## Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2021

Part I	Annual Report Id	entification Information					
For caler	ndar plan year 2021 or fisc	al plan year beginning 01/01/2021		and ending 12/31/2021			
A This	return/report is for:	a multiemployer plan	ш .	loyer plan (Filers checking this b mployer information in accordan			ns.)
		X a single-employer plan	a DFE (specify				,
R This	return/report is:	the first return/report	the final return	· <del></del>			
<b>D</b> Inist	eturn/report is.	an amended return/report	<b>=</b>	ar return/report (less than 12 mo	onthe)		
C If the	nlan is a collectively-hards	ined plan, check here					
• II tile	plair is a collectively-barge				ᆜ		
<b>D</b> Chec	k box if filing under:	X Form 5558	automatic exte	nsion	the I	DFVC program	
		special extension (enter description	n)				
E If this	is a retroactively adopted	plan permitted by SECURE Act section	201, check here				
Part II	Basic Plan Inform	nation—enter all requested informatio	n				
1a Nam	ne of plan					Three-digit plan	502
NOKIA	MEDICAL EXPENSE PLA	AN FOR MANAGEMENT EMPLOYEES				number (PN) ▶ Effective date of pla	
						10/01/1996	ш 
		er, if for a single-employer plan)				Employer Identifica	ition
		apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code	(if foreign see instr	uctions)		Number (EIN) 22-3408857	
•	OF AMERICA CORPORATION	· · · · · · · · · · · · · · · · · · ·	(ii foreign, occ mour	aotiono)	2c Plan Sponsor's telephone		
						number	prioric
						908-723-9869	
	OUNTAIN AVENUE, ROOM	16D-401A			2d Business code (see instructions)		
MURRA	AY HILL, NJ 07974					334200	
Caution	A nonalty for the late or	incomplete filing of this return/repor	t will be assessed i	unloss roasonable cause is es	tablich	and	
	-	incomplete filing of this return/repore penalties set forth in the instructions, I					dules
statemer	nts and attachments, as we	ell as the electronic version of this return	report, and to the b	est of my knowledge and belief,	it is true	e, correct, and con	iplete.
SIGN	Filed with authorized/valid	l electronic signature.	07/23/2022	INGRID ORAV			
HERE	Signature of plan admir	nistrator	Date	Enter name of individual signing as plan administrator			
SIGN							
HERE	Signature of employer/	olan sponsor	Date	Enter name of individual signi	ng as ei	mployer or plan sp	onsor
SIGN							
HERE	Signature of DEE		Date	Enter name of individual signi	na as D	FF	

Form 5500 (2021) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **4d** PN а Sponsor's name Plan Name 5 Total number of participants at the beginning of the plan year 7305 5 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 7260 a(1) Total number of active participants at the beginning of the plan year...... 6a(1) 7000 a(2) Total number of active participants at the end of the plan year ...... 6a(2)33 6b **b** Retired or separated participants receiving benefits....... 0 Other retired or separated participants entitled to future benefits ...... 6c 7033 Subtotal. Add lines 6a(2), 6b, and 6c. 6d Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item) ..... h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .. 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) ...... 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: **4A** Plan funding arrangement (check all that apply) **9b** Plan benefit arrangement (check all that apply) (1)Insurance (1) Insurance (2) Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts (3) Trust (3) Trust

(4)

(1) (2)

(3)

(4)

(5)

(6)

**b** General Schedules

X

Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

General assets of the sponsor

**H** (Financial Information)

7 A (Insurance Information)

I (Financial Information - Small Plan)

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

G (Financial Transaction Schedules)

(4)

(1)

(2)

(3)

a Pension Schedules

actuary

General assets of the sponsor

R (Retirement Plan Information)

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

Form 5500 (2021) 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 2021 Form M-1 annual report. If the plan was not required to file the 2021 Form M-1 annual report, enter 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	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

