

Get More From Your 2021 Nokia Benefits



Important Information About Using Your Benefits in 2021

UPDATED MARCH 2021

For Participants in the Active Management Plan Design

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Read This Now If You Are Enrolled in a Flexible Spending Account (FSA)

MARCH 2021 UPDATE: On December 27, 2020, the Consolidated Appropriations Act, 2021 was signed into law. Its COVID-19 relief measures, along with related regulatory guidance, allow for temporary changes that give participants more flexibility in using their FSA funds for Plan Years 2020 and 2021.

As a result, the information that originally appeared in this article regarding FSA grace periods and FSA claims filing deadlines has been suspended, and it has been removed.

Please review [this notice](#) and the [FSA Temporary COVID Relief Plan Amendment and Summary of Material Modifications](#) for details about the effect of these **temporary** COVID-19 relief measures on your use of your FSAs.

If you have any questions, please contact Smart-Choice via a link on the Your Benefits Resources™ (YBR) website at <https://digital.alight.com/nokia>. You can also call the Nokia Benefits Resource Center at 1-888-232-4111. Representatives are available from 9:00 a.m. to 5:00 p.m., Eastern time (ET), Monday through Friday.

Nokia will continue to review the details of ongoing legislation related to FSAs and communicate any additional changes to you as they are announced.

The following information, with one exception (noted in red), remains current.

Important Reminders

Here are some important reminders about your HFSA and/or DFSA.

Manage Your FSA(s) From Anywhere

Remember, you can manage your HFSA and/or DFSA on the go from your Apple® or Android™ mobile device with the Smart-Choice Mobile app.

Use the app to:

- **Save time.** Submit claims for reimbursement, quickly and conveniently, from anywhere, anytime.
- **Save money.** Forget the postage! Submit your documentation by uploading a picture of your receipt (taken with or stored on your mobile device) with your claim.
- **Get immediate access.** View account information on demand, including balances, card transactions and claim status.

Getting the app is easy. Just locate the Smart-Choice Mobile app in your mobile device's app store and download it onto your device.

Expanded Coverage for Certain Over-the-Counter Items

As a reminder, under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), the following items are considered qualified healthcare expenses and therefore eligible for reimbursement through an HFSA, retroactive to January 1, 2020:

- Over-the-counter drugs and medicines purchased without a doctor's prescription; and
- Menstrual care products.

What Documentation Do You Need to Be Reimbursed From Your HFSA?

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

- Name of the service provider or retailer;
- Date of the service or purchase;
- Identification of the drug or product, or a description of the service;
- Purchase amount for each product or service; and
- Total purchase amount.

Hang on to Those Receipts!

If you cannot provide proof of an HFSA claim with a receipt, your HFSA card will be deactivated and you will be asked to either submit payment to cover the expense or submit substitute receipts for any other eligible out-of-pocket expense.

Enrolled in a DFSA? Use Provider Certification!

The Smart-Choice Provider Certification feature can help make filing your DFSA claims easier:

- Print your online DFSA claim form from the Smart-Choice website.
- Have your dependent care provider sign the Provider Certification section.
- When you file your claim, just submit the signed form. No receipts needed!

Using the Smart-Choice Mobile app to file your DFSA claims? With the app's Dependent Care E-Signature feature, you don't need to submit a hard-copy or electronic receipt from your dependent care provider for reimbursement. Just have your provider tap and sign the signature line of your mobile device's screen. Select "Next" and then complete the rest of the claims submission process as usual.

Important: Ensure that your dependent(s) qualify for a DFSA under Internal Revenue Service (IRS) guidelines. This means your dependent child must be under the age of 13.¹

MARCH 2021 UPDATE. *For Plan Year 2020 only: If, during 2020, you were enrolled in a DFSA and your child turned age 13, you can use your DFSA to be reimbursed for eligible dependent care expenses for that child through December 31, 2021, even after he/she turns age 14. Refer to [this notice](#) and the [FSA Temporary COVID Relief Plan Amendment and Summary of Material Modifications](#) for details.*

¹ Age limit does not apply if your dependent is mentally or physically incapable of self-care, lives with you for more than half of the calendar year and has not been able to provide more than one-half of his or her own support for the calendar year.

For More Information

Questions about your FSA(s)? Contact Smart-Choice via a link on the Your Benefits Resources™ (YBR) website at <https://digital.alight.com/nokia>. You can also call the Nokia Benefits Resource Center at 1-888-232-4111. Representatives are available from 9:00 a.m. to 5:00 p.m., Eastern time (ET), Monday through Friday.

Get Ready to Use Your CVS Caremark Prescription Drug Coverage

Effective January 1, 2021, CVS Caremark will be your prescription drug administrator if you are enrolled in the Enhanced Point of Service (POS), Standard POS or Traditional Indemnity option.

Ready to get started? If you have not already done so, register at [Caremark.com](https://www.caremark.com), your central resource for everything related to the CVS Caremark prescription drug program. (Be sure to have your new CVS Caremark member ID card, which was mailed to you in December and includes your CVS Caremark member ID number, on hand.)

Welcome to CVS Caremark
[These six tips](#) can help you save time and money on your prescription medications starting in January.

