Nortel Networks
Retiree Medical Plan
Annual Enrollment Guide

2012

Nortel Networks Retiree Medical Plan Enrollment Guide

This enrollment guide provides important information regarding this year's annual enrollment. Please read it thoroughly and direct any questions to the appropriate contact as indicated in the "Contact Information" section.

This year's annual enrollment period is from November 11 to 18, 2011. This enrollment guide provides you with an overview of the Nortel Networks Retiree Medical Plan and a detailed look at the medical and prescription drug options available to you. Please take the time to read through this guide so that you make an informed choice on which available retiree medical coverage makes the most sense for you and your family.

Note: Your enrollment choices and new premiums will become effective January 1, 2012.

About the Nortel Networks Retiree Medical Plan

It's important to remember that Nortel's retiree health benefit plan is self-insured. This means that, after discounts are applied, Nortel Networks – not an insurance company – pays employees' claims. A third party administrator (i.e. CIGNA) only provides administrative services such as managing networks and processing claims.

This guide is a brief summary of some important items but may not include everything you will need to make informed choices or access benefits. For more complete information about the terms and conditions of the retiree medical plan please refer to the Nortel Networks Retiree Medical Summary Plan Description (SPD) on Nortel's health and group benefits website at http://www.nortel-us.com/current/benefits/ under "Explore Plans/Services". If you don't have internet access, you can call HR Shared Services at 1-800-676-4636 to have a copy sent to you.

This enrollment guide provides only a summary of the Nortel Networks Retiree Medical Plan. The actual plan documents govern the details of benefits coverage in all cases. Nortel continues to reserve the right to change, amend, and reduce or terminate the plan, at any time, without prior notice to, or consent by, employees, retirees or surviving beneficiaries, in accordance with the terms of the plan and subject to applicable law. Receipt of this guide does not guarantee eligibility or benefit coverage.

No Changes

Currently, the 2011 plan provisions and premiums will continue unchanged into 2012. Keep in mind that the company continues to review benefit programs. Receipt of this enrollment information does not guarantee eligibility or benefit coverage. Nortel continues to reserve the right to change, amend, and reduce or terminate the Retiree Medical plan, at any time, without prior notice to, or consent by, employees, retirees, or surviving beneficiaries in accordance with the terms of the plan and applicable law.

Reminder: For participants who retired prior to May 1, 2000 or were age 50 and a member of the Pension Service Plan as of April 30, 2000, and elected to remain in the previously available Traditional program of the Capital Accumulation and Retirement Program (grandfathered Traditional Program members), as of January 1, 2008, Nortel's annual subsidy toward your retiree medical plan premium was capped. The Company subsidy for a given year is based on the amount of the Company's 2007 subsidy, increased by *no more than 3% per year thereafter*, compounded annually.

How to Enroll

This year's annual enrollment period is November 11 to 18, 2011. During this time, you can enroll in any of the retiree medical options that are available to you. Keep in mind that the retiree medical option you choose during this enrollment period will also apply to all covered eligible dependents. For example, if you choose the 80/60 PPO option for your coverage, all your covered eligible dependents also will be covered under the 80/60 PPO option.

If you choose to stay in your current option, no action is required on your part. However, please take careful note of your current coverage and its cost for 2012 on the retiree medical annual enrollment change form sent to your home.

Please note that the annual enrollment period does *not* offer an opportunity to add or remove covered dependents unless you are enrolling a dependent less than 26 years old (without access to employer coverage) that is now eligible under the new health care reform rules. Otherwise, making changes to your covered dependents under the Nortel Networks Retiree Medical Plan is only allowed when a Status Change occurs. See the "Changing Your Coverage During the Year" section for more information.

If you do not wish to make any changes to your current coverage, you do not need to do anything. Your current coverage and premiums will remain in effect.

To make changes to your Nortel retiree medical coverage for 2012, follow these steps:

1. Carefully review the information in this guide and the Nortel Networks Retiree Medical Summary Plan Description (SPD) on Nortel's health and group benefits website at http://www.nortel-us.com/current/benefits/ under "Explore Plans/Services".

2. Carefully review, fill out and sign the *2012 Retiree Medical Plan Enrollment Letter and Change Form* and return it in the self-addressed envelope provided in the annual enrollment packet sent to your home. Your completed and signed form must be postmarked by November 18, 2011 in order for your enrollment choices to be processed.

Your enrollment choices and new premiums will become effective January 1, 2012.

Key Concept: Non-Duplication Coordination of Benefits

The Non-Duplication Coordination of Benefits (COB) feature coordinates benefits payments provided under **all** group medical plans (including Medicare) under which you are covered. This provision is designed so that you can receive no more than the maximum amount that the Nortel Networks Retiree Medical Plan would have paid if you had no other coverage. This feature reduces or often eliminates the advantages of maintaining double coverage—so, you should review your plans carefully and decide whether you wish to be covered by the Nortel Networks Retiree Medical Plan or by another coverage for which you may be eligible.

Remember, if you discontinue your coverage under the Nortel Networks Retiree Medical Plan, neither you nor your dependents can re-enroll in the plan at any time in the future. However, if you maintain your coverage under the plan, your dependents may discontinue their coverage and subsequently re-enroll if they meet the conditions outlined in the Status Change rules. See the "Changing Your Coverage During the Year" section for more information.