This Form is Open to Public

		parodantio					inspection
For calendar plan year 202	21 or fiscal plar	n year beginning 01/01/2021		and en	ding 12/31/202	1	
A Name of plan			В	Three	e-digit		
NOKIA MEDICAL EXPEN	NSE PLAN FOR	R MANAGEMENT EMPLOYEES	8	plan	number (PN)	•	502
				'	` '		
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500	D	Emplo	yer Identification I	Number	(EIN)
NOKIA OF AMERICA CO	RPORATION			22-	3408857		
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage, Fees, and	d Con	nmissions Prov	vide info	ormation for each contract
		. Individual contracts grouped a					
1 Coverage Information:							
- Covorago information.							
(a) Name of insurance ca	rrier						
KAISER FOUNDATION HE	EALTH PLAN (	DES CA					
TO HOLIN TO GOT DATE OF THE		5. G. G. C.					
	(c) NAIC	(d) Contract or	(e) Approximate numb	er of	Po	olicy or c	contract year
<b>(b)</b> EIN	code	identification number	persons covered at en		(f) From		<b>(g)</b> To
			policy or contract year	ar	(7)		(3)
94-1340523	00000	122636	11		01/01/2021		12/31/2021
							<u>-</u>
		ation. Enter the total fees and to	tal commissions paid. List ir	n line 3	the agents, broke	rs, and o	other persons in
descending order of the	amount paid.						
(a) Total a	amount of comi	missions paid		<b>(b)</b> To	otal amount of fees	s paid	
2 Damana massining sam		(Computato de montro					
3 Persons receiving com		ees. (Complete as many entries					
	(a) Name a	and address of the agent, broker	r, or other person to whom co	ommiss	ions or fees were	paid	
	<u> </u>						1
(b) Amount of sales ar	nd base	Fe	es and other commissions p	aid			
commissions pai	id	(c) Amount	(d)	Purpose	9		(e) Organization code
	(a) Name a	and address of the agent, broker	, or other person to whom co	ommiss	ions or fees were	paid	
(b) Amount of sales ar	nd base	Fe	es and other commissions p	aid			
commissions pai		(c) Amount	(d) I	Purpose	9		(e) Organization code
- Jr			\ /				

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the state of t	46
		Where individual contracts are provided, the entire group of such individual this report.	iqual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the provious year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pa	Welfare Benefit Contract Informatio If more than one contract covers the same grou the information may be combined for reporting p employees, the entire group of such individual of	p of employees of the ourposes if such cont	racts are	expe	erience-rated as a uni	t. Where co	ntracts cover indi	tions(s), vidual
8	Benefit and contract type (check all applicable boxes)	<u></u>					_	
i	a Health (other than dental or vision)	Dental	(	c 🗌	Vision		<b>d</b> Life insurar	ice
	e ☐ Temporary disability (accident and sickness) f	Long-term disabili	ty 🧐	эΠ	Supplemental unem	ployment	<b>h</b> Prescription	n drug
	i Stop loss (large deductible)	X HMO contract		kΠ	PPO contract		I  Indemnity c	ontract
	m ☐ Other (specify)			ш			,,	
	III Other (specify)							
9 F	Experience-rated contracts:							
	a Premiums: (1) Amount received		9a(1)				_	
	(2) Increase (decrease) in amount due but unpaid						_	
	(3) Increase (decrease) in unearned premium reserve		<del>``</del>					
	(4) Earned ((1) + (2) - (3))					. 9a(4)		0
	<b>b</b> Benefit charges (1) Claims paid							
	(2) Increase (decrease) in claim reserves		9b(2)					
	(3) Incurred claims (add (1) and (2))					9b(3)		0
	(4) Claims charged					9b(4)		
	c Remainder of premium: (1) Retention charges (on an	accrual basis)						
	(A) Commissions		9c(1)(A	١)				
	(B) Administrative service or other fees		9c(1)(E					
	(C) Other specific acquisition costs		9c(1)(C					
	(D) Other expenses		9c(1)(E	-				
	(E) Taxes		9c(1)(E	_			_	
	(F) Charges for risks or other contingencies		0 (4)(6				_	
	(G) Other retention charges					0 (4)(1)		
	(H) Total retention	_		_		9c(1)(H)		0
	(2) Dividends or retroactive rate refunds. (These ame	_		_		9c(2)		
	<b>d</b> Status of policyholder reserves at end of year: (1) An	•				9d(1)		
	(2) Claim reserves					9d(2)		
	(3) Other reserves					9d(3)		
40	e Dividends or retroactive rate refunds due. (Do not in	clude amount entered	d in line 90	c(2).	)	9e		
10	Nonexperience-rated contracts:					40-		75000
	<b>a</b> Total premiums or subscription charges paid to carrie					10a		75960
	<b>b</b> If the carrier, service, or other organization incurred a					10b		
;	retention of the contract or policy, other than reported Specify nature of costs.	in Part I, line 2 abov	e, report a	amo	unt	100	<u> </u>	
Pa	art IV Provision of Information							
11	Did the insurance company fail to provide any informatio	n necessary to comp	lete Sched	dule	A?	Yes	X No	
12	If the answer to line 11 is "Yes," specify the information r	not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