Once you create your username and password, log on anytime for information about the current CVS Caremark formulary (including a list of the medications that will be classified as preventive and covered at 100 percent) and drug pricing. You can also learn how to find an in-network pharmacy, manage your prescriptions, set up mail service and check order status, sign up for prescription alerts, save on prescription costs and more.

Starting January 1, 2021, you can also get a copy of the most current CVS Caremark formulary on [Caremark.com](https://www.caremark.com) by clicking on “**covered drug list**” or by calling CVS Caremark at 1-800-240-9623.

Please continue reading for additional information to help you prepare for the transition to CVS Caremark.

How to Fill Your Prescriptions Starting January 1, 2021

Retail Prescriptions for Acute Conditions (Up to a 30-Day Supply)

You can fill up to a 30-day supply of a drug for an acute condition at **ANY RETAIL PHARMACY. You are NOT required to use a CVS pharmacy to fill your retail prescriptions.** However, you will save money when you use an **in-network** pharmacy. In-network pharmacies include CVS, Giant, Kroger, Rite Aid, Target (which are CVS pharmacies), Walgreens, Walmart and many others. Be sure to provide your CVS Caremark member ID card to your pharmacist when you fill your first prescription in 2021.

Save With Generics

Why pay more for your prescriptions than you have to? Generics are just as safe and effective as their brand-name equivalents and offer savings of up to 80 percent. [Learn more.](#)

To see if your pharmacy is in-network, or to find a nearby in-network pharmacy, call CVS Caremark at 1-800-240-9623 or register at Caremark.com and click “Choose your pharmacy.” Be sure to have your CVS Caremark member ID card on hand.

Current retail pharmacy not in the CVS Caremark network? To transfer your prescriptions to a CVS Caremark network retail pharmacy, go to the CVS Caremark network pharmacy of your choice and tell the pharmacist where your prescription is currently on file. The pharmacist will contact your current pharmacy and make the transfer for you.

Please note: As under your 2020 Nokia prescription drug coverage, prescription drug copayments will **double** after the **third time** you receive a 30-day supply of a maintenance medication for a chronic condition at a retail pharmacy. For cost savings, fill up to a 90-day supply of a maintenance medication through mail order or pickup at a CVS retail pharmacy, as outlined below.

Maintenance Prescriptions for Chronic Conditions (Up to a 90-Day Supply)

For maintenance medications for chronic conditions, you can fill your prescription for up to a 90-day supply:

- Through CVS Caremark Mail Service Pharmacy. When you order online, CVS Caremark will send up to a 90-day supply of your maintenance medications to your home with free delivery.
- OR
- At a CVS retail pharmacy.

Please note:

- There may be a day supply limitation on some prescriptions, such as controlled substances, subject to state and federal dispensing limitations.
- You will need to get a new prescription from your provider for any expired prescriptions, or for prescriptions that have no refills remaining.

[Learn how to get started.](#)

Currently Taking a Brand-Name Drug Without a Generic Equivalent?

If your current brand-name prescription is identified as “non-preferred” on the CVS Caremark formulary, you may be able to save money by switching to an available, lower-cost “preferred” brand alternative.

See the Welcome Kit mailed to you in December for information about how you can check for potential cost savings on your brand-name prescriptions.

How to Refill Current Maintenance Prescriptions for Chronic Conditions Through Mail Service

Express Scripts has transferred all existing mail order maintenance prescription refills to CVS Caremark.

Starting January 1, 2021, have your CVS Caremark member ID number ready and submit your refill request for a transferred maintenance prescription to CVS Caremark Mail Service:

- **Online:** Register at [Caremark.com](https://www.caremark.com) to order refills and check the status of your order at any time;
- **By phone:** Call CVS Caremark at 1-800-240-9623 for automated refill service; or
- **By mail:** Complete a CVS Caremark Mail Service order form for each prescription. Mail the form and appropriate copayment to CVS Caremark at the address shown on the form.

To obtain a CVS Caremark Mail Service order form, go to [Caremark.com](https://www.caremark.com) and register if you have not done so already. (Be sure to have your CVS Caremark member ID number ready.) After you register, click “start mail service” to access the form. On subsequent visits, simply sign in using your username and password. **Note:** You can also call CVS Caremark at 1-800-240-9623 to request that a form be mailed to you.

How to Fill New Maintenance Prescriptions for Chronic Conditions Through Mail Service Starting January 1, 2021

For new long-term or maintenance medications, ask your doctor to write **two** prescriptions:

- The **first** for up to a 30-day supply, which you can fill at a participating retail network pharmacy for use until your mail service prescription arrives; and
- The **second** for up to a 90-day supply, plus any appropriate refills, to fill through the CVS Caremark Mail Service Pharmacy.

To fill your prescription:

- Complete a mail service order form (available at [Caremark.com](https://www.caremark.com); after you register, click “Start Rx delivery by mail” to access the form) and send it to CVS Caremark Mail Service Pharmacy, along with your original prescription(s) and the appropriate copayment for each prescription. **Be sure to include your original prescription. Photocopies are not accepted.**

OR

- Call 1-800-240-9623 for help getting set up with mail service. Be sure to have your CVS Caremark member ID number and prescription drug information ready. After verifying your demographic information and payment method, CVS Caremark can assist by contacting your doctor via fax for a new prescription. Once CVS Caremark receives the new prescription, it will be processed and mailed to you.

