same as Plan Sponsor	3b Adr	ministrator's EIN
			ninistrator's telephone nber
4	If the name and/or EIN of the plan sponsor or the plan name has changed si		١
a c	enter the plan sponsor's name, EIN, the plan name and the plan number from Sponsor's name Plan Name	4d PN	l
5	Total number of participants at the beginning of the plan year	5	8125
6	Number of participants as of the end of the plan year unless otherwise state 6a(2) , 6b , 6c , and 6d).	d (welfare plans complete only lines 6a(1),	
a(1) Total number of active participants at the beginning of the plan year		7923
a(2) Total number of active participants at the end of the plan year		7380
b	Retired or separated participants receiving benefits		179
с	Other retired or separated participants entitled to future benefits	<u>6c</u>	(
d	Subtotal. Add lines 6a(2), 6b, and 6c		7559
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefits 6e	
f	Total. Add lines 6d and 6e	6f	
g	Number of participants with account balances as of the end of the plan year complete this item)		
h	Number of participants who terminated employment during the plan year wit less than 100% vested		
7	Enter the total number of employers obligated to contribute to the plan (only		

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

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

9a	Plan fu	nding	arrangement (check all that apply)	9b	Plan b	enefi	it a	rrangement (check all that apply)
	(1)	X	Insurance		(1)	X	(Insurance
	(2)		Code section 412(e)(3) insurance contracts		(2)			Code section 412(e)(3) insurance contracts
	(3)		Trust		(3)			Trust
	(4)	×	General assets of the sponsor		(4)	X		General assets of the sponsor
10	Check	all ap	plicable boxes in 10a and 10b to indicate which schedules are at	tache	d, and,	wher	re i	indicated, enter the number attached. (See instructions)
а	Pensio	on Sc	hedules	b	Gener	ral So	che	edules
	(1)		R (Retirement Plan Information)		(1)			H (Financial Information)
	(2)	Π	MB (Multiemployer Defined Benefit Plan and Certain Money		(2)]	I (Financial Information – Small Plan)
		<u> </u>	Purchase Plan Actuarial Information) - signed by the plan		(3)	X		<u>9</u> A (Insurance Information)
			actuary		(4)			C (Service Provider Information)
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)]	D (DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)			G (Financial Transaction Schedules)

Page 3

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)					
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)					
If "Yes" is checked, complete lines 11b and 11c.					
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)					
11c Enter the Receipt Confirmation Code for the 2020 Form M-1 annual report. If the plan was not required to file the 2020 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)					

Receipt Confirmation Code_____

SCHEDULE		Insuranc	e Information			OM	B No. 1210-0110
(Form 5500 Department of the Treas Internal Revenue Servi	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2020	
Department of Labor Employee Benefits Security Ad			tachment to Form 5500		,		
Pension Benefit Guaranty Co	Insurance companies ar			ion		m is Open to Public Inspection	
For calendar plan year 202	20 or fiscal plar	year beginning 01/01/2020		and en	ding 12/3	1/2020	
A Name of plan NOKIA MEDICAL EXPEN	MANAGEMENT EMPLOYEES	-		e-digit number (Pl	N) 🕨	502	
C Plan sponsor's name a NOKIA OF AMERICA CO		e 2a of Form 5500	1		yer Identific 3408857	ation Number (EIN)
on a separa		ning Insurance Contract					
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE		F S. CA					
	(c) NAIC	(d) Contract or	(e) Approximate num			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at e policy or contract y		(f)	From	(g) To
94-1340523	00000	122636	11		01/01/2020)	12/31/2020
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	I commissions paid. List	t in line 3	the agents,	brokers, and of	ther persons in
(a) Total a	amount of comr	nissions paid	(b) Total amount of fees paid				
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all pe	ersons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commiss	ions or fees	were paid	
			s and other commissions	noid			
(b) Amount of sales ar commissions pai		(c) Amount		ions paid (d) Purpose			(e) Organization code
		(e) internet	(0	-, i diposi	-		
	(a) Name a	nd address of the agent, broker, c	or other person to whom	commiss	ions or fees	were paid	•
	(,						

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

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

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

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

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

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

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

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

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

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

Page :	3
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Par				
	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier may	/ be treated	as a unit for purposes of
	this report.			
	rrent value of plan's interest under this contract in the general account at year		4	
5 Cu	rrent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Co	ntracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
	Premiums due but unpaid at the end of the year		6C	
c d				
u	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
	Specify nature of costs		LI	
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
	If contract purchased, in whole or in part to distribute how fits from a torrel			
	If contract purchased, in whole or in part, to distribute benefits from a termi			
7 Co	ntracts With Unallocated Funds (Do not include portions of these contracts m			
а	Type of contract: (1) deposit administration (2) immedi	iate participation guarantee		
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year		7b	0
C	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits	7c(2)		
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account			
	(5) Other (specify below)	- /->		
	•			
	(6)Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	- (-)		
		- (0)		
	(3) Transferred to separate account	- (1)		
	(4) Other (specify below)	. 7e(4)		
	▶			
			70/5)	
	(5) Total deductions		7e(5)	0
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