Medical Plan Options for Retirees Age 65 and Older and for Retirees Under Age 65

The At-a-Glance chart that follows summarizes the medical plan options available under the Nortel Networks Retiree Medical Plan effective January 1, 2012 for retirees age 65 and older and for retirees under age 65. All the Nortel Networks Retiree Medical Plan options are provided through CIGNA HealthCare. The benefits payable to you depend upon which option you choose. This chart is not intended to be a complete description of the plan. If there is any conflict between this summary and the written provisions of the plan, the plan documents will always control.

Comprehensive and Indemnity Options At-a-Glance

Benefit Description	Comprehensive Option	Indemnity Option
Calendar-Year Deductible		
• Individual	• $350	• $200
• Family	• $1,050	• $400
Hospital Inpatient Stay Copayment (precertification required)2[1]	$300	N/A
Calendar-Year Out-of-Pocket Maximum[7]		
• Individual	• $3,500	• $1,500
• Family	• $7,000	• $3,000
Lifetime Maximum Benefit Per Person	Unlimited	
Physician Services		
Doctor's Office Visits	80%[1,4]	80%[1,4]
Prenatal Visits	80%[1,4]	80%[1,4]
Outpatient Surgeon's Fees	80%[1,2,3,4]	100%[1,2,3]
Inpatient Surgeon's Fees	80%[1,2,3,4]	100%[1,2,3]
Anesthetic Services and Ancillary Services	80%[1,4]	100%[2,3]
Inpatient Hospital Services	80%[1,2,3,4]	100%[2,3]
Other Professional Services		
Outpatient Short-Term Rehabilitation (including physical, speech, occupational therapy and chiropractic care)	80%[1,4]	80%[4]
Private Duty Nursing	80%, up to $10,000 per person per calendar year[1,4]	80%, up to $10,000 per person per calendar year[4]
Preventive Care		
Well Baby Care (up to age 6)	100% with no deductible[1]	100%[6]
Child's Physical Exam (age 6 and over)	100% with no deductible[1]	100% with no deductible[1]
Adult Physical Exam	100% with no deductible[1]	100% with no deductible[1]
Routine OB/GYN Exam (includes routine mammograms)	100% with no deductible[1]	100%[6]
Hospital Services		
Inpatient Treatment	80% after each hospital inpatient stay copayment[1,2,3,4]	100%[2,3]

chart continued on the next page

Comprehensive and Indemnity Option At-a-Glance (continued)

Benefit Description	Comprehensive Option	Indemnity Option
Outpatient Treatment	80%[1,2,3,4]	• Treatments, including hemodialysis, radiation and chemotherapy: 80%[4] • Services, including anesthesiologist, pathology interpretations, etc.: 100%[2]
Emergency Room	80%[1,4]	80%[4]
Skilled Nursing Facility	80%, up to 60 days per calendar year[1,2,3,4]	100%, up to 365 days per confinement[2,3]
Hospice Care	80%[1,4]	100%[1,8]
Other Medical Services		
Assisted Reproduction (up to $5,000 lifetime maximum per person)	80%[1,4,5]	Not covered
Infertility Diagnosis and Treatment	80%[1,4]	Not covered
Home Health Care	80%, up to 100 visits per calendar year[1,4]	100%, up to 100 visits per calendar year
Diagnostic X-Ray and Lab	80%[1,4]	80%[4]
Radiation and Chemotherapy	80%[1,4]	80%[4]
Durable Medical Equipment	80% ($2,000 maximum per calendar year)[1,4]	80%[4]

[1]*Subject to reasonable and customary (R&C) limits.*

[2]*Whenever a covered person faces confinement in a hospital or needs non-emergency surgery, follow the directions for Hospital Precertification of those services as described on your Medical ID Card. Eligible charges for hospitalization may be reduced for days not precertified, and eligible charges for elective surgery may also be reduced or denied for payment.*

[3]*Subject to Hospital Precertification.*

[4]*Subject to calendar-year deductible.*

[5]*The medical plan pays up to a $5,000 lifetime maximum per participant for assisted reproduction services (e.g., impregnation or fertilization). Benefits paid for both in-network and out-of-network care count toward the medical plan's lifetime benefit limit.*

[6]*100% of the charge for the following: well-child care up to age 6, pap smear each year, tetanus and diphtheria immunizations every 10 years, mammograms according to AMA recommendations, a sigmoidoscopy every three years for covered persons age 45 and over.*

[7]*Does not include charges in excess of the R&C limits, charges above plan maximum amounts, charges applied to the deductible, and any expenses you incur under the plan's Prescription Drug Benefits.*

[8]*Under the Indemnity option, hospice care benefits are subject to the following maximums: daily hospice inpatient benefit—$150 maximum; inpatient benefit—$3,000 lifetime maximum; outpatient benefit—$2,000 lifetime maximum; family unit counseling services—$200 maximum per occurrence.*

Medical Plan Options for Retirees Under Age 65

The At-a-Glance charts that follow summarize the medical plan options available under the Nortel Networks Retiree Medical Plan effective January 1, 2012 for retirees under age 65. All the Nortel Networks Retiree Medical Plan options are provided through CIGNA HealthCare. The benefits payable to you depend upon which option you choose. These charts are not intended to be a complete description of the plan. If there is any conflict between these summaries and the written provisions of the plan, the plan documents will always control.