			pursuant to	ENISA SECTION 103(a)(2)	).			Inspection
For calendar pla	an year 202	21 or fiscal pla	an year beginning 01/01/2021		and en	iding 12/31/202	1	
A Name of plan NOKIA MEDIC		ISE PLAN FO	OR MANAGEMENT EMPLOYEE	:S		e-digit number (PN)	•	502
C Plan sponso	r's name a	s shown on li	ne 2a of Form 5500		<b>D</b> Emplo	yer Identification	Number	(EIN)
NOKIA OF AMI	NOKIA OF AMERICA CORPORATION							
			erning Insurance Contra A. Individual contracts grouped					
1 Coverage Inf	formation:							
(a) Name of ins			OF CO					
<i>a</i> > = 0		(c) NAIC	(d) Contract or	(e) Approximate n		Po	olicy or co	ontract year
<b>(b)</b> EIN	N	code	identification number	persons covered a policy or contract		(f) From	1	<b>(g)</b> To
84-0591617		95669	7368	8	•	01/01/2021		12/31/2021
2 Insurance fee descending o			nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, broke	rs, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees pa					s paid			
3 Persons rece	eiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were	paid	
(b) Amount	of sales an	nd base	F	ees and other commission	ns paid			
comm	issions pai	id	(c) Amount		(d) Purpos	e		(e) Organization code
		(a) Name	and address of the agent, broke	or other person to who	m commiss	ions or fees were	naid	
		(a) Name	and address of the agent, broke	or, or other person to who	iii commiss	ions of fees were	paiu	
(b) Amount	of sales an	nd base	F	ees and other commission	ns paid			
	issions pai		(c) Amount		(d) Purpos	е		(e) Organization code

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the state of t	46
		Where individual contracts are provided, the entire group of such individual this report.	iqual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the provious year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

P	art I	II	Welfare Benefit Contract Informa	ation					
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a un	it. Where co	ontracts cove	
8	Rene	əfit ər	nd contract type (check all applicable boxes)						-
	_	_		<b>b</b> Dental	۰	Vision		d ☐ Life in	ouronoo
	a [	_	alth (other than dental or vision)	<u> </u>	<u> </u>			=	surance
	e L	Те	mporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	ployment	h Preso	ription drug
	i L	Sto	op loss (large deductible)	j X HMO contract	k _	PPO contract		I Indem	nity contract
	m	Ot	her (specify)						
9 E	Ехре	erienc	e-rated contracts:						
	a F	rem	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 ((1) + (2) - (3))				9a(4)		0
	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)		0
		(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)		1		
		(	H) Total retention				9c(1)(H)	)	0
		(2) [	Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	credited.)	9c(2)		
	d	State	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) (	Claim reserves				9d(2)		
		(3) (	Other reserves				9d(3)		
	е	Divid	dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line <b>9c(2)</b>	.)	9e		
10	No	nexp	erience-rated contracts:						
	а	Tota	I premiums or subscription charges paid to c	arrier			10a		76733
	b	If the	e carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	h the acquisition or			
	_	reter	ntion of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	ount	10b		
	Spe	cify n	ature of costs.						
_		., [							
	rt I		Provision of Information						
11	Did	l the	insurance company fail to provide any inform	ation necessary to comp	lete Schedule	e A?	Yes	X No	
12	If th	ne an	swer to line 11 is "Yes," specify the informati	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

			pursuant to	LINION Section 105(a)(2)	•			Inspection
For calendar pl	an year 202	21 or fiscal pla	an year beginning 01/01/2021		and en	iding 12/31/202	1	
A Name of pla		ISE PLAN FO	OR MANAGEMENT EMPLOYEE	S		e-digit number (PN)	•	502
C Plan sponso	or's name a	s shown on li	ne 2a of Form 5500		<b>D</b> Emplo	yer Identification	Number (	(EIN)
NOKIA OF AM	NOKIA OF AMERICA CORPORATION							
			erning Insurance Contract  A. Individual contracts grouped					
1 Coverage In	formation:							
(a) Name of ins			OF MIDATLANTIC					
<i>a</i> > = 0		(c) NAIC	(d) Contract or	(e) Approximate no		Po	olicy or co	ontract year
(b) Elf	N	code	identification number	persons covered a policy or contract		(f) From	1	<b>(g)</b> To
52-0954463		95639	2204	4	•	01/01/2021		12/31/2021
		mission inforn amount paid.	nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, broke	rs, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid								
3 Persons rec	eiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were	paid	
(b) Amount	of sales ar	nd base	F	ees and other commissio	ns paid			
comm	nissions pai	d	(c) Amount		(d) Purpose	e		(e) Organization code
		(a) Name	and address of the agent, broke	or other person to who	m commiss	ions or fees were	naid	_
		(a) Name	and address of the agent, broke	., c. outor porson to who	00:11111133	01 1003 WGIE	Puiu	
(b) Amount	of sales ar	nd base	F	ees and other commissio	ns paid		-	
	nissions pai		(c) Amount		(d) Purpose	е		(e) Organization code