Forgot to Bring Your CVS Caremark Member ID Card With You?

No problem! You can access your member ID card information on the go at [Caremark.com](https://www.caremark.com) or through the CVS Caremark mobile app. [Learn more.](#)

Bonus! Get 20 Percent Off CVS-Brand Health Items

As a CVS Caremark prescription drug program member, you can get a 20 percent discount off the regular price of most CVS-brand health-related products at retail CVS pharmacies when you use your CVS ExtraCare® Health Card.

To obtain your CVS ExtraCare Health Card:

- Register on [Caremark.com](https://www.caremark.com); then “unlock” your ExtraCare Health Benefit at [Caremark.com/ExtraCareHealth](https://www.caremark.com/ExtraCareHealth);
- or
- Call 1-888-543-5938.

Note that the CVS ExtraCare Health Card is separate from the CVS Caremark member ID card included in your Welcome Kit.

Important: You must mail in a CVS Caremark Mail Service order form the first time you request a new prescription through mail service. An automated refill service will be available after your first prescription order is processed. [Learn more.](#)

Special Situations

By now, CVS Caremark should have contacted you (or your covered family member) by mail if one or more of the following apply:

- Your current prescription is not on the CVS Caremark formulary.
- Your current prescription requires prior authorization.
- Your mail-order prescription transfer is prohibited by law, such as if it is for a controlled substance or compound medication.

If any of these situations applies to you or a covered family member, you will need a new prescription from your doctor for your medication starting January 1, 2021. The personalized letter that you or your covered family member has received provides details regarding the steps you should take to update your specific prescription(s). You may wish to share the letter with your doctor.

Specialty Medications

CVS Caremark manages specialty medications through CVS Specialty®. If you currently take specialty medication, your prescription will need to be transferred to CVS Caremark for 2021. By now, a CVS Specialty representative should have called you to answer your questions, help you enroll in the CVS Specialty program and transfer your prescriptions and assist with any infusion services that may need to be set up. For more information, call CVS Specialty at 1-800-237-2767 or [click here](#).

The Importance of Preventive Care

Protecting your and your family's health is one of the most important things you can do. Keeping a focus on regular preventive care can help you and your family get and stay healthier.

Preventive care, including regular medical checkups, screenings and immunizations, is important to maintaining your good health. It can help you avoid potentially serious health conditions and/or obtain early diagnosis and treatment. Generally, the sooner your doctor can identify and treat a medical condition, the better the outcome.

Talk with your doctor or other healthcare provider to determine the preventive care services that are appropriate for you and your family. Which services you should receive, and how often you should receive them, will depend on your current health, personal and family medical histories, age and gender, as well as any risk factors.

In addition, be sure to check with your carrier to confirm whether — and how — a particular preventive care service is covered.

Please note: If you are enrolled in a UnitedHealthcare medical plan option, you can review [UnitedHealthcare's preventive care guidelines for children and adults here](#).

What You Need to Know About Your Member ID Cards

Here is what you need to know about your medical, prescription drug and/or dental member ID cards:

Medical and Prescription Drug

- If you have enrolled in the Enhanced Point of Service (POS), Standard POS or Traditional Indemnity option for 2021, you will receive new member ID cards from UnitedHealthcare (medical) and CVS Caremark (prescription drug) by January 1, 2021, to use in 2021.
- If you have not received your new cards by January 1, 2021, or if you have misplaced your cards and need new ones, you may print them from the applicable carrier's website:
 - Medical (UnitedHealthcare): www.myuhc.com
 - Prescription drug (CVS Caremark): Caremark.com
- For HMO coverage, contact the HMO for any questions about member ID cards. You can find contact information on the back of your HMO ID card (if you are currently enrolled) and in *Benefits At-a-Glance and Resource Contact Information 2021* on the BenefitAnswers Plus website.

Starting in January, your healthcare provider or pharmacy should be able to confirm your coverage directly with UnitedHealthcare (medical for the Enhanced POS, Standard POS and Traditional Indemnity options), CVS Caremark (prescription drug for the Enhanced POS, Standard POS and Traditional Indemnity options) or your HMO (medical and prescription drug).

Dental

MetLife does not issue dental plan member ID cards; you do not need to present an ID card to receive services under the plan. Simply provide your dentist with your group information (Nokia 85848) and employee ID number. In addition, you can review your dental benefits at www.metlife.com/mybenefits. (To sign in, use the company/group name "US-Nokia" and follow the on-screen prompts.)

Get More From Your UnitedHealthcare Medical Plan Option: Choose Premium Care Physicians

Choosing a doctor is one of the most important health decisions you will make. The UnitedHealth Premium® Program can help.

How the UnitedHealth Premium Program Works

The UnitedHealth Premium Program uses evidence-based medicine and national standardized measures to evaluate physicians in various specialties. When you choose a Premium Care Physician, you can be sure that the doctor meets the program's criteria for providing quality and cost-effective care.