P	Part		Welfare Benefit Contract Informa If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employ ting purposes if s	such contracts are	expe	erience-rated as a unit	. Where co	ntracts cover	
8	Ben	efit ar	nd contract type (check all applicable boxes)							
	а	He	alth (other than dental or vision)	b Dental		С	Vision		d Life ins	urance
	еĪ	Те	mporary disability (accident and sickness)	f Long-terr	m disability	g	Supplemental unem	oloyment	h Prescri	ption drug
	ιĒ		op loss (large deductible)	j 🛛 HMO cor	-		PPO contract			nity contract
	• L	_			lituot					ity contract
	m	Ot	her (specify)							
9	Expe	erienc	e-rated contracts:							
•			iums: (1) Amount received)			-	
			ncrease (decrease) in amount due but unpaid		· ·				-	
		. ,	ncrease (decrease) in unearned premium res			<i>.</i>			1	
		(4) E	arned ((1) + (2) - (3))		·····	· · · · · · ·		9a(4)		0
	b	Bene	efit charges (1) Claims paid)				
		(2) Ir	ncrease (decrease) in claim reserves			2)				
		(3) Ir	ncurred claims (add (1) and (2))					9b(3)		0
		(4) C	laims charged					9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	on an accrual bas	sis)					
		((A) Commissions			(A)				
		((B) Administrative service or other fees						_	
		((C) Other specific acquisition costs						_	
		((D) Other expenses						_	
		((E) Taxes						_	
			(F) Charges for risks or other contingencies .						4	
			(G) Other retention charges							
			(H) Total retention	-		_		9c(1)(H)		0
			Dividends or retroactive rate refunds. (These	L				9c(2)		
	d	State	us of policyholder reserves at end of year: (1) Amount held to	o provide benefits	after	retirement	9d(1)		
		(2) (Claim reserves					9d(2)		
		(-) -	Other reserves					9d(3)		
4.0			dends or retroactive rate refunds due. (Do no	ot include amour	nt entered in line s	9c(2).)	9e		
10	-	•	erience-rated contracts:							
	а		I premiums or subscription charges paid to c					10a	+	79096
	b		e carrier, service, or other organization incurr ation of the contract or policy, other than repu					10b		

Part IV	Provision of Information
11 Did the	insurance company fail to provide any information necessary to complete Schedule A?
40	

12 If the answer to line 11 is "Yes," specify the information not provided.

Specify nature of costs.

SCHEDULE	Α	Insuranc	e Information			OM	B No. 1210-0110
Department of the Treas	(Form 5500) Department of the Treasury Internal Revenue Service This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2020		
Department of Labor			tachment to Form 5500).		
						This For	m is Open to Public
Pension benefit Guaranty Co	poration	 Insurance companies an pursuant to EF 	e required to provide the RISA section 103(a)(2).	e informat	ion		Inspection
	20 or fiscal plar	n year beginning 01/01/2020		and en	ding 12/3	1/2020	1
A Name of plan NOKIA MEDICAL EXPEN	SE PLAN FOR	MANAGEMENT EMPLOYEES			e-digit number (Pl	N) 🕨	502
C Plan sponsor's name a NOKIA OF AMERICA COI		e 2a of Form 5500			yer Identific 3408857	ation Number ((EIN)
on a separa		ning Insurance Contract (. Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE		FCO					
	(c) NAIC	(d) Contract or	(e) Approximate num			Policy or contract year	
(b) EIN	code	identification number	persons covered at e policy or contract y		(f)	From	(g) To
84-0591617	95669	7368	8		01/01/2020	0	12/31/2020
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	I commissions paid. List	t in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount	of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all pe	ersons).			
	(a) Name a	nd address of the agent, broker, c	or other person to whom	commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base		and other commissions	•			4
commissions pai	d	(c) Amount	(d	l) Purpos	9		(e) Organization code
		nd address of the agent broker a	or other person to whom	commiss	ions or foco	woro poid	
	(a) Name a	nd address of the agent, broker, c	or other person to whom	COLLINSS	IOUS OF IEES	were paiu	

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

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

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

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

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

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

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

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

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

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

Page :	3
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Par				
	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier may	/ be treated	as a unit for purposes of
	this report.			
	rrent value of plan's interest under this contract in the general account at year		4	
5 Cu	rrent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Co	ntracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
	Premiums due but unpaid at the end of the year		6C	
c d				
u	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
	Specify nature of costs		LI	
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
4	If contract purchased, in whole or in part to distribute how fits from a torrel			
	If contract purchased, in whole or in part, to distribute benefits from a termi			
7 Co	ntracts With Unallocated Funds (Do not include portions of these contracts m			
а	Type of contract: (1) deposit administration (2) immedi	iate participation guarantee		
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year		7b	0
C	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits	7c(2)		
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account			
	(5) Other (specify below)	- /->		
	•			
	(6)Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	- (-)		
		- (0)		
	(3) Transferred to separate account	- (1)		
	(4) Other (specify below)	. 7e(4)		
	▶			
			70/5)	
	(5) Total deductions		7e(5)	0
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

P	Part	111	Welfare Benefit Contract Information If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of th ting purposes if such cor	ntracts are expe	rience-rated as a unit	. Where co	ontracts cover individual	3
8	Ben	efit ar	nd contract type (check all applicable boxes)						
	a	He	alth (other than dental or vision)	b Dental	c	Vision		d Life insurance	
	e	Те	mporary disability (accident and sickness)	f Long-term disabi	lity g	Supplemental unemp	oloyment	h Prescription drug	
	ιĽ		op loss (large deductible)	j 🛛 HMO contract	· <u> </u>	PPO contract		I Indemnity contract	
	• L	_			чП				
	m	Ot	her (specify)						
9	Fxpe	erienc	e-rated contracts:						
•			iums: (1) Amount received		9a(1)			-	
			ncrease (decrease) in amount due but unpaid					-	
			ncrease (decrease) in unearned premium res					-	
		(4) E	arned ((1) + (2) - (3))				9a(4)		C
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)		C
		(4) C	laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	on an accrual basis)					
		((A) Commissions					_	
		((B) Administrative service or other fees					_	
		((C) Other specific acquisition costs					_	
		((D) Other expenses					_	
		(E) Taxes					_	
			(F) Charges for risks or other contingencies .					_	
			(G) Other retention charges				0.(4)(1)		
			(H) Total retention	_	_		9c(1)(H)		
	-		Dividends or retroactive rate refunds. (These				9c(2)		
	d		us of policyholder reserves at end of year: (1	, ,			9d(1)		
		• •	Claim reserves				9d(2)		
	-	· · /	Other reserves				9d(3)		
40			dends or retroactive rate refunds due. (Do n	ot include amount entere	ed in line 9c(2) .))	9e		
10	-	•	erience-rated contracts:				40-		
	а		I premiums or subscription charges paid to c				10a	3	32277
	b		e carrier, service, or other organization incuri				10b		

Part IV	Provision of Information
11 Did the	insurance company fail to provide any information necessary to complete Schedule A?
40	

12 If the answer to line 11 is "Yes," specify the information not provided.

Specify nature of costs.