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Pa	art I	III Welfare Benefit Contract Informati If more than one contract covers the same grunder the information may be combined for reporting employees, the entire group of such individual	oup of employees of the purposes if such conf	tracts are	expe	erience-rated as a uni	it. Where co	ntracts cover ind	
8	Bone	nefit and contract type (check all applicable boxes)	Contracts with cach o	arrior rriay	00 (	reated as a arm for p	urposes or tr	по торот.	
	_		. □ Dontol		٦.	Vicion		d 🗆 Life inquire	
	a [		Dental Dental			Vision		<b>d</b> ∐ Life insura	
	е	Temporary disability (accident and sickness) <b>f</b>	Long-term disabili	ity (	g [_	Supplemental unem	ployment	h Prescription	n drug
	i	Stop loss (large deductible)	X HMO contract		k 📗	PPO contract		I Indemnity	contract
	m	Other (specify)							
9	Ехре	perience-rated contracts:							
	a F	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid			_				
		(3) Increase (decrease) in unearned premium reser							
	_	(4) Earned ((1) + (2) - (3))					. 9a(4)		0
	b	Benefit charges (1) Claims paid			_				
		(2) Increase (decrease) in claim reserves					21 (2)		
		(3) Incurred claims (add (1) and (2))					9b(3)		0
	_	(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on a		0-(4)//					
		(A) Commissions		9c(1)(A					
		(B) Administrative service or other fees		9c(1)(E	•				
		(C) Other specific acquisition costs(D) Other expenses		9c(1)(E	_				
		(E) Taxes		9c(1)(E	•				
		(F) Charges for risks or other contingencies		0 (4)/=					
		(G) Other retention charges		0 (4)(4					
		(H) Total retention					9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These a			_		9c(2)		
	d	Status of policyholder reserves at end of year: (1) A			_		9d(1)		
	_	(2) Claim reserves	•				9d(2)		
		(3) Other reserves					9d(3)		
	е						9e		
10	No	onexperience-rated contracts:			. ,	,			
	а	Total premiums or subscription charges paid to car	rier				10a		25186
	b	If the carrier, service, or other organization incurred	any specific costs in o	connection	with	n the acquisition or			
		retention of the contract or policy, other than report					10b		
	Spe	ecify nature of costs.							
_		Dr. Brestelen ett (							
	art I								
11	Dic	id the insurance company fail to provide any informat	on necessary to comp	lete Sche	dule	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information	not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

For calendar plan year 202	21 or fiscal pla	an year beginning 01/01/2021		and en	ding 12/31/2021				
A Name of plan				<b>B</b> Thre	e-digit				
NOKIA MEDICAL EXPEN	ISE PLAN FO	R MANAGEMENT EMPLOYEE	S	plan	number (PN)	<b>&gt;</b>	502		
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500		<b>D</b> Emplo	yer Identification Nu	mber (	EIN)		
NOKIA OF AMERICA CO	RPORATION			22-	3408857				
		rning Insurance Contra  A. Individual contracts grouped							
1 Coverage Information:					•				
(a) Name of insurance ca		05.04							
KAISER FOUNDATION HE	EALTH PLAN	OF GA							
	(c) NAIC	(d) Contract or	(e) Approximate n		Polic	cy or contract year			
<b>(b)</b> EIN	code	identification number		persons covered at end of policy or contract year			<b>(g)</b> To		
58-1592076	-1592076 96237 2081 5			01/01/2021		12/31/2021			
2 Insurance fee and coming descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers,	and ot	her persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid									
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).					
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were pa	iid			
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid					
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code		
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were pa	iid			
(b) Amount of sales ar	nd base	<u>F</u>	ees and other commission	ns paid					
commissions pai		(c) Amount			(e) Organization code				

