NORTEL NETWORKS

Retiree Medical Plan

Summary Plan Description
2010

TABLE OF CONTENTS

INTRODUCTION

Nortel Networks Inc. (the "Company") and the other Employers offer the Nortel Networks Retiree Medical Plan to help protect you and your family from the high cost of medical treatment and hospitalization.

This is the Summary Plan Description (SPD) that describes the provisions of the Nortel Networks Retiree Medical Plan that are in effect as of January 2010. It is designed to provide you with a comprehensive resource providing detailed information about your medical benefits and directing you to other sources of information that could not be described fully in this SPD. It is divided into the following sections:

- SECTION ONE – PLAN BENEFITS describes the provisions of the Retiree Medical Plan that determine your benefits.
- SECTION TWO – ADMINISTRATIVE INFORMATION includes administrative details about this plan, such as how to file Claims and appeal denied Claims, where to get more information, your ERISA rights, HIPAA Privacy Notice and how the Company may amend the plan.
- SECTION THREE – GLOSSARY contains brief descriptions of terms used in this document.
- APPENDIX includes supplemental information referenced in this document.

Please note that certain key words in each section are capitalized. You can find an explanation of these words in the Glossary section at the end of this booklet. References to "you" and "your" throughout this document are references to either the enrolled Employee or an enrolled Dependent.

IMPORTANT NOTE ABOUT THIS SUMMARY

This information is a summary plan description (SPD) under the terms of the Employee Retirement Income Security Act of 1974 (ERISA). The complete terms of the Retiree Medical Plan can be found in the Plan documents. If there is a difference between the information in this summary and the Plan documents, the Plan documents will govern.

SECTION ONE –

RETIREE MEDICAL PLAN BENEFITS

As of January 1, 2008, the Nortel Capital Accumulation and Retirement Program (CARP) Traditional, Balanced and Investor programs were discontinued. The ongoing reference to these programs in this SPD pertain to those employees that participated in the previously available Nortel Capital Accumulation and Retirement Programs to which the medical benefits eligibility requirements were assigned.

If you were age 50 or older with at least five years of service on July 1, 2006,

You continue to qualify for the Company-subsidized retiree medical benefits associated with the previously available CARP Traditional and Balanced programs if you retire from Nortel and meet the eligibility requirements for retiree benefits. However, for the previously available Traditional program grandfathered members (at least age 50 and had at least one year of service on April 30, 2000 and elected to remain in the Traditional Program) the way Nortel's subsidy is calculated changed. The base line subsidy will be calculated based on the 2007 cost sharing arrangement and increased by not more than 3% each year thereafter, compounded annually. For non-grandfathered Traditional and Balanced members, the calculation of the Company's subsidy did not change.

If you were not age 50 with at least five years of service on July 1, 2006 or hired after 1/1/08,

You are not eligible for Company-subsidized retiree medical benefits upon retirement from Nortel. However, effective January 1, 2008 you will have access to the retiree medical benefits described in this SPD at your own cost, at preferred terms, if you meet the age and service requirements and are a member of the active employees' medical plan immediately before retirement .

PLAN HIGHLIGHTS

Under the Retiree Medical Plan, at Retirement you can choose from the following medical benefit options:

- Two PPO Options (available only to retirees less than age 65)
    - 90/70 PPO
    - 80/60 PPO
- Comprehensive
- Indemnity

Or, you may choose to decline Retiree Medical Plan coverage. If you decline Retiree Medical Plan coverage at Retirement, you will not be permitted to elect that coverage at

any later time. You may elect COBRA coverage when you decline Retiree Medical Plan coverage. However, if you do so, you will not be permitted to elect the Retiree Medical Plan coverage after your COBRA coverage ends. See page 70 for more information about COBRA rights.

No dental, vision or hearing care plan is available under the Retiree Medical Plan.

Here's an overview of the Retiree Medical Plan options currently offered by the Employers. Please note the PPO options are available to less than 65 year old retirees and their dependents only.

The Company reserves the right to change Plan features and Plan options at any time or to terminate the Retiree Medical Plan completely. As a result, the options described below may provide different benefits or may not be available at or during your Retirement. Please read further for details on plan limits, maximums, Deductibles, precertification requirements and other Plan features:

Benefit Description	80/60 PPO Option Administered by CIGNA		90/70 PPO Option Administered by CIGNA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible • Individual • Family	$400 $1,200	$600 $1,800	$300 $750	$500 $1,500
Calendar Year Out-of-Pocket Maximum (excludes Deductible/ /copayments/amounts exceeding R&C limits) • Individual • Family	• $3,500 • $7,000	• $7,500 • $15,000	• $3,500 • $7,000	• $7,000 • $15,000
Lifetime Medical Maximum	Unlimited	$2,000,000*	Unlimited	$2,000,000*

*Includes medical plan benefits paid by the Nortel Networks Medical Plan while you were employed with Nortel Networks but not mental health and substance abuse treatment or prescription drug benefits

Benefit Description	Comprehensive Option Administered by CIGNA	Indemnity Option Administered by CIGNA
Calendar Year Deductible • Individual • Family	$350 $1,050	$200 $400
Reimbursement *Based on Reasonable and Customary*		

Benefit Description	Comprehensive Option Administered by CIGNA	Indemnity Option Administered by CIGNA
(R &C) limits where applicable and Subject to Calendar Year Deductible • For most covered services • Hospital/outpatient surgery *If precertified*	• 80% • 80%	• 80% (other than hospital/outpatient surgery) • 100% (not subject to Calendar Year Deductible)
Calendar Year Out-of-Pocket Maximum (excludes Deductible/ /Copayments/amounts exceeding R&C limits) • Individual • Family	• $3,500 • $7,000	• $1,500 • $3,000
Lifetime Medical Maximum	$2,000,000*	

*Includes medical plan benefits paid by the Nortel Networks Medical Plan while you were employed with Nortel Networks but not mental health and substance abuse treatment or prescription drug benefits.

	Prescription Drug Benefits (Your Cost) Provided through Medco Health Solutions	
Retail Prescription Drug Benefits (Up to a 30-day supply)	**In-Network**	**Out-of-Network**
Generic Preferred Brand-Name Non-Preferred Brand-Name	• 20% of prescription cost with $7 minimum and $25 maximum • 20% of prescription cost with $15 minimum and $50 maximum • 30% Coinsurance with $30 minimum and $65 maximum)	You pay 60% of prescription cost

Home Delivery Pharmacy Service (Up to a 90-day supply)	**In-Network**	**Out-of-Network**
Generic Preferred Brand-Name Non-Preferred Brand-Name	• 20% of prescription cost with $15 minimum and $50 maximum • 20% of prescription cost with $45 minimum and $100 maximum* • 30% of prescription cost with $90 minimum and $130 maximum*	Not applicable

*Plus difference between Generic and Brand-Name cost for Brand-Name when Generic is available.

	Mental Health and Substance Abuse Treatment Benefits Administered by OptumHealth Behavioral Solutions
Mental Health and Substance Abuse Treatment Benefits	See details of coverage on page 20

Note: Prescription Drug Benefits and Mental Health/Substance Abuse Treatment benefits are the same under each of the Retiree Medical Plan options.

ELIGIBILITY

For You

For currently Retired Employees

At the time that you became a Retired Employee, you were provided with information about your eligibility for Retiree Medical Plan coverage. In order to be eligible for the Retiree Medical Plan, you must have enrolled at the time of your Retirement and you must have started receiving your retirement benefit immediately after your termination of employment.

Until March 31, 2003, you could discontinue your coverage after having participated in the Plan for at least one month and still have one time re-enrollment rights. In order to re-enroll, a Status Change (see page 12) is required and you are required to re-enroll within 31 days of the date of that Status Change. As of April 1, 2003, enrollment in the Retiree Medical Plan was a one-time choice. If you discontinue your coverage for any reason, you forfeit your right to participate in the Plan in the future.

For employees who are currently working for an Employer

Your eligibility for Retiree Medical coverage depends upon*:

- Which Capital Accumulation and Retirement Program you participated in on December 31, 2007,
- Your age and service at your Retirement Start Date,
- Your being a member of the Nortel Networks Medical Plan immediately before your Retirement Start Date,
- Your Retirement (as defined in the Glossary), and
- Your enrollment in the Retiree Medical Plan as of your Retirement Start Date.

Your eligibility for a Company Subsidy toward the cost of the Retiree Medical coverage depends upon which previously available CARP you participated in on December 31, 2007 and your age and years of service on July 1, 2006. If you were age 50 or older with at least five years of service on July 1, 2006, you continue to qualify for the Company-subsidized retiree medical benefits associated with the previously available CARP Traditional and Balanced programs you were a member of on December 31, 2007 if you retire from Nortel and meet the eligibility requirements for retiree benefits. You are not eligible for a Company Subsidy toward the cost of the Retiree Medical coverage if you participated in the previously available Investor CARP and were not age 50 or older with at least five years of service on July 1, 2006 or hired on or after January 1, 2008. However, you will have access to the retiree medical benefits described in this summary plan description at your own cost, at preferred terms, if you meet the age and service requirements and are a member of the active employees' medical plan immediately before retirement.

Below is a Table detailing the retiree medical plan eligibility requirements.

	Previously Available Traditional Program		Previously Available Balanced Program	Previously Available Investor Program & Employees hired after 1/1/08
	Grandfathered[1]	Non-grandfathered		
Eligible to participate in the Retiree Medical Plan	Age: 55 Service: 5 years[2,3]	Age: 55 Service: 10 years[3]	Age: 55 Service: 10 years[3]	Age: 55 Service: 10 years
Eligible for Employer contribution toward cost of retiree medical coverage	Age: 55 Service: 5 years[2,3]	Age: 55 10 years of service after age 40[3]	Age: 55 10 years of service after age 40[3]	Access Only No Employer contribution toward cost of coverage
Maximum service recognized for Employer contribution toward cost of retiree medical coverage	20 Years	25 Years	25 years	Access Only No Employer contribution toward cost of coverage

1 If you were at least age 50 and had at least one year of service at April 30, 2000 and elected to remain in the Traditional Program, you are "Grandfathered."

2 Grandfathered employees are also eligible to participate in the Retiree Medical Plan if they retire at age 65 with 1 year of service.

3 Employees in the Traditional and Balanced Programs who do not meet the eligibility requirements for Employer contributions toward the cost of retiree medical coverage are entitled to coverage under the Retiree Medical Plan on an access only basis (no Employer contribution toward cost of coverage).

Note: Eligibility for the Retiree Medical Plan benefits requires that you and any eligible Dependents for whom you desire coverage be covered by the Nortel Networks Medical Plan immediately prior to your Retirement Start Date. Remember that you may only make changes to the enrollment of Dependents in the Nortel Networks Medical Plan if you have a "Status Change" as defined under the Plan. So plan ahead. (See Status Changes, page 12.)

For rehired employees who had previously retired from Nortel Networks Inc.

If you had previously retired from Nortel Networks Inc. or its predecessor, Northern Telecom Inc., you may be eligible to re-enroll in the Nortel Networks Retiree Medical Plan upon a subsequent retirement from Nortel. To be eligible to re-enroll, you must have been a member of the Nortel Networks Retiree Medical Plan prior to your rehire and a member of the Medical Plan for active employees immediately prior to subsequent retirement. The terms and conditions of the Retiree Medical Plan for which you may be eligible upon a later retirement from Nortel would include immediately Company contributions toward the cost of coverage determined in the same manner as the contributions had been

determined when you previously retired with January 1, 2008 Company subsidy calculation changes described in Section 1, if applicable..

Please note, however, that the premiums are based upon the actual costs of the plan. The premium you pay for the Retiree Medical Plan is the difference between the cost of the Retiree Medical Plan and the Employer contribution. While the Employer contribution will be determined in the same manner as it was when you previously retired, the premiums you will be charged may change because the cost of the plan changes. In addition, for the previously available Traditional program grandfathered members (at least age 50 and had at least one year of service on April 30, 2000 and elected to remain in the Traditional Program) the way Nortel's subsidy is calculated changed January 1, 2008. The base line subsidy will be calculated based on the 2007 cost sharing arrangement and increased by not more than 3% each year thereafter, compounded annually. For non-grandfathered Traditional and Balanced members, the calculation of the Company's subsidy did not change.

Re-enrollment in the Nortel Networks Retiree Medical Plan is dependent upon satisfaction of the Plan's eligibility criteria. Eligibility criteria include, but are not limited to, that at the time of your rehire, you were enrolled in the Nortel Networks Retiree Medical Plan, discontinue coverage in the Retiree Medical Plan to enroll in the Nortel Networks Medical Plan and are covered under Nortel Networks Medical Plan at the time that you retire from the Company in the future.

Any Retiree Medical Plan changes that may have occurred to these plans while you are in active service and that are still in effect when you terminate/retire again would apply to you, including complete elimination of the benefit due to a plan termination.

If you had reached the maximum number of years of service that may be credited for the purposes of determining your contributions for coverage when you initially retired, no additional years of service will be credited. Otherwise, years of service will be credited as explained on page 14 of this Summary Plan Description.

For Your Eligible Dependents

If you are eligible for and enrolled in Retiree Medical Plan coverage, you may enroll your eligible Dependents.

Eligibility for the Retiree Medical Plan benefits requires that any eligible Dependents be covered by the Nortel Networks Medical Plan immediately prior to your Retirement Start Date.

Eligible Dependents include:

- your *existing* spouse (as of your Retirement Start Date), including your common-law spouse as recognized by applicable state law
- your qualified Domestic Partner, (see definition of "Domestic Partner")
- your unmarried Children and your Domestic Partner's unmarried Children who are under age 19. "Children" include:

  - your natural or legally adopted (or placed for adoption) Children
  - your step-children, legally authorized foster Children, and any child for whom you are legal guardian, if these Children depend on you for support and maintenance and live with you in a regular, parent-child relationship for at least six months of the Calendar Year.

- your unmarried Children under age 25 who are registered full-time students at an accredited school or home schooled and are primarily supported by you. A student may remain covered by this plan in the event of a Medically Necessitated Leave of Absence from school before the earlier of:

  - one year after the first day of the medically necessary leave of absence, or
  - the date on which coverage under the plan would otherwise terminate

  Written documentation from a medical professional explaining the need for a temporary medical leave will be required by the claims administrator (CIGNA or OptumHealth Behavioral Solutions).

- your eligible unmarried Children of any age who are mentally or physically incapable of self-care and dependent on you for support and maintenance. They must have become disabled and dependent before age 19 or before age 25 while a full-time student.

Your Children will be eligible for the Retiree Medical Plan if you are required to cover them as a result of a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order or judgment from a court that directs the Plan Administrator to cover a child for benefits under the health care plans. Coverage under the plan will be provided in accordance with the plan and applicable federal and state law. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the plan's procedure for determining if the order is valid. Coverage under the plan pursuant to a QMCSO will not become effective until the Plan Administrator determines that the order is a QMCSO. A Qualified Medical Child Support Order cannot create benefits or provide for eligibility that does not follow the terms of the Company plan. If you have any questions or would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact HR Shared Services. A copy of the written procedure will be provided to you without charge.

For Your Domestic Partner

You may also enroll your *existing* Domestic Partner for the Retiree Medical Plan if this Domestic Partner is covered by the Nortel Networks Medical Plan immediately prior to your Retirement Start Date. You may also enroll the Child(ren) of your Domestic Partner if they meet the definition of an eligible Dependent described on page 8 and they were also covered by the Nortel Networks Medical Plan immediately prior to your Retirement Start Date.

Note: In order for your Domestic Partner to be covered under the Nortel Networks Medical Plan prior to your Retirement, you must have received the Employer's approval of the Affidavit of Domestic Partnership and enrolled your Domestic Partner in that plan prior to your Retirement Start Date. Approval of this affidavit requires that the partner becomes qualified under the Nortel Networks Medical Plan's eligibility criteria.

Special tax and legal considerations apply when covering a Domestic Partner. The value of coverage for your Domestic Partner that is paid for by your Employer will be considered taxable income to you and will be reported to the IRS. This will not be the case, however, if your Domestic Partner qualifies as your tax "dependent" under section 152 of the Internal Revenue Code (whether or not you claim a personal exemption for them on your income tax return.) Each year when you enroll for Domestic Partner coverage, you will need to inform HR Shared Services if your Domestic Partner is your tax dependent. If you do not, it will be assumed that your Domestic Partner is not your tax dependent and coverage for that partner will be considered taxable income. You may wish to consult with a tax or legal advisor before enrollment. Also, IRS Publication 17 contains information regarding tax dependents.

Changes in Circumstances

If there is any change in circumstances attested to in the Affidavit of Domestic Partnership, you must notify HR Shared Services in writing within 31 days of the change.

If your Domestic Partnership ends, you must file a Termination of Domestic Partnership Statement with HR Shared Services within 31 days of the termination. The following rules apply:

- Your Domestic Partner's coverage will end at the end of the month when your partnership terminates.
- Under the Retiree Medical Plan you cannot add new partners. Therefore, you will not be eligible to file another Affidavit of Domestic Partnership.
- The Company or its agent(s) will not be responsible for notifying your Domestic Partner of the filing of the Statement of Termination of Domestic Partnership.
- If you do not file a request to terminate coverage within 31 days, you will have to wait until the next Annual Enrollment Period. You will continue to pay premiums for your Domestic Partner's coverage until the start of the next Plan Year, even though your Domestic Partner is ineligible for coverage.

Special Eligibility Rules

If You and Your Spouse (or Domestic Partner) Both Retire from Nortel Networks

If you and your spouse (or Domestic Partner) are both eligible to participate in the Retiree Medical Plan as Retirees, then special rules apply for enrolling in the Plan. You may enroll as a Retiree or a spouse (or Domestic Partner), but not both. Only one of you may enroll your eligible Dependent Children. In addition, both you and your spouse (or Domestic

Partner) must elect the same plan option in order for your combined expenses to apply to the family Deductible or family Out-of-Pocket Maximum.

If Both You and Your Child (or Your Domestic Partner's Child) Work for the Company
Your child (or Domestic Partner's child) will not be considered an eligible Dependent if your Child is covered under the Nortel Networks Medical Plan as an Employee.

If Your Spouse (or Domestic Partner) or Child is in the Armed Forces
Your spouse (or Domestic Partner) or child is not eligible for coverage while on Active Duty in the armed forces of any country.

If You Die while an Active Employee and met all the eligibility requirements of the Nortel Retiree Medical Plan at the time of your death:
Your spouse (or Domestic Partner) was eligible to participate in the Retiree Medical Plan as of October 1, 2007. HR Shared Services will notify eligible dependents and provide enrollment materials where applicable. If you feel you are eligible, please contact HR Shared Services at 1-800-676-4636 for assistance.

Participation

Retiree Medical Plan benefits are available to you when you become a Retired Employee provided you meet the eligibility requirements (see page 5). Upon eligible Retirement, you will have the opportunity to elect Retiree Medical Plan coverage and determine which plan option best meets your needs. Effective April 1, 2003, the choice to participate in the Retiree Medical Plan is a one-time choice at the time of retirement. For your Retiree Medical benefits to begin, you must complete the necessary election forms within 31 days after your Retirement Start Date and also make the necessary premium payments within 31 days after your Retirement Start Date.

If you choose not to enroll in the Retiree Medical Plan at that time or do not make the necessary premium payment, you will not be eligible for enrollment in the Plan later.
If you do not enroll in the Retiree Medical Plan, you may be eligible for continuation of benefits through COBRA. You may also be eligible for continuation of certain benefits not provided under the Retiree Medical Plan even if you do enroll in the Retiree Medical Plan. Please refer to the COBRA section of this document for further information. If you choose to enroll in the Retiree Medical Plan, you will be able to choose from the following Dependent coverage levels:

- you only
- you and your family. This coverage level includes your eligible spouse (or Domestic Partner) and Children.

When Coverage Begins

Provided you meet the eligibility requirements, elect coverage and pay your premium on time, your Retiree Medical Plan coverage will begin on your Retirement Start Date for your and your eligible Dependents' initial coverage.

For Your Newborn and Adopted Children
The following rules apply with respect to a child born to you or a child that you adopt after you first become covered by the Plan:

The child will become covered (temporarily) from the moment of birth, adoption or placement for adoption. The benefits for the child will end as described in "When Coverage Ends" on page 69, except that:

- That coverage will end after thirty-one (31) days unless you elect coverage for the child no later than thirty-one (31) days after the child's birth, adoption, or placement for adoption.

You must notify HR Shared Services of the birth, adoption or placement for adoption of your child within 31 days of the birth, adoption or placement for adoption and make a specific election for coverage of that child in order to have continuous coverage for that child. Neither submission of paperwork after the thirty-one (31) day deadline nor evidence of good health will continue coverage for the child beyond that period if you do not elect coverage for the child within 31 days of the child's birth, adoption, or placement for adoption.