SCHEDULE	A	Insuranc	e Information			0	IB No. 1210-0110
(Form 5500) Department of the Treasury Internal Revenue Service		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2020		
Department of Labo	r			. ,			
Employee Benefits Security Ad		,	tachment to Form 5500			This For	m is Open to Public
Pension Benefit Guaranty Co	rporation	 Insurance companies ar pursuant to EF 	e required to provide the RISA section 103(a)(2).	informati	on		Inspection
	20 or fiscal plar	n year beginning 01/01/2020		and en	ding <u>12/3</u>	1/2020	
A Name of plan NOKIA MEDICAL EXPEN	ISE PLAN FOR	MANAGEMENT EMPLOYEES	E		e-digit number (Pl	N) 🕨	502
C Plan sponsor's name a NOKIA OF AMERICA CO	RPORATION			22-3	408857	ation Number	
		ning Insurance Contract					
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE	EALTH PLAN C	-	(e) Approximate num	ber of		Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at e policy or contract ye		(f)	From	(g) To
52-0954463	95639	2204	6 01/01/202)	12/31/2020	
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	l commissions paid. List	in line 3 t	the agents,	brokers, and o	ther persons in
(a) Total a	amount of com	missions paid	(b) Total amount of fees paid				
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all pe	ersons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whom a	commissi	ons or fees	were paid	
							_
(b) Amount of sales ar	nd base		s and other commissions				4
commissions paid		(c) Amount	(d)) Purpose	9		(e) Organization code
	(a) Name a	nd address of the agent, broker, c	or other person to whom a	commissi	ons or fees	were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Denemicarly Deduction Act Natio	the Instructions for Form	n FEOD	Jula A (Farma FEOO) 0000

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

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

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

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

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

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

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

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

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

Page :	3
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Par				
	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier may	/ be treated	as a unit for purposes of
	this report.			
	rrent value of plan's interest under this contract in the general account at year		4	
5 Cu	rrent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Co	ntracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
	Premiums due but unpaid at the end of the year		6C	
c d				
u	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
	Specify nature of costs		LI	
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
4	If contract purchased, in whole or in part to distribute how fits from a torrel			
	If contract purchased, in whole or in part, to distribute benefits from a termi			
7 Co	ntracts With Unallocated Funds (Do not include portions of these contracts m			
а	Type of contract: (1) deposit administration (2) immedi	iate participation guarantee		
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year		7b	0
C	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits	7c(2)		
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account			
	(5) Other (specify below)	- /->		
	•			
	(6)Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	- (-)		
		- (0)		
	(3) Transferred to separate account	- (1)		
	(4) Other (specify below)	. 7e(4)		
	▶			
			70/5)	
	(5) Total deductions		7e(5)	0
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

F	Part		Welfare Benefit Contract Informa	ation							
			If more than one contract covers the same								
			the information may be combined for report employees, the entire group of such individu								
8	Ben	efit an	ad contract type (check all applicable boxes)			ner may be			1310	John.	
Ŭ	a	_	alth (other than dental or vision)	b∏ɑ	Dental	<u>م</u>	Vision		d∏	Life insurance	
	L		,	. 💾		-			<u> </u>		
	е	Ter	mporary disability (accident and sickness)		ong-term disability	-	Supplemental unem	nployment	h	Prescription drug	
	i	Sto	p loss (large deductible)	j×⊦	HMO contract	k	PPO contract			Indemnity contract	
	m	Oth	ner (specify)								
									_		
9			e-rated contracts:		Г				_		
	a		ums: (1) Amount received			9a(1)			_		
		• •	crease (decrease) in amount due but unpaid		-	9a(2)			-		
		• •	crease (decrease) in unearned premium res			9a(3)		0-(4)	_		
	L	• •	arned ((1) + (2) - (3))				1	9a(4)	-		0
	b		efit charges (1) Claims paid			9b(1)			_		
			crease (decrease) in claim reserves					01 (0)	_		
		• •	curred claims (add (1) and (2))					9b(3)			0
	•	• •	laims charged					9b(4)			_
	С		ainder of premium: (1) Retention charges (o		, ,	0-/4//4/			-		
		`	A) Commissions			9c(1)(A)			-		
		``	B) Administrative service or other fees			9c(1)(B) 9c(1)(C)			-		
		`	C) Other specific acquisition costs			9c(1)(D)			-		
		``	D) Other expenses E) Taxes			9c(1)(E)			-		
		`	F) Charges for risks or other contingencies			9c(1)(F)			-		
			G) Other retention charges			9c(1)(G)			-		
		`	H) Total retention					9c(1)(H)			0
			vividends or retroactive rate refunds. (These		_						
	d		us of policyholder reserves at end of year: (1						-		
	ŭ		Claim reserves					9d(2)			
		• •	Other reserves					9d(3)			
	е	· · /	lends or retroactive rate refunds due. (Do no					9e			
10			erience-rated contracts:				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	a	•	I premiums or subscription charges paid to c	arrier				10a		29	450
	b		e carrier, service, or other organization incurr								
			tion of the contract or policy, other than repo					10b			
	Spe	cify na	ature of costs.			-					

Part IV	Provision of Information			
11 Did the	nsurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