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Pa	the information may be	ct covers the same combined for repor	ation group of employees of th ing purposes if such cont ual contracts with each c	tracts are exp	perience-rat	ed as a unit	. Where cor	ntracts cover in	zations(s), dividual
8	Benefit and contract type (check a	I applicable boxes)	_	_	_			_	
	a Health (other than dental or	vision)	<b>b</b> Dental	c [	Vision		(	<b>d</b> 🗌 Life insui	rance
	e Temporary disability (accide	ent and sickness)	f Long-term disabili	ity <b>g</b>	Supplem	ental unem	oloyment	<b>h</b> Prescript	ion drug
	i Stop loss (large deductible)		j X HMO contract	k [	PPO con	tract		I Indemnity	/ contract
	m ☐ Other (specify) ▶		, 🗀	L				ш .	
	The Cure (specify)								
9 E	Experience-rated contracts:								
	a Premiums: (1) Amount receive	d		9a(1)					
	(2) Increase (decrease) in am								
	(3) Increase (decrease) in une			<del>- : :</del>					
	(4) Earned ((1) + (2) - (3))	•					9a(4)		0
	<b>b</b> Benefit charges (1) Claims pa								
	(2) Increase (decrease) in clai	m reserves		9b(2)					
	(3) Incurred claims (add (1) ar	nd <b>(2)</b> )					9b(3)		0
	(4) Claims charged						9b(4)		
	<b>c</b> Remainder of premium: (1) R	etention charges (c	n an accrual basis)						
	(A) Commissions			9c(1)(A)					
	(B) Administrative service			9c(1)(B)					
	(C) Other specific acquisi-			9c(1)(C)				_	
	(D) Other expenses			9c(1)(D)					
	(E) Taxes			9c(1)(E)					
	(F) Charges for risks or of	· ·		2 (4)(2)					
	(G) Other retention charge						0a/4\/LI\		0
	(H) Total retention			_			9c(1)(H)		0
	(2) Dividends or retroactive ra						9c(2)		
	<b>d</b> Status of policyholder reserve	• ,	•				9d(1)		
	(2) Claim reserves						9d(2)		
	(3) Other reserves						9d(3)		
10	<ul><li>e Dividends or retroactive rate</li><li>Nonexperience-rated contracts:</li></ul>	elulius due. (Do li	ot include amount entere		<i>]</i> .)		9e		
	<ul> <li>a Total premiums or subscription</li> </ul>	n charges paid to	earrier				10a		32614
	<u>.</u>	• .					100		32014
	<b>b</b> If the carrier, service, or other retention of the contract or po						10b		
	Specify nature of costs.	-,,	, , ,	-, -, -					
Pa	art IV Provision of Info	mation							
11	Did the insurance company fail to	provide any inform	nation necessary to comp	lete Schedul	e A?		Yes	X No	
12	If the answer to line 11 is "Yes," s	specify the informat	ion not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

This Form is Open to Public

For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021			and en	ding 12/31/2021			
A Name of plan					<b>B</b> Three	e-digit			
NOKIA MEDICAL EXPEN	ISE PLAN FO	R MANAGEMENT EMPLOYEE	ES		plan	number (PN)	•	502	
C Plan sponsor's name a	s shown on lin	ne 2a of Form 5500			D Employer Identification Number (EIN)				
NOKIA OF AMERICA CO		10 Zu 01 1 01111 0000		22-3408857					
		rning Insurance Contra  A. Individual contracts grouped							
1 Coverage Information:									
(a) Name of insurance ca	rrier								
KAISER FOUNDATION HE	EALTH PLAN	OF N.CA							
(c) NAIC (d) Contract or (e) Approximate number of Policy or contract ye									
<b>(b)</b> EIN	code	identification number		persons covered at policy or contract y		(f) From		<b>(g)</b> To	
94-1340523 00000 35147				458		01/01/2021		12/31/2021	
2 Insurance fee and come descending order of the		ation. Enter the total fees and t	total c	commissions paid. Lis	t in line 3	the agents, brokers	, and ot	her persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid									
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as	needed to report all pe	ersons).				
<u> </u>		and address of the agent, broke				ions or fees were pa	aid		
		-		•					
		F		and other commissions	s naid				
(b) Amount of sales ar commissions pai		(c) Amount	000 0	(d) Purpose				(e) Organization code	
		(2)		,	, , , , , , ,	-		(1)	
	(a) Name a	and address of the agent, broke	er, or	other person to whom	commiss	ions or fees were pa	aid		
	, ,	•		•		<u>.</u>			
			000	and other commissions	naid				
(b) Amount of sales ar commissions pai		(c) Amount	662 6		d) Purpose	2		(e) Organization code	
commissions par	<u> </u>	(O) / infount		(0	a, i dipost	<u> </u>		(S) Organization code	