If more than thirty-one (31) days from the date of birth, adoption or placement for adoption has elapsed, you may add the child to your Retiree Medical Plan coverage as follows:

- As of the date that your enrollment is complete if all of the following criteria are met within 12 months after the birth and in the same Calendar Year in which the 31-day Enrollment Period following the birth ended:

    1. You notify HR Shared Services of the birth of your child
    2. You complete the enrollment process to add the child to your coverage and pay the required contribution.

If you submit your election within the required 31 days and your child becomes covered, the benefits for that child will end as described in "When Coverage Ends" on page 69.

Changing Your Selections

Generally, only during the Annual Enrollment Period will you have the opportunity to change the Retiree Medical Plan options you initially select. Your Retiree Medical Plan election remains in effect for the 12-month period following the Effective Date of the annual enrollment changes. However, if you experience a Status Change and meet the eligibility requirements, you may be able to make certain changes to your Retiree Medical Plan selection (see "Status Changes" below for more information). You must request the change, document the event and HR Shared Services must receive your Change Request form within 31 days of the event. The required supporting documentation includes the legal documents (such as birth certificate or divorce decree) that prove that the event occurred.

Status Changes

The table on the following page presents the election changes that you may make throughout the year *only* if you have a **Status Change** (formerly called "qualified family status change" or "life event"). Your selection change must be consistent with the Status Change. You must submit your completed Retiree Medical Change Request form within the 31-day period after you experience the Status Change.

Dependents may be disenrolled at any time without a status change occurring but careful consideration should be given to the limited circumstances that allow re-enrollment as listed in the table below. As in the case of the restricted status changes described above, any request for disenrolling a dependent must be submitted in writing on Retiree Medical Change Request form.

The selection changes allowed as the result of a Status Change are limited to changes in Dependent coverage level (i.e., you only, you and family) or the addition or removal of an individual(s) from coverage. Changes to the choice between the Retiree Medical Plan Options (PPO, Comprehensive, and Indemnity) may not be made in conjunction with Status Changes. Changes in the Retiree Medical Plan Options can be made only during the Annual Enrollment Period.

In the table below, when referring to "new" spouses and Domestic Partners, the term "new" is defined as when the date of marriage/partnership is after the Retirement Start Date. The term "new child" refers to Children or other Dependents of the "new" spouse/Domestic Partner who are not the natural or adopted Children of the Retiree.

Eligibility limitations apply under the Retiree Medical Plan rules that require your spouse, Domestic Partner or Dependent Child to have been covered under the Nortel Networks Medical Plan for active employees immediately prior to your Retirement Start Date from Nortel Networks and commencement of coverage under the Retiree Medical Plan. Even with these plan limitations, you may still be able to make certain election changes (e.g., waive coverage) at the time of an applicable Status Change. Qualified Medical Child Support Orders may also allow you to make certain election changes.

A Special Note on Loss of Other Coverage

Where the Status Change is a loss of other health coverage, proof of loss of coverage is required. That proof may be a letter from the Employer who provided the coverage or similar documentation.

STATUS CHANGE EVENT	You Can (within 31 days)*
Birth or adoption of your child [if not "new" child]	Can add Dependent child
Dependent child age 19-25 returns to school full-time [if not "new" child]	Can add Dependent child

Dependent child becomes ineligible for Nortel Networks Retiree Medical Plan [turns 19 or 25, if full-time student]	Must drop Dependent child coverage
Your divorce or dissolution of a Domestic Partnership	Must drop spouse or Domestic Partner
Your divorce is rescinded [if not "new" spouse and Children]	Can add spouse and Dependent child
Your spouse/Domestic Partner/Dependent child loses other coverage	Can add coverage for spouse/Domestic Partner/other Dependent [if not "new" spouse, Domestic Partner, or child] if they were unenrolled because of the obtainment of other coverage
Change in spouse's or Domestic Partner's employment - loss of spouse's or Domestic Partner's employment [if not "new" spouse or Domestic Partner]	Can add spouse or Domestic Partner and Dependent child's coverage (if not "new" child)
Your Domestic Partner is no longer eligible for Nortel Networks Retiree Medical Plan	Must drop Domestic Partner coverage
Death – spouse or Domestic Partner	Drop spouse coverage
Death - Dependent child	Drop Dependent child's coverage
Death - Domestic Partner	Drop Domestic Partner coverage and Dependent child's coverage
Death of Retiree	Drop Retiree coverage and drop coverage for spouse, Domestic Partner, and Dependent child

*Changes in Dependent coverage level must be made consistent with the addition or removal of Dependents. Dependent coverage level refers to Dependent coverage category (for example, retiree plus family or retiree only).

An important note:

Effective April 1, 2003, you can no longer re-enroll in the Nortel Networks Retiree Medical Plan if you discontinue your coverage in the plan. Your Dependents may discontinue coverage and subsequently re-enroll according to the Status Change rules above.

COST OF COVERAGE

The premium you pay for the Retiree Medical Plan is the difference between the cost of the Retiree Medical Plan and the Employer contribution, if an Employer contribution is made on your behalf. Costs are determined for each of the options and Dependent coverage levels. Premiums must be made in full and on time in accordance with the Nortel contracted billing services invoice. Failure to pay in full and on time could result in cancellation of your Retiree Medical Plan coverage with no reinstatement rights.

EMPLOYER CONTRIBUTIONS

IF YOU RETIRED PRIOR TO MAY 1, 2000
Your Employer's contribution is a percentage of the cost of coverage based on:

- the year in which you retired,
- your Years of Service as a Pension Service Plan (introduced January 1, 1999) or Prior Plan (introduced May 1, 1974) member, (Years of Service for the determination of the Employer contribution toward the costs of the Retiree Medical Plan were credited as they were for the purposes of vesting under the previously available Nortel Networks Retirement Income Plan.)
- the Dependent coverage level you select (you only or you and your family), and,
- whether you or any eligible Dependent is eligible for Medicare.
- the plan option you select.

IF YOU RETIRE AFTER MAY 1, 2000, AND ARE GRANDFATHERED UNDER THE PREVIOUSLY AVAILABLE TRADITIONAL PROGRAM
You are grandfathered for the Retiree Medical Plan if you were at least age 50 on April 30, 2000, a member of the Pension Service Plan and selected the Traditional Capital Accumulation and Retirement Program.

IF YOU WERE A TRADITIONAL PROGRAM MEMBER (NON-GRANDFATHERED)
If you were an active or retired member of the previously available Traditional Program, but not grandfathered as described above, your Employer's contribution will be based on:

- your Years of Service after age 40,
- the Dependent coverage level you select (you only or you and your family), and,
- whether you or any eligible Dependent is eligible for Medicare.

For each Year of Service after the age of 40, the Employer contributes a defined annual dollar amount, referred to as "retiree units." The value of the retiree units may increase by a maximum of 2 percent per year as determined by the Nortel Networks Inc. The value of a retiree unit is $318.36 in 2003 for non-Medicare-eligible retirees and $79.68 for Medicare-eligible retirees. This amount is multiplied by your Years of Service. If you choose to cover your spouse, the Employers contribute an additional 40 percent of your allowance. To determine the premium that you pay, the total value of the retiree units is subtracted from the costs of Retiree Medical Plan coverage.

Here is an **example** of how this works:

> Assuming that you were retiring this year, if you began working for Nortel Networks at age 45 and were retiring at age 55 as a member of the Traditional Program, the Employer contribution for you would be 10 X $318.36, or $3,183.60 on an annual basis. If you also covered your spouse, the Employer contribution for coverage for your spouse would be 40% X $3,183.60, or $1,273.44. If you had started work for Nortel

Networks at 45, now are 65 and eligible for Medicare, the Employer contribution would be 20 X $79.68, or $1,593.60 on an annual basis.

IF YOU WERE A BALANCED PROGRAM MEMBER

If you are currently an employee of one of the Employers and were a member of the previously available Balanced Program, your Employer's contribution will be based on:

- your Years of Service after age 40,
- the Dependent coverage level you select (you only or you and your family), and,
- whether you or any eligible Dependent is eligible for Medicare.

The Employer contributions are determined in the same manner as described for the previously available non-grandfathered Traditional Program members, except that:

- the annual benefit units are one-half the value of the retiree units for Traditional Program members.
- an allowance is only provided to surviving spouses. In the event of your death prior to your enrolled spouse, your surviving spouse would receive an allowance that is 50 percent of the allowance that you would have received [the two (2) percent maximum cost of living adjustment would be applied as it is for Nortel Networks retirees].

Here is an **example** of how this works:

Assuming that you were retiring this year, if you began working for Nortel Networks at age 45 and were retiring at age 55 as a member of the Balanced Program, the Employer contribution for you would be 10 X $159.18, or $1,591.80 on an annual basis. If you had started work for Nortel Networks at 45, now are 65 and eligible for Medicare, the Employer contribution would be 20 X $53.06, or $1,061.20 on an annual basis.

IF YOU WERE AN INVESTOR PROGRAM MEMBER

If you are currently an employee of one of the Employers and were a member of the previously available Investor Program, your Employer will not contribute to the cost of your coverage but you may purchase the coverage at full cost if you have 10 Years of Service and meet the other eligibility requirements (see page 5).

Note:
The premiums in effect on the date you retire are subject to change at any time.

MAINTENANCE OF BENEFITS

The Retiree Medical Plan includes a Maintenance of Benefits provision that synchronizes benefits available from more than one plan. For example, if both you and your spouse (or Domestic Partner) are covered under separate plans, you and your Dependents (and/or Domestic Partner) may be covered under both the Nortel Networks Retiree Medical Plan and your spouse's (or Domestic Partner's) plan. The Maintenance of Benefits provision synchronizes benefits provided under all medical programs (including Medicare) so that

you can receive up to, but no more than, the amount that would have been covered by the Nortel Networks Retiree Medical Plan.
A medical program is defined as a program that provides benefits or services for, or by reason of, medical care or treatment, including:

- Coverage under a governmental program (e.g., Medicare) required or provided by law. This does not include a state plan under Medicaid or any law or plan with benefits in excess of those of any private insurance program or other non-governmental program.
- Group insurance or other coverage for persons in a group, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. But, this does not include:
  - school accident-type coverage for grammar school or high school students, or
  - any individually underwritten and issued contract or plan of insurance that meets both of these tests:
    - it provides solely for Accident and Sickness benefits, and
    - it is a contract or plan of insurance for which the insured, or member of the insured's family, or the insured's guardian has paid 100% of the premiums.
- Medical coverage under the "no fault" or medical payments provisions of an automobile insurance contract.

The Maintenance of Benefits provision reduces the advantages of double coverage, so you should consider whether coverage under two plans is beneficial. You may wish to be covered by this Retiree Medical Plan or by other coverage that you may have.

How the Maintenance of Benefits Provision Works

The plan that pays benefits first is "primary." The plan that pays benefits next is "secondary." When the Retiree Medical Plan is secondary, it will pay its normal benefits, reduced by any benefits paid by the primary plan. **This means that you will not receive any benefits from the Retiree Medical Plan if the primary plan pays benefits that are equal to or greater than the benefits the Retiree Medical Plan would normally pay.** Remember, both the primary and secondary plans' Deductibles must be satisfied before any plan benefits will be paid.

Determination of which plan is primary is as follows:

- Coverage as a Retiree is considered primary over coverage as a Dependent.
- When a Dependent Child is covered under two or more plans, the plan of the parent whose birthday comes earlier in the year (regardless of age) will be the primary plan. If the other plan has not adopted the birthday rule, the other plan's coordination rule will govern. If the Dependent Child's parents are separated or divorced, the following applies:
  1. The plan of the parent with custody pays first.
  2. The plan of the spouse of the custodial parent pays next.
  3. The parent without custody pays next.

4. Regardless of which parent has custody, whenever a court order specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
5. If the other plan does not have the rule concerning the custodial parent's plan paying Dependent claims second where there is a divorce, then that rule will not apply.

- If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
- Coverage as an active employee or that employee's Dependent is determined before coverage as a laid off or Retired Employee. If the other plan does not have this rule, and if, as a result, the programs do not agree on the order of benefits, this rule is ignored.
- When none of the above circumstances applies, the coverage you have had for the longest time pays first.

When the above rules reduce the Retiree Medical Plan's benefits, the benefits in each coverage category are reduced proportionately to its reimbursement level in the same manner as if no reduction in benefits had been applied.

Coordination with Medicare

Medicare Parts A and B

Retirees and covered Dependents who are eligible for Medicare or become eligible for Medicare after Retirement are eligible to participate in the Retiree Medical Plan. However, in order for a Retiree or Dependent to be eligible for coverage under the Retiree Medical Plan after becoming eligible for Medicare benefits, the Retiree or Dependent must enroll for benefits under Medicare Parts A and B. Once a Retiree or Dependent is eligible for Medicare coverage, coverage under the Retiree Medical Plan will be secondary to Medicare Parts A and B coverage, which are primary. Although plans for retirees under age 65 are generally primary (pay first) over Medicare Parts A and B, Medicare may provide primary benefits in some cases of Total Disability. Medicare Parts A and B are considered primary for anyone age 65 or older.

Medicare Part D Prescription Drug Coverage

The Retiree Medical Plan offers both medical and prescription drug benefits in a single plan. Therefore, if you elect to enroll in Medicare Part D you cannot elect to un-enroll from the prescription drug benefit offered by the Retiree Medical Plan. Additionally, the Retiree Medical Plan will not provide any out-patient prescription drug coverage if you are enrolled in Medicare Part D Prescription Drug Coverage. Since the Retiree Medical Plan has integrated medical and prescription drug coverage, your premiums for the Retiree Medical Plan will not change even though your prescription drug benefit will not be covered by the Retiree Medical Plan

<u>Important Reminder</u>: **If you drop your coverage in the Nortel Retiree Medical Plan, you cannot re-enroll in the Nortel Retiree Medical Plan at a later date.**

Precertification

To receive full benefits under the Retiree Medical Plan, you must precertify all Hospital admissions and certain other services (refer to the Summary of Benefits for each of the plan options for services requiring precertification). Precertification is designed to help save you and your Employer time and money, and to ensure a high level of medical care. It helps you make informed decisions about proposed treatment, and encourages Physicians to provide care in the most appropriate setting for your situation. Your Doctor still directs your treatment and you make the final decision about the treatment you receive.

How Precertification Works

If you or a covered Dependent is scheduled for a Hospital admission or other service requiring precertification, you must have the service authorized ahead of time for full benefits to be paid. To begin the review and authorization process, you or your Doctor must call the Claims Administrator at the number shown on your ID card for Hospital Precertification of each Inpatient Hospital admission or other service requiring precertification. For Hospital admissions, Precertification is required for authorization that the admission is appropriate for the services to be rendered. It is not a guarantee of payment for services received nor of payment at a specific benefit level.

You and your Doctor will be notified if the treatment/admission is certified. In some cases, alternate treatment options and benefits will be suggested.

If the admission or service is not certified even after further review and contact with your Doctor, you will be notified of the reasons why and given the opportunity to appeal the decision.

In an Emergency

If you are hospitalized as a result of an Emergency situation, the Hospital Precertification process must be initiated by calling the telephone number shown on your ID card within 48 hours following your admission.

Emergency rooms should only be used for Emergencies. Services rendered in emergency rooms or other non-participating offices or clinics are subject to review. The Claims Administrator will review the Claim to determine if it meets the criteria to be paid as an Emergency/urgent care Claim.

For Pregnancy

Precertification is not required for hospital lengths of stay within certain limits for childbirth. See Maternity and Newborn Coverage on page 40.

If you or your covered spouse (or Domestic Partner) is pregnant, you may contact the Claims Administrator at the number shown on your ID card during the first trimester to receive prenatal advice.

If You Don't Complete the Precertification Process

If you do not complete the Precertification process before your admission to the Hospital (or after an Emergency admission) or performance of other service requiring precertification, benefits will be reduced by 20% if the confinement or service is determined to be Medically Necessary (where allowed under Federal Law). If you stay in the Hospital longer than the approved length of stay, you will be responsible for 100% of the charges for the excess days. If you decide upon hospitalization or other service after a precertification denial, you will be required to pay 100% of the charges.

Out-of-Pocket Maximum

When the amount you have paid in a Plan Year reaches the Calendar Year Out-of-Pocket Maximum, the Retiree Medical Plan will pay 100% of the Reasonable and Customary Charge for Covered Expenses for the rest of that Plan Year. The out-of-pocket maximum varies with the specific Retiree Medical Plan option. Refer to each of those sections for details.

The following expenses do not count toward the Out-of-Pocket Maximum:

- charges for mental health and substance abuse treatment
- charges in excess of the Reasonable and Customary limit
- charges above plan maximum amounts
- charges applied to the Deductible
- charges under the Plan's Prescription Drug Benefit
- Copayments

Lifetime Maximum

For In-Network Benefits in the PPO Options there is no lifetime maximum. For all other Retiree Medical Plan options and out-of-network benefits in the PPO Options, the Lifetime Maximum benefit is $2,000,000 per covered person. This includes medical benefits paid under the Nortel Networks Medical Plan while you were employed with Nortel Networks and excludes Prescription Drug Benefits and Mental Health and Substance Abuse Treatment Benefits.

Automatic Limited Restoration

At the start of each Calendar Year, any previously used part of the Lifetime Maximum benefit will be restored for future charges, up to the lesser of:

- $2,000 or
- the amount needed to restore the full maximum.

Here's an example of automatic limited restoration:

2007 Lifetime Maximum equals	$2,000,000
2007 Benefits paid equals	$1,975,000
2007 Balance available equals	$25,000
Amount restored	$2,000
2008 Lifetime Maximum available	$27,000

OR

2007 Lifetime Maximum equals	$2,000,000
2007 Benefits paid equals	$1,200
2007 Balance available equals	$1,998,800
Amount restored	$1,200
2008 Lifetime Maximum available	$2,000,000

Covered Expenses

In general, the medical expenses described on this section are covered under all the Retiree Medical Plan options.

To be an eligible medical expense, the service must be Medically Necessary. In some cases, the charges may be subject to Reasonable and Customary limits or other limits and maximums. The Summaries of Medical Benefits starting on page 54 show the details on benefit levels and limits for Covered Expenses. Expenses specifically excluded from coverage begin on page 45.

Mental Health and Substance Abuse Treatment Benefits

Employee Assistance Program

The Retiree Medical Plan includes a confidential Employee Assistance Program (EAP), provided through the OptumHealth Behavioral Solutions.

The EAP benefit is available to you and your eligible dependents twenty-four (24) hours/seven (7) days a week. This program can help you or your family with resources and expertise on a wide variety of subjects to assist with the demands of everyday life, as well as major events. You and your eligible dependents automatically receive access to the Employee Assistance Program (EAP) --- at no cost to you. Benefits can be accessed by calling 1-800-842-2991 or via www.liveandworkwell.com (access code: 800-842-2991, include the hyphens), OptumHealth Behavioral Solutions web site. All services are confidential and in accordance with federal and state laws.

The EAP offers the following benefits:

- Confidential consultation with professional counselors
- Crisis Intervention
- Referral to a licensed network practitioner for up to eight counseling sessions at no charge per member and/or eligible dependent per calendar year (based on clinical necessity)
- Referral to community resources
- Adult and elder care resource information
- Child and family care resource information
- Educational materials specific to issue and educational resource info
- Legal consultation from a licensed attorney
- Mediation services
- Financial counseling from a credentialed financial professional
- Online work/life information

In order to receive EAP benefits, all services must be pre-certified and provided by OptumHealth Behavioral Solutions network practitioners. When you call OptumHealth Behavioral Solutions, you will speak with a mental health professional who will refer you to a licensed practitioner in your area. When you receive care through the OptumHealth Behavioral Solutions network, you have no claims to file. The OptumHealth Behavioral Solutions practitioner will handle the paper work for you.

If you or your covered family members require additional outpatient treatment beyond the eight EAP counseling visits, or any Inpatient treatment, these expenses will be covered according to the provisions of the Retiree Medical Plan's managed mental health and substance abuse treatment benefits. OptumHealth Behavioral Solutions will coordinate the additional care, and you will be required to pay the applicable Copayments or Coinsurance.

If you or a covered Dependent needs assistance with work or family issues, mental health or substance abuse concerns, or other situations that may need the support of a professional, contact OptumHealth Behavioral Solutions at 1-800-842-2991.

Note: EAP benefits are only available through OptumHealth Behavioral Solutions providers. If you choose to receive services from an Out-of-Network Provider, you will be responsible for any charges incurred.

Managed Mental Health and Substance Abuse Treatment Benefits

If you select coverage under any of the Retiree Medical Plan options, you have mental health and substance abuse treatment benefits in addition to the EAP, administered by OptumHealth Behavioral Solutions. Two levels of benefits apply for mental health and substance abuse treatment:

- *Highest Benefit Level*, which offers benefits when your care is certified by OptumHealth Behavioral Solutions and provided by a OptumHealth Behavioral Solutions Network Provider, and
- *Alternate Benefit Level*, which provides coverage when your care has been provided by an Out-of-Network Provider.