12 If the answer to line 11 is "Yes," specify the information not provided.

SCHEDULE	٨	Incuranc	e Informatior	<u> </u>			
(Form 5500		Insulatio		1		OM	B No. 1210-0110
Department of the Treas Internal Revenue Servi	ury	This schedule is required Employee Retirement Inc					2020
Department of Labor Employee Benefits Security Adr		File as an at	tachment to Form 550	00.			
Pension Benefit Guaranty Co	rporation	 Insurance companies ar pursuant to EF 	re required to provide th RISA section 103(a)(2).		ion		m is Open to Public Inspection
For calendar plan year 202	20 or fiscal plar	year beginning 01/01/2020		and en	ding 12/3	1/2020	
A Name of plan NOKIA MEDICAL EXPEN	SE PLAN FOR	MANAGEMENT EMPLOYEES	·		e-digit number (Pl	N) 🕨	502
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		D Emplo	oyer Identific	cation Number ((EIN)
NOKIA OF AMERICA COI	RPORATION			22-	3408857		
		ning Insurance Contract					
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE		F GA					
(b) EIN	(c) NAIC	(d) Contract or	 (e) Approximate nu persons covered at 			Policy or contract year	
	code	identification number	policy or contract		(f)	From	(g) To
58-1592076	96237	2081	5		01/01/202	0	12/31/2020
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. Li	st in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comr	nissions paid	(b) Total amount of fees paid				
3 Persons receiving com		ees. (Complete as many entries a					
	(a) Name a	nd address of the agent, broker, o	or other person to whor	n commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base		s and other commissior	ns paid			-
commissions pai	d	(c) Amount		(d) Purpos	e		(e) Organization code
	(a) Name a	nd address of the agent, broker, c	or other person to whom	n commiss	ions or fees	were paid	·
	.,		,				

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
Fan Dan annual Daduation Ast Matia			L

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

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

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

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

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

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

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

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

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

Page :	3
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Par				
	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier may	/ be treated	as a unit for purposes of
	this report.			
	rrent value of plan's interest under this contract in the general account at year		4	
5 Cu	rrent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Co	ntracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
	Premiums due but unpaid at the end of the year		6C	
c d				
u	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
	Specify nature of costs		LI	
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
4	If contract purchased, in whole or in part to distribute how fits from a torrel			
	If contract purchased, in whole or in part, to distribute benefits from a termi			
7 Co	ntracts With Unallocated Funds (Do not include portions of these contracts m			
а	Type of contract: (1) deposit administration (2) immedi	iate participation guarantee		
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year		7b	0
C	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits	7c(2)		
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account			
	(5) Other (specify below)	- /->		
	•			
	(6)Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	- (-)		
		- (0)		
	(3) Transferred to separate account	- (1)		
	(4) Other (specify below)	. 7e(4)		
	▶			
			70/5)	
	(5) Total deductions		7e(5)	0
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

