Form 55	00	Annual Return/Repor	t of Employee Benefit Plan		OMB Nos. 12	
		This form is required to be filed for employee benefit plans under sections 104		1210-0089		
Department of the Treasury Internal Revenue Service			ent Income Security Act of 1974 (ERISA) and f the Internal Revenue Code (the Code).	2020		
Department of Labor Employee Benefits Security Administration			ntries in accordance with ons to the Form 5500.	This	Form is Open to Pu	ublic
Pension Benefit Guaranty	Corporation			11113	Inspection	
Part I Annual	Report Ide	ntification Information				
For calendar plan year	2020 or fiscal	plan year beginning 01/01/2020	and ending 12/31/20	)20		
A This return/report is	for:	a multiemployer plan	a multiple-employer plan (Filers checking the participating employer information in accor			ns.)
		X a single-employer plan	a DFE (specify)			
<b>B</b> This return/report is	:	the first return/report	the final return/report			
	]	an amended return/report	a short plan year return/report (less than 12 months)			
<b>C</b> If the plan is a colle	ctively-bargain	ed plan, check here			• 🗙	
<b>D</b> Check box if filing u	nder: X	Form 5558	automatic extension	the	e DFVC program	
<b>J</b>		special extension (enter description)				
Part II Basic P	lan Informa	ation—enter all requested information	)			
<b>1a</b> Name of plan NOKIA RETIREE WE				1b	Three-digit plan number (PN) ▶	504
				1c	Effective date of pl 10/01/1996	an
<ul> <li>Plan sponsor's name (employer, if for a single-employer plan)</li> <li>Mailing address (include room, apt., suite no. and street, or P.O. Box)</li> <li>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)</li> </ul>				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 HERE	Filed with authorized/valid electronic signature.	10/12/2021	INGRID ORAV
	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)

v. 200204

	Form 5500 (2020)	Page <b>2</b>	
3a	Plan administrator's name and address $X$ Same as Pla	an Sponsor 3b Ad	dministrator's EIN
			dministrator's telephone umber
4		ame has changed since the last return/report filed for this plan, <b>4b</b> E	IN
а	enter the plan sponsor's name, EIN, the plan name and Sponsor's name	the plan number from the last return/report:	N
C	Plan Name		
5	Total number of participants at the beginning of the plan	year 5	74610
6	Number of participants as of the end of the plan year une <b>6a(2), 6b, 6c,</b> and <b>6d</b> ).	less otherwise stated (welfare plans complete only lines 6a(1),	
a(	1) Total number of active participants at the beginning o	f the plan year	)
a(	2) Total number of active participants at the end of the participants at the participants at the end of the participants at	plan year	) (
b	Retired or separated participants receiving benefits		7038
С	Other retired or separated participants entitled to future h	benefits	(
d	Subtotal. Add lines 6a(2), 6b, and 6c		7038
е	Deceased participants whose beneficiaries are receiving	g or are entitled to receive benefits	
f	Total. Add lines <b>6d</b> and <b>6e</b>	6f	
g	Number of participants with account balances as of the e complete this item)	end of the plan year (only defined contribution plans 6g	
h	Number of participants who terminated employment duri less than 100% vested	ng the plan year with accrued benefits that were 6h	
7		ute to the plan (only multiemployer plans complete this item)	

**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:

4A 4B 4D

9a	a Plan funding arrangement (check all that apply)				Plan be	nefit	arrangement (check all that apply)
	(1)	X	Insurance		(1)	×	Insurance
	(2)		Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts
	(3)	X	Trust		(3)	X	Trust
	(4)		General assets of the sponsor		(4)		General assets of the sponsor
10	Check a	all ap	plicable boxes in 10a and 10b to indicate which schedules are at	tache	d, and, w	vhere	e indicated, enter the number attached. (See instructions)
а	Pensio	n Scł	nedules	b	Genera	I Scl	hedules
	(1)		R (Retirement Plan Information)		(1)	X	H (Financial Information)
	(2)		<b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money		(2)		I (Financial Information – Small Plan)
	(2)		Purchase Plan Actuarial Information) - signed by the plan		(3)	X	23 A (Insurance Information)
			actuary		(4)	X	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)		<b>G</b> (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	•						
(Form 5500		Insurance Information			OM	IB No. 1210-0110	
Department of the Treas	Department of the Treasury Internal Revenue Service This schedule is required to be filed under section 104 of th Employee Retirement Income Security Act of 1974 (ERISA					2020	
Department of Labor Employee Benefits Security Administration					.).		
Pension Benefit Guaranty Co		<ul> <li>Insurance companies a</li> </ul>			tion		m is Open to Public
pursuant to ERISA section 103(a)(2							Inspection
	20 or fiscal plan	year beginning 01/01/2020		and er	0	31/2020	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (P	N) 🕨	504
		0		Draw		- C Ni	
C Plan sponsor's name a NOKIA OF AMERICA CO		2a of Form 5500			3408857	cation Number (	(EIN)
		ning Insurance Contract					
1 Coverage Information:							
(a) Name of insurance ca UHC OF COLORADO	rrier						
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of policy or contract year			Policy or contract year	
	code	identification number			(f)	From	<b>(g)</b> To
84-1004639	95090	092027	72		01/01/202	0	12/31/2020
2 Insurance fee and com descending order of the		tion. Enter the total fees and tot	tal commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total :	amount of comm	nissions paid	(b) Total amount of fees paid				
3 Persons receiving com		ees. (Complete as many entries					
	(a) Name a	nd address of the agent, broker,	, or other person to whor	m commiss	ions or fees	s were paid	
(b) Amount of sales a	nd base	Fee	es and other commissior	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
	(a) Name a	nd address of the agent, broker,	. or other person to whor	m commiss	ions or fees	s were paid	
		Fer	es and other commissior	ns paid			

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

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	(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	
<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	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.								
8	Ben	efit ar	nd contract type (check all applicable boxes)						
	а	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	y g	Supplemental unem	ployment	<b>h</b> Prescription drug	
	i [	Sto	op loss (large deductible)	j 🛛 HMO contract	k	PPO contract		I Indemnity contract	
	m	Ot	her (specify)		L				
9	Expe	erienc	ce-rated contracts:	_					
	а	Prem	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	I	9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	erve	9a(3)		1		
		(4) E	arned ((1) + (2) - (3))			1	. 9a(4)		(
	b	Ben	efit charges (1) Claims paid		9b(1)			_	
		• •	ncrease (decrease) in claim reserves	L	9b(2)		T		
			ncurred claims (add (1) and (2))				9b(3)		(
		• •	Claims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis)		1		_	
		(	(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	L	9c(1)(G)			<b>,</b>	
			(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)		
		(2) (	Claim reserves				9d(2)		
		(3) (	Other reserves				9d(3)		
	е		dends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2	<b>]</b> .)	9e		
10	) No		erience-rated contracts:						
	а	Tota	al premiums or subscription charges paid to c	arrier			10a	41	1448
	<b>b</b> Spe	reter	e carrier, service, or other organization incurr ntion of the contract or policy, other than repo nature 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

SCHEDULE		Insuran	ce Information	า		OM	B No. 1210-0110
(Form 5500 Department of the Treas Internal Revenue Serv	This schedule is required to be filed under section 104 of the					2020	
Department of Labo Employee Benefits Security Ad			attachment to Form 55				
Pension Benefit Guaranty Co		<ul> <li>Insurance companies a</li> </ul>		he informat	ion		m is Open to Public Inspection
For calendar plan year 20	20 or fiscal plan	year beginning 01/01/2020		and en	ding 12/3	1/2020	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (Pl	N) 🕨	504
C Plan sponsor's name a NOKIA OF AMERICA CO		e 2a of Form 5500		•	oyer Identific 3408857	cation Number (	EIN)
		ning Insurance Contract					
<b>1</b> Coverage Information:							
(a) Name of insurance ca EMBLEM HEALTH (HIP)	rrier						
(b) EIN	(c) NAIC	(d) Contract or (e) Approximate number of persons covered at end of (c)		Policy or co			
	code	identification number	policy or contract	,	.,	From	<b>(g)</b> To
13-1828429	55247	11021741001	25		01/01/2020	0	12/31/2020
2 Insurance fee and com descending order of the		tion. Enter the total fees and tot	al commissions paid. Li	st in line 3	the agents,	brokers, and of	ther persons in
(a) Total a	amount of comn	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons receiving com		es. (Complete as many entries	•	· · · · ·			
	(a) Name ar	nd address of the agent, broker,	, or other person to whor	n commiss	ions or fees	s were paid	
(b) Amount of sales ar			es and other commission				-
commissions paid		(c) Amount		(d) Purpose			(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
						F MIM	

(b) Amount of sales and base	Se Fees and other commissions paid		
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

		(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

		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	
<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
С	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	art III Welfare Benefit Contract Information						
		If more than one contract covers the same g the information may be combined for reportin						),
		employees, the entire group of such individu						
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	c	Vision	(	d Life insurance	
	e	Temporary disability (accident and sickness)	f Long-term disability	∕ g _	Supplemental unem	ployment I	<b>h</b> Prescription drug	
	i	Stop loss (large deductible)	j X HMO contract	k [	PPO contract		I Indemnity contract	
	m	Other (specify)	• 🗆	L	1			
	[							
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 (or	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 no	t include amount entered	in line <b>9c(2)</b> .	.)	9e		
10	) No	onexperience-rated contracts:				r		
	а	Total premiums or subscription charges paid to ca	arrier			10a	1:	<u>21408</u>
	b	If the carrier, service, or other organization incurre						
	Spe	retention of the contract or policy, other than repo ecify nature of costs.	rted in Part I, line 2 above	, report amo	ount	10b	<u> </u>	

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	Α	Insuran	ce Information	n		OM	P.No. 1210 0110	
(Form 5500	)					B No. 1210-0110		
(FORM 5500)       This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2020			
Department of Labor	r		attachment to Form 55		.).			
Employee Benefits Security Ada Pension Benefit Guaranty Co		,				This For	m is Open to Public	
	portation	Insurance companies a pursuant to E	are required to provide to ERISA section 103(a)(2)		tion		Inspection	
For calendar plan year 202	20 or fiscal plan	year beginning 01/01/2020		and er	nding 12/3	31/2020		
A Name of plan		<b>B</b> Thre	e-digit		504			
NOKIA KETIKEE WELFA	NOKIA RETIREE WELFARE BENEFITS PLAN			plan	number (P	N) 🕨	504	
<b>C</b> Plan sponsor's name a		2a of Form 5500		-	-	cation Number (	EIN)	
NOKIA OF AMERICA CO		22-	3408857					
Part I Informat	ion Concer	ning Insurance Contract	t Coverage, Fees,	and Cor	nmissior	IS Provide infor	mation for each contract	
		Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance ca KEYSTONE HEALTH PLAN								
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			,	ontract year	
(2) 2	code	identification number	policy or contrac	(†)		From	<b>(g)</b> To	
23-2399845	95199	509964	213	213 01/01/2020 12/31/2020		12/31/2020		
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	tal commissions paid. Li	ist in line 3	the agents,	brokers, and of	ther persons in	
<b>(a)</b> Total a	amount of comn	nissions paid		<b>(b)</b> To	otal amount	of fees paid		
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
	(a) Name ar	nd address of the agent, broker,	, or other person to whor	m commiss	ions or fees	s were paid		
(b) Amount of sales ar			es and other commission					
commissions pai	d	(c) Amount		(d) Purpos	e		(e) Organization code	
	(a) Name a	nd address of the agent, broker,	, or other person to who	m commiss	ions or fees	s were paid	1	
	(,							

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
East Device when Device the state Ast Matter			

## (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	
<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)			
	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.

Ρ	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 employees of th ting purposes if such com	tracts are exp	erience-rated as a unit	t. Where con	ntracts cover individ	
8	Ben	efit ar	nd contract type (check all applicable boxes)						
	a	He	alth (other than dental or vision)	<b>b</b> Dental	c	Vision	(	d Life insurance	;
	e	Те	mporary disability (accident and sickness)	f Long-term disabil	ity <b>g</b>	Supplemental unem	ployment	<b>h</b> Prescription d	rug
	iΪ		op loss (large deductible)	j 🛛 HMO contract	· • _	PPO contract		I Indemnity con	-
			her (specify)		•				liuot
	m	0	her (specify)						
9	Expe	erienc	e-rated contracts:						
•			iums: (1) Amount received		9a(1)			1	
			ncrease (decrease) in amount due but unpaid		· · · · ·			1	
			ncrease (decrease) in unearned premium res		9a(3)			-	
		(4) E	arned ((1) + (2) - (3))				9a(4)		0
	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))				9b(3)		0
		(4) C	laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	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) C	Dividends or retroactive rate refunds. (These	e amounts were paid i	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	Divio	dends or retroactive rate refunds due. (Do not	ot include amount entere	d in line <b>9c(2)</b>	.)	9e		
10	) No	•	erience-rated contracts:				r		
	а	Tota	I premiums or subscription charges paid to c	carrier			10a	<b></b>	899028
	b		e carrier, service, or other organization incurrent				10b		

Pa	art IV	Provision of Information				
11	11 Did the insurance company fail to provide any information necessary to complete Schedule A?					
12	If the ar	swer to line 11 is "Yes," specify the information not provided.				

SCHEDULE (Form 5500		Insurar	nce Informatio	n		OM	IB No. 1210-0110
Department of the Treas Internal Revenue Serv	sury	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		attachment to Form 55		.)-		
Pension Benefit Guaranty Corporation			are required to provide t ERISA section 103(a)(2)		tion	This For	m is Open to Public Inspection
For calendar plan year 20	20 or fiscal plan	year beginning 01/01/2020	(a)(_)	and er	ding 12/3	1/2020	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (Pl	N) ►	504
C Plan sponsor's name a NOKIA OF AMERICA CO		2a of Form 5500			oyer Identific 3408857	cation Number	(EIN)
		ning Insurance Contrac Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca GHC PUGET SOUND	rrier						
(b) EIN (c) NAIC		(d) Contract or		(e) Approximate number of persons covered at end of		Policy or contract year (f) From (g) To	
	code	identification number	policy or contrac	t year	.,		<b>(g)</b> To
91-0511770	95672	8800	54 01/01/2020		0	12/31/2020	
2 Insurance fee and com descending order of the		tion. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comm	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons receiving com		es. (Complete as many entrie					
	(a) Name a	nd address of the agent, broke	r, or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales and base		Fees and other commiss		sions paid			_
commissions paid		(c) Amount		(d) Purpose			(e) Organization code
	(a) Name a	nd address of the agent, broke	r. or other person to who	m commiss	ions or fees	were paid	
			., <u></u> ea.e. porodit o wild				
			aes and other commission	ne naid			

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

## (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

	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	
<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)			
	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 ting purposes if such co	ontracts are experien	nce-rated as a unit. Where	contracts cover individual	,
8	Ben	efit ar	nd contract type (check all applicable boxes)	)				
	a	He	alth (other than dental or vision)	<b>b</b> Dental	<b>C</b> Visi	ion	d Life insurance	
	еĪ	Те	mporary disability (accident and sickness)	f Long-term disat	oility <b>q</b> Sup	pplemental unemployment	t <b>h</b> Prescription drug	
	ιĽ		op loss (large deductible)	j 🛛 HMO contract		O contract	I Indemnity contract	
	• L	_				o contract		
	m	Ot	her (specify)					
9	Exne	erienc	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))				.)	(
	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))				8)	0
		(4) C	laims charged				)	
	С	Rem	nainder of premium: (1) Retention charges (c	on an accrual basis)				
		(	(A) Commissions		. 9c(1)(A)			
		(	(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				<u></u>	
			(H) Total retention	_	_			(
	-		Dividends or retroactive rate refunds. (These				<i>,</i>	
	d		us of policyholder reserves at end of year: (1	, ,		<b>`</b>	/	
		• •	Claim reserves				,	
	-	``	Other reserves					
40			dends or retroactive rate refunds due. (Do n	ot include amount enter	red in line 9c(2).)			
10	-	•	erience-rated contracts:	<b>.</b>		10		
	а		I premiums or subscription charges paid to c				2	58404
	b		e carrier, service, or other organization incur ation of the contract or policy, other than rep					

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.

	EDULE		Insuran	ce Information	n		OM	B No. 1210-0110
•	rm 5500 nt of the Treas	-	This schedule is require	ed to be filed under section	on 104 of th	ne		2020
Internal F	Revenue Servi	ce		ncome Security Act of 19				2020
Employee Benefit			File as an	attachment to Form 55	00.		This Fam	m ia Onan ta Dublia
Pension Benefi	it Guaranty Co	rporation	<ul> <li>Insurance companies pursuant to</li> </ul>	are required to provide t ERISA section 103(a)(2)		tion		m is Open to Public Inspection
		20 or fiscal plar	year beginning 01/01/2020		and er	nding 12/3	1/2020	Ι
A Name of pla NOKIA RETIRE		RE BENEFITS	PLAN			e-digit number (Pl	N) 🕨	504
C Plan sponso NOKIA OF AME			e 2a of Form 5500		-	oyer Identific 3408857	ation Number (	EIN)
			ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Inf	formation:							
(a) Name of ins		rrier						
<b>(b)</b> EIN	N	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or co	
		code	identification number	policy or contract year		(†)	From	<b>(g)</b> To
86-0507074		96016	060406	77		01/01/2020	0	12/31/2020
2 Insurance fee descending o			ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and of	ther persons in
	(a) Total a	amount of comr	nissions paid		<b>(b)</b> T	otal amount	of fees paid	
3 Persons rece	eiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
		<b>(a)</b> Name a	nd address of the agent, broker	r, or other person to who	m commiss	sions or fees	were paid	
(b) Amount				es and other commission				
comm	iissions pai	d	(c) Amount		(d) Purpose			(e) Organization code
		(a) Name a	nd address of the agent, broker	r, or other person to who	m commiss	sions or fees	were paid	•
			<b>~</b> ·					
	- ( )		Fe	es and other commissio	ns paid			
(b) Amount	of sales an	id base						1

(d) Purpose

For Paperwork Reduction Act Notice	e, see the Instructions for Forn	n 5500.	

(c) Amount

commissions paid

Schedule A (Form 5500) 2020 v. 200204

(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	
<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.