90/70 Preferred Provider Organization (PPO) Option At-a-Glance

Benefit Description	In-Network Benefits	Out-of-Network Benefits
Calendar-Year Deductible[8] • Individual • Family	 • $300/person • $750/family	 • $500/person • $1,500/family
Hospital Inpatient Stay Copayment (precertification required)[1]	• $350	• $500
Outpatient–Surgery Copayment (precertification required)[2]	• $250	• $500
Calendar-Year Out-of-Pocket Maximum[8] • Individual • Family	 • $3,500/person • $7,000/family	 • $7,500/person • $15,000/family
Lifetime Maximum Benefit Per Person	Unlimited	Unlimited
Physician Services		
Doctor's Office Visits • Primary Care • Specialty Care	 • $25 copayment • $30 copayment	 70%[1,5] 70%[15]
Prenatal Visits	$30 copayment (for first visit only; excludes X-ray and lab)	70%[1,5]
Outpatient Surgeon's Fees	90%[5]	70%[1,2,3,5]
Inpatient Surgeon's Fees	90%[2,3,5]	70%[1,2,3,5]
Anesthetic Services and Ancillary Services	90%[5]	70%[1,5]
Inpatient Hospital Services	90%[2,3,5]	70%[1,2,3,5]
Allergy Injections	$30 copayment[9]	70%[1,5]
Other Professional Services		
Outpatient Short-Term Rehabilitation, including physical, speech, occupational therapy and chiropractic care (up to 90 visits per condition, per calendar year)	$30 copayment[6,10]	70%[1,5,6,11]
Private Duty Nursing	90%[4,5]	70%, up to $10,000 per person per calendar year[1,4,5]

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90/70 Preferred Provider Organization (PPO) Option At-a-Glance (continued)

Benefit Description	In-Network Benefits	Out-of-Network Benefits
Preventive Care		
Well-Baby Care (up to age 6)	$0 copayment	70%[1,5]
Child's Physical Exam (age 6 and over)	$0 copayment	70%[1,5]
Adult Physical Exam	$0 copayment	70%[1, 5]
Routine OB/GYN Exam (includes routine mammograms)	$0 copayment	70%[1,5]
X-Ray and Laboratory—Preventive Screening	100%	70%[1,5]
Hospital Services		
Inpatient Treatment	90% after each hospital inpatient stay copayment[2,3,5]	70% after each hospital inpatient stay copayment[1,2,3,5]
Outpatient Treatment	90%[2,3,5]	70%[1,2,3,5]
Outpatient Surgery	90% after each outpatient surgery copayment[2,3,5]	70% after each outpatient surgery copayment[1,2,3,5]
Emergency Room	90% after $100 copayment (waived if admitted)	70% after $100 copayment (waived if admitted)[1,5]
Urgent Care	90%[5]	70%[1,5]
Skilled Nursing Facility (up to 60 days per calendar year)	90%[2,3,5,6]	70%[1,2,3,5,6]
Hospice Care	90%[5]	70%[1,5]
Other Medical Services		
Assisted Reproduction (up to $5,000 lifetime maximum per person)	90%[5,7]	70%[1,5,7]
Infertility Diagnosis and Treatment	90%[5]	70%[1,5]
Home Health Care	90%[4,5]	70% up to 100 visits per calendar year[1,4,5]
Diagnostic X-Ray and Lab	90%[5] (must use network labs)	70%[1,5]
Radiation and Chemotherapy	90%[5]	70%[1,5]
Durable Medical Equipment	90%[4,5]	70% ($2,000 maximum per calendar year)[1,4,5]

[1]*Subject to reasonable and customary (R&C) limits.*

[2]*Whenever a covered person faces confinement in a hospital or needs non-emergency surgery, follow the directions for Hospital Precertification of those services as described on your Medical ID Card. Eligible charges for hospitalization may be reduced for days not precertified, and eligible charges for elective surgery may also be reduced or denied for payment.*

[3]*Subject to Hospital Precertification.*

[4]*In-network benefits count toward out-of-network maximum benefit.*

[5]*Subject to calendar-year deductible.*

[6]*Benefits paid for both in-network and out-of-network care count toward the medical plan's annual benefit limit. When outpatient short-term rehabilitation services are received on an outpatient basis at a hospital facility, the medical plan's benefits are as described under "Hospital Services—Outpatient Treatment."*

[7]*The medical plan pays up to a $5,000 lifetime maximum per participant for assisted reproduction services (e.g., impregnation or fertilization). Benefits paid for both in-network and out-of-network care count toward the medical plan's lifetime benefit limit.*

[8]*Covered expenses you pay toward the in-network annual deductible and out-of-pocket maximum do not count toward the out-of-network annual deductible and out-of-pocket maximum.*

[9]*If not part of an office visit, there is no charge for the injection.*

[10]*When outpatient short-term rehabilitation services are received on an outpatient basis at a hospital facility, the Medical Plan's benefits are described under "Hospital Services – Outpatient Treatment."*

Medical Plan Options for Retirees Under Age 65 (cont.)