How to Find a Premium Care Physician

Simply log on to www.myuhc.com and select "Find a Provider." Premium Care Physicians will be at the top of your search results. Look for two blue hearts and the words "Premium Care Physician" in the doctor's profile.

Keep in mind: If a doctor does not have a Premium designation, it does not mean that he or she provides a lower standard of care. It could mean that the data available to UnitedHealthcare was not sufficient to include the doctor in the program or that the doctor practices in a specialty not evaluated as a part of the Premium designation program. All doctors who are part of the UnitedHealthcare network must meet rigorous credentialing requirements, which are separate from the Premium program.

To learn more, visit the BenefitAnswers Plus website at www.benefitanswersplus.com. Select the “Carriers & Other Resources” tab, then “Other Resources & Information” and then the “Find the Right Doctors: Use the UnitedHealth Premium® Program” link.

When Caller ID Says “UnitedHealthcare,” Please Answer the Phone

This is one call you do not want to miss.

If you are enrolled in a UnitedHealthcare medical plan option, you may receive a call from a UnitedHealthcare nurse. Why? Because you or a covered family member has been identified as someone who could benefit from a telephone conversation with a nurse. **This is not a sales call; no one will try to sell you anything.**

For instance, a UnitedHealthcare nurse may call to share information about an available program or service (such as a clinical management program or wellness coaching) that could help you improve your health. Or a nurse may call to check in and offer support if you or a covered family member has a chronic medical condition, was recently hospitalized or is pregnant.

Right Care. Right Place. Right Savings.

Doctor's office. Virtual visit.
Convenience care clinic. Urgent care center. Emergency room. You and your family have more options than ever when you need medical care.

UnitedHealthcare's **Check. Choose. Go.**® guide can help you make the right choice for your situation.

You can access the guide at uhc.com/checkchoosego or [here](#).

This telephone outreach service is an extension of your Nokia medical plan benefits and is designed to provide additional support to members. All UnitedHealthcare nurses who call will identify themselves, confirm they are speaking with the correct Nokia medical plan member, explain the reason for their call and give you the opportunity to call them back at your convenience. **You will not be asked to provide any personal health information.**

The bottom line: When UnitedHealthcare calls, please answer the phone. You have nothing to lose, and so much to gain!

Important: Your privacy is protected. UnitedHealthcare is dedicated to safeguarding your privacy. UnitedHealthcare does not share your name or any other identifying information. Your conversations will remain confidential. Any health information collected as part of the assessment will be kept confidential in accordance with the Notice of Privacy Practices; be used only for health and wellness recommendations or for payment, treatment or health care operations; and be shared with your health plan, but not with your employer.

[Learn more about UnitedHealthcare's outreach service here.](#)

Attention UnitedHealthcare Members: Take Advantage of These Tools and Resources Anytime

UnitedHealthcare offers a number of tools and resources to help you manage your and your family's health and healthcare. All are available at **no additional cost to you**.

Voice Identification (ID)

When you call UnitedHealthcare at the number on the back of your member ID card, you can use a voice ID to authenticate yourself going forward. Here is how it works:

During your call, you will have the option to record a voice ID while speaking your date of birth. Then, whenever you call UnitedHealthcare in the future, the system will recognize you when you say your birthdate.

If you prefer not to record a voice ID, no problem! Simply follow the system prompts to authenticate your identity every time you call. The choice is yours.

Virtual Visits (Now Including Virtual Therapy)

As part of your UnitedHealthcare medical benefits, you and your covered family members have a convenient alternative for nonemergency and behavioral health care: virtual visits.

A virtual visit lets you see and talk to a doctor or licensed behavioral health virtual therapist from your smartphone, tablet or computer.

(Not a UnitedHealthcare member? Check with your HMO to see if it offers a similar service.)

Nonemergency Care

Virtual visits via Teladoc[®], Doctor On Demand and Amwell are available 24/7 for help with common health conditions like allergies, flu, pink eye, rashes, sore throats, and stomachaches.

If you are enrolled in a Point of Service (POS) medical plan option, your cost for a virtual visit (\$10 copayment per visit under the Enhanced POS option or \$20 copayment per visit under the Standard POS option) is significantly less expensive than an office, urgent care center or emergency room visit. If you are enrolled in the Traditional Indemnity option, a virtual visit is covered like any physician office visit: the plan pays 80 percent after the deductible.

Most visits take about 10 – 15 minutes. Doctors can write a prescription², if needed, that you can pick up at your local pharmacy.

To register for and request a virtual visit, log on to **myuhc.com**[®]. In the center of your home page, you will see "My providers and facilities." Scroll to the right and select "Virtual Visits: Connect with a Doctor Online." You can also download the UnitedHealthcare mobile app.

Prefer a Virtual Visit for Nonemergency Care by Telephone?

Simply call 1-855-615-8335 to speak with a Teladoc, Doctor On Demand or Amwell doctor over the phone about your health concerns. Your cost is the same as for an online virtual visit.

² Doctors cannot prescribe medications in all states.

Once registered, you can request a virtual visit.