P	Part	111	Welfare Benefit Contract Information If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees o ting purposes if such o	contracts are experie	nce-rated as a unit. Wher	e contracts cover indivi	
8	Ben	efit ar	nd contract type (check all applicable boxes)	I				
	a	He	alth (other than dental or vision)	b Dental	C Vi	ision	d Life insurance	e
	еſ	Те	mporary disability (accident and sickness)	f Long-term disa	ability g Su	upplemental unemploymer	nt h Prescription	drug
	ιĽ		op loss (large deductible)	j X HMO contract	· <u>-</u>	PO contract	I Indemnity co	•
		_		J M TIMO COMULAC		o contract		intraot
	m	Ot	her (specify)					
9	Evne	arienc	ce-rated contracts:					
5			iums: (1) Amount received		9a(1)			
			ncrease (decrease) in amount due but unpaid					
			ncrease (decrease) in unearned premium res					
		• •	arned ((1) + (2) - (3))				4)	(
	b	Bene	efit charges (1) Claims paid		9b(1)			
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)			
		(3) Ir	ncurred claims (add (1) and (2))				3)	C
		(4) C	laims charged				4)	
	С	Rem	nainder of premium: (1) Retention charges (c	on an accrual basis)				
		((A) Commissions					
		((B) Administrative service or other fees					
			(C) Other specific acquisition costs					
		```	(D) Other expenses		0-(4)(5)			
			(E) Taxes					
			(F) Charges for risks or other contingencies.					
			(G) Other retention charges			00(1)		(
			(H) Total retention		_			
	-1		Dividends or retroactive rate refunds. (These					
	d		us of policyholder reserves at end of year: (1	, ,				
		• •	Claim reserves					
	•	``	Other reserves					
10			dends or retroactive rate refunds due. (Do n erience-rated contracts:	or include amount ent	erea in inte <b>90(2)</b> .)		5	
10	<i>a</i>	•	al premiums or subscription charges paid to c	arrier			a	59737
	_						u	09131
	b		e carrier, service, or other organization incur ntion of the contract or policy, other than rep				ь	

Part IV	Provision of Information				
11 Did the	insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No	
40					

12 If the answer to line 11 is "Yes," specify the information not provided.

Specify nature of costs.

SCHEDULE		Insuranc	e Information			OM	B No. 1210-0110
(Form 5500) Department of the Treasury Internal Revenue Service		- This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2020		
Department of Labo Employee Benefits Security Ad		File as an at	tachment to Form 5500	0.			
Pension Benefit Guaranty Co	orporation	<ul> <li>Insurance companies ar pursuant to EF</li> </ul>	e required to provide the RISA section 103(a)(2).	e informat	ion	This For	m is Open to Public Inspection
For calendar plan year 20	20 or fiscal plar	n year beginning 01/01/2020		and en	ding 12/3	1/2020	
A Name of plan NOKIA MEDICAL EXPEN			e-digit number (Pl	N) 🕨	502		
C Plan sponsor's name a NOKIA OF AMERICA CO		e 2a of Form 5500			yer Identific 3408857	ation Number	(EIN)
		ning Insurance Contract					
(a) Name of insurance ca KAISER FOUNDATION HE		F N. CA (d) Contract or	(e) Approximate num	nber of		Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered at e policy or contract y		(f)	From	<b>(g)</b> To
94-1340523	00000	35147			01/01/2020	)	12/31/2020
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	I commissions paid. List	t in line 3	the agents,	brokers, and o	ther persons in
	amount of com	missions paid	(b) Total amount of fees paid				
<b>3</b> Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all pe	ersons).			
	(a) Name a	nd address of the agent, broker, c	or other person to whom	commiss	ions or fees	were paid	
(b) Amount of sales ar			and other commissions	-			
commissions pa	id	(c) Amount	(d	d) Purpose	9		(e) Organization code
	(a) Name a	nd address of the agent, broker, c	or other person to whom	commise	ions or fees	were paid	
	(a) Name a	and address of the agent, bloker, t		501111133			

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

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

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

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

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

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

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

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

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

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

Page :	3
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Par				
	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier may	/ be treated	as a unit for purposes of
	this report.			
	rrent value of plan's interest under this contract in the general account at year		4	
<b>5</b> Cu	rrent value of plan's interest under this contract in separate accounts at year e	end	5	
<b>6</b> Co	ntracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
	Premiums due but unpaid at the end of the year		6C	
c d				
u	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
	Specify nature of costs		LI	
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
4	If contract purchased, in whole or in part to distribute how fits from a torrel			
	If contract purchased, in whole or in part, to distribute benefits from a termi			
7 Co	ntracts With Unallocated Funds (Do not include portions of these contracts m			
а	Type of contract: (1) deposit administration (2) immedi	iate participation guarantee		
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year		7b	0
C	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits	7c(2)		
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account			
	(5) Other (specify below)	- /->		
	•			
	(6)Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	- (-)		
		- (0)		
	(3) Transferred to separate account	- (1)		
	(4) Other (specify below)	. 7e(4)		
	▶			
			70/5)	
	(5) Total deductions		7e(5)	0
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

P	art		Welfare Benefit Contract Informa If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ntracts cover individual	,
8	Ben	efit an	d contract type (check all applicable boxes)						
	a	Hea	alth (other than dental or vision)	<b>b</b> Dental	С	Vision		d Life insurance	
	еĪ	Ter	nporary disability (accident and sickness)	f Long-term disabili	ty <b>q</b>	Supplemental unem	ployment	<b>h</b> Prescription drug	
	i [		p loss (large deductible)	j X HMO contract		PPO contract		I Indemnity contract	
	• L				ĸ				
	m	Otr	er (specify)						
a	Evn	riona	e-rated contracts:						
3			ums: (1) Amount received		9a(1)			-	
	u		crease (decrease) in amount due but unpaid					-	
		. ,	crease (decrease) in unearned premium res		9a(3)				
		• •	arned ((1) + (2) - (3))				9a(4)		(
	b	• •	fit charges (1) Claims paid						
		(2) In	crease (decrease) in claim reserves		9b(2)				
		(3) In	curred claims (add (1) and (2))				9b(3)		(
		(4) Cl	aims charged				9b(4)		
	С	Rem	ainder of premium: (1) Retention charges (o	n an accrual basis)					
		(/	A) Commissions		9c(1)(A)				
		(E	3) Administrative service or other fees		9c(1)(B)				
		(0	C) Other specific acquisition costs		9c(1)(C)			_	
		])	D) Other expenses		9c(1)(D)			_	
		`	E) Taxes		9c(1)(E)			4	
		•	F) Charges for risks or other contingencies.		a (1)(a)			_	
			G) Other retention charges		•				
		`	H) Total retention	_			9c(1)(H)		(
			ividends or retroactive rate refunds. (These				9c(2)		
	d		s of policyholder reserves at end of year: (1				9d(1)		
		. ,	laim reserves				9d(2)		
	_	( )	ther reserves				9d(3)		
40			ends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)	9e		
10	-	•	rience-rated contracts:				40-		
	a		premiums or subscription charges paid to c				10a	307	70686
	b		carrier, service, or other organization incurr				10b		

Specify nature of costs.

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

SCHEDULE		Insuran	ce Information	า		ОМ	IB No. 1210-0110
(Form 5500 Department of the Trea Internal Revenue Serv	sury	This schedule is required to be filed under section 104 of the <b>2020</b>					
Internal Revenue Service     Employee Retirement Income Security Act of 1974 (ERISA).       Department of Labor     File as an attachment to Form 5500.					_		
Pension Benefit Guaranty Co		Insurance companies		he informa	tion		m is Open to Public Inspection
For calendar plan year 20	For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020					31/2020	
A Name of plan NOKIA MEDICAL EXPENSE PLAN FOR MANAGEMENT EMPLOYEES					e-digit 1 number (P	N) 🕨	502
C Plan sponsor's name a NOKIA OF AMERICA CO			oyer Identific 3408857	cation Number (	(EIN)		