Ρ	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 employees of th ting purposes if such com	tracts are exp	erience-rated as a unit	t. Where con	tracts cover individ	
8	Ben	efit ar	nd contract type (check all applicable boxes)						
	a	He	alth (other than dental or vision)	<b>b</b> Dental	c	Vision	(	d Life insurance	е
	e	Те	mporary disability (accident and sickness)	f Long-term disabil	ity <b>g</b>	Supplemental unem	ployment	h Prescription of	drug
	iΪ		op loss (large deductible)	j 🛛 HMO contract		PPO contract		I Indemnity co	-
			her (specify)						liaot
	m	0	her (specify)						
9	Expe	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)		0
	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))				9b(3)		0
		(4) C	laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	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 .						
		(	(G) Other retention charges		9c(1)(G)		1		
		(	(H) Total retention				9c(1)(H)		0
		(2) C	Dividends or retroactive rate refunds. (These	e amounts were 🗌 paid i	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	Divio	dends or retroactive rate refunds due. (Do ne	ot include amount entere	d in line <b>9c(2)</b>	.)	9e		
10	) No	onexp	erience-rated contracts:				r		
	а	Tota	I premiums or subscription charges paid to c	carrier			10a		444033
	b		e carrier, service, or other organization incurrent				10b		

Pa	art IV	Provision of Information			
11	Did the	insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12	If the ar	swer to line 11 is "Yes," specify the information not provided.			

	r fiscal plar BENEFITS Iown on line DRATION	<ul> <li>Insurance companies are pursuant to EF</li> <li>year beginning 01/01/2020</li> <li>PLAN</li> </ul>	ome Security Act of 1974 tachment to Form 5500 e required to provide the RISA section 103(a)(2).	4 (ERISA). <b>0.</b> e information and ending <b>B</b> Three-dig plan num <b>D</b> Employer I 22-3408 <b>nd Commis</b>	12/31/2020 it ber (PN) ► dentification Number 357 Sions Provide info	ormation for each contract
Employee Benefits Security Administrat Pension Benefit Guaranty Corporation For calendar plan year 2020 or f <b>A</b> Name of plan NOKIA RETIREE WELFARE BE <b>C</b> Plan sponsor's name as show NOKIA OF AMERICA CORPOR <b>Part I</b> Information C on a separate Sci <b>1</b> Coverage Information: (a) Name of insurance carrier	r fiscal plar BENEFITS Iown on line DRATION	<ul> <li>Insurance companies are pursuant to EF</li> <li>year beginning 01/01/2020</li> <li>PLAN</li> <li>a 2a of Form 5500</li> <li>ning Insurance Contract (</li> </ul>	e required to provide the RISA section 103(a)(2).	<ul> <li>and ending</li> <li>B Three-dig plan num</li> <li>D Employer I 22-3408</li> <li>nd Commis</li> </ul>	12/31/2020 it ber (PN) ► dentification Number 357 Sions Provide info	Inspection 504 (EIN)
For calendar plan year 2020 or f         A Name of plan         NOKIA RETIREE WELFARE BE         C Plan sponsor's name as show         NOKIA OF AMERICA CORPOR         Part I       Information C on a separate Sci         1 Coverage Information:         (a) Name of insurance carrier	r fiscal plar BENEFITS Iown on line DRATION	pursuant to EF a year beginning 01/01/2020 PLAN e 2a of Form 5500 ning Insurance Contract (	RISA section 103(a)(2).	and ending B Three-dig plan num D Employer I 22-3408	12/31/2020 it ber (PN) ► dentification Number 357 Sions Provide info	Inspection 504 (EIN) prmation for each contract
A Name of plan         NOKIA RETIREE WELFARE BE         C Plan sponsor's name as show         NOKIA OF AMERICA CORPOR         Part I       Information C on a separate Sci         1 Coverage Information:         (a) Name of insurance carrier	BENEFITS own on line DRATION	PLAN e 2a of Form 5500 ning Insurance Contract (	Coverage, Fees, ar	B Three-dig plan num D Employer I 22-3408	t ber (PN) dentification Number 357 SSIONS Provide info	(EIN)
NOKIA RETIREE WELFARE BE         C Plan sponsor's name as show         NOKIA OF AMERICA CORPOR         Part I       Information C on a separate Sci         1 Coverage Information:         (a) Name of insurance carrier	own on line PRATION	e 2a of Form 5500 ning Insurance Contract (	Coverage, Fees, ar	plan num D Employer I 22-3408	dentification Number 357 SSIONS Provide info	(EIN)
Part I       Information C         0 n a separate Sci       1         1       Coverage Information:         (a)       Name of insurance carrier		ning Insurance Contract (	Coverage, Fees, ar	22-3408	357 SSIONS Provide info	ormation for each contract
On a separate Sci     Overage Information:     (a) Name of insurance carrier						
(a) Name of insurance carrier						
(c)	TH PLAN O	F S. CA	(e) Approximate num		Policy or o	contract year
	code	identification number	persons covered at e policy or contract y		(f) From	<b>(g)</b> To
94-1340523 00000	000	122636	291	01/0	)1/2020	12/31/2020
2 Insurance fee and commissio descending order of the amou		ation. Enter the total fees and total	l commissions paid. List	t in line 3 the a	gents, brokers, and	other persons in
(a) Total amoun	unt of comr	nissions paid		<b>(b)</b> Total a	mount of fees paid	
		ees. (Complete as many entries a				
(a)	a) Name a	nd address of the agent, broker, o	or other person to whom a	commissions	or rees were paid	
(b) Amount of sales and bas	ase	Fees	and other commissions	s paid		
commissions paid		(c) Amount	(d	I) Purpose		(e) Organization code
(a)					or fees were paid	

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

## (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	
<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 th ing purposes if such cor	tracts are exp	erience-rated as a uni	t. Where co	ontracts 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	c	Vision		d Life insurance	
	еĪ	Ter	nporary disability (accident and sickness)	f Long-term disabi	lity <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	Oth	ner (specify)						
a	Evn	oriona	e-rated contracts:						
3			ums: (1) Amount received		9a(1)			-	
	u		crease (decrease) in amount due but unpaid					-	
		• •	crease (decrease) in unearned premium res					-	
		• •	arned ((1) + (2) - (3))				9a(4)		(
	b	• •	efit charges (1) Claims paid						
		(2) In	crease (decrease) in claim reserves		9b(2)			1	
		(3) In	curred claims (add (1) and (2))				9b(3)		(
		(4) Cl	laims charged				9b(4)		
	С	Rem	ainder 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					_	
		``	F) Charges for risks or other contingencies .		a (1)(a)			_	
			G) Other retention charges				0-(4)(1)		
		`	H) Total retention				9c(1)(H)		(
			vividends or retroactive rate refunds. (These				9c(2)		
	d		us of policyholder reserves at end of year: (1				9d(1)		
		• •	laim reserves				9d(2)		
	•	• •	other reserves				9d(3)		
10			lends or retroactive rate refunds due. (Do no erience-rated contracts:	ot include amount entere	ea in line 90(2)	.)	9e		
10	_	•		arriar			100	10	0000
	a L		I premiums or subscription charges paid to c				10a	102	23309
	b		carrier, service, or other organization incurn				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	Α	Insuranc	e Information				
	(Form 5500)			C			B No. 1210-0110
Department of the Treasury Internal Revenue ServiceThis 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 5500.				
Pension Benefit Guaranty Co	rporation	<ul> <li>Insurance companies ar pursuant to EF</li> </ul>	re required to provide the RISA section 103(a)(2).	informati	on		m is Open to Public Inspection
For calendar plan year 202	20 or fiscal plar	year beginning 01/01/2020	1	and en	ding 12/3	1/2020	1
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN	E		e-digit number (Pl	N) ►	504
C Plan sponsor's name a NOKIA OF AMERICA COI		e 2a of Form 5500	C		yer Identific 3408857	ation Number (	EIN)
on a separa		ning Insurance Contract					
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE		F CO					
	(c) NAIC	(d) Contract or	(e) Approximate num			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered at en policy or contract ye		(f)	From	<b>(g)</b> To
84-0591617	95669	07368	255		01/01/2020	0	12/31/2020
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. List	in line 3 t	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 per	rsons).			
	<b>(a)</b> Name a	nd address of the agent, broker, o	or other person to whom o	commissi	ons or fees	were paid	
(b) Alloulit of sales and base			s and other commissions				
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
		5500	

## (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

	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	
<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 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 the ing purposes if such cont	racts are expe	erience-rated as a unit	. Where con	tracts o	cover individual
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 🗌 Lit	fe insurance
	e	Те	mporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unem	oloyment I	h 🗌 Pr	rescription drug
	iΓ	Sto	p loss (large deductible)	j 🛛 HMO contract	k [	PPO contract			demnity contract
	m		her (specify)	•		I			,
	L								
9	Expe	erienc	e-rated contracts:						
	a	Premi	iums: (1) Amount received		9a(1)				
		(2) In	ncrease (decrease) in amount due but unpaid	ł	9a(2)				
		(3) In	ncrease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		0
	b	Bene	efit charges (1) Claims paid		9b(1)				
		(2) In	ncrease (decrease) in claim reserves		9b(2)				
		(3) In	ncurred claims (add <b>(1)</b> and <b>(2)</b> )				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)				
		(	H) Total retention	······ <u> </u>	····· <u>-</u> ··		9c(1)(H)		0
		(2) C	Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)		
	d	Statu	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) C	Claim reserves				9d(2)		
		(3) C	Other reserves				9d(3)		
	е	Divic	dends or retroactive rate refunds due. (Do not	ot include amount entered	d in line <b>9c(2)</b>	.)	9e		
10			erience-rated contracts:						
	а	Tota	I premiums or subscription charges paid to c	arrier			10a		997256
	b		e carrier, service, or other organization incurrent				10b		

11 Did the insurance 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.

**Provision of Information** 

Specify nature of costs.

Part IV

SCHEDULE	Α	Insuranc	e Information	<u>ו</u>			MB No. 1210-0110	
			s required to be filed under section 104 of the ement Income Security Act of 1974 (ERISA).				2020	
Department of Labo			ttachment to Form 550					
Employee Benefits Security Ad Pension Benefit Guaranty Co		<ul> <li>Insurance companies ar</li> </ul>		ne informat	tion	This Fo	rm is Open to Public Inspection	
For calendar plan year 20	20 or fiscal pla	n year beginning 01/01/2020		and en	ding 12/3	1/2020		
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (PN	N) 🕨	504	
C Plan sponsor's name a NOKIA OF AMERICA CO		e 2a of Form 5500			oyer Identific 3408857	ation Number	(EIN)	
		ning Insurance Contract . Individual contracts grouped as						
(a) Name of insurance ca KAISER FOUNDATION H	EALTH PLAN N	1	(e) Approximate nu	mber of		Policy or c	contract year	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered at policy or contract		(f)	From	(g) To	
93-0798039	95540	8384	46		01/01/2020	)	12/31/2020	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	Il commissions paid. Lis	st in line 3	the agents,	brokers, and	other persons in	
(a) Total	amount of com	missions paid		<b>(b)</b> To	otal amount	of fees paid		
<b>3</b> Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all p	persons).				
	<b>(a)</b> Name a	nd address of the agent, broker, o	or other person to whon	n commiss	ions or fees	were paid		
(b) Amount of sales a	nd base		s and other commission	ons paid		_		
commissions pa	id	(c) Amount	(	( <b>d)</b> Purpos	e		(e) Organization code	
	<b>(a)</b> Name a	nd address of the agent, broker, o	or other person to whon	n commiss	ions or fees	were paid		

(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			
(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.			
	irrent value of plan's interest under this contract in the general account at year		4	
<b>5</b> Cu	irrent value of plan's interest under this contract in separate accounts at year e	end	5	
<b>6</b> Co	ontracts 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		60 60	
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		L I	
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
£	If contract nurchaeod in whole or in part to distribute herefits from a termi			
	If contract purchased, in whole or in part, to distribute benefits from a termi			
/ Co	ontracts 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></b>	
b			7b	0
С	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits			
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	_ /_>		
	(6)Total additions		7c(6)	0
C	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	- (0)		
	(4) Other (specify below)	- (1)		
	7			
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )		7f	0
•				

Specify nature of costs.

F	Part	III Welfare Benefit Contract Informat If more than one contract covers the same gu the information may be combined for reportin employees, the entire group of such individual	roup of employees of the og purposes if such contra	acts are expe	erience-rated as a unit	. Where con	tracts cover individu	
8	Ben	nefit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	<b>b</b> Dental	c	Vision	c	Life insurance	
	е	Temporary disability (accident and sickness)	f 🗌 Long-term disability	/ g	Supplemental unemp	ployment <b>h</b>	n Prescription dr	ug
	ιĒ		j X HMO contract	-	PPO contract		I Indemnity cont	ract
	m	☐ Other (specify) ►		[				
	L							
9		erience-rated contracts:	г					
	a	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese		9a(3)		<b>a</b> (1)		
		(4) Earned ((1) + (2) - (3))				. 9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)		<b>a</b> t (a)		
		(3) Incurred claims (add (1) and (2))				9b(3)		0
	_	(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on	· · · ·	<b>a</b> (1)( <b>a</b> )				
		(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)(H)		0
		(2) Dividends or retroactive rate refunds. (These a				9c(2)		
	d	Status of policyholder reserves at end of year: (1)	•			9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do not	include amount entered	in line <b>9c(2)</b>	)	9e	ļ	
10	D No	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to ca	rrier			10a		204583
	b	If the carrier, service, or other organization incurre				10b		

Pa	art IV	Provision of Information			
11	Did the	insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12	If the ar	swer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	A	Insuranc	e Informatior	า			
(Form 5500)		incuraire				OMB No. 1210-0110	
Department of the Treasury Internal Revenue ServiceThis 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	rporation	<ul> <li>Insurance companies ar pursuant to EF</li> </ul>	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	1
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN	·		e-digit number (Pl	N) 🕨	504
C Plan sponsor's name a NOKIA OF AMERICA COI		e 2a of Form 5500			yer Identific 3408857	ation Number (	EIN)
		ning Insurance Contract					
<b>1</b> Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE		IIDATLANTIC					
	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered at			Policy or contract year	
(b) EIN	code	identification number	policy or contract		(f)	From	<b>(g)</b> To
52-0954463	95639	2204	51		01/01/202	D	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	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	(b) Amount of sales and base Fees and other commissions paid						
commissions pai	d	(c) Amount	(d) Purpose			(e) Organization code	
	(a) Name a	nd address of the agent, broker, c	or other person to whor	n commiss	ions or fees	were paid	•
	(,						

(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	(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

		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	
<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)			
	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 ing purposes if such cont	tracts are exp	erience-rated as a uni	t. Where co	ntracts 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		d Life insurance	
	еĪ	Те	mporary disability (accident and sickness)	f Long-term disabili	itv <b>a</b>	Supplemental unem	plovment	<b>h</b> Prescription drug	
	i F		op loss (large deductible)	j X HMO contract	· · ·	PPO contract		I Indemnity contract	
	• L				ĸ				
	m	Ot	her (specify)						
0	Evo	ariona	ce-rated contracts:						
3			iums: (1) Amount received		9a(1)			-	
	u		ncrease (decrease) in amount due but unpaid					-	
		. ,	ncrease (decrease) in unearned premium res						
		• •	arned ((1) + (2) - (3))				9a(4)		(
	b	` '	efit charges (1) Claims paid						
			ncrease (decrease) in claim reserves						
		(3) Ir	ncurred claims (add <b>(1)</b> and <b>(2)</b> )				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 .		a (1)(a)			4	
			(G) Other retention charges						
		`	(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 no	ot include amount entere	d in line 9c(2)	.)	9e		
10	-		erience-rated contracts:				40-		
	а		al premiums or subscription charges paid to c				10a	18	81294
	b		e carrier, service, or other organization incurn ntion of the contract or policy, other than repo				10b		

Specify nature of costs.

Part IV	rovision of Information			
11 Did the ins	rance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
12 If the answ	r to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuranc	e Information			
(Form 5500)					OM	IB No. 1210-0110
Department of the Treas	Department of the Treasury Internal Revenue ServiceThis 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.			
Pension Benefit Guaranty Co	orporation		re required to provide the inf RISA section 103(a)(2).	ormation		m is Open to Public Inspection
For calendar plan year 20	20 or fiscal plan	year beginning 01/01/2020	а	nd ending 12	/31/2020	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN	В	Three-digit plan number (	PN)	504
C Plan sponsor's name a NOKIA OF AMERICA CO		e 2a of Form 5500	D	Employer Identi 22-3408857	fication Number	(EIN)
		ning Insurance Contract . Individual contracts grouped as				
<b>1</b> Coverage Information:						
(a) Name of insurance ca KAISER FOUNDATION HE	EALTH PLAN O		(e) Approximate number	of	Policy or c	ontract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end policy or contract year	of	f) From	(g) To
58-1592076	96237	2081	36	01/01/20	20	12/31/2020
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	l commissions paid. List in l	ine 3 the agent	s, brokers, and o	ther persons in
	amount of comn	nissions paid		(b) Total amou	nt of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all perso	ns).		
	(a) Name a	nd address of the agent, broker, o	or other person to whom con	nmissions or fe	es were paid	
(b) Amount of sales ar	nd base		s and other commissions pai			-
commissions pa	id	(c) Amount	(d) Pr	urpose		(e) Organization code
	(a) Name a	nd address of the agent, broker, o	or other person to whom con	nmissions or fe	es were paid	

(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	(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