- When you schedule an appointment, you can view the total number of appointments available, by provider, over the next seven days.
- Once you choose a provider, if the provider is currently available, an “Available Now” label will display. You can change from a scheduled visit to a “Meet Now” with the selected provider at that time, or you can continue to request an appointment time.
- When you select a scheduled visit with a specific provider, all providers with at least one appointment “slot” will display. The first available time slot you can choose will be 30 minutes from “now,” rounded up. Once you choose an appointment time with a provider, all other providers will “collapse” from the online view.
- You will be informed that the visit will start within a 15-minute window to allow the doctor to finish up with any previous patients.

Pay your portion of the service via credit or debit card (including your HFSA debit card, if applicable) according to the terms of your medical plan option. Then, enter a virtual waiting room. During your visit, you can talk to a doctor about your health concerns, symptoms and treatment options.

Referrals for Laboratory Services Through Teladoc

During a virtual visit with a Teladoc provider, he or she can order laboratory services as clinically appropriate, based on your medical issue and symptoms. You can choose to get the services at either a Quest Diagnostics™ or LabCorp lab.

Here is what to expect:

- If your Teladoc provider orders lab services, you will receive a message via the Teladoc message center after your virtual visit is complete. The message will contain a link to complete your lab order request. The link will be active for five days.
- You will be prompted to select a lab location, at which time the order will be submitted electronically to the lab.
- Go to the lab for the services; you will need to provide your insurance information.
- The results will be sent electronically from the lab to Teladoc and posted in your Teladoc medical record and member message center. Teladoc will notify you by email when the results are posted.
 - If the results are within a normal range, you will receive a message in the Teladoc message center.
 - If the lab results are outside of the normal range, a Teladoc clinician will contact you for next steps.

Important Information About Telemedicine/Telehealth Visits With Your Own Doctor

Unlike the virtual visits described above, a telemedicine/telehealth visit with your own doctor (primary care physician [PCP] or specialist) in place of an in-person office visit for non-preventive, nonemergency care is covered just like an office visit under your medical plan option:

Medical Plan Option	Cost of Nonemergency Telemedicine/Telehealth Visit With Your Own Doctor
Enhanced POS	<p>In-Network: You pay:</p> <ul style="list-style-type: none"> ▪ \$30 copayment/visit (PCP) ▪ \$40 copayment/visit (specialist) <p>Out-of-Network: Plan pays 60% after deductible is satisfied</p>
Standard POS	<p>In-Network: You pay:</p> <ul style="list-style-type: none"> ▪ \$35 copayment/visit (PCP) ▪ \$60 copayment/visit (specialist) <p>Out-of-Network: Plan pays 50% after deductible is satisfied</p>
Traditional Indemnity	Plan pays 80% after deductible is satisfied

Behavioral Health Care

When you are feeling stressed or anxious, it may be hard to reach out for help, especially if you do not want anyone to know that you are hurting. Virtual therapy offers confidential, one-on-one video counseling for conditions such as anxiety, depression, ADD/ADHD, addiction and mental health disorders from the privacy of your home.

You can see the same therapist with each appointment and establish an ongoing relationship. Your therapist can provide diagnosis, treatment and medication if needed.

If you are enrolled in a POS medical plan option, your cost for a virtual visit is the same as any in-network, outpatient behavioral health visit: you pay a \$30 copayment per visit under the Enhanced POS option or a \$35 copayment per visit under the Standard POS option. If you are enrolled in the Traditional Indemnity option, a virtual visit is covered like any outpatient behavioral health visit: the plan pays 80 percent after the deductible.

You will pay your portion of the service via credit or debit card (including your HFSA debit card, if applicable) or via direct bill, according to the terms of your medical plan option and your payment arrangement with your provider.

To find a therapist and schedule a visit, log on to myuhc.com[®]. Select “Find a Doctor,” “Behavioral Health Directory,” “People,” “Provider Type,” and then “Telemental Health Providers.” Call the provider of your choice to set up an appointment. [Learn more](#).

Rally®

You have access to Rally, a user-friendly digital experience on **myuhc.com** that will engage you by using technology, gaming and social media to help you understand, learn about and feel supported on your health journey.

Rally offers personalized recommendations to help you and your covered family members make healthier choices and build healthier habits, one small step at a time. It is available at no additional cost to you. You can access Rally at www.myuhc.com from your smartphone, tablet or computer anytime.

OptumHealth™ NurseLine³

Illness or injury can happen anytime, not just during your doctor's regular office hours. **If your situation is life- or limb-threatening, call 911 or go to the nearest emergency room (ER) immediately.** But if your situation is less serious, remember that the UnitedHealthcare OptumHealth NurseLine is a toll-free call away — 24 hours a day, seven days a week.

The NurseLine's experienced registered nurses can answer your questions about an illness, injury or medication; help you manage a chronic condition; provide information about a variety of healthcare topics; and more. Both English- and Spanish-speaking registered nurses are available.

To reach the NurseLine, call 1-866-444-3011. You can also participate in an online Live Nurse Chat. Just log on to www.myuhc.com from any device with an Internet connection.