		ning Insurance Contrac					
1 Coverage Information:							
(a) Name of insurance ca HORIZON BCBS OF NJ	arrier	1			Ι	Deliau en e	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a	t end of	(f)	From	ontract year (g) To
22-0999690	55069	77087	policy or contract	,	01/01/202	0	12/31/2020
2 Insurance fee and com descending order of the		I ation. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in
U	amount of comr	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker	r, or other person to whor	m commiss	sions or fees	s were paid	
(b) Amount of sales a	nd base		es and other commission				-
commissions paid (c) Amount			(d) Purpose			(e) Organization code	
	(a) Name a	nd address of the agent, broker	r, or other person to whor	m commiss	sions or fees	s were paid	
							1
(b) Amount of color of	ndhaaa	Fe	es and other commission	ns paid			1

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
For Paparwork Poduction Act Notice	Schodulo A (Earm 5500) 2020			

Schedule A (Form 5500) 2020 v. 200204

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

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

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

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

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

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

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

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

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

Page :	3
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Par				
	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier may	/ be treated	as a unit for purposes of
	this report.			
	rrent value of plan's interest under this contract in the general account at year		4	
<b>5</b> Cu	rrent value of plan's interest under this contract in separate accounts at year e	end	5	
<b>6</b> Co	ntracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
	Premiums due but unpaid at the end of the year		6C	
c d				
u	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
	Specify nature of costs		LI	
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
4	If contract purchased, in whole or in part to distribute how fits from a torrel			
	If contract purchased, in whole or in part, to distribute benefits from a termi			
7 Co	ntracts With Unallocated Funds (Do not include portions of these contracts m			
а	Type of contract: (1) deposit administration (2) immedi	iate participation guarantee		
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year		7b	0
C	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits	7c(2)		
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account			
	(5) Other (specify below)	- /->		
	•			
	(6)Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	- (-)		
		- (0)		
	(3) Transferred to separate account	- (1)		
	(4) Other (specify below)	. 7e(4)		
	▶			
			70/5)	
	(5) Total deductions		7e(5)	0
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

F	Part III Welfare Benefit Contract Information									
		If more than one contract covers the same g the information may be combined for reportir								
		employees, the entire group of such individu								
8	Ben	Benefit and contract type (check all applicable boxes)								
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision	(	<b>d</b> Life insurance			
	e	Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unem	ployment I	h Prescription drug			
	i	Stop loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity contract			
	m	Other (specify)			<u>i</u>					
	[									
9	Expe	erience-rated contracts:								
	а	Premiums: (1) Amount received		9a(1)						
		(2) Increase (decrease) in amount due but unpaid		9a(2)						
		(3) Increase (decrease) in unearned premium rese	erve	9a(3)						
		(4) Earned ((1) + (2) - (3))	······			9a(4)		0		
	b	Benefit charges (1) Claims paid		9b(1)						
		(2) Increase (decrease) in claim reserves		9b(2)						
		(3) Incurred claims (add (1) and (2))				9b(3)		0		
		(4) Claims charged				9b(4)				
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)							
		(A) Commissions		9c(1)(A)			_			
		(B) Administrative service or other fees		9c(1)(B)						
		(C) Other specific acquisition costs		9c(1)(C)						
		(D) Other expenses		9c(1)(D)						
		(E) Taxes		9c(1)(E)			_			
		(F) Charges for risks or other contingencies		9c(1)(F)			_			
		(G) Other retention charges		9c(1)(G)		1				
		(H) Total retention				9c(1)(H)		0		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in a	cash, or	credited.)	9c(2)				
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide b	enefits after	retirement	9d(1)				
		(2) Claim reserves				9d(2)				
		(3) Other reserves				9d(3)				
	е	Dividends or retroactive rate refunds due. (Do not	t include amount entered	in line <b>9c(2)</b> .	.)	9e				
1(	) No	onexperience-rated contracts:				r				
	а	Total premiums or subscription charges paid to ca	arrier			10a	116	909		
	b	If the carrier, service, or other organization incurre								
	Spe	retention of the contract or policy, other than reported in Part I, line 2 above, report amount								

Part IV	Provision of Information			
1 Did the	nsurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

12 If the answer to line 11 is "Yes," specify the information not provided.

	•			_			
SCHEDULE (Form 5500		Insuranc	e Informatior	ו		OM	B No. 1210-0110
Department of the Treas Internal Revenue Servi	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2020
Department of Labor Employee Benefits Security Adr		File as an at	tachment to Form 55	00.			
Pension Benefit Guaranty Co	orporation	<ul> <li>Insurance companies ar pursuant to El</li> </ul>	re required to provide tl RISA section 103(a)(2)		ion		m is Open to Public Inspection
For calendar plan year 202	20 or fiscal plar	year beginning 01/01/2020		and en	ding 12/3	1/2020	1
A Name of plan NOKIA MEDICAL EXPEN	SE PLAN FOR	MANAGEMENT EMPLOYEES			e-digit number (Pl	N) 🕨	502
C Plan sponsor's name a NOKIA OF AMERICA COI		•	oyer Identific 3408857	ation Number (	(EIN)		
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE		FHI					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	<ul> <li>(e) Approximate nu persons covered at</li> </ul>			Policy or contract year	
	code	identification number	policy or contract		(f)	From	<b>(g)</b> To
94-1340523	60053	639	0		01/01/202	0	12/31/2020
2 Insurance fee and comi descending order of the		ation. Enter the total fees and tota	l commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in
<b>(a)</b> Total a	amount of comr	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	<b>(a)</b> Name a	nd address of the agent, broker, o	or other person to whor	n commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fees	s and other commissior	ns paid			_
commissions paid		(c) Amount		(d) Purpos	e		(e) Organization code
	(a) Name a	nd address of the agent, broker, o	or other person to whor	n commiss	ions or fees	were paid	
		na address of the agent, bloker, t					

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
Fan Dan annual Daduation Ast Matia			L

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

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

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

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

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

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

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

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

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

Page :	3
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Par				
	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier may	/ be treated	as a unit for purposes of
	this report.			
	rrent value of plan's interest under this contract in the general account at year		4	
<b>5</b> Cu	rrent value of plan's interest under this contract in separate accounts at year e	end	5	
<b>6</b> Co	ntracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
	Premiums due but unpaid at the end of the year		6C	
c d				
u	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
	Specify nature of costs		LI	
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
4	If contract purchased, in whole or in part to distribute how fits from a torrel			
	If contract purchased, in whole or in part, to distribute benefits from a termi			
7 Co	ntracts With Unallocated Funds (Do not include portions of these contracts m			