Any charges you pay for mental health and substance abuse treatment expenses only apply to the Mental Health and Substance Abuse Out of Pocket Maximum.
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Certified Care

To receive mental health and substance abuse treatment benefits with no penalty or reduction in benefits, you must have your care certified by OptumHealth Behavioral Solutions.

The combined Lifetime Maximum benefit for Inpatient and outpatient In-Network and Out-of-Network mental health and substance abuse treatment is $2,000,000.

Any charges you pay for mental health and substance abuse treatment expenses do not apply to the Retiree Medical Plan's Out-of-Pocket Maximum.

See the "Summary of Mental Health and Substance Abuse Treatment Benefits" on page 20 for further details on in-network and Out-of-Network coverage amounts.

Uncertified Care

Expenses incurred for mental health and substance abuse treatment services that are not certified by OptumHealth Behavioral Solutions prior to receiving the services are subject to penalties and reductions in benefits. This includes, but is not limited to, outpatient individual, group, or family counseling and hospitalization. The services will be reviewed to determine if they were Medically Necessary. The review will be completed following receipt of the Claim by OptumHealth Behavioral Solutions. If determined to be Medically Necessary by OptumHealth Behavioral Solutions, the services will be covered at the Out-of-Network Benefit level. Coverage is limited to Reasonable and Customary Charges. The standards OptumHealth Behavioral Solutions follows in making these determinations are contained in the documents listed under "Claims Administrator Information Used in Claim Determinations" on pages 119 - 121 in Appendix A. Information on how to obtain copies is also described there.

If care is determined to be Medically Necessary and your expenses exceed Reasonable and Customary Charges, the excess amounts will be your responsibility to pay. If care is determined not to be Medically Necessary, no benefits will be paid under the plan.

Additionally, if inpatient treatment or other intensive levels of care are not pre-certified by OptumHealth Behavioral Solutions, a $200 non-notification penalty will be applied and benefits will be reduced by an additional 10%. This non-notification penalty and 10%

benefit reduction do not count toward the Retiree Medical Plan's overall Out-of-Pocket Maximum.

Summary of Mental Health and Substance Abuse (MH/SA) Treatment Benefits

Mental Health and Substance Abuse (MH/SA) treatment benefits are administered by Optum Health Behavioral Solutions. All Inpatient and outpatient services must be coordinated by Optum Health Behavioral Solutions or Out-of-Network Benefits will apply.

BENEFIT DESCRIPTION	In-Network	Out-of-Network
MH/SA Calendar Year Deductible	None	$200 per person [a,g]
Separate Deductible for Hospital Admission	None	$150 per admission Hospital Deductible
MH/SA Inpatient Services		
Mental Health	100%[c,e,h]	70% of eligible charges after $200 Calendar Year Deductible and a $150 per admission Hospital Deductible [a,b,c, d,e,g,h,i,]
Substance Abuse	100%[c,e,h]	70% of eligible charges after $200 Calendar Year Deductible and a $150 per admission Hospital Deductible [a,b,c, d,e,g,h,i,]
MH/SA Intermediate Care	100%[d,eh]	$150 per admission Hospital Deductible[a,b,c,g] 80% of eligible charges after $200 Calendar Year Deductible [a,b,c, d,e,g,h,i,]
MH/SA Outpatient Services		
Individual Treatment	Visit 1-17: $20 Copay[e,f,j] (Does not include EAP visits) Visits over 17: $25 Copay[e,f,j]	70% of Reasonable and Customary charges after $200 Calendar Year Deductible [e,g,h,i]
Group Treatment	Visit 1-17: $10 Copay[e,f,j] Visits over 17: $20 Copay[e,f, j]	70% of Reasonable and Customary charges after $200 Calendar Year Deductible with a maximum of 25 visits per Calendar Year [e,g,h,i]

BENEFIT DESCRIPTION	In-Network	Out-of-Network
Mental Health – In-home Mental Health Care	100%[e,h]	70% of Reasonable and Customary c after $200 Calendar Year Deductible maximum 100 visits per Calendar Year[e,h]
Drug Testing as an Adjunct to SA Treatment	100%[e,h]	No Benefit
Medication Management [j]	$5 copayment for up to 30-minute visit; no limit[e]	70% of Reasonable and Customary Charges, after $200 Calendar Year Deductible[e,g,h,i]
Calendar Year Out-of-Pocket Maximum (excluding Deductible and Copayments) [k]	$3,500/person $7,000/family	$7,500/person $15,000/family
MH/SA Lifetime Maximum [k,l,] (all services combined)	Unlimited	$2,000,000

a. Inpatient and intermediate care are subject to precertification. If there is a combined medical/MH or medical/SA admission, only the primary diagnosis inpatient Deductible applies.

b The $150 per admission hospital Deductible for out-of-network admissions applies after the Calendar Year $200 Deductible is met.

c If hospital or intermediate care is not precertified, there is a non-notification penalty of $200, plus 10% of the remaining hospital bill. There is a 48-hour grace period for emergencies. Non-notification penalties do not count towards the Out-of-Pocket Maximum.

d Includes, but is not limited to, 24-hour intermediate care facilities, e.g., residential treatment, group homes, half-way houses, therapeutic foster care, day/partial hospitals, structured outpatient treatment programs. Intermediate Care is subject to the same plan maximums that apply to Inpatient Care benefits.

e Subject to care manager approval.

f Concurrent review of outpatient care after the 10th visit and every 10 visits thereafter for routine cases.

g Annual out-of-network MH/SA Deductible is separate from the medical Deductible and can be met by outpatient or inpatient out-of-pocket expenses. The $200 per-person annual Deductible is subtracted from a Claim before any benefit is paid and is separate from the inpatient Deductible.

h Coverage is limited to Reasonable and Customary Charges.

i If care is not precertified by OptumHealth Behavioral Solutions, your Claim for benefits will be reviewed following receipt of the Claim by OptumHealth Behavioral Solutions to determine if the care was Medically Necessary. If the care is determined not to be Medically Necessary, no benefits will be paid under the plan.

j. Medication management visits that exceed 30 minutes are considered under outpatient individual treatment sessions

k. Deductibles and Out of Pocket Maximums do not cross accumulate between in and out of network care MH/SA Out-of- Pocket Maximum only includes charges for mental health and substance abuse treatment. 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 other Medical and Prescription Drug benefits in the Plan.

l. In-Network MH/SA Benefits count toward out-of-network maximum benefit.

Organ Transplant Benefits

All Retiree Medical Plan options offer you and your covered Dependents access to the finest Hospitals in the country for approved organ transplant procedures, as well as coronary bypass grafts, angioplasties and other procedures, through CIGNA's LIFESOURCE Organ Transplant Network®.

LIFESOURCE Organ Transplant Network ® is nationally recognized for its delivery of highly specialized procedures and for the state-of-the-art care provided to patients. However, you do not have to use LIFESOURCE Organ Transplant Network® to receive benefits for these procedures or therapies.

Any of the services and supplies described in this "Other Covered Expenses" section that are required for a live donor as a result of an organ transplant procedure, whether the covered person is the donor or the recipient, are covered under the plan.

However, if the covered person is the recipient of the transplant, the services and supplies will be considered to be furnished on account of the recipient's Illness or Injury. In addition, Covered Expenses will be limited to the extent to which benefits for the charges, services and supplies are not provided by the donor's coverage under:

- any group or individual contract
- any arrangement of coverage for individuals in a group (whether on an insured or uninsured basis), including prepayment coverage

What is covered?

The program covers both the procedure itself, according to the Retiree Medical Plan option you select, and transportation to and from the Hospital for the patient and one companion. These procedures require you or your Doctor to obtain Precertification from the Claims Administrator as soon as the possibility of the procedure arises (and, for transplants, before the time a pre-transplantation evaluation is performed at a transplant center) to be eligible for benefits.

Companion Travel Program

Under the Companion Travel Program, you can choose a person to accompany you to a Center of Excellence and to remain there for all or a portion of your stay. The Companion Travel Program pays benefits for some of the charges incurred by the person accompanying you.

Maximum Travel and Lodging Benefit

There is a $10,000 lifetime maximum benefit per procedure.

For more information on LIFESOURCE Organ Transplant Network® and participating institutions, contact CIGNA Healthcare at the number shown on your ID card.

Prescription Drug Benefits

When you choose coverage under any Retiree Medical Plan option, you and your covered Dependents receive prescription drug benefits through Medco Health Solutions, L.L.C. You can obtain prescription drug benefits through the Medco network of participating retail pharmacies, non-network retail pharmacies and through Medco Health's Home Delivery Service.

This Prescription Drug Benefits Program covers all eligible prescriptions filled on an outpatient basis. Drugs dispensed in a Hospital, other inpatient settings or physician's office are covered as Hospital or Physician expenses under the Retiree Medical Plan option in which you enrolled.

Prescription Drug Formulary

The Retiree Medical Plan's prescription drug Formulary is a list of Preferred Brand-Name and Generic Drugs that have been selected by Medco Health's independent pharmacy and therapeutics committee based on their safety, effectiveness, and cost. Brand-Name Drugs listed on the Medco Health Formulary may offer greater discounts than Non-preferred Brand-Name Drugs do.

The Formulary applies whether you buy your prescription drugs at a retail pharmacy or through the Home Delivery Pharmacy Service. You can choose between:

- Generic Drugs — that is, drugs that have the same active ingredients in the same dosage form as Brand-Name Drugs and that are therapeutically equivalent to the Brand-Name Drugs but are sold under their chemical — or "generic" — name,
- Preferred Brand-Name Drugs - drugs that are included on the Medco Health Formulary are marketed under a specific trade name by a pharmaceutical company, and are still under patent protection, and
- Non-preferred Brand-Name Drugs - drugs that aren't included on the Medco Health Formulary and that may have one or more Medco Health Formulary alternatives.

If you choose the more expensive, Brand-Name prescription drug that isn't on the Formulary, you'll pay a larger share of the cost.

To make sure you're receiving the treatment that works best for you - both clinically and financially - share the Formulary list with your Doctor and ask him/her to use it when considering which drugs to prescribe for your treatment. To request a copy of the Formulary, contact Medco Health at 1-800-711-3460 or visit www.medco.com.

Member Pay-the-Difference Feature

The Pay-the-Difference feature is designed to provide higher coverage for lower-cost alternatives to Brand-Name Drugs. Whenever you buy a Brand-Name Drug that has a lower-cost generic equivalent, whether through a retail pharmacy or through the Home

Delivery Service, you'll pay the applicable Brand-Name Copayment/Coinsurance plus the difference between the cost of the generic equivalent and the cost of the Brand-Name Drug. This includes anytime that your Doctor indicates that the prescription should be "Dispensed As Written".

Retail Pharmacy Benefits

In-Network Benefits

When you present your Medco Health Prescription Drug Program ID card at a participating retail pharmacy, you will pay the following:

Generic Drugs:
- 20% Coinsurance for up to a 30-day supply
- Maximum: $25 for up to a 30-day supply
- Minimum: $7 for up to a 30-day supply

Preferred Brand-Name Drugs:
- 20% Coinsurance for up to a 30-day supply
- Maximum: $50 for up to a 30-day supply
- Minimum: $15 for up to a 30-day supply

Non-preferred Brand-Name Drugs:
- 30% Coinsurance for up to a 30-day supply
- Maximum: $65 for up to a 30-day supply
- Minimum: $30 for up to a 30-day supply

Unless your Physician specifies a Brand-Name Drug, your prescription will be filled with a Generic Drug, where available. If you choose to purchase the Brand-Name Drug when a Generic Drug is available or if your Doctor indicates the prescription should be "Dispensed As Written", you will be responsible for the Brand-Name Drug coinsurance plus the difference between the cost of the Generic and the Brand-Name Drug.

Remaining Covered Expenses will be paid at 100%. See "What Is Not Covered Under Prescription Drug Benefits" on page 31 for charges not covered under the Prescription Drug Benefits.

Your Doctor may choose to write DAW (Dispense as Written) on your prescription if there is a medical reason (such as an allergy to certain drug ingredients) for you to take a Brand-Name Drug when a Generic Drug is available.

Out-of-Network Benefits

If you have your prescription filled at a non-participating retail pharmacy, you will pay full price at the pharmacy and then submit a Claim form to be reimbursed at 40% of the Covered Expenses.

- The Plan pays 40% of Covered Expenses for Generic, Preferred or Non-preferred Brand-Name Drugs
- You pay 60% of Covered Expenses for Generic, Preferred or Non-preferred Brand-Name Drugs

Retail Refill Allowance for Maintenance Medications

At an in-network retail pharmacy, the plan will cover the initial prescription plus two 30-day refills of your covered Maintenance Medication, and you'll pay the applicable Coinsurance (i.e., 20% or 30%, subject to the applicable minimums and maximums) each time. For any additional refills of the same Maintenance Medication at an in-network retail pharmacy, you'll pay 60% of the cost of the medication.

Alternatively, if you use the Home Delivery Pharmacy Service, your costs will be based on the applicable Home Delivery Pharmacy Service Coinsurance (i.e., 20% or 30%, subject to the applicable minimums and maximums) for up to a 90-day supply of medication.

Specialty Drug Channel Management

Specialty Drugs are managed by the Prescription Drug benefit provider (Medco Health Solutions), instead of medical claims administrators (Anthem and CIGNA). As a result of this change certain Specialty Drugs previously obtained directly from another specialty pharmacy, a home infusion company, or physician's office will be covered only if ordered through Medco's specialty care pharmacy, *Accredo Health Group.* This means that if you obtain your Specialty Drugs from a source other than Accredo, you may be fully responsible for the cost. Medications supplied by an outpatient clinic or hospital will not be affected. For a list of Specialty Drugs refer to Appendix A – Prescription Benefits or call Accredo at 1-800 501-7260 between 8:00 a.m. and 8:00 p.m., Eastern Standard Time, Monday through Friday

Accredo, Medco's specialty pharmacy, provides enhanced support for those taking Specialty Drugs. Those taking these drugs will receive personalized specialty care and support, free expedited delivery of medications, 24-hour access to registered pharmacists specializing in specific conditions, free consultation from registered nurses and guidelines specific to the medication taken.

When You are Traveling

If you need a prescription filled when you are away from home, contact Medco Health's customer service department at 1-800-711-3460 to obtain the name and location of the

nearest participating pharmacy. The same benefits are available to you at any Medco Health participating pharmacy.

If You Do Not Live Near a Network Pharmacy

If you live in an area that does not have a Medco Health participating pharmacy within seven miles of your home, you will be considered an exception to the In-Network Benefit rules and will receive a letter instructing you to:

- use your local pharmacy to have your prescription filled,
- pay the full amount for the drug at the pharmacy, and
- complete the Claim form and mail it to the address on the form within 180 days of purchasing the prescription.

Your Claim will be treated as a participating pharmacy purchase and you will be reimbursed for Covered Expenses less the applicable Copayment. As the Medco Health Network is expanded and pharmacies are added within a seven-mile radius of your home, you will no longer be considered an exception and will be expected to begin using the participating pharmacies available in your area to receive In-Network Benefits.

Emergencies

If you have a medical Emergency and Prescription Drugs are needed immediately, you will be reimbursed for those prescriptions needed for Emergency treatment at the participating pharmacy rate, provided the situation has been declared an Emergency by the attending Physician.

Home Delivery Pharmacy Service

All Medical Plan options offer the Home Delivery Pharmacy Service administered by Medco Health Solutions, L.L.C.

The Home Delivery Pharmacy Service is used for long-term or Maintenance Drugs, such as medication for high blood pressure or arthritis. It is designed to save money if you have a chronic condition that requires you to refill your prescription on an ongoing basis.

Through the Home Delivery Pharmacy Service you can receive up to a 90-day supply per prescription. You will pay the following:

For Up to a 90-day Supply

- 20% Coinsurance for Generic Drugs - $15 minimum (or the cost of the drug, whichever is less), $50 maximum.
- 20% Coinsurance for Preferred Brand-Name Drug - $45 minimum (or the cost of the drug, whichever is less), $100 maximum.

- 30% Coinsurance for Non-preferred Brand-Name Drug - $90 minimum (or the cost of the drug, whichever is less), $130 maximum.

See "What Is Not Covered Under Prescription Drug Benefits" below for charges not covered under the Prescription Drug Benefit.

You must complete the Medco Health Home Delivery Pharmacy Service Order request form found at www.medco.com or may be requested by contacting Medco Health at 1-800-711-3460, enclose the prescription written by your Physician (your Physician should write the prescription for a 90-day supply) and send it to Medco Health along with your Coinsurance for each order. You will receive the prescription along with a new order form by return mail.

Most new prescription orders take 14 days to be filled and returned to you unless there are mail delays. Refill prescription orders take up to 10 days to be filled and returned to you. If you need a supply of medication while waiting for your home delivery (mail-order) prescription, ask your Doctor for two prescriptions so you can get a small supply of medication from your local pharmacy while waiting for your home delivery (mail-order) to arrive.

The Home Delivery Pharmacy Service is used for long-term or Maintenance Drugs. Note: Any out-of-pocket expenses for prescription drug benefits administered through Medco Health (Out-of-Network Prescription Drug expenses, In-Network Prescription Drug Coinsurance) do not apply toward your Retiree Medical Plan Out-of-Pocket Maximum.

Maximum Benefit

There is no lifetime limit or lifetime maximum to the Prescription Drug Program benefit.

Home Delivery Out-of-Pocket Maximum

There is a $3,000 Calendar Year out-of-pocket maximum per person for Prescription Drugs filled through the Home Delivery (mail order) Pharmacy Service. This means that once the amount you have paid in a Calendar Year for Prescription Drugs through the Home Delivery Pharmacy Service reaches $3,000, the plan will pay 100% of the cost for the remainder of the year.

Note: The amount of the difference between the Brand Name drug and generic alternative does not count toward the satisfaction of the out-of-pocket maximum.

Covered Prescription Drugs

To be covered under the Prescription Drug Benefit, the drug must be:

- an eligible Prescription Drug for which a written prescription is required
- oral and injectable insulin dispensed only upon the written prescription of a Physician

- a compound medication of which at least one ingredient is a federal legend drug
- any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a Physician or other lawful Provider

Additionally, there are certain Medications for which prior authorization is required.

What Is Not Covered Under Prescription Drug Benefits?

The following charges are not covered under the Prescription Drug Benefit:

- charges that would not have been made if the person were not covered by these benefits
- charges that you are not legally required to pay
- drugs not approved by the Federal Drug Administration (FDA) for treatment
- expenses incurred to the extent that payment is unlawful where the person lives when the expenses are incurred
- Experimental drugs or drugs labeled "Caution — limited by federal law to investigational use"
- immunization agents, biological sera, blood or blood plasma

- medication which is taken or administered, in whole or part, at the place where it is dispensed or while a person is a patient in an institution which operates, or allows to be operated, on its premises a facility for dispensing pharmaceuticals
- non-federal legend drugs, other than insulin
- prescriptions filled in excess of the number specified by the Physician
- prescriptions dispensed more than one year from the date of the Physician's order
- prescriptions dispensed prior to consumption of 75% of existing prescription when taken as directed
- prescriptions for more than a 90-day supply at any one time
- prescriptions that can be reimbursed under any Workers' Compensation law or government program, other than Medicaid
- Rogaine or Propecia for hair growth or Renova for cosmetic use
- Retin-A/Avita for participants over age 35 without preauthorization
- therapeutic devices and supplies, except for disposable hypodermic syringes and needles for the administration of insulin and glucose test strips.

When processing your prescription benefit Claims, Medco refers to the resources listed under "Claims Administrator Information Used In Claim Determination" – see pages 112 - 114. Prescription Medications that require prior authorization and information on how you can obtain the clinical information Medco relies upon in determination of your Claim is also described there. Additional Medco information that is used in prescription benefit Claims determinations is included in Appendix B of this SPD.

Health Management Program

Health management services are provided by CIGNA. These confidential programs are offered to retirees less than 65 and their eligible dependents at no cost. They include:

- Nurse line that provides toll-free access to registered nurses at 1-800-257-2702 24-hours a day, 7 days a week, for questions about conditions, symptoms, medications, or other health information.

- Web site at www.myCIGNA.com for :
  - Health related information,
  - Health tools, such as health risk assessment, weight and exercise logs, carbohydrate calculator and blood sugar tracker,
  - E-mail a nurse feature,
  - Links to other useful web sites, and more.

  Be sure to register to fully access all the resources available on these web sites.

- **Pre-recorded health information line** toll-free at 1-800-257-2702

- **Chronic disease management assistance** toll free at 1-877-888-3091 for:
    - Understanding your condition and how to manage symptoms,
    - Understanding and following your doctor's treatment plan,
    - Understanding medications, side effects, contraindications, etc.,
    - Becoming a good health care consumer,
    - Navigating the health care system,
    - Providing your doctor with updates (requires your consent) and national treatment guidelines on your condition.

Employees and Dependents with chronic health conditions (e.g. diabetes, asthma, heart disease) can choose to participate in a confidential program to help improve their health by contacting CIGNA at 1-877-888-3091. Those participants with more serious health conditions may receive an invitation by telephone to participate from CIGNA.