Not a UnitedHealthcare member? Check your medical plan member ID card to see if your HMO offers a similar telephone or online nurse resource.

³ This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. The service is not an insurance program and may be discontinued at any time.

Real Appeal®

Real Appeal is an online weight loss and healthy lifestyle program based on the science of what really works to help people lose weight and keep it off. It is available to you and your family members age 18 and older.

Real Appeal helps you lose weight and reduce your risk of developing certain diseases like diabetes and cardiovascular disease, as it is based on decades of proven clinical research. Most members lose an average of 10 pounds after completing only four sessions of the program. Enrollment in the program includes:

- **52 weeks of access to a Transformation Coach.** Your coach guides you through the program and develops a simple, customized plan that fits your needs, preferences and goals.
- **24/7 access** to digital tools and dashboards that help you track your food, activity and weight.
- **A success kit** full of healthy weight management tools, including fitness guides, recipe book (including quick family meal ideas and fast-food eating tips), weight scale and more.
- **Support** from weekly online group classes to learn healthy ideas from your coach and other members who share what has helped them achieve success.

Real Appeal is a fun and engaging program that helps you learn simple steps for a healthier life so you can spark your transformation. To learn more or get started, visit enroll.realappeal.com.

UnitedHealthcare® Mobile App

Think of the UnitedHealthcare app as your go-to healthcare resource for whenever you are on the go. The UnitedHealthcare app makes it easy for you to access your healthcare information, anytime and anywhere, from your mobile device.

The UnitedHealthcare app gives you tools to help you find care, manage your health plan details, and stay on top of costs. You can:

- Find network care options for doctors, clinics and hospitals in your area
- Talk to a doctor by video 24/7
- See reviews and ratings for doctors
- Generate and share digital health plan member ID cards
- View claims and account balances
- Estimate the costs of common procedures
- View your copay, coinsurance, annual deductible and/or out-of-pocket expenses

To download the UnitedHealthcare app, visit the App Store or Google Play.

myHealthcare Cost Estimator

You may be surprised to learn that different doctors, labs and hospitals can charge **different** rates for the **same** medical services — even when they are all in-network. The myHealthcare Cost Estimator gives you the information you need to make the best decisions for your health **and** your wallet.

The myHealthcare Cost Estimator can help you:

- Preview and compare your costs for a procedure or treatment at different providers and facilities
- Choose the treatment option that is best for you
- Plan your care
- Budget for your medical expenses

You can access the myHealthcare Cost Estimator from www.myuhc.com or the UnitedHealthcare app. (To log on to www.myuhc.com, you will first need to register.)

Once you have accessed the myHealthcare Cost Estimator, just search for the condition (for example, back pain) or treatment (for example, physical therapy) for which you want a cost estimate. The myHealthcare Cost Estimator will show you doctors and locations that offer those services in your area. You can also learn about your treatment options, compare estimated costs, see quality and cost-efficiency ratings and map the location of the provider or facility. The cost estimator will even give you a personalized estimate of your out-of-pocket costs, based on your option's applicable deductible, coinsurance and/or out-of-pocket maximum.

Need a Helping Hand?

Count on the Employee Assistance Program (EAP)

When faced with life's challenges — whether big or small — the Nokia EAP can help. Provided through Magellan Health Services, the EAP offers you and your household members free, confidential, 24/7 assistance for a wide range of medical and behavioral health issues, such as emotional difficulties, alcoholism, drug abuse, marital or family concerns, and other personal and life issues such as elder care.

Enrollment in the EAP is not required, nor do you need to be enrolled in Nokia's medical plan in order to access the medical plan's EAP coverage.

Visit MagellanAscend.com, Your EAP Member Website

Be sure to check out MagellanAscend.com for helpful EAP tools, calculators, assessments, access to monthly newsletters and webinars, and health and wellness information. (The first time you visit, you will need to create a user/sign-in profile.)

MagellanAscend.com also offers a mobile app resources page. You will find a range of wellness-focused mobile apps to help you cope with everyday issues, including anxiety, stress, diabetes, autism, sleep, depression and more.

Check Out Clickotine, Magellan's Smoking Cessation App

Clickotine is an innovative program that uses clinically-driven app technology to help you create and stick to a quit plan and overcome nicotine cravings. Based on clinical trials and data, Clickotine has a high success rate. Key features include:

- **Personalized messaging:** Receive personal messages that keep you on track toward your quit goal.
- **Controlled breathing:** Monitor and control your breathing — an effective way to reduce nicotine withdrawal symptoms.
- **Real-time social support:** Post comments and share encouragement with others trying to quit.
- **Replacement distractions:** Get help diverting cravings to healthier actions.
- **Money saved:** Track how much money you have saved since your quit date — a powerful motivator for quitting.

For More Information

If you have questions and would like to speak with an EAP representative, call 1-800-327-7348 or visit MagellanAscend.com.

Manage Your Dental Benefits With the MetLife US App

Need to find an in-network provider? Want to check the status of a claim? You can — right from your smartphone — using the free MetLife US app.