а	Type of contract: (1) deposit administration (2) immedi	iate participation guarantee		
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year		7b	0
C	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits	7c(2)		
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account			
	(5) Other (specify below)	- /->		
	•			
	(6)Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	- (-)		
		- (0)		
	(3) Transferred to separate account	- (1)		
	(4) Other (specify below)	. 7e(4)		
	▶			
			70/5)	
	(5) Total deductions		7e(5)	0
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

F	Part	111	Welfare Benefit Contract Informa If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are exp	perience-rated as a uni	t. Where co	ontracts cover individual	
8	Ben	efit ar	nd contract type (check all applicable boxes)						
	а	He	alth (other than dental or vision)	<b>b</b> Dental	c	Vision		<b>d</b> Life insurance	
	еĪ	Te	mporary disability (accident and sickness)	f Long-term disabili	tv <b>a</b>	Supplemental unem	plovment	<b>h</b> Prescription drug	
	i		pp loss (large deductible)	j X HMO contract		PPO contract		I Indemnity contract	
	m		her (specify)	<b>,</b>	[				
	I								
9	Expe	erienc	ce-rated contracts:						
	а	Premi	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	l	9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	arned ( <b>(1) + (2) - (3)</b> )				. 9a(4)		(
	b	Bene	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)		1		
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)	_	(
		(4) C	laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis)		•			
		(	(A) Commissions		9c(1)(A)			_	
		(	(B) Administrative service or other fees		9c(1)(B)				
		(	(C) Other specific acquisition costs		9c(1)(C)				
		(	(D) Other expenses		9c(1)(D)				
		(	(E) Taxes		9c(1)(E)				
		(	(F) Charges for risks or other contingencies .		9c(1)(F)				
		(	(G) Other retention charges		9c(1)(G)		T		
		(	(H) Total retention				9c(1)(H	)	(
		(2) E	Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)		
	d	State	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits afte	r retirement	9d(1)		
		(2) C	Claim reserves				9d(2)		
		(3) (	Other reserves				9d(3)		
	е	Divid	dends or retroactive rate refunds due. (Do not	ot include amount entered	d in line <b>9c(2</b>	<b>)</b> .)	9e		
10	No	onexp	erience-rated contracts:						
	а	Tota	I premiums or subscription charges paid to c	arrier			10a	2	025
	b	If the	e carrier, service, or other organization incurr	ed any specific costs in c	onnection w	ith the acquisition or			
	Spe	reter	ntion of the contract or policy, other than report ature of costs.	, ,			10b		

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

12 If the answer to line 11 is "Yes," specify the information not provided.

**Provision of Information** 

Part IV

SCHEDUL	EA	Insuranc	e Informatior	ו		OM	1B No. 1210-0110
(Form 55) Department of the Tr Internal Revenue S	easury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2020		
Department of Labor			tachment to Form 550		,		
	Employee Benefite Geodity Administration			This For	m is Open to Public Inspection		
For calendar plan year	2020 or fiscal pla	n year beginning 01/01/2020		and en	ding 12/3	1/2020	
A Name of plan NOKIA MEDICAL EXPL	ENSE PLAN FOF	R MANAGEMENT EMPLOYEES	·		e-digit number (Pl	N) 🕨	502
C Plan sponsor's name NOKIA OF AMERICA C		e 2a of Form 5500			oyer Identific 3408857	cation Number	(EIN)
	arate Schedule A	rning Insurance Contract A. Individual contracts grouped as					
(a) Name of insurance KAISER FOUNDATION		OF WA	(e) Approximate nu			Policy or c	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To
91-0511770	95672	8800	14		01/01/202	0	12/31/2020
2 Insurance fee and co descending order of t		ation. Enter the total fees and tota	l commissions paid. Li	st in line 3	the agents,	brokers, and o	other persons in
	al amount of com	missions paid		<b>(b)</b> To	otal amount	of fees paid	
3							
3 Persons receiving co		ees. (Complete as many entries a and address of the agent, broker, o			ions or fees	were paid	
(b) Amount of sales	and base		s and other commissior				_
commissions	baid	(c) Amount		( <b>d)</b> Purpos	e		(e) Organization code
	<b>(a)</b> Name a	and address of the agent, broker, o	or other person to whor	n commiss	ions or fees	were paid	

F	ees and other commissions paid	
(c) Amount	(d) Purpose	(e) Organization code
		Fees and other commissions paid         (c) Amount       (d) Purpose

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

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

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

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

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

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

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

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

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

Page :	3
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Par				
	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier may	/ be treated	as a unit for purposes of
	this report.			
	rrent value of plan's interest under this contract in the general account at year		4	
<b>5</b> Cu	rrent value of plan's interest under this contract in separate accounts at year e	end	5	
<b>6</b> Co	ntracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
	Premiums due but unpaid at the end of the year		6C	
c d				
u	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
	Specify nature of costs		LI	
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
4	If contract purchased, in whole or in part to distribute how fits from a torrel			
	If contract purchased, in whole or in part, to distribute benefits from a termi			
7 Co	ntracts With Unallocated Funds (Do not include portions of these contracts m			
а	Type of contract: (1) deposit administration (2) immedi	iate participation guarantee		
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year		7b	0
C	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits	7c(2)		
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account			
	(5) Other (specify below)	- /->		
	•			
	(6)Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	Deductions:			
-	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	- (-)		
		- (0)		
	(3) Transferred to separate account	- (1)		
	(4) Other (specify below)	. 7e(4)		
	▶			
			70/5)	
	(5) Total deductions		7e(5)	0
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Specify nature of costs.

P	art	111	Welfare Benefit Contract Informa If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employed	ich contracts are ex	perience-rated	as a unit. Wh	ere contra	acts cover individual	s),
8	Ben	efit ar	nd contract type (check all applicable boxes)							
	a	He	alth (other than dental or vision)	<b>b</b> Dental	С	Vision		d	Life insurance	
	e	Те	mporary disability (accident and sickness)	f Long-term	disability g	Supplement	al unemploym	ient <b>h</b>	Prescription drug	
	iΪ	Sto	op loss (large deductible)	j 🛛 HMO contr		PPO contrac		1	Indemnity contrac	t
	m		her (specify)	, []				L		
9	Expe	erienc	e-rated contracts:							
	a	Premi	iums: (1) Amount received							
		(2) In	ncrease (decrease) in amount due but unpaid	1						
		(3) In	ncrease (decrease) in unearned premium res	erve						
		(4) E	arned ((1) + (2) - (3))					a(4)		0
	b		efit charges (1) Claims paid							
		(2) In	ncrease (decrease) in claim reserves							
		(3) In	ncurred claims (add (1) and (2))				9	b(3)		0
		(4) C	laims charged				9	b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis	s)					
		(	(A) Commissions							
		(	(B) Administrative service or other fees							
		(	(C) Other specific acquisition costs							
		(	(D) Other expenses							
		(	(E) Taxes							
			(F) Charges for risks or other contingencies .							
		(	(G) Other retention charges		9c(1)(G)					
		```	(H) Total retention		_	-		(1)(H)		0
		(2) C	Dividends or retroactive rate refunds. (These	amounts were	paid in cash, or	credited.)		c(2)		
	d	Statu	us of policyholder reserves at end of year: (1) Amount held to	provide benefits aft	er retirement		d(1)		
		(2) C	Claim reserves					d(2)		
		(3) C	Other reserves					d(3)		
	е	Divic	dends or retroactive rate refunds due. (Do not	ot include amount	entered in line 9c(2) .)		9e		
10) No	nexpe	erience-rated contracts:							
	а	Tota	I premiums or subscription charges paid to c	arrier			·	10a		80169
	b		e carrier, service, or other organization incurrent					10b		