		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	
<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
С	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 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 the ing purposes if such cont	racts are expe	erience-rated as a unit	t. Where con	ntracts	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	С	Vision	(	d 🗌 เ	_ife insurance
	e	Te	mporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unem	ployment	h∏⊺⊮	Prescription drug
	iΓ	Sto	p loss (large deductible)	j 🛛 HMO contract	k [	PPO contract		ıΠı	ndemnity contract
	m		her (specify)			1			
9	Expe	erienc	e-rated contracts:						
-			iums: (1) Amount received		9a(1)				
		(2) In	ncrease (decrease) in amount due but unpaid	ł					
		. ,	ncrease (decrease) in unearned premium res		9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		0
	b	Bene	efit charges (1) Claims paid		9b(1)				
		(2) In	crease (decrease) in claim reserves		9b(2)				
		(3) In	ncurred claims (add (1) and (2))				9b(3)		0
		· /	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				0=(4)(1)		0
		```	H) Total retention	_	_		9c(1)(H)		0
			Dividends or retroactive rate refunds. (These				9c(2)		
	d		us of policyholder reserves at end of year: (1	, i			9d(1)		
		. ,	Claim reserves				9d(2)		
	•	( )	Other reserves				9d(3)		
10			dends or retroactive rate refunds due. (Do no	ot include amount entered	a in line 90(2).	.)	9e		
10			erience-rated contracts:	orrior			100		010000
	_		I premiums or subscription charges paid to c				10a		212868
	b		e carrier, service, or other organization incurnation of the contract or policy, other than repo			•	10b		

11 Did the insurance 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.

Part IV Provision of Information

Specify nature of costs.

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service			Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			OMB No. 1210-0110		
							2020	
Department of Labor Employee Benefits Security Administration			File as an at	ttachment to Form 55	00.			
			This For	orm is Open to Public Inspection				
For calendar plar	n year 2020	0 or fiscal plan	year beginning 01/01/2020		and er	ding 12/3	1/2020	
A Name of plan NOKIA RETIREE		E BENEFITS	PLAN			e-digit number (Pl	N) 🕨	504
C Plan sponsor' NOKIA OF AMER			2a of Form 5500		•	oyer Identific 3408857	cation Number	(EIN)
			ning Insurance Contract Individual contracts grouped as					
1 Coverage Info	rmation:							
(a) Name of insu KAISER FOUNDA				(e) Approximate nu	imbor of	r	Policy or c	ontract year
<b>(b)</b> EIN		(c) NAIC code	(d) Contract or identification number	persons covered a		(5)	From	
				policy or contract	,	.,		<b>(g)</b> To
94-1340523	0	60053	639	9		01/01/2020	0	12/31/2020
2 Insurance fee descending or			tion. Enter the total fees and tota	al commissions paid. Li	st in line 3	the agents,	brokers, and o	ther persons in
		nount of comm	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons recei	ving comm	nissions and fe	es. (Complete as many entries a	as needed to report all	persons).			
		(a) Name a	nd address of the agent, broker, o	or other person to whor	n commiss	ions or fees	were paid	
(b) Amount o	f sales and	base		s and other commissior	ns paid			_
commissions paid			(c) Amount		(d) Purpos	е		(e) Organization code
		( ) ) (				. ,		•
		(a) Name a	nd address of the agent, broker, o	or other person to whor	n commiss	ions or tees	were paid	

(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	(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	
<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	If me the i	If are Benefit Contract Information one contract covers the same nformation may be combined for report loyees, the entire group of such individ	group of employees of the ting purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ntracts cover individual	,
8	Ben	efit and co	ntract type (check all applicable boxes)						
	a	Health (	other than dental or vision)	<b>b</b> Dental	С	Vision		d Life insurance	
	еĪ	Tempor	ary disability (accident and sickness)	f Long-term disabili	ty <b>q</b>	Supplemental unem	ployment	<b>h</b> Prescription drug	
	i [		s (large deductible)	j X HMO contract		PPO contract		I Indemnity contract	
	• L				ĸ				
	m	Other (s	specify)						
0	Evn	rionco rat	ed contracts:						
3			(1) Amount received		9a(1)			-	
	u		se (decrease) in amount due but unpaid					-	
		. ,	se (decrease) in unearned premium res		9a(3)				
		· /	d ((1) + (2) - (3))				9a(4)		(
	b	. ,	harges (1) Claims paid						
		(2) Increas	se (decrease) in claim reserves		9b(2)				
		(3) Incurre	ed claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		(
		(4) Claims	charged				9b(4)		
	С	Remainde	er of premium: (1) Retention charges (c	on an accrual basis)					
		(A) Co	ommissions		9c(1)(A)				
		(B) Ad	ministrative service or other fees		9c(1)(B)				
		(C) O	ther specific acquisition costs		9c(1)(C)			_	
		(D) O	her expenses		9c(1)(D)			_	
		( )	axes		9c(1)(E)			4	
		. ,	narges for risks or other contingencies.		a (1)(a)			_	
		( )	ther retention charges		•				
		( )	otal retention				9c(1)(H)		(
			nds or retroactive rate refunds. (These				9c(2)		
	d		policyholder reserves at end of year: (1				9d(1)		
		. ,	reserves				9d(2)		
	_	( )	reserves				9d(3)		
40			or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2)	.)	9e		
10	-		ce-rated contracts:				40-		
	a	•	niums or subscription charges paid to c				10a	5	50314
	b		ier, service, or other organization incur of the contract or policy, other than rep				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		Insuranc	e Information			OM	B No. 1210-0110
(Form 5500 Department of the Treas Internal Revenue Serv	sury	This schedule is required to Employee Retirement Inco					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 Form is Open to Public Inspection	
For calendar plan year 20	20 or fiscal plar	n year beginning 01/01/2020	1	and en	ding 12/3	1/2020	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN	-		e-digit number (Pl	N) 🕨	504
C Plan sponsor's name a NOKIA OF AMERICA CO		e 2a of Form 5500	1		yer Identific 3408857	ation Number (	EIN)
on a separ		ning Insurance Contract ( Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE		DF N. CA					
	(c) NAIC	(d) Contract or	<ul> <li>(e) Approximate num persons covered at e</li> </ul>			Policy or co	ontract year
(b) EIN	code	identification number	policy or contract y		(f)	From	<b>(g)</b> To
94-1340523	00000	35147	402		01/01/2020	0	12/31/2020
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	l commissions paid. List	t in line 3	the agents,	brokers, and of	ther persons in
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons receiving com		ees. (Complete as many entries a		,			
	(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	Fees	and other commissions	paid			
commissions pa		(c) Amount	(d	<b>l)</b> Purpose	е		(e) Organization code
	(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	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	e, see the Instructions for Forr	m 5500. Sched	ule 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	(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	
<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 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 ing purposes if such co	ontracts are expe	rience-rated as a unit	t. Where co	ntracts cover individual	),
8	Ben	efit and	d contract type (check all applicable boxes)						
	a	Hea	lth (other than dental or vision)	<b>b</b> Dental	с	Vision		d Life insurance	
	еĪ	Tem	porary disability (accident and sickness)	f Long-term disat	bility <b>a</b>	Supplemental unem	ployment	<b>h</b> Prescription drug	
	i [		o loss (large deductible)	j X HMO contract		PPO contract		I Indemnity contract	
	• L				кЦ				
	m	Oth	er (specify)						
a	Evn	rionco	e-rated contracts:						
3			ims: (1) Amount received		9a(1)			-	
	u		crease (decrease) in amount due but unpaid					-	
		• •	crease (decrease) in unearned premium res					1	
		• •	urned ((1) + (2) - (3))				9a(4)		(
	b	• •	fit charges (1) Claims paid						
		(2) Inc	crease (decrease) in claim reserves		9b(2)				
		(3) Inc	curred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		(
		(4) Cla	aims charged				9b(4)		
	С	Rema	ainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A	A) Commissions		9c(1)(A)				
		(E	B) Administrative service or other fees					_	
		(C	C) Other specific acquisition costs					_	
		(D	0) Other expenses					_	
		`	) Taxes					4	
		•	) Charges for risks or other contingencies .					4	
			6) Other retention charges				0.(1)(1)		
		``	I) Total retention				9c(1)(H)		(
			vidends or retroactive rate refunds. (These				9c(2)		
	d		s of policyholder reserves at end of year: (1				9d(1)		
		. ,	aim reserves				9d(2)		
	_	· · /	ther reserves				9d(3)		
4.0			ends or retroactive rate refunds due. (Do no	ot include amount ente	red in line <b>9c(2)</b> .)		9e		
10	-	•	rience-rated contracts:				40-		
	a		premiums or subscription charges paid to c				10a	20	26474
	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		Insura	nce Information	n		ОМ	B 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					2020
Department of Labo	pr	<ul> <li>Employee Retirement Income Security Act of 1974 (ERISA).</li> <li>File as an attachment to Form 5500.</li> </ul>					
Employee Benefits Security Ac Pension Benefit Guaranty Co		,	s are required to provide t		ion		m is Open to Public
			ERISA section 103(a)(2)				Inspection
For calendar plan year 20	20 or fiscal plan	year beginning 01/01/2020		and er	ding 12/3	1/2020	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (Pl	N) ►	504
C Plan sponsor's name a NOKIA OF AMERICA CO		e 2a of Form 5500			oyer Identific 3408857	cation Number (	EIN)
		ning Insurance Contract					
1 Coverage Information:							
(a) Name of insurance ca HORIZON BCBS OF NJ	arrier					Delimon	
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a		(6)	,	ontract year
	code	identification number	policy or contrac	,	.,	From	<b>(g)</b> To
22-2651245	95529	67-77087	101		01/01/202	0	12/31/2020
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in
	amount of comm	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales a			ees and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpose			(e) Organization code
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
							Γ

(b) Amount of sales and base			
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	
<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 th ing purposes if such cor	ntracts 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	c	Vision		d Life insurance	
	еĪ	Ter	nporary disability (accident and sickness)	f Long-term disabi	ility <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	TTO contract			
	m	Otr	ner (specify)						
a	Evn	oriona	e-rated contracts:						
3			ums: (1) Amount received		9a(1)			-	
	u		crease (decrease) in amount due but unpaid					-	
		• •	crease (decrease) in unearned premium res						
		• •	arned ((1) + (2) - (3))				9a(4)		(
	b	• •	efit 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	laims charged				9b(4)		
	С	Rem	ainder 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					_	
		`	E) Taxes					_	
		``	F) Charges for risks or other contingencies .					_	
			G) Other retention charges				0-(4)(1))		
		`	H) Total retention				9c(1)(H)		(
			vividends or retroactive rate refunds. (These				9c(2)		
	d		us of policyholder reserves at end of year: (1				9d(1)		
		• •	laim reserves				9d(2)		
	•	• •	other reserves				9d(3)		
10			lends or retroactive rate refunds due. (Do no erience-rated contracts:	ot include amount entere	ea in line 90(2)	.)	9e		
10	-	•		arriar			102	~	2402
	a L		I premiums or subscription charges paid to c				10a		24037
	b		carrier, service, or other organization incurn				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	Α	Insura	nce Informatio	n			
(Form 5500				•		OM	IB No. 1210-0110
Department of the Treas Internal Revenue Serv	sury	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			attachment to Form 55		,		
Pension Benefit Guaranty Co		Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			tion		m is Open to Public Inspection
For calendar plan year 20	20 or fiscal plar	year beginning 01/01/2020	<u></u>	and er	ding 12/3	31/2020	
A Name of plan NOKIA RETIREE WELFA					e-digit number (P	N) 🕨	504
C Plan sponsor's name a NOKIA OF AMERICA CO		∋ 2a of Form 5500		-	oyer Identific 3408857	cation Number (	(EIN)
		ning Insurance Contract. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca UHC OF CALIFORNIA	1	(1) 0	(e) Approximate nu	umber of		Policy or co	ontract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac	t end of	(f)	From	(g) To
95-2931460	00000	142111	149		01/01/202	0	12/31/2020
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in
	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 entrie	es as needed to report all	persons).			
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales a	nd base	F	ees and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpose			(e) Organization code
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	ions or fees	s were paid	
		F	ees and other commission	ns naid			

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

# (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	
<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

Ρ	art		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 con	tracts are exp	erience-rated as a uni	t. Where co	ontracts cover individual	
8	Ben	efit ar	nd contract type (check all applicable boxes)						
	a	He	alth (other than dental or vision)	<b>b</b> Dental	c	Vision		d Life insurance	
	еĪ	Те	mporary disability (accident and sickness)	f Long-term disabil	lity <b>a</b>	Supplemental unem	ployment	<b>h</b> Prescription drug	
	ιĒ		op loss (large deductible)	j 🛛 HMO contract	_	PPO contract		I Indemnity contract	
	• L			J M Hime contract	n L				
	m	Ot	her (specify)						
Q	Evne	ariono	e-rated contracts:						
3			iums: (1) Amount received		9a(1)			-	
	ŭ		ncrease (decrease) in amount due but unpaid					-	
			ncrease (decrease) in unearned premium res					-	
		• •	arned ((1) + (2) - (3))				9a(4)		(
	b	• •	efit charges (1) Claims paid		-				
			ncrease (decrease) in claim reserves		· · · ·			-	
			ncurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		(
		(4) C	laims charged				9b(4)		
	С	Rem	ainder of premium: (1) Retention charges (c	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 .					_	
			G) Other retention charges						
			H) Total retention	_			9c(1)(H)	<u> </u>	(
			Dividends or retroactive rate refunds. (These				9c(2)		
	d		us of policyholder reserves at end of year: (1	, ,			9d(1)		
		(2) C	Claim reserves				9d(2)		
		• •	Other reserves				9d(3)	_	
4.0			dends or retroactive rate refunds due. (Do n	ot include amount entere	d in line <b>9c(2)</b>	.)	9e		
10	-	•	erience-rated contracts:				10		
	a		I premiums or subscription charges paid to c				10a	72	7075
	b		e carrier, service, or other organization incur ation of the contract or policy, other than rep				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 (Form 5500		Insuranc	e Information		ОМ	IB No. 1210-0110	
Department of the Treas Internal Revenue Serv	sury	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.				
Pension Benefit Guaranty Co	rporation	•	re required to provide the informa RISA section 103(a)(2).	the information		This Form is Open to Public Inspection	
For calendar plan year 20	20 or fiscal plar	year beginning 01/01/2020	and e	nding 12/3	31/2020	_	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN		ee-digit n number (P	N) •	504	
C Plan sponsor's name a NOKIA OF AMERICA CO		e 2a of Form 5500		oyer Identific 3408857	cation Number (	(EIN)	
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca PARTNERS NATL HEALTI		IC INC.	(e) Approximate number of	1	Policy or o	ontract vear	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	(f)	From	(g) To	
56-0894904	54631	11453	495	01/01/202	0	12/31/2020	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. List in line 3	the agents,	brokers, and o	ther persons in	
	amount of comr	nissions paid	<b>(b)</b> T	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 whom commis	sions or fees	s were paid		
(b) Amount of sales ar			s and other commissions paid			4	
commissions pa	d	(c) Amount	<b>(d)</b> Purpos	e		(e) Organization code	
	(a) Nome a	nd address of the agent, broker, o	ar other percente when commis	sions or foos	woro poid		
	(a) Name a	na address of the agent, bloker, t			s were pain		

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Domentical Deduction Act Natio	a	- FEOO	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	(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	
<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 reporti						
		employees, the entire group of such individu						
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		<b>d</b> Life insurance	
	e	Temporary disability (accident and sickness)	f Long-term disability	′ g	Supplemental unem	ployment l	h Prescription drug	
	i	Stop loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)						
	[							
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 (or	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)(H)		0
		(2) Dividends or retroactive rate refunds. (These	amounts were 🗌 paid in d	cash, or 🗌 d	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 no	t include amount entered	in line <b>9c(2)</b> .	)	9e		
10	) No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to ca	arrier			10a	45730	)4
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	nnection wit	h the acquisition or			
	~	retention of the contract or policy, other than repo				10b		
	Spe	cify 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	

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

SCHEDULE / (Form 5500)		Insuran	ce Information	h			
(Form 5500)		Insurance Information			OMB No. 1210-0110		
Department of the Treasury This schedule is required to be filed under				n 101 of th			2020
Department of the Treasur Internal Revenue Service			a to be filed under section frome Security Act of 19				2020
Department of Labor Employee Benefits Security Admin	inistration	File as an a	attachment to Form 550	00.			
Pension Benefit Guaranty Corp	poration	Insurance companies pursuant to l	are required to provide th ERISA section 103(a)(2).		ion	This Form is Open to Public Inspection	
For calendar plan year 2020	) or fiscal plan	year beginning 01/01/2020		and er	ding 12/3	1/2020	
A Name of plan NOKIA RETIREE WELFARE BENEFITS PLAN			·		e-digit number (Pl	N) ►	504
C Plan sponsor's name as shown on line 2a of Form 5500 NOKIA OF AMERICA CORPORATION			D Employer Identification Number (EIN) 22-3408857				EIN)
		ning Insurance Contract Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance carri UHC OF OKLAHOMA	ier			umbor of		Policy or co	potract year
(b) EIN (c) NAIC code		(d) Contract or identification number	(e) Approximate number persons covered at end		(f)	From	(g) To
33-0115166 9	96903	008102	policy or contract		01/01/2020		12/31/2020
		000102	12		01/01/2020		12/01/2020
2 Insurance fee and commi descending order of the a		tion. Enter the total fees and tot	tal commissions paid. Li	st in line 3	the agents,	brokers, and ot	ther persons in
(a) Total an	nount of comm	nissions paid		<b>(b)</b> To	(b) Total amount of fees paid		
3 Persons receiving comm		es. (Complete as many entries					
		nd address of the agent, broker,					
(b) Amount of sales and			ees and other commissions paid				
commissions paid		(c) Amount		(d) Purpos	e		(e) Organization code
	(a) Name ar	nd address of the agent, broker,	or other person to whom	n commiss	ions or fees	were paid	
			es and other commission				

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
For Denemicarly Deduction Act Natio			Calcadula 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	(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

P	Part	III Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individual	roup of employees of the angle purposes if such contra	acts are expe	rience-rated as a unit	. Where con	tracts	cover individual
8	Ben	nefit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	<b>b</b> Dental	С	Vision	C	1 🗌 L	ife insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemp	oloyment <b>h</b>	ף 🗌 ר	Prescription drug
	i [	Stop loss (large deductible)	j 🛛 HMO contract	k	PPO contract		I∏ Ir	ndemnity contract
	m	Other (specify)	_				_	
9	Expe	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 rese	rve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		0
	b	Benefit charges (1) Claims paid	······	9b(1)				
		(2) Increase (decrease) in claim reserves						
		(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	L	9c(1)(G)				
		(H) Total retention	_	_		9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These a	amounts were paid in o	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	include amount entered i	in line <b>9c(2)</b> .	)	9e		
10	) No	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to ca	rrier			10a		361888
	b	If the carrier, service, or other organization incurre				10b		

11 Did the insurance 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.

**Provision of Information** 

Specify nature of costs.

Part IV

SCHEDUL	.E A	Insuran	nce Information	n			IP.No. 1210.0110
(Form 550	00)				/IB No. 1210-0110		