80/60 Preferred Provider Organization (PPO) Option At-a-Glance

Benefit Description	In-Network Benefits	Out-of-Network Benefits
Calendar-Year Deductible[8] • Individual • Family	 • $400/person • $1,200/family	 • $600/person • $1,800/family
Hospital Inpatient Stay Copayment (precertification required)[2]	• $350	• $500
Outpatient Surgery Copayment (precertification required)[1]	• $250	• $500
Calendar-Year Out-of-Pocket Maximum[8] • Individual • Family	 • $3,500/person • $7,000/family	 • $7,500/person • $15,000/family
Lifetime Maximum Benefit Per Person	Unlimited	Unlimited
Physician Services		
Doctor's Office Visits • Primary Care • Specialty Care	 • $25 copayment • $30 copayment	 60%[1,5] 60%[1,5]
Prenatal Visits	$30 copayment (for first visit only)	60%[1,5]
Outpatient Surgeon's Fees	80%[5]	60%[1,2,3,5]
Inpatient Surgeon's Fees	80%[2,3,5]	60%[1,2,3,5]
Anesthetic Services and Ancillary Services	80%[5]	60%[1,5]
Inpatient Hospital Services	80%[2,3,5]	60%[1,2,3,5]
Allergy Injections	$30 copayment[9]	70%[1,5]
Other Professional Services		
Outpatient Short-Term Rehabilitation, including physical, speech, occupational therapy and chiropractic care (up to 90 visits per condition, per calendar year)	$30 copayment[6,10]	60%[1,5,6,10]
Private Duty Nursing	80%[4,5]	60%, up to $10,000 per person per calendar year[1,4,5]
Preventive Care		
Well-Baby Care (up to age 6)	$0 copayment	60%[1,5]
Child's Physical Exam (age 6 and over)	$0 copayment	60%[1,5]
Adult Physical Exam	$0 copayment	60%[1,5]
Routine OB/GYN Exam (includes routine mammogram)	$0 copayment	60%[1,5]
X-Ray and Laboratory—Preventive Screening	100%	60%[1,5]

chart continued on the next page

80/60 Preferred Provider Organization (PPO) Option At-a-Glance (continued)

Benefit Description	In-Network Benefits	Out-of-Network Benefits
Hospital Services		
Inpatient Treatment	80% after each hospital inpatient stay copayment[2,3,5]	60% after each hospital inpatient stay copayment[1,2,3,5]
Outpatient Treatment	80%[2,3,5]	60%[1,2,3,5]
Outpatient Surgery	80% after each outpatient surgery copayment[2,3,5]	60% after each outpatient surgery copayment[1,2,3,5]
Emergency Room	80% after $100 copayment (waived if admitted)	60% after $100 copayment (waived if admitted)[1,5]
Urgent Care	80%[5]	60%[1,5]
Skilled Nursing Facility (up to 60 days per calendar year)	80%[2,3,5,6]	60%[1,2,3,5,6]
Hospice Care	80%[5]	60%[1,5]
Other Medical Services		
Assisted Reproduction (up to $5,000 lifetime maximum per person)	80%[5,7]	60%[1,5,7]
Infertility Diagnosis and Treatment	80%[5]	60%[1,5]
Home Health Care	80%[4,5]	60% up to 100 visits per calendar year[1,4,5]
Diagnostic X-Ray and Lab	80% (must use network labs)[5]	60%[1,5]
Radiation and Chemotherapy	80%[5]	60%[1,5]
Durable Medical Equipment	80%[4,5]	60% ($2,000 maximum per calendar year)[1,4,5]

[1]*Subject to reasonable and customary (R&C) limits.*

[2]*Whenever a covered person faces confinement in a hospital or needs non-emergency surgery, follow the directions for Hospital Precertification of those services as described on your Medical ID Card. Eligible charges for hospitalization may be reduced for days not precertified, and eligible charges for elective surgery may also be reduced or denied for payment.*

[3]*Subject to Hospital Precertification.*

[4]*In-network benefits count toward out-of-network maximum benefit.*

[5]*Subject to calendar-year deductible.*

[6]*Benefits paid for both in-network and out-of-network care count toward the medical plan's annual benefit limit. When outpatient short-term rehabilitation services are received on an outpatient basis at a hospital facility, the medical plan's benefits are as described under "Hospital Services—Outpatient Treatment."*

[7]*The medical plan pays up to a $5,000 lifetime maximum per participant for assisted reproduction services (e.g., impregnation or fertilization). Benefits paid for both in-network and out-of-network care count toward the medical plan's lifetime benefit limit.*

[8]*Covered expenses you pay toward the in-network annual deductible and out-of-pocket maximum do not count toward the out-of-network annual deductible and out-of-pocket maximum.*

[9]*If not part of an office visit, there is no charge for the injection.*

[10]*When outpatient short-term rehabilitation services are received on an outpatient basis at a hospital facility, the Medical Plan's benefits are described under "Hospital Services – Outpatient Treatment."*

Prescription Drug Benefits Under the Nortel Networks Retiree Medical Plan for All Retirees

Prescription drug coverage for all the Nortel Networks Retiree Medical Plan options is provided through Medco Health Solutions (Medco). You'll receive the highest level of benefits if you use a retail pharmacy that participates in the Medco network or Medco's home delivery pharmacy service.

Prescription Drug Benefits At-a-Glance

Retail[1] (Up to a 30-day supply for each prescription)		
	In-Network[4]	**Out-of-Network**
Generic	20% of prescription cost with a $7 minimum and $25 maximum	You pay 60% of the prescription cost.
Preferred Brand Name[3]	20% of prescription cost with a $15 minimum and $50 maximum	
Non-Preferred Brand Name[3]	30% of prescription cost with a $30 minimum and $65 maximum	
Home Delivery Pharmacy Service[2] (up to a 90-day supply for each prescription)		
	In-Network[4]	**Out-of-Network**
Generic	20% coinsurance ($15 minimum, $50 maximum)[5]	You pay 100% of the prescription cost.
Preferred Brand Name[3]	20% coinsurance ($45 minimum, $100 maximum)[5]	
Non-Preferred Brand Name[3]	30% coinsurance ($90 minimum, $130 maximum)[5]	
Out-of-Pocket Maximum[6]	$3,000/year/per person[3]	N/A

[1]If you reside outside the United States, you must file for reimbursement of prescription expenses on a Medco Reimbursement Form.

[2]Please note that the home delivery pharmacy service is not available to retirees residing outside of the United States.