Preventive Care Benefits

Preferred Provider Organization (PPO) In-Network Coverage

When you choose coverage in one the PPO Options and use an In-Network Provider, Preventive Care expenses are covered at 100% (no office visit copayment) for you and your eligible Dependents

In-Network Preventive Care services are based on American Medical Association (AMA) schedules for recommended periodic health examinations for Children and adults. Some of the preventive services that are eligible under the plan include:

Well-child care for children

- height and weight screening
- immunizations (according to AMA recommendations) for your infant from birth to eighteen months (at ages two, four, six, fifteen and eighteen months)
- parent education on diet, injury protection and dental health for infants and Children
- screening for infants and Children at high risk for health problems, including hearing tests at 18 months for infants with a family history of childhood hearing impairment

Adults

- annual flu shots
- annual Pap smear for women
- immunizations for tetanus-diphtheria every 10 years

- laboratory and diagnostic procedures for individuals at high risk for particular health problems
- mammograms (according to AMA recommendations)
- physical exam (according to AMA recommendations)
- sigmoidoscopy (according to AMA recommendations)
- vision and hearing tests for adults

In-Network Preventive Care services are based on American Medical Association (AMA) schedules for recommended periodic health examinations for Children and adults.

Preferred Provider Organization (PPO) Options Out-of-Network Coverage

When you use an Out-of-Network Provider under one of the PPO Options, you and your eligible Dependents age six and over will generally be covered at 60% (80/60 PPO) or 70% (90/70 PPO) for routine Preventive Care.

Well-baby care expenses up to age six, including immunizations, are also generally covered at 60% (80/60 PPO) or 70% (90/70 PPO).

Note that the PPO Options' out-of-network Preventive Care benefits are limited to Reasonable and Customary Charges.

Comprehensive Option Coverage

If you are enrolled in the Comprehensive Option, you and your eligible Dependents age six and over will generally be covered at 100% for a routine Preventive Care.

Well-baby care expenses up to age six, including immunizations, are also generally covered at 100%.

Note that the Comprehensive Option's Preventive Care benefits are limited to Reasonable & Customary Charges.

Indemnity Option Coverage

If you are enrolled in the Indemnity Option, you and your eligible Dependents age six and over will generally be covered at 100% for routine Preventive Care.

Well-baby care expenses up to age six, including immunizations, are also generally covered at 100%.

Note that the Indemnity Option's Preventive Care benefits are limited to Reasonable & Customary Charges.

Other Covered Expenses

The following expenses are also covered under the Retiree Medical Plan options. See the Summaries of Medical Benefit, pages 55 – 58; 61 – 63; and 67 - 69, for details on coverage levels, limits and maximums.

Remember: To be an eligible medical expense, the service must be Medically Necessary and adhere to Common Medical Standards. In some cases, coverage is limited to Reasonable and Customary Charges or other limits and maximums. The Claims Administrator determines whether a service meets the plan's Medically Necessary criteria and Common Medical Standards under the plan. The Claims Administrator also determines what Reasonable and Customary Charges are under the plan. Certain services and supplies require Precertification or preauthorization by the Claims Administrator in advance of receiving the services and supplies for full benefits to be paid. Services for which you must receive Precertification or preauthorization are noted in this section. Expenses specifically excluded from coverage are shown in "What is Not Covered" beginning on page 49.

Chiropractic Benefits

The plan covers chiropractic services including diagnosis and related services. Remember: Covered services are limited to Common Medical Standards. To qualify for coverage under the plan, the service must adhere to generally accepted medical practice based on recommendations from the American Medical Association (AMA). Pretreatment evaluation and progress reports may be requested by the plan at various intervals to ensure treatment is Medically Necessary.

All chiropractic expenses are covered under **Outpatient Short-Term Rehabilitation** benefits. In the PPO Options, any combination of In-Network and Out-of-Network Benefits for chiropractic treatment is limited to 90 visits per condition, per Calendar Year. The amounts you must pay for covered chiropractic expenses (including Copayment and any annual Deductible) are the same as required under the **Outpatient Short-Term Rehabilitation** benefits and the same limits (e.g., Reasonable and Customary Charge limits) are applicable.

Both the Comprehensive and Indemnity Options provide coverage at 80%, after the Deductible is met, subject to Reasonable and Customary per the Summary of Medical Benefits (see pages 61 - 63 and 67-69).

Please see the Summaries of Medical Benefits on pages 55 – 58; 61 – 63; and 67 - 69 for further information on benefits under the option you have selected.

Dental Care Coverage

Dental coverage is provided under the Medical Plan for treatment due to Accidental Injury to sound, natural teeth. This treatment must be provided within twelve months of the Accident. Coverage includes charges for Doctor's services, X-ray exams and services necessary to restore or replace injured teeth. When you receive preauthorization from the Claims Administrator, Dental Coverage under the Medical Plan is also provided for:

- a charge made for removal of a malignant or nonmalignant Non-odontogenic tumor.
- other Medically Necessary services to treat:
  - Temporomandibular Joint Disorder (TMJ)
  - malocclusion involving joints or muscles (such as for wiring or repositioning teeth)
  - correction of Congenital anomaly in Children that occurred at birth.

No other charge for dental services is covered under the Medical Plan.

Additional dental exclusion information can be referenced in "What is Not Covered" on pages 45- 56

Durable Medical Equipment

The plan covers the rental or purchase of medical, surgical or related Hospital equipment and supplies, including, but not limited to:

- equipment for administration of oxygen
- Hospital beds
- ventilator
- wheelchairs
- artificial limbs, larynx and eyes (for functionally necessary replacements)
- heart pacemaker (for functionally necessary replacements)
- orthopedic braces, splints, trusses, casts, crutches or other similar items (for functionally necessary replacements)
- surgical dressings (for functionally necessary replacements)

If you are enrolled in a PPO Option, the Network Manager determines whether the equipment will be rented or purchased for coverage under the plan. If you are enrolled in

the Comprehensive Option or the Indemnity Option, the plan will cover either rental or purchase of the equipment.

If equipment is purchased, repair and maintenance of Durable Medical Equipment (not covered under a manufacturer's warranty or purchase agreement) is also covered. Benefits are provided for a single unit of Durable Medical Equipment (example: one insulin pump).

For a PPO Option, to receive In-Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor the Network Manager identifies.

Predetermination Review:
For all Retiree Medical Plan options: You are strongly urged to contact Member Services and submit a written Claim to predetermine that the Durable Medical Equipment you plan to purchase is a Covered Expense. You should obtain an estimate of the benefits considered eligible for payment under the plan from the Claims Administrator before your purchase of the Durable Medical Equipment.

For the Comprehensive options and Out-of-Network Benefits under the PPO options, there is a $2,000 benefit maximum per participant for Durable Medical Equipment each Calendar Year (external prosthetic appliances are excluded from this limit). For the PPO Options, benefits paid for Durable Medical Equipment received in-network will also count toward the $2,000 Out-of-Network Benefit maximum. The Indemnity Option does not have a Calendar Year maximum.

Emergency Care

An Emergency is a sudden and serious situation that happens unexpectedly and requires immediate medical attention. If an emergency room is used for a condition that is not a medical Emergency, benefits will be reduced (and in some cases no benefits will be paid). See the "Summary of Benefits" for details. Examples of emergencies include an apparent heart attack, loss of consciousness, excessive bleeding, severe or multiple Injuries or serious burns.

The Plan covers the following types of Emergency care:

- Ambulance transportation to the nearest Emergency facility and transfers to other facilities in order to receive appropriate services
- Doctor's office
- Hospital emergency room care — within 48 hours of an Accidental Injury or the onset of a sudden or serious Illness
- Urgent care centers

Home Health Care

Through the use of an authorized Home Health Care Agency, you may be able to shorten your Hospital stay and speed your recovery in your own home. The plan covers Home Health Care for covered services and supplies.

For the Comprehensive and Indemnity Options and for Out-of-Network Benefits under the PPO Options, there is a benefit maximum of 100 visits per participant each Calendar Year. For the PPO Options, benefits paid for Home Health Care visits that are received in-network will also count toward the 100 visit Out-of-Network Benefit maximum. There is an unlimited maximum on the number of visits for In-Network Benefits under the PPO Options.

For all Retire Medical Plan Options:

- Two hours of home health aide care counts as one visit; each visit by any other member of the home health team counts as one visit, regardless of the length of visit.
- Durable Medical Equipment billed by the Home Health Care Agency will be covered under the Durable Medical Equipment benefit.

The following are expenses covered under the Plan for Home Health Care services and supplies:

- part-time or intermittent home nursing care given or supervised by a registered nurse
- part-time or intermittent home health aide service, mainly for care of the person
- physical, occupational or respiratory therapy by a qualified therapist
- therapy by a qualified speech therapist if needed to restore or rehabilitate any speech loss or impairment caused by an Illness or Injury, or by surgery for that Illness or Injury (If the Illness or Injury is a Congenital defect, this includes therapy only after surgery for that defect). Covered therapy does not include therapy for which no further improvement can be expected.
- nutritional counseling furnished or supervised by a registered dietitian
- medical supplies, lab services, drugs and medicines prescribed by a Physician

These services and supplies will be covered only if **all** of the following conditions are met:

- the services are furnished to a person who is under a Physician's care,
- the services are prescribed in writing by the person's Physician,
- the services are not mainly Custodial Care,
- the services are Medically Necessary for the care and treatment of the person's Illness or Injury as part of a Home Health Care plan submitted by the Physician to a Home Health Care Agency,
- the services are in substitution of the person's Inpatient stay in a Hospital or Skilled Nursing Facility that would be required in the absence of such services,
- the services are furnished by the Home Health Care Agency for that care and treatment is in the patient's home and charged for by the Home Health Care Agency.

Hospice Care Program

The Retiree Medical Plan covers Hospice care services provided to a covered person diagnosed with a Terminal Illness. Terminally Ill means a life expectancy of six months or less, as certified by the patient's treating Physician who recommends admittance to a Hospice care facility. The Retiree Medical Plan also covers Hospice care expenses incurred for counseling services provided to the Terminally Ill patient's family unit after that person's death.

A Hospice is a facility that provides short periods of stay for a Terminally Ill person in a homelike setting for either direct care or respite. This facility may be either free-standing or affiliated with a Hospital. It must operate as an integral part of the Hospice Care Program.

A Hospice team is a team of professionals and volunteer workers who provide care to:

- reduce or abate pain or other symptoms of mental or physical distress and
- meet the special needs arising out of the stresses of a terminal illness, dying and bereavement.

The Hospice team must include a Physician and a registered nurse and may consist of a social worker, a clergyman/counselor, volunteers, a clinical psychologist, a physiotherapist and/or an occupational therapist.

All Hospice care will be considered one period of care unless the patient is readmitted to a Hospice for a subsequent period of care at least three months after he or she last received Hospice care.

Eligible services and supplies are considered Covered Expenses only if they meet ***all*** of the following conditions:

- the Hospice facility operates as an integral part of a Hospice Care Program that meets standards set by the National Hospice Organization and is approved by the Terminally Ill person's chosen medical provider. If such a facility is required by a state to be licensed, certified, or registered, it must also meet that requirement to be considered a Hospice,
- the Hospice team includes at least a Physician and a registered nurse,
- services and supplies are ordered by the Physician directing the Hospice Care Program (treating Physician) as part of the Hospice Care Program,
- services and supplies are furnished while the Terminally Ill person is in a Hospice Care Program (certification of the Terminal Illness must be provided by the Physician before treatment can be confirmed as Hospice Care), and
- services and supplies are provided within six months from the date the Terminally Ill person entered the Hospice Care Program or re-entered such program for the Comprehensive and Indemnity Options. For the PPO Options, the limit is seven months.

Covered charges include:

- counseling services provided by members of the Hospice team
- Hospice Room and Board while an inpatient in a Hospice facility and
- necessary medical and surgical supplies.

Counseling services are defined as supportive services provided by members of the Hospice team in counseling sessions with the family unit. The services are to assist the family unit in dealing with the death of the Terminally Ill person.

There is a benefit maximum of 3 bereavement counseling sessions per family, per occurrence, for in-network and out-of-network care combined.

Hospice benefits are subject to the following maximums for the Indemnity Option:

- 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

The following charges related to Hospice care are ***not covered*** under any option:

- charges for a service furnished by a close relative. "Close relative" means, you, your spouse, your Domestic Partner, a child, a Domestic Partner's child, brother, sister, your parent, your spouse's parent or the Terminally Ill person
- charges incurred after the Terminally Ill person has been discharged from the Hospice Care Program
- charges for the treatment of a diagnosed Illness or Injury of a member of the family unit if covered, in full or in part, under any other coverage

Infertility

The plan covers charges for the diagnosis and medical treatment of infertility. Additionally, a benefit is available for "assisted reproduction" expenses (which includes actual or attempted impregnation or fertilization, including artificial insemination, gamete intrafallopian transfer (gift) and in-vitro fertilization). There is a $5,000 lifetime benefit maximum per covered member (employee, spouse and any Dependents) for assisted reproduction expenses.

Inpatient Hospital Services

The Retiree Medical Plan covers services and supplies furnished by a Hospital during a Hospital stay, including:

- Ambulance use for local travel to the nearest facility that can provide the appropriate services*
- Anesthetics and their administration
- chemotherapy or radiation therapy
- diagnostic laboratory and x-ray services
- drugs and Medications
- Hemodialysis

- Hospital Room and Board — charges for a Semi-Private Room and Board, private room if Medically Necessary, or 90% of the lowest room rate in a facility that only has private rooms
- operating and recovery room charges
- rehabilitation services
- other Medically Necessary Inpatient services and supplies

**If you are enrolled in the Indemnity Option, Ambulance use is covered in full if the service is provided by the Hospital. However, if the Ambulance services are provided by an agency other than the Hospital, the benefit for Ambulance use is limited to 80% after the Calendar Year Deductible. If you are enrolled in the Comprehensive Option, Ambulance services are covered at 80% of Reasonable and Customary Charges after the Calendar Year Deductible. For the PPO Options, Ambulance services are covered at 80% after the Calendar Year Deductible in the 80/60 PPO Option or 90% after the Calendar Year Deductible in the 90/70 PPO Option for true emergencies. Otherwise, Ambulance services are covered at60% in the 80/60 PPO Option or 70% in the 90/70 PPO Option after the Calendar Year Deductible.*

Inpatient Hospital benefits will be paid at 100% for a maximum of 365 days under the basic medical coverage provision of the Indemnity Option. After exhaustion of benefits under the Basic Medical coverage provision, the Major Medical benefit provisions take effect and provide 80% coverage thereafter. The Comprehensive Option pays In Patient Hospital benefits at 80% Coinsurance after the Deductible. For the PPO Options, Inpatient Hospital benefits will be paid at 80% for In-Network Benefits and 60% for Out-of-Network Benefits in the 80/60 PPO Option. In the 90/70 PPO Option, Inpatient Hospital benefits will be paid at 90% for In-Network Benefits and 70% for Out-of-Network Benefits.

Inpatient Physician and Surgeon Services

Medical care or treatment by a Physician during a Hospital stay is covered under the Plan when all Precertification requirements have been satisfied.

Mastectomy

Under Federal Law (the Women's Health and Cancer Rights Act of 1998) breast reconstruction benefits in connection with a mastectomy necessitated by cancer will include:

- reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance
- prostheses and treatment of physical complications in all stages of mastectomy, including lymphedema (swelling associated with the removal of lymph nodes)

Maternity and Newborn Coverage

Maternity
Maternity Care is covered as any other diagnosis under the mother's medical plan .

Newborn
The following services and supplies authorized by your Physician and furnished by a Hospital to a healthy Newborn baby for routine nursery care are covered for the first seven days after the baby's birth:

- Hospital Room and Board
- supplies and non-professional services furnished by the Hospital for medical care in
  that Hospital

Under Federal Law, the Retiree Medical Plan may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that providers obtain authorization for stays which are not in excess of the above stated periods. The attending provider, after consulting with the mother, may discharge the mother or her Newborn earlier than 48 or 96 hours as applicable.

Medical Supplies
Covered medical supplies include:
- allergy sera and biological sera
- anesthetics and their administration
- blood and blood transfusions by or for the patient (if blood is not replaced)
- drugs and medication prescribed by a Doctor, or dispensed and administered in a Doctor's office
- hypodermic needles and syringes other than for insulin
- casts
- other fluids to be injected into the circulatory system
- oxygen
- surgical dressings

Organ Transplant
Any of the services and supplies described in this "Other Covered Expenses" section that are required for a live donor as a result of an organ transplant procedure, whether the covered person is the donor or the recipient, are covered under the Retiree Medical Plan. See the "Organ Transplant Benefits" section on page 24 for more information.

If the covered person is the recipient of the transplant, the services and supplies will be considered to be furnished on account of the recipient's Illness or Injury. In addition, Covered Expenses will be limited to the extent to which benefits for the charges, services and supplies are not provided by the donor's coverage under:

- any group or individual contract
- any arrangement of coverage for individuals in a group (whether on an insured or uninsured basis), including prepayment coverage

Orthoptic (Visual) Therapy

Coverage is provided for Medically Necessary eye muscle exercises; including training by an Ophthalmologist, Optometrist or orthoptic technician.

Outpatient Physician Services

Coverage for outpatient services includes:

- Anesthesiologists
- Surgeons

Outpatient Services

The following outpatient treatments are covered under the Retiree Medical Plan:

- chemotherapy and radiation therapy
- Hemodialysis
- pathology interpretations
- x-ray and laboratory exams made to diagnose Illness or Injury

Outpatient Short-Term Rehabilitation

The Retiree Medical Plan covers charges by a Physician or a licensed or certified physical, occupational or speech therapist for services to restore a body function that has been lost or impaired due to an Injury, Illness or Congenital defect.

Covered services include:

- cardiac rehabilitation
- chiropractic therapy
- speech therapy to:
    - develop or improve speech after Surgery to correct a defect that existed at birth **and** impaired or would have impaired the ability to speak.
    - restore speech after a loss or impairment of a demonstrated previous ability to speak caused by an Injury or Illness.
- Covered speech therapy does not include therapy for which no further improvement can be expected.

- Speech therapy expenses for Children under age 5 whose speech is impaired due to one of the following conditions:
    - infantile autism
    - developmental delay or cerebral palsy
    - hearing impairment
- major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate
- to correct pre-speech deficiencies
- to improve speech skills that have not fully developed
- for the diagnosis of developmental delay
- treatment by a physical or occupational therapist

Physician Services

Medical care or treatment is covered under the Retiree Medical Plan for services provided by a family practitioner, internist, pediatrician, obstetrician/gynecologist, or other licensed medical practitioner who is practicing within the scope of his license and is licensed to prescribe and administer drugs or to perform surgery.

Private Duty Professional Nursing

Private duty professional nursing services by a registered nurse are covered under the Retiree Medical Plan, as long as:

- intensive nursing care by such a nurse is required to medically treat an acute Illness or Injury and
- the patient is not in either a Hospital, or any other health care institution that provides nursing care.

There is a $10,000 limit on private duty professional nursing services in each Calendar Year for the Comprehensive and Indemnity Options and Out-of-Network Benefits under the PPO Options. There is no Calendar Year limit for In-Network Benefits in the PPO Options but benefits paid for In-Network private duty professional nursing will count toward the $10,000 Out-of-Network Calendar Year maximum.

Skilled Nursing Facility

The Retiree Medical Plan options cover Skilled Nursing Facility services and supplies that are furnished for recovery from either an Illness or Injury that caused a prior Hospital stay or from a related Illness or Injury.

The following are expenses covered under the Plan for services and supplies furnished during a person's Skilled Nursing Facility stay:

- daily Room and Board up to the Semi-Private room rate, including normal daily services and supplies furnished by the Skilled Nursing Facility
- general nursing care
- necessary medical supplies furnished by the facility for use during confinement

These services and supplies will be covered only if **all** of the following conditions are met:

- the person is under continuous care of his or her Physician and
- the stay is not in connection with care for a mental disorder. Mental disorders include, but are not limited to, senile deterioration, drug addiction, alcoholism, chronic brain syndrome and mental retardation.

If a confinement is in a distinct part of an institution which meets both the definition of a Hospital and of a Skilled Nursing Facility, then the benefits, if any, payable for that

confinement will be determined on the basis of the benefits payable for the Skilled Nursing Facility confinement rather than those for a Hospital confinement.

The Medical Plan options cover Skilled Nursing Facility services and supplies that are furnished for recovery from either an Illness or Injury that caused a prior Hospital stay or from a related Illness or Injury.

Depending on the option you select, certain conditions must be met. There are differences in the benefit levels dependent on the option selected. Please see the Summaries of Medical Benefits on pages 55 – 58; 61 – 63; and 67 – 69 for details.