The app is available 24/7. Just follow these three easy steps:

Step 1: If you haven't already, register at www.metlife.com/mybenefits (sign in using the company code "US-Nokia") from any computer. **Important:** You cannot register from your phone. (Already registered? Start with Step 2 and download the app directly!)

Step 2: Search for "MetLife US app" on the App Store or Google Play to download the app.

Step 3: Use your MyBenefits log-on information to access the app features.

Find Out How You Can Save on Your Dental Costs

As a reminder, both the Enhanced and Standard Dental Options have a difference in benefit levels based on whether you use an in-network provider (general dentist or a specialist) versus an out-of-network provider. **To receive the in-network level of benefits, you are required to use an in-network provider.**

You can use any dental provider you choose. However, your out-of-pocket costs will be less if you use MetLife Preferred Dentist Program (PDP) Plus network providers because:

- PDP Plus network providers offer lower negotiated fees (usually 30 percent to 45 percent less than the average charges in the same community⁴), and
- Both dental options offer more generous coverage for PDP Plus network providers.

In contrast, if you use an out-of-network provider, your out-of-pocket costs will be based on reasonable and customary (R&C) charges, and your coverage will be lower.

Lower fees can help you cut your final costs and stretch your annual maximums. This can be especially important when you need specialty care like implants, root canals and crowns. The cost of these services can really add up. That is why it is good to know the network is there to help you manage your out-of-pocket costs.

You can view your potential savings on in-network vs. out-of-network fees by using the Dental Procedure Fee Tool⁵ located on www.metlife.com/mybenefits. (To sign in, use the company/group name "US-Nokia" and follow the on-screen prompts.)

Take a look at the example on the following page, which shows you how you can save by going to an in-network specialist.

Continued on next page

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Example for a Specialty Service — Crown

(Note: This is an example for illustration purposes only and may not reflect the actual charges in your area.)

	In-Network	Out-of-Network
Specialist charge ⁶	\$1,300.00	
MetLife negotiated fee	\$698.00	Not applicable
MetLife pays ⁷ (In-network is based on 80 percent coinsurance amount under the Enhanced Dental option for this type of service; out-of-network is based on 70 percent coinsurance)	\$558.40	\$910.00
Your out-of-pocket cost⁸	\$139.60	\$390.00
Approximate savings by visiting a participating dentist: \$250.40.⁸ The savings is the difference between the in-network out-of-pocket cost and the out-of-network out-of-pocket cost.		

The table above is a typical example of how in-network savings work. It shows that you usually save more when you stay in the network. So the next time you need dental care, find out what your plan covers and what you could save by going to a participating general dentist or specialist.

To check your coverage or find a general dentist or specialist, log on to www.metlife.com/mybenefits or call 1-888-262-4876. You can also ask your dentist to recommend a network specialist in your community.

Best of all, participating dentists and specialists have undergone a careful selection process.⁹ You will never need a referral. So you get convenient access to quality care and support for better savings.

⁴ Based on internal analysis by MetLife. Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services rendered by them, subject to any copayments, deductibles, cost-sharing and benefits maximums. Negotiated fees are subject to change.

⁵ The Dental Procedure Fee Tool is provided by VerifPoint, an independent vendor. This tool does not provide the payment information used by MetLife when processing your claims. Prior to receiving services, pretreatment estimates through your dentist will provide the most accurate fee and payment information.

⁶ Approximate costs provided by VerifPoint, Inc., an industry source independent of MetLife.

⁷ This example reflects an in-network coinsurance amount of 80 percent and an out-of-network coinsurance amount of 70 percent for major services under the Enhanced option.

⁸ The potential savings is based on the average charges. Actual savings will vary depending on the out-of-network dentist's actual charge for the service.

⁹ Certain providers may participate with MetLife through an agreement that MetLife has with a vendor. Providers available through a vendor are subject to the vendor's credentialing process and requirements, rather than MetLife's. If you should have any questions, contact MetLife Customer Service.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact MetLife for complete details.

Save on Taxes With the Commuter Benefits Program

Do you pay to park your car or take public transportation to get to and from work? Then consider enrolling in the commuter benefits program offered through WageWorks. You can use pre-tax earnings to pay for public transit — including train, subway, bus, ferry and eligible vanpool — and qualified parking as part of your daily commute.

You decide how much you want to contribute to your WageWorks commuter benefits account each month, up to the IRS limit. Your contributions are automatically deducted from your paycheck on a pre-tax basis (up to the IRS limit) and deposited into your WageWorks account. If you elect a monthly contribution that is higher than the pre-tax limit, the difference will be deducted from your paycheck on an after-tax basis, subject to program limits.







You can enroll in the program or suspend or cancel your contributions at any time. As long as you submit any changes by the 10th of the month, they will be effective on the first of the following month.

Questions?

- **For an overview of the program**, visit www.benefitanswersplus.com/active_m/other_resources.html. Select “Other Benefits” from the primary tiles and then the “Commuter Benefits” tile.
- **For detailed information about the program or to enroll**, visit www.wageworks.com anytime or call WageWorks at 1-877-WageWorks (1-877-924-3967). Representatives are available Monday through Friday, from 8:00 a.m. to 8:00 p.m., ET.

There's an App for That!