[3]If you choose a brand name drug when a generic equivalent is available, you will pay the applicable brand name coinsurance, plus the difference between the cost of the generic equivalent and brand name drug.

[4]Coinsurance is a portion (percentage) of covered expenses paid. For example, if your coinsurance is 20% of the amount of covered expenses, you'll pay 20% of the cost and the plan will cover 80% of the cost.

[5]On occasion, the discounted cost of your prescription through the home delivery pharmacy service will be less than the minimum coinsurance amount. In those instances, you will be charged the discounted cost of the drug.

[6]The amount of the difference between the brand name drug and generic alternative does not count toward satisfying the out-of-pocket maximum.

"Pay the Difference" Feature
The "pay the difference" feature gives you a financial incentive to use a generic drug when it is available. If you choose a brand name drug and a generic version is available, you pay:

- The applicable brand name coinsurance

PLUS

- The difference between the cost of the generic equivalent and the brand name drug.

This includes any prescriptions where your doctor indicates "Dispense as Written." However, you will not pay more than the cost of the brand name drug.

To avoid paying more for a drug that has a generic equivalent, always ask if a generic is available and appropriate for your needs when getting a prescription from your doctor.

Retail Refill Allowance for Maintenance Medications
You are permitted to purchase up to *three fills* (the original fill plus two 30-day refills) of a maintenance medication at an in-network retail pharmacy at the retail coinsurance amount. Generally, maintenance medications are prescription drugs taken on a long-term basis to manage an illness or symptoms of illness typically for a chronic condition, such as high blood pressure or diabetes.

Once you have exhausted your three fills of the same maintenance medication at the in-network retail pharmacy, you will have to pay 60% of the cost of the drug. **To avoid paying 60% of the cost, you will be required to get remaining refills of that same prescription through Medco's home delivery pharmacy service see "Home Delivery" section below.**

By using the home delivery pharmacy service for remaining fills of the same maintenance medication, you will only pay one copayment for up to a 90-day supply of medication. You still have a choice to continue using an in-network retail pharmacy or the home delivery pharmacy service for maintenance medications, but you'll receive significant cost savings through home delivery.

To find out your portion of the cost for a 90-day supply of a maintenance medication filled through Medco's home delivery pharmacy service, visit **www.medco.com** or call Medco at **1-800-711-3460**.

Home Delivery
The home delivery pharmacy service offers you the opportunity to save money on your maintenance medications. In addition, you can enjoy the convenience of having your prescriptions delivered directly to your home.

Example: How Home Delivery Can Save You Money:*
Let's assume you need a six-month (180-day) supply of Prevacid® Caps (15 mg), a non-preferred brand name drug, which costs $161.21 for a one-month (30-day) supply at an in-network retail pharmacy and $429.07 for a three-month (90-day) supply through the home delivery pharmacy service.

	In-Network Retail Pharmacy	Home Delivery Pharmacy Service
Month 1	$48.36 (30% of $161.21) for first 30-day prescription	$128.72 (30% of $429.07) for a 90-day supply
Month 2	$48.36 (30% of $161.21) for first refill	N/A
Month 3	$48.36 (30% of $161.21) for second refill	N/A
Months 4 – 6	$290.18 (60% of $483.63 for 3 months) for additional refills	$128.72 (30% of $429.07) for a 90-day supply

Total	**$435.26 for a 180-day supply**	**$257.44 for a 180-day supply**

**All drug prices in this example are current as of October 13, 2011.*

By using the home delivery pharmacy service, you could save $177.82, and your prescriptions can be delivered to any U.S. address you choose.

Getting Started with Home Delivery

First, talk with your physician about your desire to save money by using the home delivery pharmacy service for your maintenance medication. Then, ask him/her to fill out the "Prescription Fax Form"—which can be found on the Medco Web site at **www.medco.com** or by calling **1-888-EASYRX1** (number for physicians only).

The form includes instructions on how to fill out and fax it. Please note that only your physician can fax the completed form. However, your physician may prefer to have you mail in your prescription. You can access the online form at **www.medco.com,** or you can call Medco at **1-800-711-3460** and ask to have a form mailed to you.

Instructions on how to download and print the form are included on the Medco Web site. Just complete the form and mail it with your prescription.

Once Medco receives your prescription, your order will be processed within three to five days. **It may take up to two weeks until you receive your new order, so have your doctor write a 30-day prescription for you to have filled at your local pharmacy in addition to the 90-day prescription for home delivery.** All prescriptions will be delivered to you with free standard shipping, unless you request express shipping.

Keep in mind, for a new prescription, it makes sense to use your local retail pharmacy until your doctor is comfortable that the new drug will work for you.

Specialty Drug Channel Management
Specialty medications—that is, medications for treating chronic and often complex conditions—are managed by Medco's specialty pharmacy, Accredo. Most specialty drugs are administered by infusion or self-injection, and some require special handling procedures or expanded patient support.

Through Accredo, you'll receive personalized specialty care and support, free expedited delivery of medications, 24-hour access to registered pharmacists specializing in specific conditions, free consultations from registered nurses, and guidelines specific to the medication you take.

Clinical Management

Medco's clinical management program requires that selected classes of drugs undergo review by a pharmacist and the prescribing doctor before the plan will pay for the medication. The purpose of this review is to determine if the selected medication is being used appropriately for the patient's condition. The quantity of some prescriptions may be limited to an amount consistent with what the reviewers determine is needed to treat the condition.