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

SCHEDULE A		Insurance Information			ON	/B No. 1210-0110	
(Form 5500 Department of the Treas Internal Revenue Serv	sury	This schedule is required Employee Retirement Inc					2020
Department of Labo Employee Benefits Security Ad		File as an at	tachment to Form 55	00.			
Pension Benefit Guaranty Co	orporation	 Insurance companies an pursuant to El 	re required to provide t RISA section 103(a)(2)		tion	This For	rm is Open to Public Inspection
For calendar plan year 20	20 or fiscal pla	n year beginning 01/01/2020		and er	nding 12/3	1/2020	1
A Name of plan NOKIA MEDICAL EXPEN					e-digit number (Pl	N) 🕨	502
				_			
C Plan sponsor's name a NOKIA OF AMERICA CO		e 2a of Form 5500		•	oyer Identific 3408857	ation Number	(EIN)
		ning Insurance Contract					
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE	EALTH PLAN N	1	(e) Approximate nu	imber of		Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac	t end of	(f)	From	(g) To
93-0798039	95540	8384	0		01/01/2020	0	12/31/2020
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. Li	ist in line 3	the agents,	brokers, and c	other persons in
	amount of com	missions paid	(b) Total amount of fees paid				
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	and address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	Fees	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
	(a) Name a	and address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Denemyork Deduction Act Nation, and the Instructions for Form FEOD			Jula A (Farma EE00) 2020

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

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

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

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

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

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

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

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

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

Page :	3
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Pa	art II Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indi	ividual contracts with each carrier may	/ be treated a	as a unit for purposes of
4 0	this report. Current value of plan's interest under this contract in the general account at yea	r end	4	
	Current value of plan's interest under this contract in the general account at year		5	
-	Contracts With Allocated Funds:		•	
	a State the basis of premium rates			
k	b Premiums paid to carrier		6b	
C	C Premiums due but unpaid at the end of the year		6c	
C	d If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	6d	
	Specify nature of costs			
e	e Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
	f If contract purchased, in whole or in part, to distribute benefits from a term	inating plan, check here		
7 C	Contracts With Unallocated Funds (Do not include portions of these contracts m	naintained in separate accounts)		
a	a Type of contract: (1) deposit administration (2) immed	liate participation guarantee		
	(3) guaranteed investment (4) other	•		
k	b Balance at the end of the previous year		7b	0
	C Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits	7.(0)		
	(3) Interest credited during the year	- (-)		
	(4) Transferred from separate account	. 7c(4)		
	(5) Other (specify below)	. 7c(5)		
	▶			
	(6)Total additions		7c(6)	0
	d Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	e Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(3) Transferred to separate account			
	(4) Other (specify below)	. 7e(4)		
	▶			
	(5) Total deductions		7e(5)	0
·	f Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

P	art	lf th	Velfare Benefit Contract Information more than one contract covers the same is information may be combined for report mployees, the entire group of such individ	group of employees of th ing purposes if such cor	tracts are exp	erience-rated as a uni	t. Where co	ntracts cover individual	1
8	Ben	efit and	contract type (check all applicable boxes)						
	a	Healt	h (other than dental or vision)	b Dental	c	Vision		d Life insurance	
	еĪ	Temp	orary disability (accident and sickness)	f Long-term disabi	lity q	Supplemental unem	ployment	h Prescription drug	
	i [loss (large deductible)	j X HMO contract		PPO contract		I Indemnity contract	
	• L				ĸ				
	m	Othe	r (specify)						
0	Evn	rionco	rated contracts:						
3			ns: (1) Amount received		9a(1)			-	
	u		ease (decrease) in amount due but unpaid					-	
		. ,	ease (decrease) in unearned premium res					-	
		• •	ned ((1) + (2) - (3))				9a(4)		(
	b	``	charges (1) Claims paid						
			ease (decrease) in claim reserves						
		(3) Incu	rred claims (add (1) and (2))				9b(3)		(
		(4) Clai	ms charged				9b(4)		
	С	Remai	nder of premium: (1) Retention charges (o	n an accrual basis)					
		(A)	Commissions		9c(1)(A)				
		(B)	Administrative service or other fees						
		(C)	Other specific acquisition costs		-				
		(D)	Other expenses		9c(1)(D)				
		(E)	Taxes					_	
		. ,	Charges for risks or other contingencies .		a (1)(a)			4	
		. ,	Other retention charges						
		()	Total retention				9c(1)(H)		(
	_		dends or retroactive rate refunds. (These				9c(2)		
	d		of policyholder reserves at end of year: (1				9d(1)		
		. ,	m reserves				9d(2)		
	_	()	er reserves				9d(3)		
40			nds or retroactive rate refunds due. (Do no	ot include amount entere	ed in line 9c(2)	.)	9e		
10	_	•	ence-rated contracts:				40-		
	a		remiums or subscription charges paid to c				10a		4767
	b		arrier, service, or other organization incurr on of the contract or policy, other than repo				10b		

Specify nature of costs.

Part IV Pro	vision of Information			
11 Did the insura	ce company fail to provide any information necessary to complete Schedule A?	Yes	× No	
12 If the answer	line 11 is "Yes," specify the information not provided.			