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Б	art III	Welfare Benefit Contract Informa	ation				
Г	art III	If more than one contract covers the same the information may be combined for report	group of employees of the ing purposes if such cont	racts are e	xperience-rated as	a unit. Where	contracts cover individual
_	D ("	employees, the entire group of such individ	uai contracts with each ca	aniei may i	De treateu as a uriit	ioi puiposes o	i tilis report.
8	_	t and contract type (check all applicable boxes)	. —				
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Supplemental	unemployment	<b>h</b> Prescription drug
	i 🗌	Stop loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Experie	ence-rated contracts:					
	<b>a</b> Pre	emiums: (1) Amount received		9a(1)			
	(2	) Increase (decrease) in amount due but unpaid	d	9a(2)			
	(3	) Increase (decrease) in unearned premium res	serve	9a(3)			
	(4	) Earned ( <b>(1)</b> + <b>(2)</b> - <b>(3)</b> )				9a(4)	0
	<b>b</b> B	enefit charges (1) Claims paid		9b(1)			
	(2	) Increase (decrease) in claim reserves		9b(2)			
	(3	) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	0
	(4	) Claims charged				9b(4)	)
	C R	emainder of premium: (1) Retention charges (c	n an accrual basis)				
		(A) Commissions		9c(1)(A)	)		
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)	)		
		(E) Taxes		9c(1)(E)	)		
		(F) Charges for risks or other contingencies .		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)	)		
		(H) Total retention				9c(1)(I	H) 0
	(2	2) Dividends or retroactive rate refunds. (These	amounts were paid ir	cash, or	credited.)		
		tatus of policyholder reserves at end of year: (1	_	_			
		2) Claim reserves	•				
	`	B) Other reserves					
	`	ividends or retroactive rate refunds due. (Do n					,
10		experience-rated contracts:			. , ,		
	<b>а</b> т	otal premiums or subscription charges paid to c	arrier			10a	3026958
		the carrier, service, or other organization incur				-	
		etention of the contract or policy, other than rep					
		y nature of costs.					
D	art IV	Provision of Information					
						П Усс	V No
		ne insurance company fail to provide any inform		lete Schedi	ule A?	Yes	X No
12	If the	answer to line 11 is "Yes," specify the informat	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

			pursuant to	אם כ	15A section $103(a)(2)$				Inspection	
For calendar plan	n year 202	21 or fiscal pla	n year beginning 01/01/2021			and en	ding 12/3	31/2021		
A Name of plan	ı					<b>B</b> Three	e-digit			
NOKIA MEDICA	AL EXPEN	SE PLAN FO	R MANAGEMENT EMPLOYEE	S		plan	number (PI	N) •	502	
C Plan sponsor's	's name as	s shown on lin	e 2a of Form 5500			<b>D</b> Employer Identification Number (EIN)				
NOKIA OF AME	RICA CO	RPORATION				22-3408857				
			rning Insurance Contract. Individual contracts grouped							
1 Coverage Info	rmation:									
(a) Name of insu HORIZON BCBS		rier								
		(c) NAIC	(d) Contract or		(e) Approximate nu			Policy or co	contract year	
<b>(b)</b> EIN		code	identification number		persons covered a policy or contrac		(f)	From	<b>(g)</b> To	
22-0999690 55069			77087		10 01/01/		01/01/202	1	12/31/2021	
2 Insurance fee descending or			ation. Enter the total fees and to	otal	commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid										
3 Persons recei	iving comr	nissions and f	ees. (Complete as many entrie	es as	s needed to report all	persons).				
		(a) Name a	and address of the agent, broke	er, or	r other person to whor	m commiss	ions or fees	were paid		
<b>(b)</b> Amount of	of sales an	d base	F	ees	and other commission	ns paid			_	
	ssions pai		(c) Amount			(d) Purpose	е		(e) Organization code	
		(a) Name a	and address of the agent, broke	er, or	r other person to who	m commiss	ions or fees	were paid		
			<u>,                                     </u>	•						
(b) Amount of	of sales an	d hase	F	ees	and other commission	ns paid				
` '	ssions pai		(c) Amount		(d) Purpose				(e) Organization code	