Behavioral Health Benefits

Behavioral health benefits are the same under all the Nortel Networks Retiree Medical Plan options. Your Nortel behavioral health benefits include the Employee Assistance Program (EAP) and mental health/substance abuse treatment and are provided by OptumHealth Behavioral Solutions.

The At-a-Glance chart on the following page summarizes the behavioral health benefits available under all the Nortel Networks Retiree Medical Plan options.

In order to receive maximum benefits and reduce your out of pocket expenses, there are two important steps you need to remember:

Step 1: Call OptumHealth Behavioral Solutions (1-800-942-2991) for precertification before you seek EAP, mental health or substance abuse services; and

Step 2: Use a provider of facility from the OptumHealth Behavioral Solutions network. OptumHealth Behavioral Solutions offers you a comprehensive network of resources and experienced providers from which to obtain EAP, mental health and substance abuse services.

If you receive care from a provider or facility that is not part of the OptumHealth Behavioral Solutions network, your benefit level will be lower than the network level. These reduced benefits are defined as out-of-network benefits. If you fail to call OptumHealth Behavioral Solutions to precertify your care, you may be charged a penalty and your benefits may be reduced. In some case, if you fail to precertify your care, no benefits will be paid. Please refer to Behavioral Benefits See "At-a-Glance" section below for a description of your network and out –of-network benefits, as well as specific precertification requirements for out-of-network outpatient services.

Benefits will be denied if your care is considered not to be a covered service.

Summary of Health Benefits – Mental Health & Substance Abuse Treatment

This chart outlines the mental health and substance abuse treatment benefits available. The provisions described below apply to those retirees covered by the PPO plans.

Mental Health and Substance Abuse Treatment Benefits		
Feature	**In-Network**	**Out-of-Network**
Calendar year deductible	None	$200/person[2,6]
Calendar year out-of-pocket maximum[2,6]	• $3,500/person • $7,000/family	• $7,500/person • $15,000/family
Lifetime maximum benefit (all services combined)	Unlimited	Unlimited
Inpatient services (Precertification required) • Mental health	• 100%[1]	• 70% of eligible charges after $200 calendar year deductible and $150 deductible/hospital admission[1, 2,,3,]
• Substance abuse	• 100% [1]	• 70% of eligible charges after $200 calendar year deductible and $150 deductible/hospital admission[1,2,3]
Intermediate care Mental health and substance abuse	100%[1,3]	80% of eligible charges after $200 calendar year deductible and $150 deductible/hospital admission[1,2,3,]
Outpatient services Individual Treatment	• Visits 1 - 17: $20 copayment (Does not include EAP visits) • Visits over 17: **$25** copayment	70**%** after $200 calendar year deductible, [2,3.]
Group Treatment	• Visits 1 - 17: $10 copayment (Does not include EAP visits) • Visits over 17: $20 copayment	70**%** after $200 calendar year deductible [2,3]
In-home mental health care	100%	70**%** of eligible charges after $200 calendar year deductible are met up to 100 visits per calendar year[3]
Drug testing as an adjunct to substance abuse treatment	100%	70% after $200 calendar year deductible [2,3]
Medication management[5]	$5 copayment for up to 30-minute visit; no limit	70**%** after $200 calendar year deductible for up to a 30-minute visit; unlimited visits [2,3]

[1] Precertification required for all inpatient admissions and intermediate care. . If hospital or intermediate care is not precertified, there is a non-notification penalty of 20%. There is a 48-hour grace period for emergencies. The non-notification penalty does not count toward the out-of-pocket maximum. 100% denial for no authorization

[2]The annual out-of-network mental health and substance abuse treatment deductible and out of pocket maximum cross accumulates with the medical deductible and out of pocket maximum.

[3]Subject to reasonable and customary (R&C) limits.

[4]Includes, but is not limited to, 24-hour intermediate care facilities (e.g., residential treatment, group homes, halfway houses, therapeutic foster care, partial hospital/day treatment, structured outpatient treatment programs). Intermediate care is subject to the same plan maximums that apply to inpatient care benefits.

[5] Medication management visits that exceed 30 minutes are considered under outpatient individual treatment sessions.

[6] Deductibles and Out of pocket maximum do not cross accumulate between in and out of network care. Behavioral Healt Out-of- Pocket Maximum includes charges for medical, mental health and substance abuse treatment. Does not include charges in excess of the R&C limits, charges above plan maximum amounts, and charges applied to the deductible.

If You Are Eligible for Medicare

Medicare is a federal health insurance program for people who are age 65 and older (as well as for people under age 65 who qualify for disability benefits). Medicare includes the following:

- Part A, which covers hospital stays, care in skilled nursing facilities, home health care, hospice care and blood transfusions. Everyone who's eligible for Medicare gets Part A, and there's no monthly premium.

- Part B, which covers doctors' services (including certain preventive care services), outpatient hospital care, and some medical supplies and equipment. It also covers some services that Part A doesn't cover, such as certain physical and occupational therapy and home health care services. Part B has a monthly premium that's deducted from your monthly Social Security benefits.

- Part C, which provides Medicare Advantage Plans (such as Medicare HMOs and other managed care plans).

- Part D, which helps cover the cost of many types of prescription drugs. Medicare prescription drug coverage is provided through health plans that are approved by the government. Part D coverage is optional; you aren't required to enroll. If you do enroll in Part D, you'll pay a monthly premium directly to your Medicare prescription drug plan, not to Medicare itself.