Need benefits information on the go? With these free apps, you can manage your Nokia health and welfare benefits from your smartphone or tablet, anytime and anywhere.

Name of App	What You Can Do With It	Where to Find It
UnitedHealthcare 	Find in-network medical providers, estimate costs, view and manage claims, access your ID card and connect with customer service representatives.	Search for "UnitedHealthcare" on the App Store and Google Play
UnitedHealthcare Rally 	Get personalized support and information to help you and your covered family members make healthier choices and build healthier habits.	Search for "Rally" on the App Store and Google Play
CVS Caremark 	Refill mail service prescriptions, get drug and pricing information, find a network pharmacy, track order status, view prescription history, and access your prescription plan member ID card.	Search for "CVS Caremark" on the App Store and Google Play
MetLife 	Find in-network dentists, check the status of a claim and view an ID card.	Search for "MetLife US app" on the App Store and Google Play
Smart-Choice Mobile 	See your HFSA and/or DFSA balance(s), upload documentation, submit claims and more.	Search for "Smart-Choice Mobile app" on the App Store and Google Play
WageWorks EZ Receipts 	Manage your commuter benefits account, including checking your balance and viewing and submitting claims.	Search for "EZ Receipts" on the App Store and Google Play

Take a Fresh Look at Your Savings Plan

Are you contributing to the Nokia Savings/401(k) Plan?

If you are not contributing, now might be a good time to consider enrolling or restarting your contributions.

If you are contributing, you already understand the value of making contributions to a savings account. But when is the last time you took a close look at **your** account?

Unfortunately, many participants choose their Savings Plan contribution rate and investments when they first join the plan and never look back. But your situation may change over time, so it is important to review your contributions and investments on a regular basis to ensure that they are still in line with your retirement and other long-term savings goals.

Now is a good time to check — or check back — in with your Savings Plan. Take a fresh look at your savings and investment strategy and see if you want (or need) to make any adjustments.

- **For general information and to access important Savings Plan documents**, visit the BenefitAnswers Plus website at http://benefitanswersplus.com/active_m/index.html. Select “Retirement Savings & Pension” in the primary tiles.
- **For personalized information and to manage your Savings Plan account**, log on to the YBR website at <https://digital.alight.com/nokia>. Select “Savings/401(k) & Pension” in the primary tiles. Then follow the prompts to enroll, access online account statements, see your transaction history, make changes to your contribution rate, investments and/or beneficiaries, perform other account transactions, find fund information, use retirement planning and modeling tools and more. You can also call the Nokia Benefits Resource Center at 1-888-232-4111.

Keep Your Life Insurance and/or Savings Plan Beneficiaries Up to Date

It is important to keep your Nokia life insurance and/or Nokia Savings/401(k) Plan beneficiary information up to date. This will help your loved ones avoid delays in receiving your Nokia benefits in the event of your death. You can change your beneficiary information at any time.

To change your beneficiary designations and contact information for:

- **Life insurance** — Complete and submit the form(s) available on the BenefitAnswers Plus website at http://www.benefitanswersplus.com/active_m/index.html. Select “Forms” in the primary tiles and then select “Insurance Forms.” Or, contact MetLife at 1-888-201-4612.
- **Savings Plan** — Log on to the YBR website at <https://digital.alight.com/nokia> to access your Savings Plan account. Select “Your Profile” in the primary tiles and then select “Beneficiaries.” Or, call the Nokia Benefits Resource Center at 1-888-232-4111.

Coming Your Way: Tax Form 1095

As required by the Affordable Care Act (ACA; healthcare reform), employers must provide IRS Form 1095-C to certain (but not all) plan participants each year. The form serves as proof that you met the ACA's requirement for having qualifying healthcare coverage during the year. If this applies to you, you should expect to receive your 2020 Form 1095-C no later than January 31, 2021.

Form 1095 indicates the months of the year that you (and your dependents, if applicable) were offered or were enrolled in medical coverage during 2020. You may need Form 1095 or the information it includes in order to file your federal tax return for 2020. Nokia cannot offer tax advice, so you might consider consulting a tax advisor for further guidance on Form 1095. **(Please note:** Form 1095 will not replace any state forms you may receive that provide proof of medical insurance.)

Please note: For the 2020 tax year, California (CA), the District of Columbia (DC), New Jersey (NJ) and Rhode Island (RI) require copies of the federal 1095 tax forms (used to report healthcare coverage) for employees who are residents during the tax year. Nokia has partnered with Alight to ensure compliance with these healthcare tax filing requirements, and 1095 data will be provided to CA, DC, NJ and RI as required.

This communication is intended to highlight some of the benefits provided to eligible participants under the Nokia health and welfare plans. More detailed information is provided in the official plan documents. In the event of a conflict between any information contained in this communication and the terms of the plans as reflected in the official plan documents, the official plan documents shall control. The Board of Directors of Nokia of America Corporation (the "Company") (or its delegate[s]) reserves the right to modify, suspend, change or terminate any of the benefit plans at any time. Participants should make no assumptions about any possible future changes unless a formal announcement is made by the Company. The Company cannot be bound by statements about the plans made by unauthorized personnel.

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