Department of the Tr Internal Revenue S			ed to be filed under section ncome Security Act of 19				2020
Department of La Employee Benefits Security			attachment to Form 55	,	,		
Pension Benefit Guaranty		Insurance companies pursuant to	are required to provide t ERISA section 103(a)(2)		tion		m is Open to Public Inspection
For calendar plan year	2020 or fiscal pla	n year beginning 01/01/2020		and er	nding 12/3	31/2020	
A Name of plan NOKIA RETIREE WELI	FARE BENEFITS	S PLAN			e-digit number (P	N) 🕨	504
C Plan sponsor's name NOKIA OF AMERICA C		e 2a of Form 5500			oyer Identific 3408857	cation Number (	(EIN)
		rning Insurance Contrac					
1 Coverage Information							
(a) Name of insurance HUMANA HEALTH PLAI	NS, INC. (c) NAIC	(d) Contract or	(e) Approximate nu				ontract year
	code	identification number		persons covered at end of policy or contract year		From	<b>(g)</b> To
61-1279717	95158	SEE BELOW*	94	Ļ	01/01/202	0	12/31/2020
2 Insurance fee and co descending order of t		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
	al amount of com	missions paid		<b>(b)</b> T	otal amount	of fees paid	
3 Persons receiving co		ees. (Complete as many entries	•	•			
	(a) Name a	and address of the agent, broker				איפופ אמע	
(b) Amount of sales			Fees and other commissions paid				
commissions	paid	(c) Amount		(d) Purpos	e		(e) Organization code
	(a) Name a	and address of the agent, broker	r, or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales	and base	Fe	es and other commissio	ns paid			

(b) Amount of sales and base		Fees and other commissions paid		
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	

	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	art III Welfare Benefit Contract Information							
		If more than one contract covers the same g the information may be combined for reportin						),	
		employees, the entire group of such individu							
8	Ben	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	<b>b</b> Dental	c	Vision	(	<b>d</b> Life insurance		
	e	Temporary disability (accident and sickness)	f Long-term disability	∕ g _	Supplemental unem	ployment l	<b>h</b> Prescription drug		
	i	Stop loss (large deductible)	j X HMO contract	k [	PPO contract		I Indemnity contract	t	
	m	Other (specify)							
	[								
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 (or	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		······ <u></u> ··		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 no	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	2	05688	
	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			
11 Did the	insurance 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 A (Form 5500) Department of the Treasury Internal Revenue Service		Insurance Information			OMB No. 1210-0110		
		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					
Department of Labor Employee Benefits Security Adr		File as an attachment to Form 5500.					
Pension Benefit Guaranty Co		<ul> <li>Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</li> </ul>			tion	This Form is Open to Public Inspection	
For calendar plan year 202	20 or fiscal plan	year beginning 01/01/2020		and er	ding 12/3	1/2020	
A Name of plan NOKIA RETIREE WELFA		<b>B</b> Thre plan	e-digit number (Pl	PN) ▶ 504			
C Plan sponsor's name a NOKIA OF AMERICA COI		D Employer Identification Number (EIN) 22-3408857					
		ning Insurance Contrac					
1 Coverage Information:							
(a) Name of insurance ca METROPOLITAN LIFE INS		IPANY					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or (e) Approxima persons cove				Policy or contract year	
	code	identification number		policy or contract year		From	<b>(g)</b> To
13-5581829	65978	95083-G 69995			01/01/2020 1		12/31/2020
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comn	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
		180000	0000 526038				
3 Persons receiving com	missions and fe	es. (Complete as many entries	s as needed to report all	persons).			
	(a) Name ar	nd address of the agent, broker	, or other person to whor	m commiss	ions or fees	were paid	
AON CONSULTING INC			NETWORK PLACE AGO, IL 60673-1298				
(b) Amount of sales and base		Fees and other commissions paid					
commissions paid		(c) Amount	(d) Purpose			(e) Organization code	
180000		526038 O M	OTHER SUPPLEMENTAL COMPENSATION NON- MONETARY COMPENSATION		ON-	3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
	( <b>-</b> )		es and other commission				1

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

Schedule A (Form 5500) 2020 v. 200204
Page **2** – 1

# (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

	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

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

Schedule A (Form 5500) 2020

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

b         Benefit charges (1) Claims paid	Contract Information	
employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.         8       Benefit and contract type (check all applicable boxes)         a       Health (other than dental or vision)       b       Dental       c       Vision       d       ⊥ Life insurance         e       Temporary disability (accident and sickness)       f       Long-term disability       g       Supplemental unemployment       h       Prescription drug         i       Stop loss (large deductible)       j       HMO contract       k       PPO contract       l       Indemnity contract         m       Other (specify)       ▶         9       Experience-rated contracts:		
8       Benefit and contract type (check all applicable boxes)         a       Health (other than dental or vision)       b       Dental       c       Vision       d       X       Life insurance         e       Temporary disability (accident and sickness)       f       Long-term disability       g       Supplemental unemployment       h       Prescription drug         i       Stop loss (large deductible)       j       HMO contract       k       PPO contract       I       Indemnity contract         m       Other (specify)       ▶         9       Experience-rated contracts:       a       Premiums: (1) Amount received       g       3050877         (2) Increase (decrease) in amount due but unpaid       g       9a(1)       83050877       0         (3) Increase (decrease) in unearned premium reserve       9a(3)       0       0         (4) Earned ((1) + (2) - (3))       9a(3)       0       83050         b       Benefit charges (1) Claims paid.       9b(1)       87303627       0         (2) Increase (decrease) in claim reserves.       9b(2)       3222545       0         (3) Incurred claims (add (1) and (2))       9b(3)       90522         (4) Claims charged.       9b(4)       90521		
a       Health (other than dental or vision)       b       Dental       c       Vision       d       Life insurance         e       Temporary disability (accident and sickness)       f       Long-term disability       g       Supplemental unemployment       h       Prescription drug         i       Stop loss (large deductible)       j       HMO contract       k       PPO contract       I       Indemnity contract         m       Other (specify)       >        9a(1)       83050877       30(2)       0       9a(2)       0       9a(3)       0       83050877       9a(4)       83050 <td></td> <td></td>		
e       Temporary disability (accident and sickness)       f       Long-term disability       g       Supplemental unemployment       h       Prescription drug         i       Stop loss (large deductible)       j       HMO contract       k       PPO contract       I       Indemnity contract         m       Other (specify)       ▶         9       Experience-rated contracts:       a       Premiums: (1) Amount received       9a(1)       83050877       9a(2)       0         (2)       Increase (decrease) in amount due but unpaid       9a(3)       0       9a(3)       0         (3)       Increase (decrease) in unearned premium reserve       9a(3)       0       9a(4)       83050         b       Benefit charges (1) Claims paid       9b(1)       87303627       9b(2)       3222545         (3)       Incurred claims (add (1) and (2))       9b(3)       90522       9b(3)       90522         (4)       Claims charged       9b(4)       90522       9b(4)       90522		
i       Stop loss (large deductible)       j       HMO contract       k       PPO contract       I       Indemnity contract         m       Other (specify)       >         9a(1)       83050877         (2) Increase (decrease) in amount due but unpaid       9a(2)       0       0          (3) Increase (decrease) in unearned premium reserve       9a(3)       0           (4) Earned ((1) + (2) - (3))       9a(3)       0             b       Benefit charges (1) Claims paid       9b(1)       87303627              (2) Increase (decrease) in claim reserves       9b(2)       3222545		
m □ Other (specify)         9 Experience-rated contracts:         a Premiums: (1) Amount received		
9 Experience-rated contracts:       9a(1)       83050877         (2) Increase (decrease) in amount due but unpaid       9a(2)       0         (3) Increase (decrease) in unearned premium reserve       9a(3)       0         (4) Earned ((1) + (2) - (3))       9a(3)       0         (2) Increase (decrease) in claim reserve       9b(1)       87303627         (2) Increase (decrease) in claim reserves       9b(2)       3222545         (3) Incurred claims (add (1) and (2))       9b(3)       90520         (4) Claims charged       9b(4)       90520		
a       Premiums: (1) Amount received		
a       Premiums: (1) Amount received		
(2) Increase (decrease) in amount due but unpaid		
(3) Increase (decrease) in unearned premium reserve       9a(3)       0         (4) Earned ((1) + (2) - (3))       9a(4)       83050         (b) Benefit charges (1) Claims paid		
(4) Earned ((1) + (2) - (3))       9a(4)       83050         b Benefit charges (1) Claims paid		
b         Benefit charges (1) Claims paid         9b(1)         87303627           (2) Increase (decrease) in claim reserves         9b(2)         3222545           (3) Incurred claims (add (1) and (2))		0877
(2) Increase (decrease) in claim reserves		
(3) Incurred claims (add (1) and (2))       9b(3)       90520         (4) Claims charged       9b(4)       90520		
		3172
C Remainder of premium: (1) Retention charges (on an accrual basis)	90526 <sup>°</sup>	6172
	Retention charges (on an accrual basis)	
(A) Commissions 9c(1)(A) 180000		
(B) Administrative service or other fees 9c(1)(B) 0		
(C) Other specific acquisition costs		
(D) Other expenses		
(E) Taxes		
(F) Charges for risks or other contingencies		
(G) Other retention charges		2562
(3) Other reserves		915U
10 Nonexperience-rated contracts:		
a Total premiums or subscription charges paid to carrier	on charges paid to carrier	_
<ul> <li>b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.</li> <li>10b</li> </ul>		

Part IV	Provision of Information			
11 Did the	insurance 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 A (Form 5500)         Insurance Information         OME No. 12100110           Determent of the Tempore Retirement income Security Act of 1974 (ERIS).         File as an attachment form 5500.         This Sorbeidue Is equired to provide the information pursuant to ERISA section 103(a)(2).         This Form is Open to Public particular biased discovery and ending.         Total Plan very 2000           For calendar plan very 2020 of fiscal plan very beginning.         0.001022200         and ending.         1231/2020           A Here of plan         B         Three-digt         good         dodd           OKIA RETIREE WELFARE BENEFITS PLAN         B         Three-digt         good           C Plan sponsor's name as schoord none 2a of Fom 5500         D         Engloyee Identification Number (PN)         codd           OKIA OF ALERICA CORPORATION         22-34086071         D         Engloyee Identification Number (EIN)         codd           1 Coverage Information:         (e) Name of the insurance carrier         A         diamination:         (f) From is 20 contract year           (b) EIN         (c) NAIC         (e) NAIC         (f) Contract or periors covered at end of policy or contract year         (f) From is 20 contract year           (b) FIN         (c) NAIC         (e) Contract or periors covered at end of policy or contract year         (f) From is 20 contract year           (b) FIN         (c) NAIC		•	•					
This schedule is required to be filed under section 104 of the Employee Retirement Hocan Security Act 1974 (ERISA).         2020           Prequest Retirement of Lator Employee Retirement to CRISA section 1008(a)(2).         This Schedule action 1008(a)(2).         This Form is Open to Public Inspection           For calendar plan year 2020 of fiscal plan year beginning.         0.101/2020         and ending         1231/2020           A Name of plan         B         Three-digit plan number (PN)         \$64           NCKIA RETIREE WELFARE BENEFITS PLAN         B         Three-digit plan number (PN)         \$64           C         Plans sponsor's name as shown on line 2a of Form 5500 NOKIA OF AMERICA CORPORATION         D         Employer Identification Number (EIN) 22340857           Part I         Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide Information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.         1           1         Coverage Information: (a) Name of insurance carrier ARTM HEALTH PLANS         (a) Contract or identification number         Pailoy or contract year persons covered at end of poly or contract year           (b) EIN         (c) NAIC         (d) Contract or identification number         Pailoy or contract year           (c) Diamance carrier ARTM HEALTH PLANS         12/31/2020         12/31/2020         12/31/2020         2			Insuran	ice information	n		ОМ	B No. 1210-0110
Description       Participation       > File as an attachment to Form 5500.       This Form is Open to Public Inspection Disk (2).         Person based Guarany Corporation       > Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).       This Form is Open to Public Inspection Disk (2).         For calendar plan year 2020 or fiscal plan year beginning OLDIZ/2020       and ending 12/31/2020       504         A Name of plan NOKIA CENPORATION       B Three-digit plan number (PN)       \$ 504         C Plan sponsor's name as shown on line 2a of Form 5500 NOKIA OF AMERICA CORPORATION       D Employeer Identification Number (EIN) 22-3408857         Part 1       Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide Information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and II can be reported on a single Schedule A.         1 Coverage Information:       (a) Name of insurance carrier AETNA HEALTH PLANS       (b) EIN       (c) NAIC       (d) Contract or persons covered at end of persons covered at end of policy or contract year       Policy or contract year         (b) EIN       (c) NAIC       (d) Contract or person persons in descending order of the amount paid.       (e) Approximate number of persons in descending order of the amount of commissions paid       (b) Total amount of fees paid         3 Persons receiving commissions and fees, (Complete as many entries as needed to report all persons).       (e) Organization code         (b) Amount of sales a	Department of the Treas				2020			
Enclose Bounds Society Administration <ul> <li>File as an attachment to Form \$500.</li> <li>Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</li> <li>For calendar plan year 2020 or fiscal plan year beginning 01/01/2020</li> <li>and ending 12/31/2020</li> <li>This Form is Open to Public inspection</li> <li>C Plan sponsor's name as shown on line 2a of Form 5500.</li> <li>D Employer Identification Number (EIN)</li> <li>22-3408857</li> <li>Part I</li> <li>Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.</li> <li>1 Coverage Information:</li> <li>(a) Name of insurance carrier</li> <li>AETINA HEALTH PLANS</li> <li>(b) EIN</li> <li>(c) NAIC</li> <li>(d) Contract or policy or contract year</li> <li>(e) Approximate number of policy or contract year</li> <li>(f) From</li> <li>(g) To</li> <li>52.1270921</li> <li>(g) Contract or policy or contract year</li> <li>(g) To</li> <li>(g) To</li> <li>(g) Total amount of commission information. Enter the total fees and total commissions paid</li> <li>(h) Total amount of commissions paid</li> <li>(h) Total amount of fees paid</li> <li>(g) Name and address of the agent, broker, or other person to whom commissions or fees were paid</li> <li>(h) Amount of sales and base</li> <li>(c) Amount</li> <li>(d) Name and address of the agent, broker, or other person to whom commissions or fees were paid</li> <li>(e) Amount of sales and base</li> <li>(f) Amount of sales and base</li> <li>(h) Name and address of the agent, broker, or other person to whom c</li></ul>					.).			
Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).       Inspection         For calendar plan year 2020 or fiscal plan year beginning       01/01/2020       and ending       12/31/2020         A Name of plan       B       Three-digit plan number (PN)       \$04         OC Plan sponsor's name as shown on line 2a of Form 5500       D       Employer Identification Number (EIN)         OCAL OF AMERICA CORPORATION       D       Employer Identification Number (EIN)         2.3-408657       2.3-408657         Part 1       Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.         1       Coverage Information:       (e) Approximate number of Policy or contract year         (b) EIN       (c) NAIC       (d) Contract or identification number       Persons covered at end of Policy or contract year         52-1270921       95287       US028740       81       01/01/2020       12/31/2020         2       Insurance fee and commissions information. Enter the total fees and total commissions paid.       (b) Total amount of fees paid         3       Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).       (e) Organization code         (b) Amount of sales and base       (c)	Employee Benefits Security Ad	Iministration	,				This For	m is Open to Public
A Name of plan NOKIA RETIREE WELFARE BENEFITS PLAN       B       Three-digit plan number (PN)       504         C Plan sponsor's name as shown on line 2a of Form 5500 NOKIA OF AMERICA CORPORATION       D       Employer Identification Number (EIN) 22:3408857         Part I       Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.         1       Coverage Information:         (a) Name of insurance carrier AETNA HEALTH PLANS         (b) EIN       (c) NAIC code       (d) Contract or identification number policy or contract year policy or contract year         (b) EIN       (c) NAIC code       (d) Contract or identification number policy or contract year         (a) Total amount of commissions paid       (b) Total amount paid.         (c) Total amount paid.       (b) Total amount of commissions paid         (c) Amount of commissions and fees. (Complete as many entries as needed to report all persons).         (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid         (b) Name and address of the agent, broker, or other person to whom commissions or fees were paid	<ul> <li>Insurance companies are required to provide the information</li> </ul>				•			
NOKIA RETIREE WELFARE BENEFITS PLAN       plan number (PN)       504         plan number (PN)       504         C Plan sponsor's name as shown on line 2a of Form 5500       D Employer Identification Number (EIN)         NOKIA OF AMERICA CORPORATION       D Employer Identification Number (EIN)         Part I       Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.         1 Coverage Information:       (a) Name of insurance carrier         (b) EIN       (c) NAIC       (d) Contract or identification number of persons covered at end of policy or contract year         (b) EIN       (c) NAIC       (d) Contract or identification number of persons covered at end of the anount paid.       Policy or contract year         52:1270921       95287       US028740       81       01/01/2020       12/31/2020         2 Insurance fee and commission information. Enter the total fees and total commissions paid.       List in line 3 the agents, brokers, and other persons in descending order of the amount paid.       (b) Total amount of commissions paid       (b) Total amount of fees paid         3 Persons receiving commissions and fees.       (Complete as many entries as needed to report all persons).       (e) Organization code         (b) Armount of sales and base       Fees and other commissions or fees were paid       (e) Or		20 or fiscal plan	year beginning 01/01/2020			0	31/2020	1
NOKIA OF AMERICA CORPORATION         22-3408857           Part I         Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.           1         Coverage Information:           (a) Name of insurance carrier AETNA HEALTH PLANS           (b) EIN         (c) NAIC code         (d) Contract or identification number         (e) Approximate number of parsons covered at end of policy or contract year         Policy or contract year           52-1270921         95287         US028740         81         01/01/2020         12/31/2020           2         Insurance fee and commission information. Enter the total fees and total commissions paid.         List in line 3 the agents, brokers, and other persons in descending order of the amount paid.           (a) Total amount of commissions paid         (b) Total amount of fees paid           (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid           (b) Amount of sales and base 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         (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			-	0	N) 🕨	504		