The Nortel Networks Retiree Medical Plan provides supplemental coverage for Medicare-eligible retirees and their Medicare-eligible dependents who are age 65 and older *and for retirees who meet Medicare eligibility requirements due to disability.*

Nortel Retiree Medical Coverage Coordinates With Medicare

Once you become eligible for Medicare, you must enroll in Medicare Parts A and B to continue to be eligible to participate in the Nortel Networks Retiree Medical Plan.

Important: You and your Medicare-eligible dependents must enroll in Medicare Parts A and B, and request the benefits of the Medicare Supplemental Coverage under the Nortel Networks Retiree Medical Plan in writing, three months prior to the month in which you reach age 65 or become eligible for Medicare due to disability in order to receive the benefits of the Nortel Medicare Supplemental Coverage.

Retirees who have not worked 40 qualifying quarters in the U.S. and are therefore not entitled to receive Medicare Part A coverage at no cost *still must enroll in Medicare Parts A and B* in order to be eligible for the benefits of the Medicare Supplemental Coverage under the Nortel Networks Retiree Medical Plan. This is the only Nortel Networks Retiree Medical Plan coverage available for retirees and their dependents who are age 65 and older.

Nortel Retiree Medical Coverage and Medicare Part D
Once you become eligible for Medicare, you have the option to enroll in Medicare prescription drug coverage (Medicare Part D). Several months prior to the date you become Medicare-eligible, you will receive information from Medicare describing the Medicare Part D plans available in your area. At that time, you will have a choice between prescription drug coverage through Nortel as part of your Nortel Networks Retiree Medical Plan or prescription drug coverage through a Medicare Part D prescription drug plan (PDP).

As a Nortel retiree who is currently enrolled in the Nortel Networks Retiree Medical Plan, you do not have to do anything to ensure that you and any covered dependents will continue to have valuable prescription drug protection in 2012 through your Nortel plan, assuming that you are enrolled in Medicare Parts A and B.

However, if you want to explore some Medicare Part D alternatives, remember that the Nortel Networks Retiree Medical Plan offers ***both*** medical and prescription drug benefits in a single plan. You cannot elect one benefit without the other through the Nortel Networks Retiree Medical Plan.

If you stay in the Nortel plan and enroll in a Medicare Part D prescription drug plan, the Nortel Networks Retiree Medical Plan will **not** include prescription drug benefits. However, your premium for the Nortel plan will reflect the cost of both medical and prescription drug coverage—that's because we cannot charge separate premiums for medical coverage and prescription drug coverage. In other words, you'll pay for Nortel prescription drug coverage but receive no prescription drug benefits in return.

If you're interested in joining a Medicare Part D plan, you may want to consider a Medicare supplemental coverage plan for medical benefits without prescription drug benefits or a Medicare Advantage plan rather than the Nortel Networks Retiree Medical Plan. **However, if you drop your coverage in the Nortel Networks Retiree Medical Plan, neither you nor your covered dependents can re-enroll in the Nortel Networks Retiree Medical Plan at a later date**.

It's important to remember that Nortel's health benefit plans change periodically—so, it's impossible to guarantee what coverage will be available in the future. If, at a later point, prescription drug coverage through Medicare Part D or a Medicare Advantage Plan becomes the best alternative for you, you will not be penalized by Medicare for enrolling later in Medicare Part D (as long as you do not have more than a 63-day break in prescription drug coverage between the Nortel Networks Retiree Medical Plan and a Medicare Part D plan). See the "Notice of Creditable Prescription Drug Coverage" section for more information.

To find out more about Medicare Part D prescription drug coverage, visit the Medicare Web site at **www.medicare.gov** or call Medicare at **1-800-MEDICARE** (**1-800-633-4227**).

Changing Your Coverage During the Year

You can only change your coverage level during the year if you have a Status Change. You must request a change in coverage within 31 days of the Status Change, and your request must be consistent with the change.

Please contact HR Shared Services for information about the documentation required for Status Changes. Requirements vary depending on the specific type of Status Change. The following chart outlines the election changes allowed during the year as a result of a Status Change.

NOTE: Your spouse/domestic partner must have been enrolled when you commenced coverage under the Nortel Networks Retiree Medical Plan to be covered at any time in the future. However, if your spouse was covered on commencement of your coverage and later de-enrolled she/he can be added back to the plan as described below:

If…	You Can (within 31 days)…
You get divorced or dissolve a domestic partnership	Drop ex-spouse or domestic partner coverage**
Your divorce is rescinded (if not "new"* spouse)	Add spouse coverage
Birth or adoption of your child (if not "new"* child)	Add dependent child coverage
A dependent child becomes ineligible for the Nortel Networks Retiree Medical Plan [e.g., turns 26)	Drop dependent child coverage**
Your spouse or domestic partner is no longer eligible for the Nortel Networks Retiree Medical Plan	Drop spouse or domestic partner coverage**
Your spouse, domestic partner or dependent child loses other medical coverage (if not "new"* spouse or domestic partner or child)	Add spouse or domestic partner or dependent child coverage
Your spouse or domestic partner's employment changes (if not "new"* spouse or domestic partner): • Commencement of employment • Termination of employment	 • Drop your spouse or domestic partner coverage • Add your spouse or domestic partner coverage
Death of a: • Spouse or domestic partner • Dependent child • Retiree	 • Drop spouse or domestic partner coverage • Drop dependent child coverage • Drop retiree's medical coverage; spouse and other dependents cannot re-enroll if they drop their coverage at any time

**When referring to "new" spouses, domestic partners and children, the term "new" is defined as when the date of marriage/partnership occurs after the date of retirement, or, if the dependents of the "new" spouse or domestic partner are not the natural or adopted dependents of the retiree.*

***Coverage **MUST** be dropped if the person fails to meet the eligibility requirements.*

Tips on How to Become a Better Health Care Consumer

Here are some specific actions you can take to make a difference in managing your health and your use of health care services throughout the year.