Specialty Physician Services

Coverage for specialty Physician services includes:

- allergy testing and treatment
- office visits
- pre- and post-natal exams
- referral Physician services
- Second Surgical Opinion

Surgical Services

The Retiree Medical Plan covers services performed in connection with surgical procedures in a Hospital, outpatient department, surgical facility or Physician's office (in certain situations). Surgical procedures include the closed or open reduction of fractures or dislocations of the jaw.

A charge is a Covered Expense if it is made by a Doctor for a service in connection with a covered surgical procedure. The service must be included in the following list to be covered under the Retiree Medical Plan:

- the immediate pre-operative exam of the person by the Doctor who performs the surgical procedure
- the performance of the surgical procedure by a Doctor
- aid by a Doctor in the performance of the surgical procedure, if such aid is required by the nature of the surgical procedure or the person's condition, or if it is required by the Hospital in which the surgical procedure is performed
- the post-operative care that is required by and directly related to the surgical procedure and is given by a Doctor
- the closed or open reduction of fractures or dislocation of the jaw

If two or more surgical procedures are performed in one session, benefits depend on the nature of the additional procedures. The maximum benefit will be:

- 100% of the charges for the major procedure, plus

- 50% of the fee for the other procedure(s) as if both(all) operations had been performed separately.

Temporomandibular Joint Disorder

To the extent that the services or supplies provided are recommended by a Physician, and are essential and necessary care and treatment of an Injury or an Illness, coverage is applicable. Covered services include medical or surgical treatments directed exclusively at the temporomandibular joint (i.e. intracapsular structures).

All treatment must be authorized by the Claims Administrator in advance for coverage under the plan. The Claims Administrator will determine whether the treatment is medical or dental in nature and if medical in nature, whether the plan's Medical Necessity criteria is satisfied.

Urgent Care Center Services

The plan covers services received at an urgent care center. An urgent care center is a facility, other than a Hospital, that provides covered services, as determined by the Claims Administrator, required:

- to prevent serious deterioration of your health,
- as a result of an unforeseen Illness, or Injury, or the onset of acute or severe symptoms.

WHAT IS NOT COVERED

The following services and supplies are not covered by any Retiree Medical Plan Option, except as specifically noted in the Plan. Consult **"SECTION THREE – GLOSSARY"** for definitions of all capitalized terms.

Blood

The amount that a charge for blood is reduced by blood donations.

Chiropractor

Charges by a chiropractor for:

- Preventive Care, vitamins, liniments, nutritional supplements and cervical pillows
- Any type of service or supply for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning.

Common Medical Standards

Charges for services that do not meet Common Medical Standards.

Confinement

Expenses for:

- confinement in an extended care facility for Custodial Care, senile deterioration, mental deficiency or mental retardation
- education, training and Room and Board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home

Convenience Items

Charges for personal comfort items and services.

Cosmetic Surgery

Charges for Cosmetic Surgery, except when necessary:

- because of an Accidental Injury while covered
- because of infection or other diseases, such as Surgery to reconstruct a breast after a mastectomy
- to treat a condition, including a birth defect, which impairs the function of a body organ of a Child

Custodial Care

Expenses for Custodial Care (See the Glossary for definition).

Dental Care Expenses for:

- routine dental services, including X-ray exams of the teeth, nerves or roots of the teeth, tissue and structure surrounding the teeth, gingival or alveolar, except for:
  - accidental Injuries to natural teeth treated within twelve months of the Accident
  - treatment or removal of a malignant or nonmalignant Non-odontogenic tumors
- Hospital confinements as an Inpatient or outpatient for dental Surgery, unless the dental Surgery is a covered medical expense (due to a concurrent medical condition or child's age) and it is Medically Necessary for the dental Surgery to be performed in a Hospital
- temporomandibular (TMJ) or maxillofacial Surgery, except when Medically Necessary and as described under the "Other Covered Expenses" section.

Equipment

Charges for purchase or rental of common use items such as motorized transportation equipment, saunas, whirlpools, air purifiers, air conditioners, hypoallergenic pillows or mattresses or exercise equipment.

Experimental

Investigational, Experimental or educational charges.

Eye Care

The following charges related to treatment of the eye:

- eyeglasses or contact lenses of any type, except for initial replacements for loss of the natural lens
- eye exams to determine the need for or changes in eyeglasses or lenses of any type
- radial keratotomy or any surgical procedure to correct refraction errors of the eye, e.g., myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (distortion), including any confinement, treatment, services or supplies given in connection with or related to the Surgery

Foot Conditions

A charge for Doctor's services for:

- corns, calluses or toenails, except the removal of nail roots and necessary services in the treatment of metabolic or peripheral-vascular disease
- weak, strained, flat, unstable or unbalanced feet, except open cutting operations
- metatarsalgia or bunions, except open cutting operations

Hearing Care

Charges for:

- hearings aids
- exams to determine the need for hearing aids or the need to adjust them

Homemaker

Charges for services of a homemaker.

Hospital

Any charges:

- for Hospital care and services rendered after the patient has been discharged from the Hospital
- for Hospital care and services when a registered bed patient is absent from the Hospital
- for Inpatient Hospital care and services if the covered person's condition does not require:
    - constant direction and supervision by a Physician
    - constant availability of nursing personnel

    - immediate availability of diagnostic therapeutic facilities and equipment found only in a Hospital setting
- for private Hospital room, unless Medically Necessary or unless the Hospital has no Semi-Private room
- at a federal Hospital or any other Hospital operated by a government unit, except for charges you are legally required to pay, or charges covered under any government law or plan, except a federal/state program (e.g., Medicaid) or law or plan where benefits are in excess of the benefits provided by the Retiree Medical Plan

Hypnosis

Charges for hypnosis, except as part of the Physician's treatment of a mental Illness, or when used instead of an anesthetic.

Insurance Laws

Charges paid or payable under any no-fault automobile insurance law or an uninsured motorist insurance law. The Claims Administrator will take into account any adjustment option chosen under such part by you or any one of your qualified Dependents (or Domestic Partner).

Medically Unnecessary

Charges for any treatment or services that are not Medically Necessary as determined by the Claims Administrator.

Obesity

Charges for treatment of obesity, weight reduction, diet pills or dietetic control unless Medically Necessary.

Observation or Diagnostic Study

Charges incurred for:

- any medical observation or diagnostic study when no disease or Injury is revealed, unless:
    - the Claim is in order in all other respects
    - there is definite symptomatic condition other than hypochondria
    - they are not part of a routine physical exam or check-up
- routine check-up examinations or tests, except as specified under the Preventive Care Benefit

Other Charges

- Charges made by the Company, a family member or someone who lives in your household. This includes you and your spouse (or Domestic Partner), child, brother, sister, parent or spouse's (or Domestic Partner's) parent.
- Charges in excess of any plan limitations, maximums or Reasonable and Customary Charges.
- Charges for which the patient is not legally required to pay.

Sexual Function

Expenses for:

- treatment to improve sexual function (an implantable penile prosthesis is considered an eligible expense when Medically Necessary to restore sexual function caused by certain medical conditions, such as diabetes, cancer, spinal cord injury and Peyronie's disease)
- sex change operations and therapies, including hormonal therapy

Therapy and Counseling

Charges for marital/family therapy and counseling, except through the Mental Health and Substance Abuse Treatment Benefits.

TMJ

Expenses for treatment of Temporomandibular Joint Dysfunction (TMJ), unless Medically Necessary.

Travel

Expenses for travel or accommodations (except through the Companion Travel Program).

War

Charges for Illness and Injury due to a war or any act of war.

Work-Related Injuries

Expenses for work-related Injuries or Illnesses for which benefits under Workers' Compensation or any other occupational disease law or similar law are payable.

HOW THE PPO OPTIONS WORK

The PPO Options represent a managed medical approach with a network referred to as a Preferred Provider Organization or PPO. The PPO network is the same for both the 80/60 PPO and the 90/70 PPO. This network is a group of Physicians, Hospitals and other health

care Providers. Physicians must meet strict eligibility standards before they can be admitted to the Network. Some of the considerations are:

- graduation from an accredited medical school
- completion of an approved residency program
- board certification or board eligible in specialty (internal medicine, cardiology, etc.)
- admitting privileges to a Network Hospital
- appropriate treatment history
- state licensing.

The Network Manager screens and contracts with the Providers, and continues to monitor them on an ongoing basis. The Network Manager for the Retiree Medical Plan PPO Options is CIGNA. A CIGNA network may or may not be available where you live. Your home ZIP code will determine which Network is available in your area.

A major advantage of the PPO Network is that the Providers in the network have contracted with CIGNA to provide discounted fees, creating savings for both you and Nortel Networks.

The PPO Options are available to Retirees less than 65 years of age and their enrolled eligible Dependents.

Provider Directory

The Provider Directory lists Primary Care Physicians, specialists, independent practitioners, Hospitals, and other Network Providers. You can obtain a copy of the Provider Directory from:

The Claim Administrator's internet site or by calling their Member/Customer Services. See the "Contact Information for Claims Filing" chart in **"SECTION TWO – ADMINISTRATIVE INFORMATION."**

Plan Benefits

The PPO Options pay the maximum level of benefits when you use In-Network Providers. In-Network means that you are receiving care from a Doctor, laboratory, Hospital, etc. that is participating in the Network. You may use Out-of-Network Providers, but benefits are reduced, except in a life-threatening Emergency.

Keep in mind that all benefits are limited to plan maximums and coverage for a particular service is based on how it is billed by the Provider.

NOTE: Deductibles and Out of pocket maximums do not cross accumulate between in and out of network care.

In-Network Benefits

You will pay a Copayment, a flat dollar amount, for certain Physician and other professional services received from In-Network Providers (without having to first meet the Calendar Year Deductible). Then for all other services you must first satisfy a Calendar Year Deductible before In-Network Benefits begin. When the Deductibles for all family members combined reach the family Deductible for In-Network care, the Deductible for In-Network care will be considered satisfied for all family members that Calendar Year. However, in reaching the family Deductible, no one person can contribute more than one individual Deductible. There is a separate Deductible for each In-Network Hospital admission. For most other in-network services, like hospitalization, the plan pays 80% of covered charges in the 80/60 PPO Option or 90% of covered charges in the 90/70 PPO Option, and you pay the rest. When the amount of Covered Expenses you pay reaches the Out-of-Pocket Maximum for In-Network care in a Calendar Year (not including the Deductible, Copayments or amounts exceeding Reasonable and Customary Charges), the plan pays 100% of the covered In-Network charges for the rest of the Calendar Year. (See the PPO Options Summary of Benefits on pages 59 - 61.

The separate Deductible for each In-Network Hospital admission applies to the mother and each Newborn.

Note: Under the PPO Options, the Hospital Inpatient Deductible per admission, whether an In-Network or Out-of-Network Hospital, will be waived if a person is released from the Hospital and readmitted for the same or related condition within 14 consecutive calendar days.

When you use In-Network Providers, you will not have to file Claim forms, your Doctor takes care of Hospital Precertification, and Reasonable and Customary Charge coverage limits do not apply. Your Doctor is just acting on your behalf, however. Your benefits and rights under the plan are not assignable to the Doctor or to any other Provider. The rights and benefits of you and your eligible Dependents under this plan are not subject to the Claim of your creditors and cannot be voluntarily or involuntarily assigned, sold, or transferred to anyone else. Employees and their eligible Dependents are the only “participants” and “beneficiaries” of this plan, as defined under the provisions of the Employee Retirement Income Security Act of 1974.

It is the Retiree Medical Plan’s intention, under certain circumstances, to provide benefits above the PPO Options’ In-Network Benefit limit for the following benefits:

- Skilled Nursing Facility
- Outpatient Short-Term Rehabilitation.

In this respect, the Plan Administrator reserves the right to waive the PPO Options’ In-Network Benefit limits on the above listed benefits in order to provide alternatives to an acute care setting when all of the following criteria are met:

- the service or treatment is Medically Necessary and the Claims Administrator approves the service or treatment

- there is a potential improvement in quality of life due to care being provided outside of the Hospital
- the person's Physician recommends the services or treatment
- the person agrees to the service or treatment
- if the waiver of the benefit limit is not granted, the person must return to the Hospital
- there is a cost savings to the Medical Plan for waiving the limit.

The determination of waiving these plan limits is made by the Claims Administrator on the criteria listed above.

If You are in the Middle of a Course of Medical Treatment

If you are in the middle of a course of medical treatment with an Out-of Network Doctor it may be possible for you to continue using that provider for a limited time, but receive certain In-Network Benefits for that provider's services. Depending on the Network option you choose, you may be eligible for transition benefits if you are:

- In the second or third trimester of pregnancy (or at any point in a high-risk pregnancy),
- Receiving a course of chemotherapy or radiation for cancer,
- Undergoing dialysis for end-stage renal disease (ESRD),
- Recovering from a transplant operation or
- Terminally Ill.

If you are in counseling treatment with an Out-of Network mental health Specialist, you may also be able to continue treatment for a limited period of time.

The Medical Plan Claim Administrators determine transition benefit eligibility on a case-by-case basis. If you believe you may qualify for transition benefits, contact Member Services for the Medical Plan Network option you chose.

These are the circumstances under which transition benefits may be appropriate, but only if the criteria described above applies at the time of such circumstances. Those circumstances are:

- When you enroll as a new participant in the Retiree Medical Plan,
- When you change your Retiree Medical Plan selection from one option (e.g., PPO, Comprehensive) to another, or
- When your participating Provider leaves the Network.

Out-of-Network Benefits

Under PPO Options, you may use Out-of-Network Providers any time you need health care, but benefits are reduced. With the PPO Options, you must first satisfy a Calendar Year Deductible before Out-of-Network Benefit payments begin. When the Deductibles for all

family members combined reach the family Deductible for Out-of-Network care, the Deductible for Out-of-Network care will be considered satisfied for all family members that Calendar Year. However, in reaching the family Deductible, no one person can contribute more than their individual Deductible. There is a separate Hospital Admission Deductible for each Out-of-Network Hospital admission under the PPO Options.

... you may use Out-of-Network Providers any time you need health care, but benefits are reduced. You will have to pay an annual Deductible for most Covered Expenses before benefit payments begin.

Then the plan pays a percentage of the cost, and you pay the rest. When the amount of Covered Expenses you pay out of your own pocket reaches the "Out-of-Pocket Maximum" for Out-of-Network care in a Calendar Year (not including certain expenses like the Deductible, any Copayments and any charges in excess of the Reasonable and Customary Charges), the plan pays 100% of the covered Out-of-Network charges for the rest of that Calendar Year. The Out-of-Network Out-of-Pocket Maximum is shown in the "Summary of Health Benefits." (See pages 55 - 58)

When you use Out-of-Network Providers, you will have to file a Claim to be reimbursed for plan benefits. Refer to "SECTION TWO – ADMINISTRATIVE INFORMATION," under "Filing Claims" for information about how and where to file Claims.
Note that the separate Deductible for each Out-of-Network Hospital admission applies to the mother and each Newborn.

Important Note: Out-of-Network Benefits are limited to Reasonable and Customary Charges. You will have to pay any charges above those considered Reasonable and Customary Charges. These additional charges do not count toward the Out-of-Pocket Maximum.

A Note About the Out-of-Pocket Maximum

When the amount you have paid in a Calendar Year reaches the Out-of-Pocket Maximum, the plan will pay 100% of the cost for Covered Expenses for the rest of that Calendar Year. Out of Pocket Maximums do not cross accumulate between In-Network and Out-of-Network care. This means when you meet the Out of Pocket Maximum for In-Network care the plan will pay 100% of the cost for future In-Network Covered Expenses for the rest of that Calendar Year. However, if you have not met the separate Out of Pocket Maximum for Out-of-Network care the plan will not pay 100% for Out-of-Network care until a separate Out of Pocket Maximum is met.

The following expenses do not count toward the Out-of-Pocket Maximum:

- charges for mental health and substance abuse treatment
- charges in excess of Reasonable and Customary Charges
- charges above plan maximums
- charges applied to the Deductibles

- expenses incurred under the plan's Prescription Drug Program
- Copayments

Emergencies

An Emergency is a sudden and serious situation that happens unexpectedly and requires immediate medical attention. Examples include an apparent heart attack, severe bleeding, sudden loss of consciousness, severe or multiple injuries, convulsions, apparent poisoning. If you are enrolled in a PPO Option, contact Member Services if there is any question of whether a condition is considered an Emergency. The contact information is included on your Retiree Medical ID card.

In an Emergency, you should get medical care as quickly as possible. If you are a PPO Option participant, In-Network Benefits may be available even though you may receive treatment from an out-of-network Hospital. To be eligible for In-Network Benefits due to an Emergency, there are specific procedures you must follow. In general, you should contact your In-Network Physician within 48 hours so she or he can coordinate your care. Failure to contact your In-Network Physician within 48 hours will result in benefits payable at the applicable Out-of-Network Benefit level or lower.

To qualify as an Emergency, the care must be provided within 48 hours of an Accidental Injury or the onset of a sudden or serious Illness. Remember, emergency rooms should only be used for Emergencies.

Services rendered in emergency rooms or other non-participating offices or clinics may be subject to review for coverage by the Claims Administrator.

Your Retiree Medical ID Card

Your Retiree Medical ID Card includes your Copayment amount for easy reference when you need care. You will need to show your card when you go to In-Network Providers for care so your Physician will know how much your Copayment is. In addition, there are important telephone numbers printed on the card which you may need for Emergencies and Hospital Precertification. Be sure to keep your Medical ID Card with you at all times to ensure you receive In-Network Benefits.

Your Retiree Medical ID Card includes your Copayment amount for easy reference when you need care. You will need to show your card when you go in-network for care so your Physician will know how much your Copayment is.

Member Services

All the Networks have customer service centers called Member Services. Trained Network representatives are available to answer your questions about your PPO Option. You can call Member Services to:

- learn about Network Providers
- arrange care with Network Providers if you are away from home
- get a new Network Provider Directory
- register comments or complaints about Network Providers or services
- order a Medical ID Card
- check on plan features and procedures
- check on Claims payments and/or denials
- ask questions about your Explanation of Benefits (EOB).

Member Services' telephone numbers are listed on your Retiree Medical ID Card.

Note: You must contact HR Shared Services in order to add or drop a Dependent from coverage or request other such changes that are permitted due to a Status Change. **Do not** contact the Network Manager (e.g., CIGNA) to facilitate these types of requests.

Remember: Benefits are paid under the plan in accordance with the written terms of the plan. Member Services responds to your questions based on the specific information that you provide to them. If you provide incomplete or inaccurate information, Member Services' response to you, being based on your incomplete or inaccurate information, will also be inaccurate or incomplete. If clerical errors or other mistakes occur, those errors do not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverages.

While Member Services will make every effort to ensure their information provided to you is complete, their response is not exhaustive nor is it the final determinant of benefits. It is your responsibility to confirm the accuracy of Member Services statements, in accordance with the terms of this SPD and other Retiree Medical Plan documents. You are responsible for reading the written plan provisions and asking questions about these plan provisions.

The final determinant of benefits is the governing plan documentation contained in this SPD and the other written documents described in this document as setting the provisions and standards of the Plan. The Plan Administrator (or its delegate) has the discretionary authority to administer and interpret the Retiree Medical Plan.