on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.         1 Coverage Information:         (a) Name of insurance carrier         AETNA HEALTH PLANS         (b) EIN       (c) NAIC         (d) Contract or identification number       (e) Approximate number of persons covered at end of policy or contract year         (f) From       (g) To         52-1270921       95287         US028740       81         01/01/2020       12/31/2020         2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.         (a) Total amount of commissions paid       (b) Total amount of fees paid         (a) Total amount of commissions and fees. (Complete as many entries as needed to report all persons).       (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid         (b) Amount of sales and base commissions paid       Fees and other 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       (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	•		e 2a of Form 5500		-		cation Number (	EIN)
(a) Name of insurance carrier         AETNA HEALTH PLANS         (b) EIN       (c) NAIC code       (d) Contract or identification number       (e) Approximate number of persons covered at end of policy or contract year       (f) From       (g) To         52-1270921       95287       US028740       81       01/01/2020       12/31/2020         2       Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.       (a) Total amount of commissions paid       (b) Total amount of fees paid         (a) Total amount of commissions and fees. (Complete as many entries as needed to report all persons).       (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid         (b) Amount of sales and base commissions paid       Fees and other commissions paid       (e) Organization code         (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid       (e) Organization code								
AETNA HEALTH PLANS         (b) EIN       (c) NAIC code       (d) Contract or identification number       (e) Approximate number of persons covered at end of policy or contract year       Policy or contract year         52-1270921       95287       US028740       81       01/01/2020       12/31/2020         2       Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.       (b) Total amount of fees paid         (a) Total amount of commissions paid       (b) Total amount of fees paid       3         (b) Amount of sales and base       Fees and other commissions paid       (c) Amount         (b) Amount of sales and base       Fees and other commissions paid       (c) Organization code         (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid       (e) Organization code	<b>1</b> Coverage Information:							
(b) EIN       code       identification number       persons covered at end of policy or contract year       (f) From       (g) To         52-1270921       95287       US028740       81       01/01/2020       12/31/2020         2       Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.       (b) Total amount of commissions paid       (b) Total amount of fees paid         3       Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).       (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid         (b) Amount of sales and base       Fees and other 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       (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	AETNA HEALTH PLANS	1	(d) Contract or	(e) Approximate nu	umber of		Policy or co	ontract year
2       Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.         (a) Total amount of commissions paid       (b) Total amount of fees paid         3       Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).         (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid         (b) Amount of sales and base       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	<b>(b)</b> EIN		( )	persons covered at e		(t) From		<b>(g)</b> To
descending order of the amount paid.         (a) Total amount of commissions paid         (b) Total amount of fees paid         3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).         (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid         (b) Amount of sales and base commissions paid       (c) Amount         (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	52-1270921 95287 US028740		81	•	01/01/202	0	12/31/2020	
(a) Total amount of commissions paid       (b) Total amount of fees paid         3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).       (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid         (a) Name and address of the agent, broker, or other person to whom commissions paid       (b) Amount of sales and base         (b) Amount of sales and base       Fees and other commissions paid       (c) Amount         (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       (c) Amount			tion. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid         (b) Amount of sales and base commissions paid       Fees and other commissions paid       (e) Organization code         (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			nissions paid		<b>(b)</b> To	otal amount	of fees paid	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid         (b) Amount of sales and base commissions paid       Fees and other commissions paid       (e) Organization code         (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								
(b) Amount of sales and base commissions paid       Fees and other commissions paid       (e) Organization code         (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       Image: commission of the agent, broker, or other person to whom commissions or fees were paid	3 Persons receiving com	missions and fe	es. (Complete as many entries	s as needed to report all	persons).			
(b) Anothe of sales and base (c) Amount (d) Purpose (e) Organization code (e) Organization code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid		(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	sions or fees	s were paid	
(b) Anothe of sales and base (c) Amount (d) Purpose (e) Organization code (e) Organization code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								_
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	(b) Amount of sales a	nd base	Fe	es and other commission	ns paid			-
	commissions paid (c) Ar		(c) Amount		(d) Purpos	e		(e) Organization code
		(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	sions or fees	s were paid	
Fees and other commissions paid								

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose		(e) Organization code
For Denemyerk Deduction Act Nation	, and the Instructions for For		Cahaa	ula A (Earm EE00) 2020

Page **2** – 1

# (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

	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	

Schedule A (Form 5500) 2020

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.

Ρ	Part	III Welfare Benefit Contract Informat If more than one contract covers the same gr the information may be combined for reportin employees, the entire group of such individual	oup of employees of the s g purposes if such contra	acts are expe	rience-rated as a unit	. Where co	ntracts cover ind	
8	Ben	nefit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		d Life insura	ance
	е	Temporary disability (accident and sickness)	Long-term disability	g	Supplemental unemp	oloyment	h Prescriptio	on drug
	ίĪ	☐ Stop loss (large deductible)	HMO contract	k∏	PPO contract		I Indemnity	contract
	m							
9	Expe	perience-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 reser	rve	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)		1		
		(3) Incurred claims (add (1) and (2))				9b(3)		0
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on					_	
		(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	L	9c(1)(G)		<b>a</b> (1)(1)	_	
		(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)	Amount held to provide be	enefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do not	include amount entered i	in line <b>9c(2)</b> .	)	9e		
10	) No	onexperience-rated contracts:					_	
	а	Total premiums or subscription charges paid to car	rier			10a		552840
	b	If the carrier, service, or other organization incurred retention of the contract or policy, other than report				10b		

Pa	art IV	Provision of Information			
11	Did the	insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12	If the ar	swer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insura	nce Informatio	n			
(Form 5500						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			attachment to Form 55				
Pension Benefit Guaranty Co					ion		m is Open to Public
	<ul> <li>Pension Benefit Guaranty Corporation</li> <li>Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</li> </ul>				Inspection		
For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020				1/2020	1		
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (Pl	N) 🕨	504
C Plan sponsor's name as shown on line 2a of Form 5500							
C Plan sponsor's name a NOKIA OF AMERICA COI		2a of Form 5500			oyer Identific 3408857	cation Number (	EIN)
		ning Insurance Contract Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca AETNA LIFE INSURANCE		Γ		unalization of		Deliev or co	
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a		(0)	Policy or contract year	
	code	identification number		policy or contract year		From	<b>(g)</b> To
06-6033492	60054	0700140-RET	22214		01/01/202	0	12/31/2020
2 Insurance fee and com descending order of the		tion. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and of	ther persons in
(a) Total a	amount of comn	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons receiving com	missions and fe	es. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name ar	nd address of the agent, broke	er, or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales ar			ees and other commission				
commissions pai	id	(c) Amount		(d) Purpos	е		(e) Organization code
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
							1

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	e, see the Instructions for Form	n 5500. Sc	hedule A (Form 5500) 2020
			v. 200204

Page **2** – 1

# (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

(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

Schedule A (Form 5500) 2020

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)			
	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

Ρ	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	racts are exp	perience-rated as a unit	t. Where co	ontracts cover individual	
8	Ben	efit ar	nd contract type (check all applicable boxes)						
	a	He	alth (other than dental or vision)	<b>b</b> X Dental	С	Vision		d Life insurance	
	еĪ	Те	mporary disability (accident and sickness)	f Long-term disabilit	tv <b>a</b>	Supplemental unem	plovment	<b>h</b> Prescription drug	
	i [		op loss (large deductible)	j HMO contract	· · · ·	PPO contract		I Indemnity contract	
	' L	_			ĸ				
	m	Oti	her (specify)						
Q	Evn	ariona	e-rated contracts:						
3	•		iums: (1) Amount received		9a(1)			-	
	u		crease (decrease) in amount due but unpaid		9a(2)			-	
		• •	crease (decrease) in unearned premium res		9a(3)			-	
		• •	arned ((1) + (2) - (3))			I	9a(4)		- (
	b		efit charges (1) Claims paid		9b(1)				
			crease (decrease) in claim reserves					-	
			curred claims (add (1) and (2))				9b(3)		(
			laims charged				9b(4)		
	С	Rem	ainder 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)	)	(
		(2) D	Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)		
	d	Statu	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) C	Other reserves				9d(3)		
			dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line <b>9c(2</b> )	<b>(</b> .)	9e		
10	No		erience-rated contracts:				r		
	а	Tota	I premiums or subscription charges paid to c	arrier			10a	8220	3463
	b		e carrier, service, or other organization incurr ntion of the contract or policy, other than repo				10b		

Part IV	Provision of Information			
11 Did the	insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
10				

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

Specify nature of costs.

SCHEDULE	A	Insurar	ce Information	n		OM	IB No. 1210-0110
(Form 5500	))						
Department of the Treas Internal Revenue Serv			ed to be filed under section ncome Security Act of 19				2020
Department of Labo Employee Benefits Security Ad		File as an	attachment to Form 55	00.			
Pension Benefit Guaranty Co	orporation	<ul> <li>Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</li> </ul>			This Form is Open to Public Inspection		
For calendar plan year 20	20 or fiscal plan	year beginning 01/01/2020		and en	ding 12/3	1/2020	
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (Pl	N) 🕨	504
C Plan sponsor's name a NOKIA OF AMERICA CO		e 2a of Form 5500			oyer Identific 3408857	cation Number	(EIN)
		ning Insurance Contract					
1 Coverage Information:							
(a) Name of insurance ca HUMANA HEALTH PLANS						Delianan	
(b) EIN	(c) NAIC	(d) Contract or		(e) Approximate number of persons covered at end of		Policy or contract year	
	code	identification number	policy or contrac	t year	(f) From		<b>(g)</b> To
61-1103898	95270	SEE BELOW*	63		01/01/202	0	12/31/2020
2 Insurance fee and com descending order of the		tion. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total	amount of comm	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons receiving com		ees. (Complete as many entries		· · · · · ·			
	(a) Name a	nd address of the agent, broke	r, or other person to whor	m commiss	ions or fees	were paid	
(b) Amount of sales a		Fees and other commission		•			-
commissions paid		(c) Amount		(d) Purpose			(e) Organization code
	(a) Name a	nd address of the agent, broke	or other person to who	m commiss	ions or fees	were paid	
		nu address of the agent, broke					
	1						

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

Page **2** – 1

# (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

(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

Schedule A (Form 5500) 2020

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.

F	Part	III Welfare Benefit Contract Informat If more than one contract covers the same gu the information may be combined for reportin employees, the entire group of such individual	roup of employees of the og purposes if such contra	acts are expe	rience-rated as a unit	. Where cont	tracts cover individual	
8	Ben	nefit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	<b>b</b> Dental	c	Vision	d	Life insurance	
	е	Temporary disability (accident and sickness)	f 🗌 Long-term disability	, g	Supplemental unemp	oloyment <b>h</b>	Prescription drug	3
	ιĒ		j X HMO contract		PPO contract		I Indemnity contra	ct
	m	☐ Other (specify) ►				-		
9	Expe	perience-rated contracts:						
Ū		Premiums: (1) Amount received	Г	9a(1)				
		(2) Increase (decrease) in amount due but unpaid .		9a(2)				
		(3) Increase (decrease) in unearned premium rese		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)		<b>a</b> (1)(1)		
		(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)	•			9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do not	include amount entered	in line 9c(2).	)	9e		
1(	-	onexperience-rated contracts:				- 10		
	а	Total premiums or subscription charges paid to ca	rrier			10a		60102
	b	If the carrier, service, or other organization incurre retention of the contract or policy other than repor				10b		

Pa	art IV	Provision of Information			
11	Did the	insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12	If the ar	swer to line 11 is "Yes," specify the information not provided.			

SCHEDUL		Insuran	ce Informatior	ו		OM	IB No. 1210-0110
(Form 550		<b>-</b>		101 (1)			
Department of the Tre Internal Revenue Se		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2020	
Department of Lat Employee Benefits Security		File as an a	ttachment to Form 550	00.			
Pension Benefit Guaranty	ty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).		This For	This Form is Open to Public Inspection			
	020 or fiscal plar	n year beginning 01/01/2020		and er	nding 12/3	1/2020	
A Name of plan NOKIA RETIREE WELF	ARE BENEFITS	PLAN	-		e-digit number (P	N) 🕨	504
C Plan sponsor's name NOKIA OF AMERICA CO		e 2a of Form 5500		•	oyer Identific 3408857	cation Number	(EIN)
		ning Insurance Contract					
1 Coverage Information	1:						
(a) Name of insurance of AETNA HEALTH PLANS		(d) Contract or	(e) Approximate nu			Policy or c	ontract year
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To
23-2169745	95109	US028740	58		01/01/202	0	12/31/2020
2 Insurance fee and con descending order of th		ation. Enter the total fees and tota	al commissions paid. Li	st in line 3	the agents,	brokers, and o	ther persons in
<b>(a)</b> Tota	l amount of com	missions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons receiving co		ees. (Complete as many entries		,			
	(d) Name a	nd address of the agent, broker,	or other person to whom				
(b) Amount of sales			s and other commission				_
commissions p	paid	(c) Amount	(	( <b>d)</b> Purpos	e		(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to whon	n commiss	sions or fees	s were paid	
(b) Amount of sales	and have	Fee	s and other commission	ns paid			

For Domentium Production Act Nation	the lucture tions for Four		Calcadula A (Farma EE00) 0000
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(b) Amount of sales and base	F		

Page **2** – 1

# (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

(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

Schedule A (Form 5500) 2020

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	Part		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 emplo ting purposes if	such contracts ar	e exp	erience-rated as a uni	t. Where co	ontracts cover individual	6),
8	Ben	efit ar	nd contract type (check all applicable boxes)							
	а	He	alth (other than dental or vision)	<b>b</b> Dental		С	Vision		d Life insurance	
	еĪ	Те	mporary disability (accident and sickness)	f Long-te	rm disability	a	Supplemental unem	ployment	<b>h</b> Prescription drug	
	ιĒ		op loss (large deductible)	j 🛛 HMO co	-	_	PPO contract	. ,	I Indemnity contrac	+
	• L	_			maer					
	m	Ot	her (specify)							
Q	Evne	riona	ce-rated contracts:							
3			iums: (1) Amount received			1)			-	
			ncrease (decrease) in amount due but unpaid		•	-			-	
			ncrease (decrease) in unearned premium res			-			-	
		• •	arned ((1) + (2) - (3))		· · ·			9a(4)		C
	b	Bene	efit charges (1) Claims paid			1)				
		(2) Ir	ncrease (decrease) in claim reserves			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 (c	on an accrual ba	asis)				_	
		(	(A) Commissions						_	
		(	(B) Administrative service or other fees						_	
			(C) Other specific acquisition costs						_	
		```	(D) Other expenses		0-(4)				_	
			E) Taxes		<b>a</b> (1)				_	
			(F) Charges for risks or other contingencies.							
			(G) Other retention charges					0~(1)(1)		
			(H) Total retention		_			9c(1)(H)	<u>/</u>	(
			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)		
10			dends or retroactive rate refunds due. (Do n erience-rated contracts:			3U(2)	.)	9e	_	
10	a	•	I premiums or subscription charges paid to c	arrier				10a		358817
	_							100		10001
	b		e carrier, service, or other organization incur ation of the contract or policy, other than rep					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	Δ	Insura	nce Information	n			
(Form 5500						OM	B No. 1210-0110
Department of the Treas	ury	This schedule is required to be filed under section 104 of the					2020
Internal Revenue Servi Department of Labor		Employee Retirement Income Security Act of 1974 (ERISA).					
Employee Benefits Security Adr	ministration	,	attachment to Form 55			This For	m is Open to Public
Pension Benefit Guaranty Co		pursuant to	s are required to provide to ERISA section 103(a)(2)		ion		Inspection
	20 or fiscal plan	year beginning 01/01/2020		and en	ding 12/3	31/2020	1
A Name of plan NOKIA RETIREE WELFA	RE BENEFITS	PLAN			e-digit number (Pl	N) 🕨	504
C Plan sponsor's name a NOKIA OF AMERICA COS		≥ 2a of Form 5500			yer Identific 3408857	cation Number (	EIN)
		ning Insurance Contrac Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance can HUMANA HEALTH PLANS		Γ				Deliau en es	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a		(6)	Policy or co	
			policy or contract		.,	From	<b>(g)</b> To
37-1326199	60052	304356, 303931	116		01/01/2020	0	12/31/2020
2 Insurance fee and comr descending order of the		tion. Enter the total fees and t	otal commissions paid. Li	ist in line 3	the agents,	brokers, and of	ther persons in
(a) Total a	amount of comn	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons receiving com	missions and fe	es. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name a	nd address of the agent, broke	er, or other person to whor	m commiss	ions or fees	s were paid	
(b) Amount of sales an		Fees and other commission		•			
commissions paid		(c) Amount		(d) Purpose			(e) Organization code
	(a) Name a	nd address of the agent, broke	er, or other person to whor	m commiss	ions or fees	s were paid	
							Γ