- Visit **,** http://www.nortel-us.com/current/ a Web site that's available to you and your family 24/7/365. Use this site to find health *insights* and learn how to make the most of your health care dollars, choose a doctor or hospital, get support with managing conditions, and connect with your health plan if you have questions.

- Protect your health by following a few simple guidelines from the American Council on Science and Health (see **www.acsh.org**).

- If you are under 65, discounted fees are available to you if you use in-network providers. Using in-network providers allows both you and Nortel to share in network discounts.

- Don't be reluctant to ask your doctor questions about recommended tests or treatments, and take an active part when you need medical care.

- Only use an emergency room facility when it's appropriate.

- Consider outpatient services or same-day surgery as an alternative to hospitalization whenever possible.

- When you do need medicine, check to see if an over-the-counter option will work as well as a prescription drug.

- If your doctor believes you need a prescription drug, ask if a generic option is available; if not, check to see if a preferred brand name drug is acceptable for your needs.

- From time to time, additional prescription drugs will become available over the counter, so it's important to check with your physician or pharmacist regarding alternatives to your prescribed medications.

- If you take maintenance medications, take advantage of Medco Health's home delivery pharmacy service.

- Make sure all of your doctors are aware of everything you're taking—not only prescription drugs, but also over-the-counter medications and dietary supplements such as vitamins.

- If you are taking medications, make sure you follow the instructions; if you have questions, ask your doctor or pharmacist.

Contact Information

	Telephone	Address	Online
NORTEL			
Nortel Health & Group Benefits Website (Your 24/7/365 online resource for health and retiree medical benefits information)			http://www.nortel-us.com/current/
MEDICAL BENEFITS			
HR Shared Services	**Direct: (919) 905-9351** **Toll-free:** **1-800-676-4636** Monday – Friday, 8:30 a.m. to 5:00 p.m. ET	HR Shared Services Nortel MS 570/02/0C2 P.O. Box 13010 Research Triangle Park, NC 27709-3010	
CIGNA HealthCare **(Note: CIGNA refers to its PPO network as "Open Access Plus.")**	**Toll-free:** **1-800-257-2702** **In Puerto Rico:** **(787) 753-6868** **International Locations:** **1-800-441-2668**	CIGNA P.O. Box 5200 Scranton, PA 8505-5200 **OR** CIGNA P.O. Box 182223 Chattanooga, TN 37422-7223 See the back of your CIGNA ID card for the address that applies to you.	**www.cigna.com**
PRESCRIPTION DRUG BENEFITS			
Medco Health Solutions	**Toll-free:** **1-800-711-3460**	Medco Health P.O. Box 2187 Lee's Summit, MO 64063-2187	**www.medco.com**
BEHAVIORAL HEALTH BENEFITS			
OptumHealth Behavioral Solutions	**Toll-free:** **1-800-842-2991**	OptumHealth Behavioral Solutions P.O. Box 30755 Salt Lake City, UT 84130	**www.liveandworkwell.com** Access code: 800-842-2991 (Include the hyphens)
OTHER			
Medicare	**Toll-free:** **1-800-MEDICARE** **(1-800-633-4227)** TTY: **1-877-486-2048**		**www.medicare.gov**
Social Security Administration	**Toll-free:** **1-800-772-1213** TTY: **1-800-325-0778**		**www.socialsecurity.gov**
Ceridian – Benefits Billing Services	**Toll-free:** **1-800-995-9935**	3201 34th St South St Petersburg, FL 33711	**www.ceridian.com**
Pension Benefit Guarantee Corporation (PBGC)			**www.pbgc.gov**

Notice of Creditable Prescription Drug Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Nortel and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Nortel has determined that the prescription drug coverage offered by the Nortel Networks Retiree Medical Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan from October 15 through December 7. Beneficiaries leaving employer coverage may be eligible for a Special Enrollment period in which to sign up for a Medicare prescription drug plan.

Be aware that if you decide to enroll in a Medicare prescription drug plan, you will not have prescription drug coverage provided by your Nortel Networks Retiree Medical Plan. Also, if you drop your Nortel Networks Retiree Medical Plan coverage, you will not be able to re-enroll.

If you drop your Retiree Medical Plan coverage with Nortel and enroll in a Medicare prescription drug plan, you will not be able to get the Nortel Networks Retiree Medical Plan coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

In addition to prescription drugs, your current Nortel Networks Retiree Medical Plan coverage pays for other health expenses. If you enroll in a Medicare prescription drug plan and continue to participate in the Nortel Networks Retiree Medical Plan for medical coverage, the Nortel plan will not provide any additional drug coverage and your premiums will not be reduced. If a drug is not covered by the Medicare plan or is covered at a lower level, the Nortel Networks Retiree Medical Plan will not provide any additional prescription drug benefits.

You should also know that if you drop or lose your coverage with the Nortel Networks Retiree Medical Plan and don't enroll in Medicare prescription drug coverage after your Nortel coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If, after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage.

For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage.

For more information about this notice or your current prescription drug coverage…
Contact HR Shared Services for further information at **1-800-676-4636** or send an email to hrssna@nortel.com..

For more information about your options under Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program for personalized help. Go to www,medicare.gov/contacts for their telephone number.
- Call **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit the SSA online at **www.socialsecurity.gov**, or call them at **1-800-772-1213** (TTY: **1-800-325-0778**).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare that offers prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.