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	octs with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
		opeony materio or coole				
	_	T ( ( ( ( ( )				
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan.	check here		
7		tracts With Unallocated Funds (Do not include portions of these contracts mai				
•						
	а	(1) = 1,   1   1   1   1   1   1   1   1   1	te participa	tion guarantee		
		(3) guaranteed investment (4) dother				
		<del>-</del>				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1.0	0
	C					
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Total additions			70(6)	0
	لہ	(6)Total additions			7c(6)	
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).	г		7d	0
	е	Deductions:	- (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Pa	art I	III Welfare Benefit Contract Informati If more than one contract covers the same group the information may be combined for reporting employees, the entire group of such individual	oup of employees of the purposes if such cont	tracts are	expe	erience-rated as a uni	it. Where co	ntracts cover ind	
8	Bone	nefit and contract type (check all applicable boxes)	Contracto with Cach of	unior may	50 (	reated as a arm for p	urposes or tr	по торота	
	_		. □ Dontol		- □	Vicion		d 🗆 Life inquire	
	a [		Dental		느	Vision		<b>d</b> Life insura	
	е	Temporary disability (accident and sickness) <b>f</b>	Long-term disabili	ity	9 📙	Supplemental unem	ployment	h Prescription	n drug
	i	Stop loss (large deductible) j	X HMO contract		k 📗	PPO contract		I Indemnity	contract
	m	Other (specify)							
	_								
9	Ехре	perience-rated contracts:							
	a F	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid			_				
		(3) Increase (decrease) in unearned premium reserved							
	_	(4) Earned ((1) + (2) - (3))					. 9a(4)		0
		<b>5</b> ( ) 1		/->	_				
		(2) Increase (decrease) in claim reserves					01 (0)		
		(3) Incurred claims (add (1) and (2))					9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on a		0-(4)//					
		(A) Commissions		9c(1)(A					
		(B) Administrative service or other fees		9c(1)(E	_				
		(C) Other specific acquisition costs(D) Other expenses		9c(1)(E					
		(E) Taxes		9c(1)(E					
		(F) Charges for risks or other contingencies		0 (4)(=					
		(G) Other retention charges		0 (4)(6					
		(H) Total retention					9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These ar	_		_		9c(2)		
	d	Status of policyholder reserves at end of year: (1) A			_		9d(1)		
	_	(2) Claim reserves	•				9d(2)		
		(3) Other reserves					9d(3)		
	е						9e		
10	No	onexperience-rated contracts:			, , ,	,			
	а	Total premiums or subscription charges paid to care	ier				10a		136463
	b	If the carrier, service, or other organization incurred	any specific costs in o	connection	with	n the acquisition or			
		retention of the contract or policy, other than reporte					10b		
	Spe	ecify nature of costs.							
_		Dr. Breedelen of L.C.							
	art I								
11	Did	id the insurance company fail to provide any informati	on necessary to comp	lete Sched	dule	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information	not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

This Form is Open to Public

		parouant to	=:::e;::e::::::::::::::::::::::::::::::				inspection		
For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and en	ding 12/31/2021				
A Name of plan			E	3 Three	e-digit				
NOKIA MEDICAL EXPEN	NSE PLAN FO	R MANAGEMENT EMPLOYEES	S		number (PN)	•	502		
					, ,				
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>)</b> Emplo	yer Identification N	lumber	(EIN)		
NOKIA OF AMERICA CO					3408857		,		
TOTAL TAMEROOF	ard Ordanion								
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage Fees an	nd Con	nmissions Prov	ide info	rmation for each contract		
		. Individual contracts grouped							
•	ato conocato /	marriada contracto groupea (	ao a unit in i ano ii ana iii o	un 50 10	portod on a omgio	<u> </u>	1071.		
1 Coverage Information:									
(a) Name of insurance ca	rrior								
` ,									
KAISER FOUNDATION HE	EALTH PLAN (	OF WA							
	1	<u> </u>	(e) Approximate num	her of	Pol	licy or c	ontract year		
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	persons covered at e						
(2) =	code	identification number	policy or contract ye		(f) From		<b>(g)</b> To		
91-0511770	95672	8800	16		01/01/2021		12/31/2021		
91-0311770	93072	8800	10		01/01/2021		12/31/2021		
2 Inquironas foe and some	missism inform	ation. Enter the total face and to	tal commissions paid List	in line 2	the execute broker		that naraana in		
descending order of the		ation. Enter the total fees and to	nai commissions paid. List	in line 3	the agents, broker	s, and d	uner persons in		
		migaiona paid		/b) To	atal amount of face	noid			
(a) Total amount of commissions paid (b) Total amount of fees paid									
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all pe	rsons).					
		and address of the agent, broke			ions or fees were r	naid			
	(4) 114	ara adarese er me agem, brener	, σ. σσ. μοισσιι τοσ						
(b) Amount of sales ar	nd base		ees and other commissions						
commissions pai	id	(c) Amount	(d)	(d) Purpose			(e) Organization code		
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
(b) Amount of sales ar	nd base	Fe	es and other commissions	paid					
commissions pai		(c) Amount	(4)	Purpose	e		(e) Organization code		
COMMISSIONS PAI		(5),	(u)	, . u.pco	-		(3) Organization code		
							1		