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Schere			Schedule A (Form 5500) 2020
			v. 200204

Page **2** – 1

# (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

(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

Schedule A (Form 5500) 2020

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)			
	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	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 ing purposes if such conf	tracts are exp	erience-rated as a uni	t. Where co	ntracts cover individual	1
8	Ben	efit ar	nd contract type (check all applicable boxes)						
	a	He	alth (other than dental or vision)	<b>b</b> Dental	c	Vision		d Life insurance	
	еĪ	Те	mporary disability (accident and sickness)	f Long-term disabili	ity <b>q</b>	Supplemental unem	ployment	<b>h</b> Prescription drug	
	i [	_	op loss (large deductible)	j X HMO contract	·	PPO contract		I Indemnity contract	
	• L	_			ĸ				
	m	Ot	her (specify)						
a	Evn	riona	ce-rated contracts:						
3			iums: (1) Amount received		9a(1)			-	
	u		ncrease (decrease) in amount due but unpaid					-	
		. ,	ncrease (decrease) in unearned premium res					-	
		• •	arned ((1) + (2) - (3))		,,		9a(4)		0
	b	• •	efit charges (1) Claims paid						
			ncrease (decrease) in claim reserves						
		(3) Ir	ncurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		C
		(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 .		a (1)(a)			4	
		```	(G) Other retention charges				<b>a</b> (1)(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)		
		(2) C	Claim reserves				9d(2)		
		• •	Other reserves				9d(3)		
4.0			dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)	9e		
10	-	•	erience-rated contracts:				10		
	a		I premiums or subscription charges paid to c				10a	31	4849
	b		e carrier, service, or other organization incurr ation of the contract or policy, other than repu				10b		

Specify nature of costs.

Part IV	rovision of Information			
11 Did the ins	rance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
12 If the answ	r to line 11 is "Yes," specify the information not provided.			

SCHEDULE C	Service Provide	r Information		OMB No. 1210-0110			
(Form 5500)			2020				
Department of the Treasury Internal Revenue Service	This schedule is required to be filed un Retirement Income Securit						
Department of Labor Employee Benefits Security Administration	<ul> <li>File as an attachm</li> </ul>	This	Form is Open to Public Inspection.				
Pension Benefit Guaranty Corporation For calendar plan year 2020 or fiscal p	olan year beginning 01/01/2020	and ending 12/31	/2020				
A Name of plan NOKIA RETIREE WELFARE BENEFI		B Three-digit plan number (PN)	•	504			
C Plan sponsor's name as shown on NOKIA OF AMERICA CORPORATIO		D Employer Identificati 22-3408857	D Employer Identification Number (EIN) 22-3408857				
Part I Service Provider Inf	ormation (see instructions)						
or more in total compensation (i.e., n plan during the plan year. If a person answer line 1 but are not required to	rdance with the instructions, to report the infe- noney or anything else of monetary value) in n received <b>only</b> eligible indirect compensatio include that person when completing the ren	connection with services rendered to t in for which the plan received the requi nainder of this Part.	he plan or	the person's position with the			
	ceiving Only Eligible Indirect Con her you are excluding a person from the rem	-	ed only elig	nible			
	blan received the required disclosures (see ir	-	-				
	the name and EIN or address of each personsation. Complete as many entries as needed		r the servic	e providers who			
(b) Enter no	me and EIN or address of person who provid	lad you diaglagurag on oligible indirect		tion			
THE DREYFUS CORPORATION	me and Ein of address of person who provid		compensa	lion			
13-5673135							
(b) Enter na	me and EIN or address of person who provid	led you disclosures on eligible indirect	compensa	tion			
METLIFE							
40 5004000							
13-5881829							
(b) Enter na	me and EIN or address of person who provid	ded you disclosures on eligible indirect	compensa	tion			
(b) Enter na	me and EIN or address of person who provid	ded you disclosures on eligible indirect	compensa	tion			

Page 2- 1

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(a) Enter name and EIN or address (see instructions)

## ALIGHT SOLUTIONS LLC

#### 82-1061233

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
13 15 50	NONE	3042754	Yes 🗌 No 🗙	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		

## EXPRESS SCRIPTS, INC

## 22-3461740

<b>(b)</b> Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest		<b>(e)</b> Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	
13 50	NONE	1530532	Yes 🗌 No 🗙	Yes No	Yes 🗌 No 🗌

(a) Enter name and EIN or address (see instructions)

**IBM WATSON HEALTH** 

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
15 50	NONE	228722	Yes 🗌 No 🔀	Yes 🗌 No 🗌		Yes 🗌 No 🗍

(a) Enter name and EIN or address (see instructions)

## UNITED HEALTHCARE

#### 36-2739571

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
13 50	NONE	182835	Yes 🗌 No 🛛	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		

# AON CONSULTING, INC.

#### 22-2232264

<b>(b)</b> Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest		(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element	
11 16 38 50	NONE	155841	Yes 🗌 No 🗙	Yes No	(f). If none, enter -0	Yes   No

(a) Enter name and EIN or address (see instructions)

NOKIA INVESTMENT MNGMT CORP.

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
31 50	AFFILIATE	42701	Yes 🗌 No 🔀	Yes No		Yes No

(a) Enter name and EIN or address (see instructions)

BANK OF NEW YORK MELLON

#### 13-5160382

<b>(b)</b> Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0				
19 21 25 49 50 62	TRUSTEE	23000	Yes 🗙 No 🗌	Yes 🕺 No 🗌	0	Yes 🗴 No 🗌			
	(a) Enter name and EIN or address (see instructions)								

BLACKROCK INSTITUTIONAL TRUST CO

# 94-3112180

<b>(b)</b> Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
21 24 28 50 51	NONE	22606	Yes 🛛 No 🗌	Yes 🕅 No 🗌	0	Yes 🗌 No 🗙

(a) Enter name and EIN or address (see instructions)

**CANDID LITHO** 

<b>(b)</b> Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest		(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
36 50	NONE	16830	Yes 🗌 No 🛛	Yes 🗌 No 🗌		Yes 🗌 No 🗌

(a) Enter name and EIN or address (see instructions)

PRICEWATERHOUSE COOPERS LLC

#### 13-4008324

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
10 50	NONE	15757	Yes 🗌 No 🗙	Yes 🗌 No 🗌		Yes 🗌 No 🗍
		(	a) Enter name and EIN or	address (see instructions)		

UNIVERSAL MAILING SERVICE

## 22-2381663

<b>(b)</b> Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest			(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
38 50	NONE	13626	Yes 📔 No 🛛	Yes 🗌 No 🗌		Yes 🗌 No 🗍

(a) Enter name and EIN or address (see instructions)

TAX SAVER

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect	Did indirect compensation include eligible indirect	Enter total indirect compensation received by	Did the service provider give you a
Code(s)			compensation? (sources other than plan or plan sponsor)		compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
13 50	NONE	5956	Yes 🗌 No 🔀	Yes No		Yes 🗌 No 🗍

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Part I	Service Provider Information (continued)		
or provid question provider	eported on line 2 receipt of indirect compensation, other than eligible indirect comp des contract administrator, consulting, custodial, investment advisory, investment n is for (a) each source from whom the service provider received \$1,000 or more in i gave you a formula used to determine the indirect compensation instead of an am ntries as needed to report the required information for each source.	nanagement, broker, or recordkeeping ndirect compensation and (b) each so	g services, answer the following burce for whom the service
	(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
	(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.
	(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
	(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.
	(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
	(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

Pa	Int II Service Providers Who Fail or Refuse to	Provide Infor	mation
4	Provide, to the extent possible, the following information for eact this Schedule.	ch service provide	er who failed or refused to provide the information necessary to complete
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service	(C) Describe the information that the service provider failed or refused to provide
_	, 	Code(s)	
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide

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Pa	art III	Termination Information on Accountants and Enrolled Actuaries (see in (complete as many entries as needed)	structions)	
а	Name:	PRICEWATERHOUSECOOPERS LLP	<b>b</b> EIN:	13-4008324
С	Positic	n: ACCOUNTANT		
d	Addres	SS: 300 MADISON AVENUE NEW YORK, NY 10017	e Telephone:	646-471-3000

Explanation: CHANGED AUDITOR DUE TO AUDIT FIRM ROTATION BY PARENT COMPANY.

а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

SCHEDULE D (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	This schedule is Retir	<ul> <li>Participating Plan Information</li> <li>is required to be filed under section 104 of the Employee irement Income Security Act of 1974 (ERISA).</li> <li>File as an attachment to Form 5500.</li> </ul>			OMB No. 1210-0110 2020 This Form is Open to Public			
						Inspect	юп.	
For calendar plan year 2020 or fiscal A Name of plan NOKIA RETIREE WELFARE BENEFI		<u>01/01/2020</u> ar	B	ling <u>12/3</u> Three-digit plan numb	1/2020 ber (PN)	•	504	
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 NOKIA OF AMERICA CORPORATION			D	D Employer Identification Number (EIN) 22-3408857				
	entries as needed	Ts, PSAs, and 103-12 IEs (to be co to report all interests in DFEs)	ompl	eted by pla	ans and D	FEs)		
<b>b</b> Name of sponsor of entity listed in		(INSTITUTIONAL TRUST CO. N.A.						
C EIN-PN 94-3167617-001	d Entity C code	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instructi		or		81	331213	
a Name of MTIA, CCT, PSA, or 103-	12 IE: BLACKROCK	EAFE EQUITY INDEX FUND						
<b>b</b> Name of sponsor of entity listed in	(a): BLACKROCK	INSTITUTIONAL TRUST CO. N.A.						
C EIN-PN 94-6581674-001	d Entity C code	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instructi		or		27	7933177	
a Name of MTIA, CCT, PSA, or 103-	12 IE: BLACKROCK	U.S. DEBT INDEX FUND						
<b>b</b> Name of sponsor of entity listed in	(a): BLACKROCK	INSTITUTIONAL TRUST CO. N.A.						
C EIN-PN 94-3138366-001	d Entity C code	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instructi		or		35	5856083	
a Name of MTIA, CCT, PSA, or 103-	12 IE:							
<b>b</b> Name of sponsor of entity listed in	(a):							
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instructi		or				
a Name of MTIA, CCT, PSA, or 103-	12 IE:							
<b>b</b> Name of sponsor of entity listed in	(a):							
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instructi		or				
a Name of MTIA, CCT, PSA, or 103-	12 IE:							
<b>b</b> Name of sponsor of entity listed in	(a):							
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instructi		or				
a Name of MTIA, CCT, PSA, or 103-	12 IE:							
<b>b</b> Name of sponsor of entity listed in	(a):							
C EIN-PN	<b>d</b> Entity code	e Dollar value of interest in MTIA, CCT, 103-12 IE at end of year (see instructi		or				

Page **2 -** 1

a Name of MTIA, CCT, PSA, or 103-12 IE:							
<b>b</b> Name of sponsor of entity listed in (a):							
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
a Name of MTIA, CCT, PSA, or 103	a Name of MTIA, CCT, PSA, or 103-12 IE:						
<b>b</b> Name of sponsor of entity listed in	<b>b</b> Name of sponsor of entity listed in (a):						
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
<b>a</b> Name of MTIA, CCT, PSA, or 103-	-12 IE:						
<b>b</b> Name of sponsor of entity listed in (a):							
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
<b>a</b> Name of MTIA, CCT, PSA, or 103-	a Name of MTIA, CCT, PSA, or 103-12 IE:						
<b>b</b> Name of sponsor of entity listed in	(a):						
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
<b>a</b> Name of MTIA, CCT, PSA, or 103-	-12 IE:						
<b>b</b> Name of sponsor of entity listed in	(a):						
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
<b>a</b> Name of MTIA, CCT, PSA, or 103-	-12 IE:						
<b>b</b> Name of sponsor of entity listed in	<b>b</b> Name of sponsor of entity listed in (a):						
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
a Name of MTIA, CCT, PSA, or 103	a Name of MTIA, CCT, PSA, or 103-12 IE:						
<b>b</b> Name of sponsor of entity listed in	(a):						
C EIN-PN	<b>d</b> Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
a Name of MTIA, CCT, PSA, or 103	-12 IE:						
<b>b</b> Name of sponsor of entity listed in	<b>b</b> Name of sponsor of entity listed in (a):						
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
<b>a</b> Name of MTIA, CCT, PSA, or 103	-12 IE:						
<b>b</b> Name of sponsor of entity listed in	(a):						
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)					
a Name of MTIA, CCT, PSA, or 103-12 IE:							
<b>b</b> Name of sponsor of entity listed in (a):							
C EIN-PN	d Entity code	<ul> <li>Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)</li> </ul>					

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F	Part II	Information on Participating Plans (to be completed by DFEs) (Complete as many entries as needed to report all participating plans)	
а	Plan na		
b	Name o plan spo		C EIN-PN
а	Plan na	me	
b	Name o plan spo		C EIN-PN
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(Form 5500)         Deservor of the Tenary Items Revenue Lator         Deservor of the Tenary Items Revenue Lator         Deservor of the Tenary Items Revenue Cator         Deservor of the Tenary Item Revenue Cator         A new of plan NOKA RETREES WELFARE BENEFITS PLAN         B Trace digit plan number (PN)       504         Part I Asset and Liability Statement         1         Complay Interview Cator         Part I Asset and Liability Statement         1         Complay Revent State S	SCHEDULE H	Financial In	formatio	on			OMB No. 1210-	·0110	
Lower of the sub-off part set of the feed under section 104 of the Employee Retirement Incense Security Action Security Act						This Form is Open to Public			
Engineering based structures <ul> <li>             Pile as an attachment to Form 5500.         </li> </ul> Inth Form Structures <ul> <li>             Paration and the same Conservation of the same conserva</li></ul>	Department of the Treasury	Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).							
For calendar plan year 2020 or fiscal plan year beginning       01/01/2020       and ending       12/021/2020         A Name of plan       B       Tree-digit plan number (PN)       \$94         MCKIA RETIREE WELFARE BENEFITS PLAN       B       Tree-digit plan number (PN)       \$94         C Plan sponsor's name as shown on line 2a of Form 5500       D       Employer Identification Number (EIN)       22-3406857         Part I       Asset and Liability Statement       D       Employer Identification Number (EIN)       22-3406857         1       Current value of plan assets and liabilities at the beginning the assets of more than one plan on a line-by-line basis unless the value is perportable on lines tr(3) through 1c(14). Do not enter the value of that portion of an instructore.       So and the plan interest perportable on lines through the plan year. Combinet the value of plan assets and 128. If the one complete lines 11 and the See instructores.         I       Current value of plana to accommode of anounts to the nearest collater. MTIAs, CCTR - SAS, and 103-12. IEs also do not complete lines 11 and the See instructores.       Imployer contributions in the second the nearest collater. MTIAs, CCTR - SAS, and 103-12. IEs also do not complete lines 11 and the See instructores.       Imployer contributions.       Imployer conthy-building.       Imployer contri									Thi
A Name of plan       NOKIA RETIREE WELFARE BENEFITS PLAN       B       Three-digit plan number (PN)       504         C Plan sponsor's name as shown on line 2a of Form 5500       D       Employer Identification Number (EIN) 22-3408857         Part I       Asset and Liability Statement		an year beginning 01/01/2020		and	endina 12/3	1/2020			
NOKIA RETIREE WELFARE BENEFITS PLAN       plan number (PN) ▶ 504         C Pian sponsor's name as shown on line 2 of Form 5500       D         NOKIA OF AMERICA CORPORATION       D         Part I Asset and Liability Statement       0         1 Current value of plan assets and liabilities at the beginning and end of the plan year. Corpt as genetic dolar on insurance contract which purparities, during this plan year. Corpt as genetic dolar on insert stole, introduced the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on times test (b) through 10(14). Do of enter the value of that point on a insurance contract which purparitees, during this plan year. to pay a genetic dolar of an insurance contract which purparitees, during this plan year. to pay a genetic dolar of an insurance contract which purparites, during this plan year. to pay a genetic dolar of an insurance contract which purparites, during this plan year. to pay a genetic dolar of an insurance contract which purparites, during this plan year. to pay a genetic dolar of an insurance contract which purparites, during this plan, to pay a state and the set in transmittations.         I a       I a       I a         I b Receivables (less allowance for doubtul accounts):       1 b(1)       I b(2)         (i) Interest-bearing cash.       1 a       I b(2)         I (b) Interest-bearing cash (include money market accounts & certificates of deposit).       1 b(3) 36342000 35290000         I (c) Corporate stocks (other than employer securities):       1 c(4)       I c(2)       I c(4) <th></th> <th></th> <th></th> <th>unu</th> <th>L</th> <th></th> <th></th> <th></th>				unu	L				
NOKA OF AMERICA CORPORATION         22-3408857           Part I Asset and Liability Statement         1         Current value of plan assets and liabilities at the boginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a comming/def fund containing the asset of more than one trust. Report the value of the plan's interest in a comming/def fund containing the asset of more than one trust. Report the value of the plan's interest in a comming/def fund containing the asset of more than one trust. Report the value of the plan's interest in a comming/def fund containing the asset of the plan's interest in a comming/def fund containing of the art of the plan's interest into the interest in a comming/def fund containing.           Assets         (a) Beginning of Year         (b) End of Year           B Total noninterest-bearing cash.         1a         1           Deceivables (less allowance for doubtful accounts):         1b(1)         1           (i) Employer contributions.         1b(3)         36342000         362290000           C General investments:         1c(1)         1c(3)(A)         1c(3)(A)           (b) Preferred         1c(3)(A)         1c(3)(A)         1c(3)(A)           (c) Preferred         1c(4)(A)         1c(3)(A)         1c(3)(A)           (c) Preferred         1c(4)(A)         1c(4)(A)         1c(4)(A)           (d) Preferred         1c(4)(A)         1c(4)(A)         1c(4)(B) <tr< th=""><th></th><th>TS PLAN</th><th></th><th></th><th></th><th>0</th><th>1) 🕨</th><th>504</th></tr<>		TS PLAN				0	1) 🕨	504	
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NOKA OF AMERICA CORPORATION         22-3408857           Part I Asset and Liability Statement         1         Current value of plan assets and liabilities at the boginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a comming/def fund containing the asset of more than one trust. Report the value of the plan's interest in a comming/def fund containing the asset of more than one trust. Report the value of the plan's interest in a comming/def fund containing the asset of more than one trust. Report the value of the plan's interest in a comming/def fund containing the asset of the plan's interest in a comming/def fund containing of the art of the plan's interest into the interest in a comming/def fund containing.           Assets         (a) Beginning of Year         (b) End of Year           B Total noninterest-bearing cash.         1a         1           Deceivables (less allowance for doubtful accounts):         1b(1)         1           (i) Employer contributions.         1b(3)         36342000         362290000           C General investments:         1c(1)         1c(3)(A)         1c(3)(A)           (b) Preferred         1c(3)(A)         1c(3)(A)         1c(3)(A)           (c) Preferred         1c(4)(A)         1c(3)(A)         1c(3)(A)           (c) Preferred         1c(4)(A)         1c(4)(A)         1c(4)(A)           (d) Preferred         1c(4)(A)         1c(4)(A)         1c(4)(B) <tr< th=""><td></td><th>ing 2g of Form 5500</th><td></td><td></td><td></td><td>or Idoptific</td><td>otion Number (E</td><td></td></tr<>		ing 2g of Form 5500				or Idoptific	otion Number (E		
Part I       Asset and Liability Statement         1       Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report Inse t(c) through to(c) 10.0 not enter the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on times t(c) through to(c) 10.0 not enter the value of that points of an insurance contract which guarantees. during this plan year. to pey a specific dollar during the plan year. to pey a specific dollar on the part set of the plan's interest on the one complete lines 1d and 1e. See instructions.         Assets       (a) Beginning of Year       (b) End of Year         a Total noninterest-bearing cash.       1a       (b) End of Year         b Receivables (less allowance for doubtful accounts):       1b(1)       (c) Enderstimestimestimestimestimestimestimestime				1.9					
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the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines to(9) through 15(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs allow do not complete lines 1and 1e. See instructions.          Assets       (a) Beginning of Year       (b) End of Year         a Total noninterest-bearing cash.       1a          b Receivables (less allowance for doubful accounts):       1b(1)           (i) Employer contributions       1b(1)            (j) Other       1b(3)       36342000       35290000          C General investments:       1c(1)             (j) Interest-bearing cash (include money market accounts & certificates of deposit)       1c(2)             (j) Ocrporate stocks (other than employer securities):       1c(3)(A)	Part I Asset and Liability	Statement							
lines tc(9) through tc(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at future date. Round off amounts to the nearest dollar. MTAs, CCTs, PSAs, and 103-12 IEs do not complete lines tb(1), tb(2), tc(8), tg, th, and ti. CCTs, PSAs, and 103-12 IEs do not complete lines to and te. See instructions.         A Statts       (a) Beginning of Year       (b) End of Year         a Total noninterest-bearing cash.       1a       1a         D Receivables (less allowance for doubtful accounts):       1b(1)       1b(2)         (1) Employer contributions.       1b(2)       365342000       35290000         (2) Participant contributions.       1b(3)       365342000       35290000         (3) Other       1c(1)       1b(3)       365342000       35290000         (4) Prefered       1c(2)       1c(1)       1c(3)       1c(3)       1c(3)         (b) All other       1c(3) (A)       1c(3)       1c(3)       1c(3)       1c(3)       1c(3)       1c(3)       1c(3)       1c(3)       1c(4)       1c(3)       1c(4)									
benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1).         a Total noninterest-bearing cash (include money market accounts & certificates of deposit).       1b(1)         (1) Interest-bearing cash (include money market accounts & certificates of deposit).       1b(2)         (2) U.S. Government securities.       1c(2)         (3) Other       1c(3) (A)         (4) Corporate debt instruments (other than employer securities):       1c(3) (A)         (A) Prefered       1c(4) (A)         (B) All other       1c(4) (A)         (B) Common       1c(4) (B)         (C) Drane (other than employer real property)       1c(6)         (6) Participant bin/point venture interests       1c(6)         (7) Loans (other than employer real property)       1c(6)									
Assets       (a) Beginning of Year       (b) End of Year         a Total noninterest-bearing cash	benefit at a future date. Round off	amounts to the nearest dollar. MTIAs, Co	CTs, PSAs, a	nd 103-12					
a Total noninterest-bearing cash			e instructions.						
b       Receivables (less allowance for doubtful accounts):         (1)       Employer contributions         (2)       Participant contributions         (3)       Other         (3)       Other         (1)       Interest-bearing cash (include money market accounts & certificates of deposit)         (1)       Interest-bearing cash (include money market accounts & certificates of deposit)         (2)       U.S. Government securities         (3)       Corporate debt instruments (other than employer securities):         (A)       Preferred         (B)       All other         (B)       Common         (a)       Corporate stocks (other than employer securities):         (A)       Preferred         (B)       Common         (C)       Ic(4)(A)         (B)       Common         (C)       Lec(4)(A)         (b)       Participant loans         (c)       Participant loans         (c)       Interest in common/collective trusts         (c)       Value of interest in master trust investment accounts         (1)       Value of interest in ongistered investment companies (e.g., mutual funds)         (14)       Value of interest in negistered investment companies (e.g., mutual funds) <t< th=""><td></td><th></th><td></td><td><b>(a)</b> B</td><td>eginning of Y</td><td>ear</td><td><b>(b)</b> End (</td><td>of Year</td></t<>				<b>(a)</b> B	eginning of Y	ear	<b>(b)</b> End (	of Year	
(1) Employer contributions       1b(1)         (2) Participant contributions       1b(2)         (3) Other       1b(2)         (3) Other       1b(3)         (3) Other       1b(3)         (3) Other       1b(3)         (1) Interest-bearing cash (include money market accounts & certificates of deposit)       1c(1)         (2) U.S. Government securities       1c(1)         (3) Corporate debt instruments (other than employer securities):       1c(3)(A)         (A) Preferred       1c(3)(A)         (B) All other       1c(4)(A)         (B) Common       1c(4)(B)         (5) Partnership/joint venture interests       1c(6)         (6) Real estate (other than employer real property)       1c(6)         (7) Loans (other than to participants)       1c(7)         (8) Participant loans       1c(7)         (9) Value of interest in moster trust investment accounts       1c(9)         (10) Value of interest in moster trust investment accounts       1c(1)         (11) Value of interest in moster trust investment companies (e.g., mutual funds)       1c(12)         (14) Value of interest in negistered investment companies (e.g., mutual funds)       1c(14)       232641000       271003000         (14) Value of interest in negistered investment companies (e.g., mutual funds)       1c(14)			1a						