PPO Options Summary of Medical Benefits				
	80/60 PPO		90/70 PPO	
Benefit Description	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Calendar Year Deductible[8]				
▪ Individual	▪ $400	▪ $600	▪ $300	▪ $500
▪ Family	▪ $1,200	▪ $1,800	▪ $750	▪ $1,500
Separate Deductible Per Hospital Admission (precertification required)[2]	▪ $350	▪ $500	▪ $350	▪ $500
Outpatient Surgery Copayment (precertification required)	• $250	• $500	• $250	• $500
Calendar Year Out-of-Pocket Maximum[8]				
▪ Individual	▪ $3,500	▪ $7,500	▪ $3,500	▪ $7,500
▪ Family	▪ $7,000	▪ $15,000	▪ $7,000	▪ $15,000
Lifetime Maximum Per Person	Unlimited	$2,000,000[4,10]	Unlimited	$2,000,000[4,10]
Physician Services				
Doctor's Office Visits				
• Primary Care	$25 Copay	60%[1,5]	$25 Copay	70%[1,5]
• Specialty Care	$30 Copay	60%[1,5]	$25 Copay	70%[1,5]
Pre-natal Visits	$30 Copayment (for first visit only)	60%[1,5]	$30 Copayment (for first visit only excludes x-rays and labs)	70%[1,5]
Outpatient Surgeon's Fees	80%[2,5]	60%[2,3,5]	90%[2,5]	70%[2,3,5]
Inpatient Surgeon's Fees (precertification required)	80%[2,3,5]	60%[1,2,3,5]	90%[2,3,5]	70%[1,2,3,5]
Specialty Physician Services				
Allergy testing and treatment	$30 Copayment[11]	60%[1,5]	$30 Copayment[11]	70%[1,5]
Second surgical opinion				
Inpatient Hospital Services				
(precertification required)	80%[2,3,5]	60%[1,2,3,5]	90%[2,3,5]	70%[1,2,3,5]
Semi-Private Room & Board				
Operating & Recovery Room				
Anesthetic Services and Ancilla Services				
Lab & X-Ray				

Drugs, Medications
Hemodialysis

Benefit Description	80/60 PPO		90/70 PPO	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Inpatient Hospital Services				
Radiation & Chemotherapy Rehab Services Intensive Care Preadmission Testing Well-Newborn Care Other Eligible Hospital Charges	80%[2,3,5]	60%[1,2,3,5]	90%[2,3,5]	70%[1,2,3,5]
Outpatient Hospital Services				
Operating & Recovery Room	80%[2,5]	60%[1,2,3,5]	90%[2,5]	70%[1,2,3,5]
Presurgical testing	80%[2,5]	60%[1,2,3,5]	90%[2,5]	70%[1,2,3,5]
Anesthesiologist, pathology Interpretations, etc.	80%[2,5]	60%[1,2,3,5]	90%[2,5]	70%[1,2,3,5]
Other Professional Services				
Outpatient Short-Term Rehabilitation (including physical, speech[2], occupational therapy and chiropractic care, up to 90 visits per condition per Calendar Year)	$30 Copayment[4,6]	60%[1,5,6]	$30 Copayment[4,6]	70%[1,5,6]
Private Duty Nursing	80%[4,6]	60%[1,4,5] up to $10,000 per person per Calendar Year	90%[4,6]	70%[1,4,5] up to $10,000 per person per Calendar Year
Preventive Care				
Well-baby Care (up to age 6)	No Copayment	60%[1,5]	No Copayment	70%[1,5]
Child's Physical Exam (age 6 and over)	No Copayment	60%[1,5]	No Copayment	70%[1,5]
Adult Physical Exam	No Copayment	60%[1,5]	No Copayment	70%[1,5]
Routine OB/GYN Exam (includes routine mammogram)	$No Copayment	60%[1,5]	No Copayment	70%[1,5]
Hospital Services				
Inpatient Treatment	80% after per hospital admission	60% after per hospital admission	90% after per hospital admission	70% after per hospital admission

	Deductible[2,3,5]	Deductible[1,2,3,5]	Deductible[2,3,5]	Deductible[1,2,3,5]
Outpatient Treatment	80%[2,3,5]	60%[1,2,3,5]	90%[2,3,5]	70%[1,2,3,5]

Benefit Description	80/60 PPO		90/70 PPO	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Emergency Room	80% after $100 Copayment (waived if admitted)	60% [1,5,9,13] after$100 Copayment (waived if admitted)	90% after $100 Copayment (waived if admitted)	70%[1,5,9,13] after $100 Copayment (waived if admitted)
Emergency Care-Ambulance	80%[5]	60%[1,5]	90%[5]	70%[1,5]
Skilled Nursing Facility (up to 60 days per Calendar Year)	80%[2,3,5,6]	60%[1,2,3,5,6]	90%[2,3,5,6]	70%[1,2,3,5,6]
Hospice	80%[5]	60%[1,5]	90%[5]	70%[1,5]
Other Medical Services				
Assisted Reproduction (up to $5,000 lifetime maximum per person)	80%[5,7]	60%[1,5,7]	90%[5,7]	70%[1,5,7]
Infertility diagnosis and treatment	80%[5]	60%[1,5]	90%[5]	70%[1,5]
Home Health Care	80%[4,5]	60%[1,4,5] up to 100 visits per Calendar Year	90%[4,5]	70%[1,4,5] up to 100 visits per Calendar Year
Diagnostic X-ray and Lab	80%[5] (must use network labs)	60%[1,5]	90%[5] (must use network labs)	70%[1,5]
Radiation and Chemotherapy	80%[5]	60%[1,5]	90%[5]	70%[1,5]
Durable Medical Equipment	80%[4,5]	60%[1,4,5] ($2,000 maximum per Calendar Year)	90%[4,5]	70%[1,4,5] ($2,000 maximum per Calendar Year)
External Prosthetic Appliances	80%[1,5]	60%[1,5]	90%[1,5]	70%[1,5]
Dental	For Accidental Injury to		For Accidental Injury to	

	sound, natural teeth		sound, natural teeth	
Precertification	Provider initiated[12]	Patient initiated[2]	Provider initiated[12]	Patient initiated[2]

[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 Precertification of these services as described on your Retiree 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.
[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]Deductibles and Out of pocket maximum do not cross accumulate between in and out of network care.

[9]Note concerning Emergency Room: In-Network Benefits are available for Emergency Room charges only for medical emergencies. If the Emergency Room is used for a condition that is not a medical Emergency, out-of-network benefits apply. A medical Emergency is generally defined as an illness or injury of such a nature that failure to get immediate medical care could put a person's life in danger or cause serious harm to bodily functions. Some examples of a medical Emergency are apparent heart attack, severe bleeding and sudden loss of consciousness.
[10]Benefits incurred as an active employee are included in the $2 million limit, excluding behavioral health and prescription drug benefits.
[11]In-network allergy injections when billed independently without an office visit are not subject to the office visit Copayment
[12]TheEmployee is responsible for ensuring that the admitting Doctor completes the Precertification process.
[13]In-network benefits are available for emergency room charges only for medical emergencies. If the emergency room is used for a condition that is not a medical emergency, out-of-network benefits apply. A "medical emergency" is generally defined as an illness or injury of such a nature that failure to get immediate medical care could put a person's life in danger or cause serious harm to bodily functions. Some examples of a medical emergency are apparent heart attack, severe bleeding, sudden loss of consciousness, severe or multiple injuries, convulsions, and apparent poisoning

How the Comprehensive Option Works

See the "Summary of Benefits" for further information on benefit levels for each category of service. The following is an overview of the features of the Comprehensive Option.

Calendar Year Deductible

Before benefits are paid for Covered Expenses, you pay a Calendar Year individual Deductible of $350. When the Deductibles for all `family members combined reaches the Calendar Year family Deductible of $1050, the Deductible will be considered satisfied for all family members that Calendar Year. However, in reaching the family Deductible, no one person can contribute more than their individual Deductible of $350.

Coinsurance

Coinsurance is the portion of Covered Expenses paid by the Retiree Medical Plan after you pay your Deductible or Copayment.

Reimbursement Level

After you satisfy the Deductible, the Comprehensive Option generally pays 80% of Reasonable and Customary Charges for most Covered Expenses.

Out-of-Pocket Maximum

When the amount you have paid in a Calendar Year reaches the Out-of-Pocket Maximum, the plan will pay 100% of the cost for Covered Expenses for the rest of that Calendar Year.

The following expenses do not count toward the Out-of-Pocket Maximum:

- charges for mental health and substance abuse treatment
- charges in excess of the Reasonable and Customary Charge
- charges above plan maximum amounts
- charges applied to the Deductible
- any expenses you incur under the plan's Prescription Drug Program

Before benefit payments begin, you will pay an annual Deductible. After you satisfy the Deductible, the Comprehensive Option pays 80% of Reasonable and Customary Charges for most Covered Expenses.

When the amount you have paid in a Calendar Year reaches the Out-of-Pocket Maximum, the plan will pay 100% of the cost for Covered Expenses for the rest of that Calendar Year.

Passive PPO

The Comprehensive Option includes a "passive PPO network" feature for retirees less than age 65. The passive PPO feature means that if you seek treatment from a CIGNA network provider, you will receive the benefit of their discounted fee. The passive PPO *does not* have in-network and out-of-network benefit levels. This feature does not affect the services covered and the benefit level. With the passive PPO network discounts, however, your out-of-pocket costs should be lower if you obtain care from an in-network provider.

Common Accident Exception

When two or more covered persons in a family are injured in the same Accident, Covered Expenses for those Injuries will be combined to meet one Deductible for all such covered persons for that Calendar Year. This exception applies only to determine benefits for those Injuries. Any amount payable solely because of this exception will not count against the Lifetime Maximum benefit.

Precertification

You must call CIGNA at 1-800-257-2702 to get Precertification for all Hospital Inpatient Stays, Skilled Nursing Facility admissions and certain other services (see table, this page and the following two pages).

Filing Medical Claims

You must submit a written Claim along with the original bills or receipts for services to the Claims Administrator to receive benefits under the plan.

Refer to "SECTION TWO – ADMINISTRATIVE INFORMATION," under "Filing Claims" for information about how and where to file Claims.

Comprehensive Option
Summary of Medical Benefits

Benefit Description	Benefit Level
Calendar Year Deductible (Individual/Family)	$350/$1,050
Calendar Year Out-of-Pocket Maximum (Individual/Family)	$3,500/$7,000 (plus Deductible)
Hospital Inpatient Stay Copayment (precertification required	$300
Lifetime Medical Maximum	$2,000,000[7]
Inpatient Hospital Services: • Semi-private Room & Board • Operating & Recovery Room • Intensive Care; Lab & X-Ray • Drugs, Medications; Pre-admission Testing • Hemodialysis; Radiation & Chemotherapy • Rehab Services; Well-Newborn Care • Other Eligible Hospital Charges	80% Coinsurance[1,2,3,4]
Inpatient Physician Services	80% Coinsurance[2,3,4]
Inpatient Surgeon's Services	80% Coinsurance[2,3,4]
Physician Services: • Preventive Care • Well-Child Care • Routine Immunization & Injections • Annual OB/GYN Exam	100% Coinsurance[2,5]
Physician Services: • Adult Medical Care • Child Medical Care	80% Coinsurance[2,4]
Specialty Physician Services: • Office Visits • Second Surgical Opinion • Pre- and Post-Natal Exam • Allergy Testing & Treatment	80% Coinsurance[2,4]
Outpatient Surgical Charges: • Operating & Recovery Room • Presurgical Testing	80% Coinsurance[2,3,4]

Comprehensive Option
Summary of Medical Benefits

Benefit Description	Benefit Level
Outpatient Treatments • Hemodialysis • Radiation & Chemotherapy	80% Coinsurance[2,4]
Outpatient Services: (includes anesthesiologist, pathology interpretations, etc.)	80% Coinsurance[2,3,4]
Outpatient Surgeon's Services	80% Coinsurance[2,3,4]
Outpatient X-Ray & Lab	80% Coinsurance[2,4]
Emergency Care: • Doctor's Office	80% Coinsurance[2,4]
Emergency Care: • Hospital Emergency Room • Accident or Illness	80% Coinsurance[2,4]
Emergency Care: • Ambulance	80% Coinsurance[2,4]
Outpatient Short-Term Rehabilitation (including physical, speech[1], occupational therapy and chiropractic care, up to 90 visits per condition per Calendar Year)	80% Coinsurance[2,4]
Private Duty Professional Nursing	80% Coinsurance up to $10,000 per patient per Calendar Year[2,4]
Home Health Care	80% Coinsurance to a $50 maximum per visit[2,4]
Skilled Nursing Facility	80% Coinsurance[1,2,4] (Semi-private room, limited to 60 days per Calendar Year)
Durable Medical Equipment	80% Coinsurance, $2,000 maximum per Calendar Year[2,4]
External Prosthetic Appliances	80% Coinsurance[2,4]
Assisted Reproduction (up to $5,000 lifetime maximum per person)	80% Coinsurance[2,4,6]
Infertility diagnosis and treatment	80% Coinsurance[2,4]
Chiropractic Services	80% Coinsurance[2,4]
Dental Emergency Surgery	For Accidental Injury to sound, natural teeth
Precertification	Patient initiated[3]

1 Subject to Precertification.
2 Subject to Reasonable and Customary Charges (R&C).

3 *Whenever a covered person faces confinement in a Hospital or needs non-emergency surgery, follow the directions for Hospital Precertification of these services 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.*

4 *Subject to Calendar Year Deductible.*

5 *100% of R&C for the following: well-child care up to age 6, Pap smear every year, immunization for tetanus-diphtheria every ten years, mammograms according to AMA recommendations, sigmoidoscopy every three years for covered persons age 45 and over. $300 per Calendar Year for preventive care for children 6 yrs of age and older and adults (not subject to the Deductible).*

6 *The Medical Plan pays up to a $5,000 lifetime maximum per participant for assisted reproduction services (e.g., impregnation or fertilization).*

7 *Benefits incurred as an active employee are included in the $2 million limit, excluding mental health and substance abuse treatment and prescription drug benefits.*

How the Indemnity Option works

See the "Summary of Medical Benefits" for further information on benefit levels. The following is an overview of the features of the Indemnity Option:

The Indemnity Option is comprised of two parts. The first part is the Basic Medical Expense coverage that pays first and covers 100% of the Covered Expenses (subject to the limitation described on the pages that follow). The second part is the Major Medical Expense coverage that provides benefits for any Covered Expenses not eligible under the Basic Medical Expense coverage, in addition to any Covered Expenses that exceed the Basic Medical Expense coverage maximums.

To the extent that there is coverage for a particular service under both the Basic and Major Medical Expense coverage, Major Medical Expense coverage would begin only after the maximums for the particular coverage under the Basic Medical coverage are exhausted.

Basic Medical Expense Coverage

Basic Medical consists of Hospital Expense Coverage, Surgical Expense Coverage, Hospital Medical Expense Coverage, Diagnostic X-Ray and Laboratory Expense Coverage, Accident Expense Coverage, Home Health Care Expense Coverage, Skilled Nursing Facility, Preventive Services Expense Coverage and Hospice Care Coverage.

Hospital Expense Coverage

Under the Indemnity Option, the Basic Medical provision provides coverage at 100% without a Deductible, as long as the hospitalization is precertified, for Inpatient Hospital expenses, Inpatient and outpatient surgical expenses, and Inpatient and Surgery-related outpatient diagnostic X-ray and laboratory exams. Surgeon's expenses are subject to Reasonable and Customary limits.
Note: Precertification is not required for certain lengths of stay for childbirth. See Maternity and Newborn Coverage, page 40.

Covered Hospital Expenses

This coverage pays benefits for Covered Expenses incurred for a Hospital stay. Benefit maximums apply to any one period of a person's Hospital stay.

Inpatient Hospital benefits will be paid at 100% for a maximum of 365 days under the Basic Medical provision. After exhaustion of benefits under the Basic Medical provision, the Major Medical provisions take effect and provide 80% coverage thereafter.

The benefit for each day is the amount of the Covered Expenses for room and board for that day, but not more than the Hospital's Semi-private Rate.

"Semi-private Rate" means the Hospital's standard semi-private room daily rate. If the Hospital has no semi-private rooms, the Semi-private Rate is 90% of its lowest private room daily rate.

One period of Hospital stays consists of all related Hospital stays. Separate Hospital stays of a person starting while the person is covered are considered related if the confinement is separated by less than three months **or** the confinement results from related causes.

Covered Surgical Expenses

A charge is a Covered Expense if it is made by a Doctor for a service in connection with a surgical procedure performed. The service must be included in the following list to be covered:

- the immediate pre-operative exam by the Doctor who performs the surgical procedure
- the performance of the surgical procedure by a Doctor
- aid by a Doctor in the performance of the surgical procedure, if such aid is required by the nature of the surgical procedure or the person's condition or required by the relevant Hospital in which the surgical procedure is performed
- the post-operative care that is required by and directly related to the surgical procedure and is given by a Doctor
- the closed or open reduction of fractures or dislocation of the jaw.

Accident Expense Coverage

The Indemnity Option provides coverage for medical care of your or your Dependent's Accidental Injuries that are not otherwise covered under Basic Medical. If the service is covered by another coverage under Basic Medical (regardless of the Covered Expense), it will not be covered under Accident Expense Coverage. However, Accident Expense Coverage (which has no Deductible) would pay prior to coverage under Major Medical (which generally has a Deductible).

Accident benefits are limited to $300. For all Injuries that result from one Accident, the amount payable is the amount of Covered Expenses for those Injuries, but not more than $300.

A charge is a Covered Expense under the Accident Expense Coverage if made for the medical care of an Accidental Injury. The service or supply must be ordered by a Doctor and must be furnished within 90 days after the Accident. Covered Expenses are:

- services and supplies, including room and board, furnished by a Hospital for medical care in that Hospital
- Doctor's services for surgery and for other medical care
- X-ray exams and laboratory exams
- private duty professional nursing by a registered graduate nurse
- casts, splints, trusses, braces, crutches, artificial limbs and artificial eyes
- surgical dressings
- Ambulance use for local travel to the nearest facility that can provide the appropriate services
- treatment of Accidental Injury to natural teeth when the charges are for Doctors' services or x-ray exams ("treatment" includes replacement/restoration of those teeth)
- rental of wheelchairs, Hospital type beds and artificial respirators

Please refer to the section entitled "What is Not Covered" for a list of services and supplies not covered by this benefit.

Major Medical Expense Coverage

Major Medical pays benefits for many of the charges incurred for care and treatment of Illnesses and Injuries. There is a Deductible that applies to all Covered Expenses. The amount payable, once the Deductible is satisfied, is the Covered Percent for the particular charge. This is generally 80% of Reasonable and Customary Charges, subject to benefit maximums, as well as the $1,000,000 lifetime medical maximum. If a charge is covered by both Basic and Major Medical coverage, benefits under Basic Medical will be exhausted prior to coverage under Major Medical.

Major Medical also includes the following special provisions for charges incurred for:

- Home Health Care (after exhaustion of Basic Medical Expense coverage, covered at 80% and a $50 per visit maximum, unlimited visits)
- a Skilled Nursing Facility stay (after exhaustion of Basic Medical Expense coverage, covered at 80%, unlimited visits)
- Hospice Care (after exhaustion of Basic Medical Expense coverage, covered at 80%; unlimited Hospice care coverage)

Calendar Year Deductible

Before benefits are paid for other Covered Expenses, you pay a Calendar Year individual Deductible of $200. When the Deductibles for all family members combined reaches the Calendar Year family Deductible of $400, the Deductible will be considered satisfied for all family members that Plan Year. However, in reaching the family Deductible, no one person can contribute more than their individual Deductible of $200.

Coinsurance

Coinsurance is the portion of Covered Expenses paid by your Retiree Medical Plan after you pay your Deductible or Copayment.

Reimbursement Level

After you satisfy the Deductible and any applicable Copayments, the Indemnity Option pays either 100% or 80% (depending on the services rendered) of Reasonable and Customary Charges for most Covered Expenses.

Out-of-Pocket Maximum

When the amount you have paid in a Calendar Year reaches the Out-of-Pocket Maximum, the plan will pay 100% of the cost for Covered Expenses for the rest of that Calendar Year.

The following expenses do not count toward the Out-of-Pocket Maximum:

- charges for mental health and substance abuse treatment
- charges in excess of the Reasonable and Customary Charge
- charges above plan maximum amounts
- charges applied to the Deductible
- expenses you incur under the plan's Prescription Drug Program

Before certain benefit payments begin, you will pay an annual Deductible. After you satisfy the Deductible, the Indemnity Option pays 80% of Reasonable and Customary Charges for many Covered Expenses.

When the amount you have paid in a Calendar Year reaches the Out-of-Pocket Maximum, the plan will pay 100% of the cost for Covered Expenses for the rest of that Calendar Year.

Passive PPO

The Indemnity Option includes a "passive PPO network" feature for retirees less than age 65. The passive PPO feature means that if you seek treatment from a CIGNA network provider, you will receive the benefit of their discounted fee. The passive PPO *does not* have in-network and out-of-network benefit levels. This feature does not affect the services covered and the benefit level. With the passive PPO network discounts, however, your out-of-pocket costs should be lower if you obtain care from an in-network provider.

Common Accident Exception

When two or more covered persons in a family are injured in the same Accident, Covered Expenses for those Injuries will be combined to meet one Deductible for all such covered persons for that year. This exception applies only to determine benefits for those Injuries. Any amount payable solely because of this exception will not count against the lifetime maximum benefit.

Precertification

You must call CIGNA at 1-800-257-2702 to get Precertification for all Hospital Inpatient Stays, Skilled Nursing Facility admissions and certain other services (see table, this page and the following two pages).

Filing Medical Claims

You must submit a written Claim along with the original bills or receipts for services to the Claims Administrator to receive benefits under the plan.

Refer to "SECTION TWO – ADMINISTRATIVE INFORMATION," under "Filing Claims" for information about how and where to file Claims.