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
	<u> </u>		1						
(In) Assessment of a standard the second		Fees and other commissions paid	(e)						
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code						
commissions paid			COGC						
			•						
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
		Francisco de alban accomplication (1)							
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization						
commissions paid	(c) Amount	(d) Purpose	code						
•									
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid							
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid							
		Fees and other commissions paid	(e)						
(b) Amount of sales and base	Amount of sales and base								
commissions paid	(C) Amount	(u) Fulpose	code						
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
	<u> </u>		1						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization						
commissions paid	(c) Amount	(c) Amount (d) Purpose							
			code						
(-) No.									
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid							
		Face and other commissions naid	(e)						
(b) Amount of sales and base		Fees and other commissions paid	Organization						
commissions paid	(c) Amount	(d) Purpose	code						

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	octs with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
		opeony materio or coole				
	_	T ( ( ( ( ( )				
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan.	check here		
7		tracts With Unallocated Funds (Do not include portions of these contracts mai				
•						
	а	,,,, =	te participa	tion guarantee		
		(3) guaranteed investment (4) dother				
		<del>-</del>				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1.0	0
	C					
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Total additions			70(6)	0
	لہ	(6)Total additions			7c(6)	
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).	г		7d	0
	е	Deductions:	- (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Part III  Welfare Benefit Contract Information  If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.									
•	Don		CONTRACTS WITH EACH CA	ainei ma	y De i	ireated as a utilit for p	uiposes oi t	riis report.	
8	г	nefit and contract type (check all applicable boxes)				1		الم	
	а	<b>₫</b> `	Dental		СП	Vision		d Life insura	ice
	е	Temporary disability (accident and sickness) <b>f</b>	Long-term disabilit	ty	g	Supplemental unem	ployment	<b>h</b> Prescriptio	n drug
	i	Stop loss (large deductible) j	X HMO contract		k 🗌	PPO contract		I Indemnity	contract
	m	Other (specify)							
	,	<b>_</b>							
9	Exp	erience-rated contracts:							
	a	Premiums: (1) Amount received		9a(1)	)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)	)				
		(3) Increase (decrease) in unearned premium reserv		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 a	ın accrual basis)						
		(A) Commissions		9c(1)(	A)				
		(B) Administrative service or other fees		9c(1)(					
		(C) Other specific acquisition costs		9c(1)(					
		(D) Other expenses		9c(1)(l					
		(E) Taxes		9c(1)(l					
		(F) Charges for risks or other contingencies		9c(1)(l				_	
		(G) Other retention charges		9c(1)(			T = (1)(1)		
		(H) Total retention	_		_		9c(1)(H)	)	
		(2) Dividends or retroactive rate refunds. (These ar	<b></b>				9c(2)		
	d	Status of policyholder reserves at end of year: (1) A	mount held to provide	benefits	after	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е_		nclude amount entered	d in line 9	c(2).	)	9e		
1(	_	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carr	ier				10a		92128
	b	If the carrier, service, or other organization incurred					401-		
	Sne	retention of the contract or policy, other than reported if you nature of costs.	ed in Part I, line 2 above	e, report	amo	unt	10b		
	Орс	Tature or costs.							
_	) ort	IV Provision of Information							
۲	art						1		
11	<b>l</b> Di	d the insurance company fail to provide any informati	on necessary to compl	ete Sche	dule	A?	Yes	X No	
12	2 If t	the answer to line 11 is "Yes," specify the information	not provided.						