(2) Participant contributions       1b(2)         (3) Other       1b(3)         (3) Other       1b(3)         (3) Other       1b(3)         (3) Other       1b(3)         (4) Preferred       1c(1)         (5) Corporate debt instruments (other than employer securities):       1c(2)         (4) Preferred       1c(3)(A)         (5) All other       1c(3)(B)         (4) Corporate stocks (other than employer securities):       1c(4)(A)         (6) Common       1c(4)(A)         (7) Loans (other than to participants)       1c(6)         (7) Loans (other than to participant loans       1c(6)         (9) Value of interest in nooled separate accounts       1c(1)         (11) Value of interest in nooled separate accounts       1c(1)         (12) Value of interest in nooled separate accounts       1c(1)         (11) Value of interest in noster trust investment accounts       1c(1)         (12) Value of interest in noster trust investment accounts       1c(1)         (14) Value of interest in noster trust investment account (unallocated contracts).       1c(14)       232641000       271003000         (14) Value of interest in noster account (unallocated contracts).       1c(14)       232641000       271003000	<b>b</b> Receivables (less allowance for do	ubtful accounts):							
(3) Other       (3) Other         (3) Other       (3) Other         (3) Other       (5) General investments:         (1) Interest-bearing cash (include money market accounts & certificates of deposit)       (14) Value of interest in rogistered investment accounts & certificates:         (2) U.S. Government securities       1c(1)         (3) Corporate debt instruments (other than employer securities):       1c(3)(A)         (4) Preferred       1c(3)(B)         (4) Corporate stocks (other than employer securities):       1c(4)(A)         (B) Common       1c(4)(A)         (B) Common       1c(4)(A)         (B) Common       1c(6)         (6) Real estate (other than employer real property)       1c(6)         (7) Loans (other than to participants)       1c(7)         (7) Loans (other than to participants)       1c(10)         (10) Value of interest in noold separate accounts       1c(10)         (11) Value of interest in 103-12 investment accounts       1c(12)         (12) Value of interest in 03-12 investment accounts       1c(12)         (14) Value of interest in nogistered investment companies (e.g., mutual funds)       1c(14)       232641000       271003000         (14) Value of interest in company general account (unallocated contracts)       1c(14)       232641000       271003000 <td></td> <th></th> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
c General investments:       1 <td colspan="2">(2) Participant contributions</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	(2) Participant contributions								
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(11) Value of interest in master trust investment accounts       1c(11)         (12) Value of interest in 103-12 investment entities       1c(12)         (13) Value of interest in registered investment companies (e.g., mutual funds)	(9) Value of interest in common/c	ollective trusts			1314	28000		145121000	
(12) Value of interest in 103-12 investment entities       1c(12)         (13) Value of interest in registered investment companies (e.g., mutual funds)       1c(13)       28142000       13683000         (14) Value of funds held in insurance company general account (unallocated contracts)       1c(14)       232641000       271003000	(10) Value of interest in pooled sep	parate accounts							
<ul> <li>(13) Value of interest in registered investment companies (e.g., mutual funds)</li></ul>	(11) Value of interest in master true	st investment accounts							
funds)       10(13)       20142000       10000000         (14) Value of funds held in insurance company general account (unallocated contracts)       1c(14)       232641000       271003000			1c(12)						
(14) Value of funds held in insurance company general account (unallocated contracts).       1c(14)       232641000       271003000			1c(13)		281	42000		13683000	
(15) Other	(14) Value of funds held in insuran	ce company general account (unallocated	1c(14)		2326	41000		271003000	
	,		1c(15)						
<ul> <li>(1) Employer securities</li> <li>(2) Employer real property</li> </ul>	1d(1)								
---	-------	-----------	-----------						
(-)	1d(2)								
e Buildings and other property used in plan operation	1e								
f Total assets (add all amounts in lines 1a through 1e)	1f	428553000	465097000						
Liabilities									
g Benefit claims payable	1g	6800000	7400000						
h Operating payables	1h	332000	217000						
i Acquisition indebtedness	1i								
j Other liabilities	1j	9695000	7051000						
<b>k</b> Total liabilities (add all amounts in lines 1g through1j)	1k	16827000	14668000						
Net Assets	·								
Net assets (subtract line 1k from line 1f)	11	411726000	450429000						

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	3909000	
(B) Participants	2a(1)(B)	89688000	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		93597000
b Earnings on investments:			
(1) Interest:			
<ul> <li>(A) Interest-bearing cash (including money market accounts and certificates of deposit)</li> </ul>	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)	461000	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		461000
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
<ul> <li>(C) Total unrealized appreciation of assets.</li> <li>Add lines 2b(5)(A) and (B)</li> </ul>	2b(5)(C)		0

Schedule H (Form 5500) 2020 Page <b>3</b>							
		<b>(a)</b> A	mount		(b) Total		
(6) Net investment gain (loss) from common/collective trusts	2b(6)				18767000		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)						
(8) Net investment gain (loss) from master trust investment account	ts 2b(8)						
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)						
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)						
C Other income	2c				16938000		
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total	2d				129763000		
Expenses							
<b>e</b> Benefit payment and payments to provide benefits:							
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		689	27000			
(2) To insurance carriers for the provision of benefits	2e(2)		117	66000			
(3) Other	2e(3)						
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)				80693000		
f Corrective distributions (see instructions)	2f						
g Certain deemed distributions of participant loans (see instructions)	2g						
h Interest expense	2h						
i Administrative expenses: (1) Professional fees	2i(1)		103	67000			
(2) Contract administrator fees	2i(2)						
(3) Investment advisory and management fees	2i(3)						
(4) Other	2i(4)						
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)				10367000		
i Total expenses. Add all expense amounts in column (b) and enter t	otal 2j				91060000		
Net Income and Reconciliation							
k Net income (loss). Subtract line 2j from line 2d	2k				38703000		
Transfers of assets:							
(1) To this plan							
(2) From this plan	2l(2)						
Part III Accountant's Opinion							
<b>3</b> Complete lines 3a through 3c if the opinion of an independent qualifier attached.	ed public accountant i	s attached to thi	s Form	5500. Co	omplete line 3d if an opinion is not		
<b>a</b> The attached opinion of an independent qualified public accountant for	or this plan is (see ins	tructions):					
(1) 🛛 Unmodified (2) 🗌 Qualified (3) 🗌 Disclaimer	(4) Adverse						
<b>b</b> Check the appropriate box(es) to indicate whether the IQPA performed					oxes (1) and (2) if the audit was		
performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.1 (1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-		.,			OI Regulation 2520 103-12(d)		
<b>C</b> Enter the name and EIN of the accountant (or accounting firm) below			.020.10				
(1) Name: DELOITTE & TOUCHE LLP		(2) EIN: 13-	3891517	7			
<b>d</b> The opinion of an independent qualified public accountant is <b>not atta</b>	ched because:	(-) 10	0001011				
· _ · · · · _	be attached to the ne	ext Form 5500 p	ursuant	to 29 CF	FR 2520.104-50.		
Part IV Compliance Questions							
4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not		e lines 4a, 4e, 4f	, 4g, 4h	, 4k, 4m,	4n, or 5.		
During the plan year:			Yes	No	Amount		
<b>a</b> Was there a failure to transmit to the plan any participant contributi period described in 29 CFR 2510.3-102? Continue to answer "Yes	" for any prior year fai						
fully corrected. (See instructions and DOL's Voluntary Fiduciary Co	prrection Program.)	4a		Х	<u> </u>		

	Schedule H (Form 5500) 2020 Page <b>4</b> -	1				
			Ye	s No	Am Am	ount
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loan secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		4b	;	×	
C	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		4c		×	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transaction reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		ld		x	
е	Was this plan covered by a fidelity bond?		le >	(		12000000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was cause fraud or dishonesty?		4f	2	×	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		lg		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		łh		x	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked see instructions for format requirements.)		4i )	(		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		4j )	<		
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to anothe plan, or brought under the control of the PBGC?		1k	>	<	
Ι	Has the plan failed to provide any benefit when due under the plan?		41	>	<	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFI 2520.101-3.).		m			
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or or the exceptions to providing the notice applied under 29 CFR 2520.101-3		ln			
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If "Yes," enter the amount of any plan assets that reverted to the employer this year	. Yes	X No			
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan transferred. (See instructions.)	n(s), ident	ify the p	lan(s) to	which assets or lia	bilities were
	5b(1) Name of plan(s)				5b(2) EIN(s)	<b>5b(3)</b> PN(s)
	Vas the plan a defined benefit plan covered under the PBGC insurance program at any time dure the plan structions.)					
lt	"Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this	s plan yea	ar		·	

Nokia Retiree Welfare Benefits Plan

Employer ID No: 22-3408857 Plan Number: 504

Financial Statements as of December 31, 2020 and 2019 and for the Year Ended December 31, 2020, Supplemental Schedules as of and for the Year Ended December 31, 2020, and Independent Auditors' Report

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NOTE: All other schedules required by Section 2520.103-10 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 have been omitted because they are not applicable.

# Deloitte.

Deloitte & Touche LLP 30 Rockefeller Plaza New York, NY 10112-0015 USA Tel: 1-212-492-4000

Fax: 1-212-492-4000 Fax: 1-212-489-1687 www.deloitte.com

## **INDEPENDENT AUDITORS' REPORT**

To the Administrator of the Nokia Retiree Welfare Benefits Plan

We have audited the accompanying financial statements of Nokia Retiree Welfare Benefits Plan (the "Plan"), which comprise the Statement of Benefit Obligations and Net Assets Available for Benefits as of December 31, 2020, and the related Statement of Changes in Benefit Obligations and Net Assets Available for Benefits for the year ended December 31, 2020, as well as the related notes to the financial statements.

#### Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

#### Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Plan's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

#### Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of Nokia Retiree Welfare Benefits Plan as of December 31, 2020, and the changes in its financial status for the year ended December 31, 2020, in accordance with accounting principles generally accepted in the United States of America.

#### **Predecessor Auditor's Opinion on 2019 Financial Statement**

The Statement of Benefit Obligations and Net Assets Available for Benefits as of December 31, 2019 was audited by predecessor auditors. Their report, dated September 10, 2020, indicated that the Statement of Benefit Obligations and Net Assets Available for Benefits presented fairly, in all material respects, the Benefit Obligations and Net Assets Available for Benefits of the Plan as of December 31, 2019 in accordance with accounting principles generally accepted in the United States of America.

#### **Report on Supplemental Schedules**

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of assets (held at end of year) as of December 31, 2020, and schedule of reportable transactions for the year ended December 31, 2020 are presented for the purpose of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. These schedules are the responsibility of the Plan's management and were derived from and relate directly to the underlying accounting and other records used to prepare the financial statements. Such schedules have been subjected to the auditing procedures applied in our audit of the financial statements and certain additional procedures, including comparing and reconciling such schedules directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such schedules are fairly stated in all material respects in relation to the financial statements as a whole.

Deloitte & Josche UP

September 22, 2021

# Statements of Benefit Obligations and Net Assets Available for Benefits

As of December 31, 2020 and 2019

(In Thousands)

	December 31			
	2020	2019		
BENEFIT OBLIGATIONS				
Postretirement benefit obligation:				
Current retirees	\$ 2,508,100 \$	2,613,500		
Medical claims payable and liability for claims incurred				
but not reported	7,400	6,800		
Other participants fully eligible for benefits	-	4,100		
Other participants not yet fully eligible for benefits	 45,000	43,700		
Total benefit obligations	2,560,500	2,668,100		
ASSETS				
Group life insurance policies	271,003	232,641		
Net assets held in Lucent Technologies Inc. Master Pension Trust	271,003	232,041		
Restricted for 401(h) account	156,710	169,230		
Restricted for applicable life insurance account	130,710	109,230		
Common/collective trusts	145,121	131,428		
Registered investment company	13,683	28,142		
Rebates receivable	35,290	36,300		
Interest receivable		42		
Total assets	 621,807	597,785		
LIABILITIES		o (o <b>-</b>		
Due to Sponsor, net	7,051	9,695		
Accrued administrative expenses	 217	332		
Total liabilities	 7,268	10,027		
Net assets available for benefits	614,539	587,758		
EXCESS OF BENEFIT OBLIGATIONS OVER NET	,	<u> </u>		
ASSETS AVAILABLE FOR BENEFITS	\$ 1,945,961 \$	2,080,342		

See notes to financial statements.

# Statement of Changes in Benefit Obligations and Net Assets Available for Benefits

For the Year Ended December 31, 2020

(In Thousands)

Net decrease in benefit obligations		
Increase (decrease) during the period attributable to:	\$	(205, 200)
Benefits reclassified to amounts currently payable Plan amendments	Φ	(205,300) (109,500)
		(109,300) (73,700)
Change in actuarial assumptions and experience		(73,700) 71,900
Interest due to the passage of time Change in discount rate		
Change in discount rate		209,000
Net decrease in benefit obligations		(107,600)
Net change in net assets available for benefits ADDITIONS:		
		2 000
Sponsor contributions		3,909
Participant contributions		89,688
Total contributions		93,597
Investment income:		16.000
Income from insurance policies		16,938
Net appreciation in fair value of investments		18,767
Interest income		461
Total investment income		36,166
Total additions		129,763
DEDUCTIONS:		
Payments for benefits, net		80,093
Net decrease in 401(h) account		12,520
Net decrease in applicable life insurance account		2
Administrative expenses		10,367
Total deductions		102,982
		<b>A</b> ( <b>F</b> 01
Net increase in net assets available for benefits		26,781
Decrease in excess of benefit obligations over net assets available for benefits		(134,381)
EXCESS OF BENEFIT OBLIGATIONS OVER NET ASSETS AVAILABLE FOR BENEFITS:		
Beginning of year		2,080,342
End of year	\$	1,945,961
	*	,,

See notes to financial statements.

## Notes to Financial Statements

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

#### 1. Description of the Plan

The following description of the Nokia Retiree Welfare Benefits Plan (the Plan) provides only general information. Participants should refer to the Plan document, and the plan documents and the summary plan descriptions of each of the component plans, for a more complete description of the Plan's provisions.

#### General

The Plan is an umbrella plan comprised of the following component plans: the Nokia Medical Expense Plan for Retired Employees (the Retiree Dental Plan) and the Nokia Group Life Insurance Plan for Retired Employees (the Retiree Group Life Plan). The Retiree Medical Plan and the Retiree Dental Plan are contributory employee welfare benefit plans that provide standard health benefits to eligible retired employees and eligible dependents of Nokia of America Corporation (the Sponsor, the Company and the Plan Administrator), and its domestic subsidiaries. Although the Retiree Group Life Plan permits participant contributions, the plan has been non-contributory to date. It provides basic life insurance coverage to eligible retired employees of the Sponsor and its domestic subsidiaries who are eligible for disability or service pensions. The Plan and its component plans are employee welfare benefit plans subject to the provisions of Employee Retirement Income Security Act of 1974 (ERISA).

In August 2019, the Sponsor and the Communications Workers of America and International Brotherhood of Electrical Workers (collectively, the Unions) entered into an agreement (i) to continue health benefits for formerly represented retirees through December 31, 2024, (ii) to reduce the Sponsor's funding commitment with respect to such health benefits for the 2020, 2021, 2022, 2023 and 2024 plan years by \$40,000 each year, and (iii) to continue life insurance coverage for such retirees through December 31, 2024. In October 2020, the Sponsor and the Unions entered into a further agreement (i) to continue health benefits for formerly represented retirees through December 31, 2027, (ii) to reduce the Sponsor's funding commitment with respect to such health benefits for the 2025, 2026, and 2027 plan years by \$40,000 each year, and (iii) to continue life insurance coverage for such retirees through December 31, 2027, plan years by \$40,000 each year, and (iii) to continue life insurance coverage for such retirees through December 31, 2027. The impact of this agreement is reflected as a plan amendment on the Statement of Changes in Benefit Obligations and Net Assets Available for Benefits presented herein.

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

## 1. Description of the Plan (continued)

#### Benefits

The Plan provides health benefits (hospital, surgical, medical, prescription drug and mental health/chemical dependency), including a Health Maintenance Organization (HMO) option and a Medicare Advantage Preferred Provider Organization (MAPPO) option, and dental benefits, including a Dental Maintenance Organization (DMO) option and a Preferred Provider Organization (PPO) option, to eligible retired participants, their lawful spouses, and eligible dependents. The Plan provides for continuation of certain benefits upon the occurrence of a qualifying event through the Consolidated Omnibus Budget Reconciliation Act of 1985.

In addition to health benefits, the Plan provides death benefits to eligible retired employees of the Sponsor which are payable to their beneficiaries. A participant may assign his or her life insurance under the Plan in accordance with the terms and conditions of the policy. Benefit payments for these benefits are administered under insurance contracts with Metropolitan Life Insurance Company (MetLife).

The Sponsor pays for the benefits under the Plan, and the Plan then reimburses the Sponsor for certain benefit payments.

#### Section 420 maintenance of cost obligation

Section 420 of the Internal Revenue Code of 1986, as amended (the Code) permits employers maintaining an overfunded defined benefit pension plan to transfer excess pension assets (as defined in Section 420) from the pension plan to a health benefits account, a retiree life insurance account, or both, established within the pension plan and to use the assets in such accounts to pay for applicable health benefits or applicable life insurance benefits (each as defined in Section 420) for retired employees (and, with respect to health benefits, their spouses and dependents). Under current law, no such transfers may be made after December 31, 2025.

A transfer of excess pension assets under Section 420 imposes certain "maintenance of cost" obligations on the group health plan or arrangement and group term life insurance plan under which the applicable health benefit and applicable life insurance benefits, as the case may be, are provided.

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

#### 1. Description of the Plan (continued)

#### Contributions

The Sponsor has also created two voluntary employees' beneficiary association trusts (the Trusts). According to the Trusts' agreements, the Sponsor may contribute such assets to the Trusts as it reasonably determines necessary and appropriate to pay expenses under the various medical, dental, and group life benefit plans consistent with any limitations under Section 419 of the Code and shall specifically indicate the allocation of such assets among the plans.

Participant contributions are made primarily through pension deductions and direct billing by the Sponsor, which in turn remits contributions to the Plan on the participants' behalf. Participant contributions reflect the cost of the selected coverage level and optional dependent coverage less the amount of cost paid by the Sponsor. Participant contributions also include elections to continue coverage for dependents of deceased retired participants.

For eligible formerly represented occupational retirees who retired before March 1, 1990, the Sponsor pays the entire cost of the medical and dental coverage, except for non-grandfathered Class II dependents for whom the retiree pays the entire cost. In addition, the Sponsor reimburses the entire amount of Medicare Part B premiums for these Medicare-eligible retired employees and/or their spouses.

For eligible formerly represented occupational retirees who retire on or after March 1, 1990, sponsor contributions are limited to the following annual amounts for medical and dental coverage:

	Formerly Represented Occupational
	(In Whole Dollars)
Retired under age 65 – single coverage	\$ 4,225
Retired under age 65 – family coverage	8,600
Retired age 65 and over – single coverage	2,000
Retired age 65 and over – family coverage	4,625

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

## 1. Description of the Plan (continued)

In addition, the amount the Sponsor reimburses for Medicare Part B premiums for these Medicareeligible retired employees will not exceed \$46.00 per month (\$33.00 for spouses) (in whole dollars). However, no reimbursement is made for spouses of employees who retired after May 31, 1998.

For eligible management and non-represented occupational retirees who retired before March 1, 1990, the Sponsor pays the entire cost of the medical coverage, except for non-grandfathered Class II dependents for whom the retiree pays the entire cost. Management and non-represented occupational retirees pay the full dental cost.

Effective January 1, 2017, medical and dental coverage was eliminated for post-March 1, 1990 non-Medicare eligible management retirees and their dependents and for post-March 1, 1990 non-Medicare eligible non-represented occupational retirees and their dependents. For post-March 1, 1990 Medicare-eligible management and non-represented occupational retirees and their dependents, the retiree pays the entire cost.

Pursuant to a December 2004 collective bargaining agreement between the Sponsor and the Unions, the Lucent Supplemental Healthcare Benefits Trust for Formerly Represented Retirees (SHBT) was established for the exclusive purpose of paying a portion of the retiree healthcare benefits that eligible participants and their beneficiaries who are covered by the agreement would otherwise be required to absorb through premiums and other payments. The SHBT provides reimbursement to the Sponsor for a portion of the participants' medical and/or dental expenses. This reimbursement is recorded as Other contributions on the Statement of Changes in Benefit Obligations and Net Assets Available for Benefits.

Prescription drug benefits are provided for Medicare-eligible management and non-represented occupational retirees through a Medicare Prescription Drug Plan (PDP). In a PDP, the prescription drug vendor contracts directly with The Centers for Medicare and Medicaid Services (CMS) to provide Medicare Part D coverage. Plan sponsors who offer PDPs do not receive Medicare Part D Retiree Drug Subsidies for these plans. The Plan's PDP is a self-insured program administered by Express Scripts. Other self-insured programs include certain medical options administered by UnitedHealthcare and a dental option administered by Aetna. Effective January 1, 2021, the PDP is administered by UnitedHealthcare, through an insured UnitedHealthcare® Group MAPPO plan with prescription drug coverage. Also, effective January 1, 2021, formerly represented occupational retirees are covered under a self-insured drug program administered by CVS Caremark.

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

## 1. Description of the Plan (continued)

## **Benefit obligations funding**

The Sponsor makes contributions to the Plan as needed to fund claims in excess of participants' contributions. At December 31, 2020 and 2019, the Plan's benefit obligations exceeded its net assets available for benefits. However, management expects that the Plan's net assets available for benefits and future Sponsor contributions will be sufficient to fund obligations as they become due.

#### **Plan termination**

Although it has not expressed any intention to do so, the Sponsor has the right under the Plan, subject to collective bargaining agreements, to modify the benefits provided to participants, to discontinue its contributions at any time, and to terminate the Plan, subject to the provisions set forth in ERISA. In the event of such termination, the net assets of the Plan shall be allocated to pay the benefit obligations of the Plan in accordance with ERISA.

## 2. Summary of significant accounting policies

## **Basis of accounting**

The financial statements of the Plan have been prepared in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP).

## Valuation of investments and income and expense recognition

The Plan invests in common/collective trusts and a registered investment company. Investments in common/collective trusts are valued at fair value based on the net asset values (NAV), as a practical expedient, on the last business day of the plan year as determined by the trusts' managers. There are no unfunded commitments and currently no redemption restrictions on the common/collective trusts. The investment in the registered investment company is valued at fair value based on the fund's quoted NAV on the last business day of the plan year as determined by the fund's manager. See Note 3 for additional information.

Purchases and sales of investments are recorded on a trade-date basis. Interest income and administrative expenses are recorded on an accrual basis. Dividend income is recorded on investments held as of the ex-dividend dates. The net appreciation/(depreciation) in fair value of investments consists of the realized gains and losses on the sales of securities and the unrealized appreciation/ (depreciation) of investments.

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