Indemnity Option
Summary of Medical Benefits

Benefit Description	Benefit Level
Calendar Year Deductible	$200/$400
Calendar Year Out-of-Pocket Maximum	$1,500/$3,000 (plus Deductible)
Lifetime Medical Maximum	$2,000,000[7]
Inpatient Hospital Services: • Semi-private Room & Board • Operating & Recovery Room • Intensive Care; Lab & X-Ray • Drugs, Medications; Pre-admission Testing • Hemodialysis; Radiation & Chemotherapy • Rehab Services; Well-Newborn Care • Other Eligible Hospital Charges	100% Coinsurance[1,3]
Inpatient Physician Services	100% Coinsurance[3]
Inpatient Surgeon's Services	100% Coinsurance[2,3]
Physician Services: • Preventive Care (Children 6 and over and adults) • Well-Child Care (up to age 6) • Routine Immunization & Injections • Annual OB/GYN Exam • Sigmoidoscopy	100% Coinsurance[5]
Physician Services: • Adult Medical Care • Child Medical Care	80% Coinsurance[4]
Specialty Physician Services:	80% Coinsurance[4]

Indemnity Option
Summary of Medical Benefits

Benefit Description	Benefit Level
• Office Visits • Second Surgical Opinion • Pre- and Post-Natal Exam • Allergy Testing & Treatment	100% Coinsurance 100% Coinsurance 80% Coinsurance[4]
Outpatient Surgical Charges: • Operating & Recovery Room • Presurgical Testing	100% Coinsurance[4]
Outpatient Treatments • Hemodialysis • Radiation & Chemotherapy	80% Coinsurance[4]
Outpatient Services: (includes anesthesiologist, pathology interpretations, etc.)	100% Coinsurance[3]
Outpatient Surgeon's Services	100% Coinsurance[3]
Outpatient X-Ray & Lab	80% Coinsurance[4]
Emergency Care: • Doctor's Office	80% Coinsurance[4]

Emergency Care:
• Hospital Emergency Room
  • Accident
  • Illness
	
	• 100% Coinsurance if treatment rendered within 48 hours
	• 80% Coinsurance after $25 Copay[4]

Emergency Care: • Ambulance	100% Coinsurance if hospital Ambulance, otherwise $25 base benefit; remainder at 80% Coinsurance[4]
Outpatient Short-Term Rehabilitation (including physical, speech[1], occupational therapy and chiropractic care, no visit maximum)	80% Coinsurance[4]
Private Duty Professional Nursing	80% Coinsurance up to $10,000 per patient per plan year[4]
Home Health Care	Basic medical: 100% Coinsurance limited to 100 visits per plan year to a maximum of $50 per visit Major medical: 80%, unlimited visits, maximum $50 per visit[2, 4]
Skilled Nursing Facility	Basic medical: 100% Coinsurance limited to

	365 days per confinement[1] Major medical: 80%, unlimited days[2, 4]
Durable Medical Equipment	80% Coinsurance [4]
External Prosthetic Appliances	80% Coinsurance [4]
Assisted Reproduction (up to $5,000 lifetime maximum per person)	80% Coinsurance[2,4,6]
Infertility diagnosis and treatment	80% Coinsurance[2,4,6]
Chiropractic Services	80% Coinsurance[4]
Dental Emergency Surgery	For Accidental Injury to sound, natural teeth
Precertification	Patient-initiated[3]

1 *Subject to Precertification.*
2 *Subject to Reasonable and Customary Charges (R&C).*
3 *Whenever a covered person faces confinement in a Hospital or needs non-emergency surgery, follow the directions for Hospital Precertification of these services 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.*
4 *Subject to Calendar Year Deductible.*
5 *100% of R&C for the following: well-child care up to age 6, Pap smear every year, immunization for tetanus-diphtheria every 10 years, mammograms according to AMA recommendations, sigmoidoscopy every 3 years for covered persons age 45 and over. $200 per 24 consecutive months for preventive care, including immunizations, for Children 6 yrs of age and older and adults (100% of R&C, up to $200 maximum, not subject to the Deductible).*
6 *The medical plan pays up to a $5,000 lifetime maximum per participant for assisted reproduction services (e.g., impregnation or fertilization).*
7 *Benefits incurred as an active employee are included in the $2 million limit, excluding mental health and substance abuse treatment and prescription drug benefits.*

When Coverage Ends

For You

Retiree Medical Plan coverage will end on the last day of the month in which one of the following occurs:

- the date you stop qualifying for coverage,
- the date the Retiree Medical Plan is terminated,
- the date you fail to pay any required contribution

For Your Dependents (or Domestic Partner)

Retiree Medical Plan coverage for your Dependents (or Domestic Partner) will end on the last day of the month in which the following occurs:

- the date you stop qualifying for coverage or your covered Dependent (or Domestic Partner) stops qualifying for coverage, or
- the date the part of the Plan providing the coverage ends, or
- the date you fail to pay any required contribution

Extension of Health Care Protection

The following applies to all coverages other than the Hospice Care Program.

Your protection under the Retiree Medical Plan may be extended after the date you cease to be covered under the Plan. Coverage will be extended if, on the date you cease to be covered, you are Totally Disabled from a Sickness or Injury and are under a Doctor's care. The extension covers any Sickness or Injury that results in Total Disability. However, the extension applies only to those expenses incurred in connection with the Illness or Injury that caused the Total Disability. Coverage will be extended for the time you remain Totally Disabled from that Sickness or Injury and under a Doctor's care.

The following applies to Hospice Care Program coverage:

If you or a covered Dependent is Totally Disabled and under a Doctor's care on the date coverage under the Plan terminates, Hospice Care coverage during that Total Disability will be extended up to three (3) months if coverage terminated because:

- the Plan was terminated
  OR
- the Hospice Care Program within the Retiree Medical Plan was terminated for all Retired Employees of the Company or for a group of Retired Employees of which the person is a member.

If such coverage terminates for any other reason, Hospice Care Program coverage during that Total Disability will be extended for up to twelve (12) months.

Extended Hospice Care Program coverage will cease immediately when you or your covered Dependent becomes covered under any other group plan.

COBRA

You and your covered Dependents may have the option to temporarily extend your health care coverages at full group rates, plus a 2% administration fee, in certain instances when coverage under the Nortel Networks FLEX Benefits program or Retiree Medical Plan would otherwise end.

This is called COBRA coverage. COBRA refers to the Consolidated Omnibus Budget Reconciliation Act of 1985. To be eligible for COBRA coverage continuation you must first be enrolled in the health plan the day before you become ineligible for the respective plan.

BEFORE YOU RETIRE OR LEAVE ACTIVE SERVICE

At the time of your Retirement, if you and your Dependents are members of the FLEX Benefits Program, you and those covered Dependents will have the option of selecting COBRA coverage continuation for Medical, EAP, Dental/Vision/ Hearing Care Plans and the

Health Care Reimbursement Account. For complete information regarding COBRA coverage continuation, see the Summary Plan Description(s) in the Benefits folder on Services@Work for the plan(s) for the plans that you may wish to continue coverage.

Note: If you or your covered Dependents elect COBRA medical coverage, eligibility for the Nortel Networks Retiree Medical Plan is forfeited.

If, on the other hand, you waive COBRA medical coverage continuation at the time of your Retirement from Nortel Networks and enroll in the Retiree Medical Plan, under some circumstances, your covered Dependents may continue coverage under the Retiree Medical Plan through COBRA provisions. See the section below.

FOR RETIREE MEDICAL PLAN MEMBERS

COBRA Qualifying Events for Retiree Medical Plan Members

If one of the qualifying events listed in the COBRA Continuation Period chart on the following page causes one or more of your covered Dependent(s) to lose Retiree Medical Plan coverage, they may continue coverage in this plan as described in the chart.

Circumstances	YOU	SPOUSE/ DOMESTIC PARTNER	CHILD(REN)
You and your spouse are divorced	N/A	36 months	36 months
Your or your spouse's/Domestic Partner's covered child no longer qualifies as a Dependent	N/A	N/A	36 months

NOTIFICATION

The COBRA Administrator, COBRAServ, will notify you or your Dependents by mail of your COBRA election rights when the qualifying event is termination of employment or Retirement. You will receive instructions on how to continue your health care benefits under COBRA.

If you and your eligible Dependents are covered through the Retiree Medical Plan and a covered Dependent loses coverage due to divorce or loss of Dependent status, you (or a family member) must notify HR Shared Services within 60 days of the event so that COBRA can be offered and their election rights can be mailed to them.

ELECTION

It is the responsibility of you, your spouse, your Domestic Partner, or your Dependent Children to contact HR Shared Services within 60 days of the event to elect continued participation under COBRA. You or your eligible Dependent will have an additional 45-day period (after the 60-day election period) to pay any premiums missed.

If HR Shared Services is not notified within 60 days of the qualifying event, eligibility to elect COBRA is forfeited.

If COBRA continuation coverage is elected:

- The level of coverage must be appropriate to the individuals covered (single coverage or family coverage if a parent and child will be participating).
- Coverage will be effective as of the date of the qualifying event.

COBRA participants are held to similar guidelines concerning their Retiree Medical coverage elections as Retiree Medical Plan participants. Changes in the Retiree Medical Plan Option elected can only be made during the Annual Enrollment Period that typically occurs in the summer. Changes in participants (e.g., dropping a Dependent) can be made under the usual plan rules (see Status Changes, page 11).

COST OF PARTICIPATION

COBRA participants must pay the full monthly premiums for their coverage:

- For Retiree Medical coverage, premiums are based on a group rate per covered person set at the beginning of the Coverage Year, plus 2% to cover administrative costs.
- Regular monthly premiums are due to the COBRA Administrator (COBRAServ) by the first day of each month.

WHEN COBRA ENDS

COBRA coverage will end before the maximum continuation period if:

- a person who was covered under COBRA becomes covered under another group health plan not offered by the Employer (providing the plan does not have Preexisting Condition limitations affecting the covered person). COBRA coverage will end if the Preexisting Condition limitation does not apply, or will end as of the date when that limitation expires. The covered person is entitled to receive credit equal to the period of his/her COBRA coverage against the new plan's Preexisting Condition limitation period, so long as the new coverage begins without a break in coverage of 63 days or longer.
- a person covered under COBRA becomes entitled to Medicare. Other covered Dependents who are not entitled to Medicare can continue coverage under COBRA until the maximum continuation period is reached.

- a person covered under COBRA meets the Preexisting Condition exclusions under a new Employer's plan.
- any required premium for continued coverage is not paid within 30 days after it is due. (Payments are due on the first day of each month.)
- the Employer ceases to provide benefits to all active employees or Retirees, whichever is applicable.

SPECIAL NOTE REGARDING HEALTH CARE REIMBURSEMENT ACCOUNTS FOR EMPLOYEES WHO HAVE NOT YET LEFT ACTIVE SERVICE

If you retire or terminate employment with the Company, you may be able to continue to participate in the Health Care Reimbursement Account through COBRA coverage continuation on an after-tax basis if the remaining benefit available, as of the date of the qualifying event, exceeds the maximum COBRA premium that could be charged for the balance of the plan year. In this situation, continuation of the Health Care Reimbursement Account is allowed only the remainder of the year of the qualifying event and not for subsequent years.

If you do not elect COBRA, you can still use any money left in your account to pay eligible health care expenses **incurred before** your employment ends. However, expenses **incurred after** your employment ends cannot be reimbursed and you will forfeit any prior contributions left in your account.

Third Party Liability

Recovery of Benefits if Payable by any Other Party

Medical benefits otherwise payable to you (i.e., the participant Employee or your covered Eligible Dependent) under the Nortel Networks Medical Plan (the "Plan") will be reduced to the extent that payment is made directly or indirectly to you or on your behalf, or to your assignee, by any other party or its insurer. This could occur as the result of the actual or alleged wrongful act or omission of any third party (e.g., an automobile accident) or a payment made or to be paid from your own insurance policy [i.e., uninsured motorist coverage, underinsured motorist coverage, medical payments coverage ("Med Pay"), no-fault coverage, and/or personal injury coverage ("PIP")].

If the Plan provides medical benefits to you, or your covered Eligible Dependent, that are later determined to be the legal responsibility of a third person, company, or insurer, the Plan has a 100%, first priority right to recover these payments from you or your covered Eligible Dependent in full and regardless of whether you have been made whole. This Recovery of Benefits provision also survives to your heirs and/or the heirs of your covered Eligible Dependent.

If you make a claim for medical benefits before you receive payment from any third party or its insurer, or any other insurer, you are considered by the Plan to have agreed that any

recovery you receive from any third party, its insurer, or any other insurer will be used to repay the Plan for its payments on your behalf. The Plan's right to recovery applies whether:

You receive payment due to a legal judgment, an arbitration award, a compromise settlement or any other arrangement;

Any third party, its insurer, or any other insurer admits liability for the payment; or

The expenses the Plan paid are separately identified or otherwise itemized in the payment made to you by the third party, its insurer, or any other insurer.

You should know that an assignment of your claim to any third party does not exempt you from your responsibility for repayment. Any attorney fees or costs incurred by you are not the responsibility of the Plan and are to be paid solely by you.

You Must Give Notice

Within ten days of institution of any legal proceedings on your behalf against any other party or its insurer for recovery of any amount that otherwise would be payable to the Plan under this section, you must notify the Plan of the legal proceedings, including the names of the parties, the name and location of the forum, the status of the case, the names, addresses and phone numbers of all attorneys and the case number. You must also, within 30 days prior to any settlement of any legal proceedings against the other party, its insurer, or any other insurer, notify the Plan of the terms of the proposed settlement.

The Plan's Legal Rights

By accepting payment from the Plan of medical benefits, you are deemed to have agreed that the Plan may take all action necessary or appropriate in the discretion of the Plan Administrator or its delegate to enforce its rights under this section. Such action includes, but is not limited to:

Subrogation: The Plan is subrogated to (stands in the place of) all rights of recovery you or your covered Eligible Dependent have against any third party or insurer for all or any portion of the benefits provided or to be provided by the Plan.

Restitution: In addition, if you or a covered Eligible Dependent receives any payment from any third party or insurer, the Plan has the right to obtain restitution from you, your attorney or any third party, for all amounts the Plan has paid and will pay, up to and including the full amount you receive.

Constructive Trust: The Plan has a right to obtain a legal order that you, your attorney, or anyone acting on your behalf is considered to hold any amount you recover from any third party or insurer for medical benefits provided or to be provided under the Plan in a constructive trust for the benefit of the Plan.

Lien Rights: Further, the Plan will automatically have an equitable lien to the extent of medical benefits paid by the Plan for which any other party is liable.

The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any insurance coverage, for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of medical benefits paid by the Plan including, but not limited to you or your representative or agent; any third party or insurer; and/or any other source possessing funds representing the amount of medical benefits paid by the Plan.

Stay or Other Equitable Relief: The Plan has a right to obtain a stay of any legal proceedings brought by you or your covered Eligible Dependent against any third party and to enjoin you and your assignees from adjudicating the matter. It also may obtain a preliminary or permanent injunction, a declaration of rights, or specific performance against you, your attorney, or any assignee of either of them. Moreover, the Plan has the right to obtain any other appropriate equitable relief to redress any violation of the Plan or enforce the terms of the Plan. The Plan also has the right to obtain such judicial relief against you or any assignee as may be available under state law, including a claim for breach of contract.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any third party or insurer and regardless of whether the settlement or judgment received by you identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to the payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages.

Cooperation

You and your covered Eligible Dependents are prohibited from prejudicing the Plan's subrogation or recovery interest or prejudicing the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude any portion of the cost of any medical benefits provided by the Plan. The Plan has the right to conduct an investigation regarding the injury, illness, or condition for which medical benefits were provided under the Plan to identify any third party or insurer responsible for the payment of all or any portion of those benefits. The Plan reserves the right to notify the third party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Written Agreement to Repay

The Plan may require you to sign a written agreement to repay any amounts received by you in the event you recover such amounts from any third party or its insurer, including establishing a trust or lien on any monies you are to receive.

Failure to Comply

If you fail to timely provide the notice required under this section or refuse to execute any agreement, if requested to do so, no further medical benefits will be paid on your behalf under the Plan until the Plan either recovers all amounts you are required to repay or offsets against your future medical benefits payable under the Plan, any payments made by the Plan that it was unable to recover. In the sole discretion of the Plan Administrator or its delegate, any action by you to frustrate or avoid recovery by the Plan, as required by this section may be grounds for termination of all your benefits under the Plan.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator or its delegate has the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting medical benefits (whether the payment of such medical benefits is made to you or your covered Eligible Dependent or made on your behalf to any provider) from the Plan, you and your covered Eligible Dependent agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such medical benefits, you and your covered Eligible Dependent hereby submit to each such jurisdiction, waiving whatever rights you and your covered Eligible Dependent may have by reason of his or her present or future domicile.

Recovery of Overpayment

If the Medical Plan provides benefits to you or a covered Eligible Dependent that are later determined to be in excess of the covered amounts, the Medical Plan has the right to recover these payments from you. You should know that an assignment of your claim to any third party does not exempt you from your responsibility for repayment of overpayments.

SECTION TWO -

ADMINISTRATIVE INFORMATION

Plan Administration

This section contains information on the administration of Nortel Networks Retiree Medical Plan, contacts you may need in certain situations and your rights as a plan participant.

Please note that certain key words in each section are capitalized. You can find these words in the Glossary section of the Summary Plan Description (SPD).

Plan Year

- For Deductibles and Calendar Year Out-of-Pocket Maximums the Plan Year is January 1 to December 31.
- The period for which selections remain in effect, excluding Status Changes, is January 1 to December 31 (this date is subject to change based on the determined dates for the Annual Enrollment Period).

Plan Administrator and ERISA Claims Fiduciaries

Nortel Networks Inc. is the Plan Administrator. The Plan Administrator has delegated various responsibilities for plan administration to other entities. HR Shared Services provides basic information to Retirees regarding vendors of benefit services and enrollment processes. Some of the Claims Administrators have been contracted to provide administrative services as well as process Claim reimbursements.

The ultimate decision about your eligibility for benefits under the plan is made by the named ERISA "claims fiduciary" that has responsibility for the determination of your Claim. For Claims filed on or after January 1, 2003, certain Claim Administrators have been designated claims fiduciaries.

Each of the Claims fiduciaries has been delegated the exclusive authority by the Plan Administrator to interpret and administer the provisions of the Plan that apply to the Claim under review, including discretionary authority to:

- construe and interpret the terms of the plan,
- determine the validity of charges submitted under the plan, and
- make final, binding determinations concerning the availability of plan benefits.

Please note that determinations made by the claims fiduciary relate solely to whether or not benefits are available under the plan for the proposed treatment or procedure or whether eligibility for plan participation is available under the written terms of the plan. The determination as to whether a health service will be provided to you is between you and your Physician.

The claims fiduciaries for each type of Claim under the Retiree Medical Plan are noted in the list on pages 76 - 77, except for determination of prescription drug benefits under the plan for which the Company is the final claims fiduciary.

The Employee Benefits Committee (EBC) is the final authority to review denied Claims for those benefits for which the Company is the final claims fiduciary. Should you need to contact the Plan Administrator or the Employee Benefits Committee, refer to the following address:

Employee Benefits Committee
c/o Nortel Networks
Mailstop: 570 02 0C3
PO Box 13010
Research Triangle Park, NC 27709-3010

Plan Identifying Information

Plan Type under ERISA: Welfare Plan

Plan Number: 520

Funding Method: Self-funded with contributions held in trust

Contribution Source: the Companies that sponsor the Plan and participating Retirees contribute to the cost of coverage

Companies that Sponsor the Plan: Nortel Networks Inc. (Employer identification number 04-2486332) and certain other related companies sponsor this Plan for their eligible Employees. For a current list of sponsoring companies, please contact HR Shared Services .

The address for Nortel Networks Inc. is:

Nortel Networks Inc.
220 Athens Way, Suite 300
Nashville, TN 37228

Agent for Service of Legal Process:

The Corporation Trust Company
Corporation Trust Center
1209 Orange Street
Wilmington, DE 19801

Legal Process may also be served upon the trustee of a trust that funds benefits under the Plan.

Trustee of the Nortel Networks Inc. Health & Welfare Benefits Trust (which funds benefits under the Plan):

Retirement Services Group
Bank of America
213 South LaSalle Street
Chicago, IL 60697
312-828-2345

CLAIMS PROCEDURES

Contact Information for Claims Filing

The chart below provides addresses and phone numbers both for filing Claims and appealing denials of Claims for each of the listed benefits. Call HR Shared Services at 1-800-676-4636 if you cannot locate the information you need in the list that follows.

The claims fiduciaries for each type of Claim under the Medical Plan are noted in the list below.

Claims Administrator	Address	Phone Number

1. Medical Benefits

All Claims and appeals of denied Claims for medical benefits as described in this Summary Plan Description other than eligibility to participate in the plan and cost of coverage of the EAP, Mental Health and Substance Abuse Treatment Benefits, Prescription Drug benefits, and COBRA should be filed with the applicable entity listed below, based on the coverage you selected.

CIGNA	PO Box 33668 Charlotte, NC 28233-3668	1-800-257-2702

2. Employee Assistance Program (EAP), Mental Health and Substance Abuse Treatment Benefits

All Claims and appeals of denied Claims for EAP and/or mental health and substance abuse benefits as described in this Summary Plan Description (other than eligibility to participate in the plan and cost of coverage issues) should be filed with:

OptumHealth Behavioral Solutions	P O Box 30755 Salt Lake City, UT 84130-0755	1-800-842-2991

3. Prescription Drug Benefits

Medco Health Solutions makes the initial decision on whether the Plan will pay for a Prescription Drug as described in this Summary Plan Description. If they deny your Claim, you may file your first appeal with them. Their address and other contact information is provided below:

Medco Health Solutions, Inc.	PO Box 2187 Lee's Summit, MO 64063-2187	1-800-711-3460

If your first appeal of a Claim for payment of a Prescription Drug is denied, you may file a second appeal with the Employee Benefits Committee at the address provided below. The Second appeal is your final appeal right. The Employee Benefits Committee is the final Claims fiduciary for all appeals of denied Claims for Prescription Drug benefits as described in this Summary Plan Description.