#### 2. Summary of significant accounting policies (continued)

#### Valuation of group life insurance policies

The Sponsor has prepaid premiums for life insurance policies with an insurance company. The prepaid premiums are invested by the insurance company at the Plan's direction in equity, fixed income and international separate accounts and general accounts, all of which are valued by the insurance company at net asset values, as a practical expedient. The underlying investments in the separate accounts are valued at fair value generally using readily available market values. If there is no readily available market value for any asset in the separate accounts, the insurance company determines, at its discretion and in accordance with any applicable laws and regulations, the value to be used as such asset's market value. The Plan is allocated a portion of the earnings from these investments. The income from insurance policies on the Statement of Changes in Benefit Obligations and Net Assets Available for Benefits for the year ended December 31, 2020 in the amount of \$16,938 includes \$2,984 of investment income and \$13,954 of net realized/unrealized appreciation. The general account's interest crediting rate is currently based upon the six-month U.S. Treasury Bill plus 0.25%. The policies are valued by the insurance company based on the fair value of the underlying assets in the separate accounts and the general account balance.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

## Postretirement benefit obligation (PBO)

The PBO represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered to December 31 of the applicable year. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired employees and eligible dependents and beneficiaries, (2) active management employees with more than 15 years of service as of June 30, 2001, eligible dependents and beneficiaries and (3) all represented employees and eligible dependents and beneficiaries after retirement from the Sponsor. Prior to an active employee's full eligibility date, the PBO is the portion of the expected postretirement benefit obligation that is attributed to that employee's service performed prior to the valuation date.

The PBO is determined by the Plan's actuary, Aon, and is the amount which results from applying actuarial assumptions to historic claims cost data to estimate future annual incurred claims cost per participant and to adjust such estimates for the time value of money (through

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

#### 2. Summary of significant accounting policies (continued)

discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal or retirement) between the valuation date and the expected date of payment.

For purposes of determining the actuarial present value of the PBO for medical as of December 31, 2020, a 6.0% post-65 medical, 6.0% pre-65 medical and 6.90% pre- and post-65 prescription drug annual rate of increase in the per capita cost of covered benefits were assumed for 2021 for formerly represented occupational retirees and a 6.0% post-65 medical, 6.1% pre-65 medical and 7.05% pre- and post-65 prescription drug annual rate of increase in the per capita cost of covered benefits were assumed for 2021 for management and non-represented occupational retirees. These rates were assumed to decline gradually after 2021 to 4.5% by the year 2028 and then remain constant.

For purposes of determining the actuarial present value of the PBO for medical as of December 31, 2019, a 6.2% post-65 medical, 6.1% pre-65 medical and 6.95% pre- and post-65 prescription drug annual rate of increase in the per capita cost of covered benefits were assumed for 2020. These rates were assumed to decline gradually after 2019 to 4.5% by the year 2028 and then remain constant.

These assumptions could greatly affect the amounts reported. To illustrate, increasing the assumed trend rate by 1% in each year could increase the PBO for medical benefits by \$17,200 and \$24,000 at December 31, 2020 and 2019, respectively.

For purposes of determining the actuarial present value of the PBO for dental as of December 31, 2020, a rate of 3.0% was assumed for 2021 and beyond. For purposes of determining the actuarial present value of the PBO for dental as of December 31, 2019, a rate of 3.0% was assumed for 2020 and beyond. These assumptions could greatly affect the amounts reported. To illustrate, increasing the assumed trend rate by 1% in each year could increase the PBO for dental benefits by \$900 and \$1,100 at December 31, 2020 and 2019, respectively.

For group life costs, the PBO is the amount that results from applying actuarial assumptions to participant census data to estimate future annual incurred claims cost per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal or retirement) between the valuation date and the expected date of payment.

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

#### 2. Summary of significant accounting policies (continued)

The following summarizes other significant actuarial assumptions used in the valuations as of December 31, 2020 and 2019, respectively:

Weighted-average discount rate: Mortality:	<ul> <li>1.94% (2020), 2.80% (2019)</li> <li>2020: Society of Actuaries Pri-2012 amounts – weighted, white collar for management retirees and blue collar for occupational retirees with MP-2020 generational projection scale</li> <li>2019: Society of Actuaries Pri-2012 amounts – weighted, white collar for management retirees and blue collar for occupational retirees with MP-2019 generational projection scale</li> </ul>
Weighted average rate of compensation increase:	2.00% (2020), 2.14% (2019)

The foregoing assumptions are based on the presumption that the benefits will continue. Were the benefits to terminate, different actuarial assumptions and other factors might be applicable in determining the PBO. The changes in actuarial assumptions and experience on the Statement of Changes in Benefit Obligations and Net Assets Available for Benefits for the year ended December 31, 2020 in the amount of (\$73,700) includes increases of \$1100 related to benefits accumulated and \$600 related to changes in the liability for claims incurred but not reported.

In March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the Act) were enacted. The primary focus of the Act was to significantly reform health care in the U.S. The Plan has included the estimated effect of the Act in the valuation of its postretirement benefit obligation as of December 31, 2020 and 2019. The Plan continues to evaluate the various provisions of the Act.

The Bipartisan Budget Act of 2018 was signed by the President of the United States of America on February 9, 2018. The impact of this legislation was reflected in the present value of the PBO as of December 31, 2020 and 2019.

#### **Medicare subsidy**

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 provides for a government subsidy to plan sponsors that maintain a prescription drug plan for Medicare-eligible participants that is at least actuarially equivalent to the benefit provided by Medicare Part D. The

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

#### 2. Summary of significant accounting policies (continued)

Plan does provide an actuarially equivalent benefit. Therefore, the Sponsor expects to receive a subsidy. The Plan's benefit obligation does not reflect the subsidy because the subsidy is provided to the Sponsor and not the Plan.

#### **Claims incurred but not reported**

Plan obligations at December 31, 2020 and 2019 for incurred but not reported claims are estimated by the Plan's actuary in accordance with accepted actuarial principles based on claims data provided by the Plan's third-party administrator and are reported on the Statements of Benefit Obligations and Net Assets Available for Benefits. These amounts are paid by the Plan only if claims are submitted and approved for payment. The liability for claims incurred but not reported as of December 31, 2020 is \$7,400.

#### Use of estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make significant estimates and assumptions that affect the reported amounts of assets and benefit obligations and changes therein and disclosures of contingent assets and liabilities. These significant estimates include the Plan's benefit obligations and market value of investments. Actual results could differ from those estimates.

#### **Risks and uncertainties**

Plan contributions and the actuarial present value of the Plan's benefit obligations are determined based on certain assumptions pertaining to per capita claim estimates, interest and mortality rates, inflation rates and participant demographics, all of which are subject to change. As of the date of these financial statements, the Sponsor believes these estimates and assumptions concerning matters such as interest rates and participant demographics are reasonable. However, due to the uncertainties inherent in making any estimate or assumption, it is at least reasonably possible that actual results may differ materially from what has been estimated or assumed.

Investment securities held by the Trusts are exposed to various risks, such as interest rate, market and credit risk. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is at least reasonably possible that changes in market conditions could differ materially from what has been reported in the financial statements.

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

## 2. Summary of significant accounting policies (continued)

In December 2019, an outbreak of a novel strain of coronavirus (COVID-19) emerged globally. Global financial markets have experienced and may continue to experience significant volatility resulting from the spread of COVID-19. The extent of the impact of COVID-19 on the Plan's benefit obligations and net assets available for benefits will depend on future developments, including the duration and continued spread of the outbreak.

#### Payments for benefits, net

Benefits are recorded when paid and are presented net of rebates and refunds. Certain premiums and claims are paid from the general assets of the Sponsor; however, all premiums and claims are recorded in the accompanying Statement of Changes in Benefit Obligations and Net Assets Available for Benefits, regardless of whether they were paid from Plan assets or from the general assets of the Sponsor.

During 2020, the Plan paid \$11,766 in premiums to insurance carriers, which are included in payments for benefits, net in the accompanying Statement of Changes in Benefit Obligations and Net Assets Available for Benefits.

#### Administrative expenses

The Plan pays certain administrative expenses that include, but are not limited to, fees paid to the plan recordkeeper, third-party claims administrators, auditor, trustee, investment manager, actuary and allocable portions of certain salaries and fringe-benefit costs. These expenses are reported on the Statement of Changes in Benefit Obligations and Net Assets Available for Benefits as administrative expenses. All other administrative expenses are paid by the Sponsor.

#### **Rebates and refunds**

Rebates and refunds are recorded when earned from the provider and netted with payments for benefits in the accompanying Statement of Changes in Benefit Obligations and Net Assets Available for Benefits. The Plan utilizes a pharmacy benefit manager which periodically issues rebates to the Plan based on the Plan's actual utilization pattern of specific drugs. The Plan also periodically receives premium refunds from the provider administering the MAPPO plan based on the ratio of revenues received to medical costs incurred. Rebates and refunds due as of the financial statement date have been reported as a receivable, with the offset being netted against payments for benefits. Rebates and refunds totaling \$107,409 have been netted with payments for

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

#### 2. Summary of significant accounting policies (continued)

benefits in the accompanying Statement of Changes in Benefit Obligations and Net Assets Available for Benefits for the year ended December 31, 2020.

#### Due to Sponsor, net

The Sponsor makes benefit payments on behalf of the Plan, net of participant contributions of \$2,683, and has the right to receive subsequent reimbursement from the Plan. As a result of timing, a liability has been reported on the Statements of Benefit Obligations and Net Assets Available for Benefits as Due to Sponsor relating to such benefit payments made by the Sponsor that are not yet reimbursed by the Plan as of December 31, 2020 and 2019. Such reimbursements may be made subsequent to the Plan's year-end.

#### 3. Investments

Plan investments are held in two separate Trusts: (1) the Lucent Technologies Inc. Postretirement Welfare Benefits Trust for Represented Employees (the Represented Trust), and (2) the Lucent Technologies Inc. Postretirement Welfare Benefits Trust for Nonrepresented Employees (the Nonrepresented Trust). Each of these trusts qualifies as a Voluntary Employees' Beneficiary Association (VEBA) under Section 501(c)(9) of the Code. The exclusive purpose of these trusts is to fund future postretirement health and life benefits to eligible participants of the Plan.

#### Fair value measurements

The Plan follows a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

Level 1 – inputs to the valuation methodology are quoted prices (unadjusted) for identical assets or liabilities in active markets.

Level 2 – inputs to the valuation methodology include quoted prices for similar assets and liabilities in active markets, quoted market prices for identical or similar assets or liabilities in markets that are not active, and inputs that are observable for the assets or liability, either directly or indirectly, for substantially the full term of the financial statements.

Level 3 – inputs to the valuation methodology are unobservable and significant to the fair value measurements.

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

#### 3. Investments (continued)

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value, as of December 31, 2020 and 2019. Assets are classified in their entirety based upon the lowest level of input that is significant to the fair value measurement. The Plan did not hold any Level 2 or Level 3 investments in 2020 or 2019.

	As of December 31, 2020								
	Level 1		el 1 Level 2		evel 3 NAV		Т	otal	
				(In Thous	and	s)			
Registered investment company	\$	13,683 \$	<b>.</b> .	- \$	- \$	_	\$	13,683	
Group life insurance policies		-		_	-	271,003		271,003	
Commingled funds - Common/collective									
trusts		-		_	_	145,121		145,121	
Total assets	\$	13,683 \$		- \$	- \$	416,124	\$	429,807	

<sup>1</sup> Assets measured at NAV represents investments fair valued using NAV as a practical expedient. These investments are not leveled on the fair value hierarchy table. The common/collective trusts of \$145,121 includes \$81,332 of an equity index fund, \$35,856 of a U.S. debt index fund and \$27,933 of an EAFE equity index fund.

	As of December 31, 2019								
	Level 1		Level 1 Level 2 Level 3 M		12 Level 3		Т	Total	
				(In Thous	sand	ls)			
Registered investment company	\$	28,142 \$	-	- \$	_	\$ -	\$	28,142	
Group life insurance policies		-	-	_	_	232,641		232,641	
Commingled funds		_	-	_	_	131,428		131,428	
Total assets	\$	28,142 \$	-	- \$	_	\$ 364,069	\$	392,211	

<sup>1</sup> Assets measured at NAV represents investments fair valued using NAV as a practical expedient. These investments are not leveled on the fair value hierarchy table.

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

#### 4. Section 420 transfers

From time to time, the Sponsor makes "Collectively Bargained Transfers" of excess pension assets of the Lucent Technologies Inc. Master Pension Trust (MPT) held for the Lucent Technologies Inc. Pension Plan (the LTPP) to an account of the LTPP under the MPT established under section 401(h) of the Code, pursuant to Section 420 of the Code to cover retiree healthcare costs, for eligible retirees covered by its Agreement with the Unions. In 2012, the Sponsor began making collectively bargained transfers of excess pension assets of the LTPP to an applicable life insurance account of the LTPP under the MPT established under Section 420(a) of the Code, pursuant to Section 420 of the Code, to pay for retiree life insurance coverage for eligible retirees.

In December 2020, the Sponsor made a "Qualified Future Transfer" (multi-year transfer) of excess pension assets of the Nokia Retirement Income Plan (the NRIP) to an applicable life insurance account of the NRIP under the MPT established under Section 420(a) of the Code, pursuant to Section 420 of the Code, to pay for retiree life insurance coverage for the tax years ending December 31, 2020 and December 31, 2021.

In accordance with sections 401(h) and 420(a) of the Code, the Plan's investments in the 401(h) account may not be used for or diverted to any purpose other than providing health benefits for eligible participants as well as administration costs and the Plan's investments in the applicable life insurance account may not be used for or diverted to any purpose other than providing applicable life insurance benefits with respect to eligible participants as well as administrative costs. The related obligations for health benefits and applicable life insurance benefits are not reported in the LTPP's or the NRIP's Statement of Accumulated Plan Benefits but are reported as obligations in the Plan.

The following tables present the net assets held in the LTPP for retiree healthcare obligations funded under Code section 401(h) as of December 31, 2020 and 2019 and the related changes in net assets for the year ended December 31, 2020.

	Decemb	ber 3	1
	 2020		2019
Net assets held in LTPP - restricted for 401(h) account	\$ 156,710	\$	169,230

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

#### 4. Section 420 transfers (continued)

Changes in net assets in the 401(h) account for the year ended December 31, 2020:

Transfer from LTPP	\$ 80,000
Interest income	1,119
Administrative expenses	(6,455)
Benefit payments	 (87,184)
Net decrease in 401(h) account	\$ (12,520)

Detailed disclosures on the investments in the 401(h) account, which is held by the MPT, are presented in the LTPP financial statements as of December 31, 2020 and 2019 and for the year ended December 31, 2020.

The following tables present the net assets held in the LTPP and NRIP for applicable life insurance benefits under Code section 420 as of December 31, 2020 and 2019 and the related changes in net assets for the year ended December 31, 2020:

		December 31		
	2	020	2019	
Net assets held in LTPP - restricted for applicable life insurance account	\$	- \$	2	
Net assets held in NRIP - restricted for applicable life insurance account	\$	- \$	-	

Changes in net assets in the applicable life insurance account for the year ended December 31, 2020:

	LTPP	NRIP
Transfer from pension plan	\$ 39,997 \$	76,095
Benefit payments	 (39,999)	(76,095)
Net decrease in applicable life insurance account	\$ (2) \$	-

Detailed disclosures on the investments in the applicable life insurance account, which is held by the MPT, are presented in the LTPP and NRIP financial statements as of December 31, 2020 and 2019 and for the year ended December 31, 2020.

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

#### 5. Tax status

The Plan was originally funded by means of a trust established effective as of October 1, 1996 known as the Lucent Technologies Inc. Postretirement Life Insurance Benefits Trust (Life Insurance Benefits Trust). The Life Insurance Benefits Trust obtained a recognition of exemption letter from the Internal Revenue Service (IRS) dated November 25, 1998. The Life Insurance Benefits Trust was amended and restated in 2002, and its tax-exempt status was confirmed by a private letter ruling issued by the IRS on October 10, 2002. Pursuant to the private letter ruling, a further trust was established – the Nonrepresented Trust, and certain life insurance assets associated with the Life Insurance Trust were transferred to the Nonrepresented Trust. The Life Insurance Trust were each further amended in 2004. The IRS confirmed the tax-exempt status of both the Represented Trust and the Nonrepresented Trust by a private letter ruling issued September 8, 2004. The Nonrepresented Trust also obtained a recognition of exemption letter from the IRS dated May 24, 2011.

The Plan, the Represented Trust and the Nonrepresented Trust are required to operate in conformity with the Code to maintain their tax-exempt status. The Plan Administrator believes the Plan is being operated in compliance with the applicable requirements of the Code and, therefore, believes the related trusts are tax exempt. Accordingly, no provision for income taxes has been made.

U.S. GAAP requires the Plan Administrator to evaluate uncertain tax positions taken by the Plan. The financial statement effects of a tax position are recognized when the position is more likely than not, based on the technical merits, to be sustained upon examination by the IRS. The Plan Administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2020, there are no uncertain tax positions taken or expected to be taken. The Plan has recognized no interest or penalties related to uncertain tax positions. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

#### 6. Party-in-interest and related-party transactions

As described in Note 1, the Plan pays certain investment and administrative expenses of the Plan to various service providers that are deemed parties-in-interest under the provisions of ERISA. The payment of these expenses meets the requirements of one or more prohibited transaction exemptions under ERISA.

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

#### 6. Party-in-interest and related-party transactions (continued)

Nokia Investment Management Corporation (NIMCO), a wholly owned subsidiary of the Company, provides fiduciary services to the Plan. NIMCO charges the Plan only for the costs that are incurred for providing such services to the Plan. For the year ended December 31, 2020, the

Plan incurred fiduciary service fees of \$43, which are included in administrative expenses on the Statement of Changes in Benefit Obligations and Net Assets Available for Benefits. At December 31, 2020 and 2019, the Plan had a payable due to NIMCO of \$14 and \$12, respectively, which is included in accrued administrative expenses on the Statements of Benefit Obligations and Net Assets Available for Benefits.

Certain Plan investments are managed by affiliates of the trustee, Bank of New York Mellon. At December 31, 2020 and 2019, the Plan held \$13.7 million and \$28.1 million, respectively, of the Dreyfus Treasury and Agency Cash Management Fund, which is a fund that is managed by affiliates of the trustee.

#### 7. Reconciliation of financial statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 as of December 31, 2020 and 2019:

	 2020	2019
Net assets available for benefits per the financial		
statements	\$ 614,539 \$	587,758
Less:		
Medical claims payable and claims incurred		
but not reported	(7,400)	(6,800)
Net assets held in LTPP $-401(h)$ account	(156,710)	(169,230)
Net assets held in LTPP – applicable life insurance		
account	-	(2)
Net assets available for benefits per Form 5500	\$ 450,429 \$	411,726

## Notes to Financial Statements (continued)

As of December 31, 2020 and 2019, and for the Year Ended December 31, 2020

(In Thousands)

#### 7. Reconciliation of financial statements to Form 5500 (continued)

The following is a reconciliation of the increase in net assets per the financial statements to the Form 5500 for the year ended December 31, 2020:

Net increase in net assets per the financial statements	\$ 26,781
Add:	
Medical claims payable and liability for claims incurred but not	
reported at December 31, 2019	6,800
Net decrease in 401(h) account	12,520
Net decrease in applicable life insurance account	2
Less:	
Medical claims payable and liability for claims incurred but not	
reported at December 31, 2020	 (7,400)
Total net income per Form 5500	\$ 38,703

Claims that have been processed and approved for payment at year-end but not paid and claims incurred but not reported are not considered liabilities under U.S. GAAP and, therefore, are not presented as liabilities or claims paid in the accompanying financial statements but are recorded on the Form 5500 as a liability.

The net assets and related activity of the 401(h) account and applicable life insurance account included in the financial statements are not included in the Form 5500 because the assets are held by the MPT.

#### 8. Subsequent events

Management has evaluated subsequent events through September 22, 2021, the date the financial statements were available to be issued. There were no material subsequent events that occurred between January 1, 2021 through September 22, 2021, that required disclosure in the financial statements, except as disclosed in Note 1 and as follows:

In June 2021, the Sponsor made a "Qualified Future Transfer" (multi-year transfer) of excess pension assets of the NRIP in the amount of \$319,095 to an applicable life insurance account of the NRIP under the MPT established under Section 420 of the Code, pursuant to Section 420 of the Code, to pay for retiree life insurance coverage for the tax years ending December 31, 2022 through December 31, 2030.

Supplemental Schedules

# Nokia Retiree Welfare Benefits Plan

# EIN #22-3408857 Plan #504

# Form 5500, Schedule H, Part IV, Line 4i – Schedule of Assets (Held at End of Year)

## As of December 31, 2020

<u>(a</u>	(b) Identity of Issue Borrower, Lessor or ) Similar Party	c) Description of Investment	(d) Cost	(e) Current Value
	BlackRock	BlackRock Equity Index Fund B Lendable	\$ 25,799,090	\$ 81,331,213
	BlackRock	BlackRock U.S. Debt Index Fund B	28,882,482	35,856,083
	BlackRock	Blackrock EAFE Equity Index Fund B	16,874,202	27,933,177
*	Dreyfus	Dreyfus Treasury Obligations Cash Management Fund	13,683,225	13,683,225
	MetLife	Insurance Policy 95083-G	73,151,936	74,337,513
	MetLife	Insurance Policy 190374-G	 177,195,011	196,665,942
			\$ 335,585,946	\$429,807,153

\* Represents party-in-interest

					) Jain OSS)	I I
					(j) t Net Gain or (Loss)	\$
					(h) (j) Current Value of Asset Net Gain on Transaction Date or (Loss)	1 4
		ctions			(h) urrent Value of Asse on Transaction Date	
		ransac			Curr	$\boldsymbol{\diamond}$
		ortable T			(g) Cost of Asset	\$ 104,786,424
efits Plan	Plan #504	lule of Rep	31, 2020		(d) Selling Price	– 104,786,424 r 31, 2020.
'elfare Ben		4j – Sched	For the Year Ended December 31, 2020		(c) Purchase Price	90,327,741 \$ - ended Decembe
ree W	-3408	Line	r Ende		Ι	sh sh e year e
Nokia Retiree Welfare Benefits Plan	EIN #22-3408857	0, Schedule H, Part IV, Line 4j – Schedule of Reportable Transactions	For the Yea	.9	(b) Description of Asset	Dreyfus Treasury Obligations Cash13690,327,741DreyfusManagement Fund63104,786,424DreyfusManagement Fund-104,786,41There were no category (i), (ii) or (iv) reportable transactions during the year ended December 31, 2020.
		Form 5500, Schedul		Series of transactions in excess of 5%	(a) Identity of Party Involved	L Dreyfus L Dreyfus ory (i), (ii) or (iv) 1
				f transactio	Shares	<ul> <li>136 90,327,741 Dreyfus</li> <li>63 104,786,424 Dreyfus</li> <li>here were no category (i), (ii)</li> </ul>
				Series o	Count	136 63 1 There w

Plan Name	Nokia Retiree Welfare Benefits Plan
Plan Sponsor EIN	22-3408857
ERISA Plan No.	504
Plan Year End	12/31/2020

The required attachment noted below is included within the Accountant's Opinion attachment to the Form 5500 Schedule H, Part III, which consists of the entire Audit report issued by the Plan's Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line Item	Description
5500 Schedule H	Line 4j	Schedule of Reportable Transactions

Plan Name	Nokia Retiree Welfare Benefits Plan
Plan Sponsor EIN	22-3408857
ERISA Plan No.	504
Plan Year End	12/31/2020

The required attachment noted below is included within the Accountant's Opinion attachment to the Form 5500 Schedule H, Part III, which consists of the entire Audit report issued by the Plan's Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line Item	Description
5500 Schedule H	Line 4i	Schedule of Assets (Held at End of Year)