Employee Benefits Committee

c/o Nortel Networks
Mailstop: 570 02 0C3
PO Box 13010
Research Triangle Park, NC 27709-3010

For information about Claims concerning eligibility to participate in the plan and cost of coverage issues, see item #4 below.

4. Eligibility to Participate; Dependent Enrollment; Coverage Options; Enrollment Date; COBRA Eligibility

Initial Claims regarding eligibility to participate in the Medical Plan; enrollment of Dependents in the Medical Plan; disputes about the coverage option elected; the Effective Date of your enrollment in the Medical Plan; and COBRA eligibility should be filed with HR Shared Services. If they deny your Claim, you may then appeal to the Employee Benefits Committee regarding such issues. The Employee Benefits Committee has the discretion and the authority to make the final decision about such Claims. Information about HR Shared Services and the EBC follows:

Claims Administrator	Address	Phone Number
HR Shared Services	c/o Nortel Networks PO Box 13010 Research Triangle Park, NC 27709-3010	Toll-free: 1-800-676-4636 Direct: 919-905-9351 ESN: 355-9351
Employee Benefits Committee	c/o Nortel Networks Mailstop: 570 02 0C3 PO Box 13010 Research Triangle Park, NC 27709-3010	

COBRA

The contact information for the Medical Plan's administrator of COBRA benefits and the HIPAA certificate of health coverage is:

Ceridian COBRA Continuation Services (CobraServ)	3201 34th Street South St. Petersburg, FL 33711-3828	Toll-free: 1-800-877-7994

Ceridian COBRA Continuation Services (CobraServ) is an external vendor which has been contracted to provide only administrative services for COBRA and the HIPAA certificate of health coverage. They review Claims or appeals of denied Claims only as they relate to termination of coverage due to lack of timely payment. They do not review Claims or appeals of denied Claims regarding the Medical Plan benefits coverages that are provided during your elected COBRA period.

Filing Claims

This section outlines the procedures and applicable time limits for filing Claims and filing appeals of denied Claims and other benefit determinations under the Retiree Medical Plan. These procedures are intended to comply with the requirements of ERISA and will be interpreted in accordance with ERISA requirements. These procedures are effective for Claims filed on or after January 1, 2003.

To make a formal Claim for benefits, you must file the appropriate Claim form, if applicable, (along with the original bills or receipts for services) with the appropriate Claims Administrator. Providers may also file Claims directly for you if you authorize them to do that on your behalf.

In order to properly process your request, please refer to the "Contact Information for Claims Filing" chart on pages 78 - 79 for a complete list of all Claims Administrators, their respective addresses and phone numbers. Claim forms are available from HR Shared Services. The Claim must describe the occurrence, character and extent of the service.

You must file your Claim by the end of the Calendar Year after the Calendar Year in which the service was rendered. If you don't submit the Claim by the end of the Calendar Year after the Calendar Year in which the service was rendered, benefits for that health service will be denied. This time limit does not apply if you are legally incapacitated to file a Claim.

Please note that determinations made by the Claims Administrator or Employee Benefits Committee (EBC) relate solely to whether or not benefits are available under the plan for the proposed treatment or procedure or whether eligibility for plan participation is available under the written terms of the plan. The determination as to whether a health service will be provided to you is between you and your Physician or other health care provider.

Payment of Plan Claims

The Claims Administrator will make a benefit determination as set forth below. Benefits will be paid to the Provider as soon as possible after your Claim is received by the Claims Administrator when any of the following is true.

- The Provider is an In-Network Provider and In-Network Benefits are applicable.
- The Provider notifies the Claims Administrator that your signature is on file on a document requesting that payment of benefits on your behalf be made to that Provider.
- You make a written request for the Out-of-Network Provider to be paid directly at the time you submit your Claim.

You will be responsible for payment to the Provider if none of the above is true.

Should you die before a benefit that is to be paid to you is paid, the benefit will be paid to your estate.

The rights and benefits of you (Retiree Medical Plan members) and your eligible Dependents under this plan are not subject to the Claims of your creditors and cannot be voluntarily or involuntarily assigned, sold or transferred to anyone else. Retirees and their eligible Dependents are the only "participants" and "beneficiaries" of this plan, as defined under the provisions of the Employee Retirement Income Security Act of 1974.

The plan will not reimburse third parties who have purchased or been assigned benefits by Physicians or other Providers.

Claim Determinations

Federal regulations define guidelines for review, payment and appeal of four types of Claims:

- Urgent care Claims – Claims for treating conditions that could seriously jeopardize your life, health or your ability to recover or would result in severe pain, if not treated.
- Pre-service Claims – Claims that involve advance coverage authorization of a non-urgent course of treatment.
- Concurrent care Claims – Claims where you are notified that your benefit for an ongoing course of treatment (urgent or non-urgent) will be reduced or terminated.
- Post-service Claims – Claims that involve non-urgent courses of treatment that have already been provided.

Timeframe for Claim Determinations

Urgent Care Claims that Require Immediate Action

Urgent care Claims are those Claims where:

- the terms of the Retiree Medical Plan condition receipt of the benefit on approval of the benefit prior to receiving medical care, and
- a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain.

In these situations:

- The Claims Administrator will notify you of the initial benefit determination in writing or electronically within 72-hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation.
- If you filed an urgent Claim improperly, or did not supply enough information for the Claim Administrator to make a decision, here is the process for urgent Claim determinations:
    1. The Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent Claim was received.

2. If additional information is needed to process the Claim, the Claims Administrator will notify you of the information needed within 24 hours after the Claim was received.
3. You will then have 48 hours to provide the specified additional information to the Claims Administrator.
4. The Claims Administrator will notify you of a determination no later than 48 hours after:
   - The Claims Administrator's receipt of the requested information; or
   - The end of the 48 hour period within which you were to provide the additional information to the Claims Administrator, if the information is not received within that time.

   If you don't provide the specified additional information within the 48 hour period to the Claims Administrator, your Claim may be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the Claim appeal procedures.

If you are asking for an extension of a course of treatment that is already in progress, the Claims Administrator will respond within 24 hours of the receipt of your request, provided that the request is made at least 24 hours before the previously approved benefits for the course of treatment expires.

Pre-Service Claims

Pre-service Claims are those Claims where the terms of the Retiree Medical Plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical non-urgent care. This decision can be a determination of whether or not benefits will be paid at all, or the level of benefits that will be received.

If your Claim was a pre-service Claim and was submitted properly with all needed information, the Claims Administrator will notify you of the Claim decision within 15 days of receipt of the Claim.

The Claims Administrator may request a one-time 15-day extension if:

1. An extension is necessary, due to matters beyond the control of the plan and
2. The Claims Administrator notifies you before the initial 15-day period expires of the reasons why an extension is required and a date by which you can expect a decision.

If the extension is necessary due to your failure to submit necessary information to make a determination, the extension notice will describe the information needed. You will have 45 days after you receive the Claims Administrator’s notice to provide all of the specified additional information.

The plan's timeframe for making a benefit determination stops on the date the Claims Administrator sends you the extension notification until the date you provide all of the specified additional information to the Claims Administrator.

If all of the needed information is received by the Claims Administrator within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If all of the needed information is not received by the Claims Administrator within the 45-day period, your Claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the Claim appeal procedures.

Concurrent Care Claims

Concurrent care Claims are those Claims where the terms of the Retiree Medical Plan require the Claims Administrator to reduce or terminate benefits for an on-going (already in progress) treatment that benefits were previously approved by the Claims Administrator.

If benefits were previously approved for treatment already in progress and you request benefits for an extension of that treatment under an urgent care Claim as defined above:

- The Claims Administrator will notify you of a determination on your request for benefits for the extended treatment within 24 hours, provided the Claims Administrator receives your request at least 24 hours prior to the end of the treatment for which benefits were previously approved.

- If your request for benefits for the extended treatment is not made at least 24 hours prior to the end of the treatment for which benefits were previously approved, the request will be treated as an urgent care Claim and decided according to the timeframes described above.

If benefits were previously approved for treatment already in progress and you request benefits for an extension of that treatment in a non-urgent circumstance, your request will be considered a new Claim and decided according to post-service or pre-service timeframes, whichever applies.

Post-Service Claims

Post-Service Claims are those Claims that are filed for payment of benefits after medical care has been received. If your post-service Claim was submitted properly with all needed information, the Claims Administrator will notify you of the Claim decision within 30 days of receipt of the Claim.

The Claims Administrator may request a one-time 15-day extension if:

1. An extension is necessary, due to matters beyond the control of the plan and

2. The Claims Administrator notifies you before the initial 30-day period expires of the reasons why an extension is required and a date by which you can expect a decision.

If the extension is necessary due to your failure to submit necessary information to make a determination, the extension notice will describe the information needed. You will have 45 days after you receive the Claims Administrator's notice to provide all of the specified additional information.

The plan's timeframe for making a benefit determination stops on the date the Claims Administrator sends you the extension notification until the date you provide all of the specified additional information to the Claims Administrator.

If all of the needed information is received by the Claims Administrator within the 45-day time frame, the Claims Administrator will notify you of the determination within 30 days after the information is received. If all of the needed information is not received by the Claims Administrator within the 45-day period, your Claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the Claim appeal procedures.

Appealing a Denied Claim

If You Receive an Adverse Benefit Determination

The Claims Administrator will provide you with notification of any adverse benefit determination, which will set forth:

1. The specific reason(s) for the adverse benefit determination.
2. Reference to the specific plan provisions on which the benefit determination is based.
3. A description of any additional material or information that is necessary for you to perfect the Claim and an explanation of why that material or information is necessary.
4. A description of the plan's appeal procedures and time limits applicable to such procedures, including a statement of your right to bring civil action under Section 502(a) of ERISA after a final adverse benefit determination on appeal.
5. A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, as well as a statement of your right to bring an action under ERISA.
6. Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination; a statement or copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination will be provided free of charge to you upon request.
7. If the adverse benefit determination was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the

scientific or clinical judgment for the adverse determination (applying the terms of the plan to your medical circumstances) or a statement that such explanation will be provided free of charge upon request.

8. If the adverse determination involves urgent care, a description of the expedited appeal process applicable.

Procedures for Appealing an Adverse Benefit Determination

If you disagree with a Claim for payment determination, you can file an appeal with the Claims Administrator who denied your original Claim by writing to the Claims Administrator and including the following in your written appeal request:

The patient's name and the identification number from the ID card (if applicable).

The date(s) of medical service(s).

The Provider's name.

The reason you believe the Claim should be paid.

Any documentation or other written information to support your request for Claim payment.

You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to submit your first appeal request to the Claims Administrator.

You have the right to:

1. Submit written comments, documents, records and other information relating to the Claim for benefits.
2. Request free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your Claim for benefits. For this purpose, a document, record or other information is treated as "relevant" to your Claim if it:
    - Was relied upon in making the benefit determination
    - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
    - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
    - Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
3. A review that takes into account all comments, documents, records and other information submitted by you relating to the Claim, regardless of whether such information was submitted or considered in the initial benefit determination.
4. A review that does not defer to the initial adverse benefit determination and that is conducted by the claims fiduciary of the plan who is neither the individual who made the adverse determination nor that person's subordinate.

5. If the appeal involved an adverse benefit determination based in whole, or in part, on a medical judgment, you have the right to require the claims fiduciary to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the initial adverse benefit determination nor the subordinate of any such individual.
6. The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the decision.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your Claim for benefits.

Urgent Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call the claims fiduciary to request the appeal as soon as possible.

The claims fiduciary will provide you with a written or electronic determination as soon as possible, but no longer than 72 hours following receipt by the claims fiduciary of your request for review of the determination taking into account the seriousness of your condition.

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows.

For appeals of **pre-service Claims** (as defined on page 81):

The first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied Claim. If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the claims fiduciary. Your second level appeal request must be submitted to the claims fiduciary within 60 days from receipt of the first level appeal decision.

The second level appeal will be conducted and you will be notified by the claims fiduciary of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of **post-service Claims** (as defined on page 83):

The first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied Claim. If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the claims fiduciary. Your second level appeal request must be submitted to the claims fiduciary within 60 days from receipt of the first level appeal decision.

The second level appeal will be conducted and you will be notified by the claims fiduciary of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Participation Appeals

For appeals regarding denial of your eligibility to participate in the plan, the enrollment of your Dependents in the plan, coverage option elections, the Effective Date of enrollment in the plan under all options, or COBRA eligibility, the Company retains the exclusive right to interpret and administer the participation provisions of the Retiree Medical Plan.

- The first level appeal will be conducted and you will be notified by HR Shared Services of the decision within 60 days from receipt of a request for appeal of a denied Claim. HR Shared Services will provide to you all of the information described under the "**If You Receive an Adverse Benefit Determination" section above.**
- If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level (final) appeal from the Employee Benefits Committee, the claims fiduciary. Your second level appeal request must be submitted to the claims fiduciary within 180 days from receipt of the first level appeal decision.

See below for a description of procedures for the second level appeal conducted by the Employee Benefits Committee.

The Employee Benefits Committee (EBC) conducts the second level (final) appeal for determining your eligibility to participate in the Retiree Medical Plan, the enrollment of your Dependents in the Retiree Medical Plan, coverage option elections or the Effective Date of enrollment in the plan under all options. The EBC will make a decision on your appeal of a denial of your participation Claim under the plan no later than the date of the meeting of the EBC that immediately follows the plan's receipt of a request for review, unless the request for review is filed within thirty (30) days preceding the date of such meeting. (The EBC holds monthly meetings.) In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the EBC following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the EBC will provide you with written notice of the extension, describing the

special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension.

In the event an extension is necessary due to your failure to submit necessary information, the plan's timeframe for making a benefit determination on review stops on the date the EBC sends you the extension notification until the date you respond to the request for additional information.

The EBC will notify you of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made. The EBC will provide to you all of the information described under the "If You Receive an Adverse Benefit Determination" section above when they notify you of their benefit determination.

Final Note on Retiree Medical Plan Claim Appeals

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or Federal court, *but only after you have exhausted the plan's claims and appeals procedure as described on page 84.*

YOUR RIGHTS UNDER ERISA

As a participant in the Company's Employee benefit plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that, as a plan participant, you will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office or your work location, during normal working hours, all plan documents governing the plan, including insurance contracts (if any), and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may request a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a summary of this annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for your spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. Your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon those who are responsible for the operation of your Employee benefit plan.

The people who supervise the operation of your plans, called "fiduciaries," have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your Claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a Claim for benefits that is denied or ignored, in whole or in part, you may file suit in Federal or state court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that a plan fiduciary misuses the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in Federal court.

In the event of legal action, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if the court finds your Claim is frivolous.

Assistance With Your Questions

If you have questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory.

If you have any problem obtaining copies of your plan's Annual Return or other plan documents, please contact the ERISA Public Disclosure Room. If you believe that your plan did not file an Annual Return (or that the information provided on your Annual Return is not accurate), please contact EBSA's Office of the Chief Accountant at 202-219-8360. If you

have any technical questions concerning ERISA, call 1-866-444-3272 or submit your inquiry electronically at askebsa.dol.gov.

Health Insurance Portability and Accountability Act ("HIPAA")

Your rights under HIPAA

Privacy

The Nortel Networks Group Health Plan which includes this plan (to the extent that it covers Employees of NNI or other U.S. subsidiary that has adopted the Plan) the Nortel Networks (Plan Name) was amended to include the health information privacy requirements effective April 14, 2003 and security requirements effective April 20, 2005 specified in HIPAA. The following section describes the permitted use and disclosure of protected health information under HIPAA.

Nortel Networks (including Nortel Networks Inc., Nortel Networks Limited and any subsidiary of either or of Nortel Networks Corporation whose Employees are covered by the Plan) may only use and disclose protected health information it receives from the Plan as permitted and/or required by, and consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying Privacy and Security regulations found at 45 CFR Part 164, Subparts A and C. This includes, but is not limited to, the right to use and disclose participant's protected health information (including electronic protected health information) in connection with payment, treatment and health care operations (as defined within the regulations).

The Plan will disclose protected health information to Nortel Networks only upon receipt of a certification by Nortel Networks Inc., the Plan Sponsor that the plan documents have been amended to incorporate all of the required provisions as described below.

Nortel Networks will:

- Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;
- Ensure that any agents, including a subcontractor, to whom it gives protected health information received from the Plan, agree to the same restrictions and conditions that apply to Nortel Networks with respect to such information;
- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that is creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that any agent, including a subcontractor, to whom it gives electronic protected health information, agrees to implement reasonable and appropriate security measures to protect such information;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of Nortel Networks;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which Nortel Networks becomes aware;
- Report to the Plan any security incident of which Employer becomes aware
- Make available protected health information in accordance with individuals' rights to review their protected health information;
- Make available protected health information for amendment and incorporate any amendments to protected health information consistent with the HIPAA rules;
- Make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules;
- Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of HHS for purposes of determining compliance by the Plan;
- If feasible, return or destroy all protected health information received from the Plan that Nortel Networks still maintains in any form. Nortel Networks will retain no copies of protected health information when no longer needed for the purpose for which disclosure was made. An exception may apply if such return or destruction is not feasible, but the Plan must limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

SPECIAL ENROLLMENT

If you decline enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in the Plan if you or your Dependents lose eligibility for that other coverage (or if the Company stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 30 days [or any longer period that applies under the Company Plan] after your or your Dependents' other coverage ends (or after the Company stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days [or any longer period that applies under the Company Plan] after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information,
contact:

HR Shared Services
Nortel Networks
PO Box 13010
Research Triangle Park, N.C. 27709-3010
Toll-free: 1-800-676-4636

Direct: 919-905-9351 ESN: 355-9351

CERTIFICATE OF HEALTH COVERAGE

Under HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems. When you leave the Company's employment for any reason, or terminate your coverage in this Plan, the Company will provide you a written certificate confirming the period of your participation in this Plan. This certificate must include a statement of your rights under HIPAA as outlined in sample language provided by the US Department of Labor below. The Company will also provide a certificate for any Dependent who ends coverage under this Plan for any reason. The Company will provide a certificate to former Employees and/or their Dependents automatically when coverage terminates, automatically when COBRA continuation, if elected, terminates and upon request at any time within 24 months of the date plan coverage terminates. (Note: COBRA continuation coverage also counts as creditable coverage.)

The contact information of the plan's administrator for the HIPAA certificate of health coverage is:

Ceridian COBRA Continuation Services (CobraServ)
3201 34th Street South
St. Petersburg, FL 33711-3828
Toll-free: 1-800-877-7994

Ceridian COBRA Continuation Services (CobraServ) is an external vendor which has been contracted to provide only administrative services for COBRA and the HIPAA certificate of health coverage. They do not review any Claims or appeals of denied Claims for any benefits that are provided during your elected COBRA period.

STATEMENT OF HIPAA PORTABILTY RIGHTS

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is

creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use your certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your Dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your Dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by the certificate of coverage);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages - Health *E*laws, or http://www.cms.hhs.gov/hipaa1.

FUTURE OF THE PLAN

Although the benefits currently available (in the 2010 Plan Year) are described in this summary for the Company's Retiree Medical Plan, the Company reserves the right to change or end the plan described in this summary at any time. Any plan changes will result from actions taken and approved by the Company. The Company may adopt such changes or terminate the plan at any time and for any reason.

The Company's practices, polices, and benefits are outlined here for your information as required by law.

SECTION THREE –

GLOSSARY

Sometimes, to describe a benefit plan accurately, some technical terms must be used. Here to help you understand them are brief definitions in alphabetical order. If there are any differences between this Glossary and the terms contained in the plan documents, the plan documents will govern.

If a different definition of any of the following words is provided in the section describing a particular benefit plan that definition applies instead of the definition listed below.

Accident
An unexpected event resulting in bodily Injury by an external trauma.

Accidental Injury
Injuries sustained as the direct result of an Accident.

Active Duty
Currently enlisted in the armed forces of any country and called upon to serve.

Affiliates
Subsidiaries of, or other companies related to, Nortel Networks Inc. (NNI), that have been authorized by the Board of Directors of NNI to provide coverage for their employees under the Company's benefit programs and have adopted those programs

Alternate Benefit Level:
If your care is provided by a non- OptumHealth Behavioral Solutions Provider (Out-of-Network Benefits), you will have to satisfy a $200 per person Deductible before your benefits can begin. All intermediate and Inpatient levels of care must be certified by OptumHealth Behavioral Solutions or benefits will be reduced. In addition, Out-of-Network Benefits under the Mental Health and Substance Abuse Program are limited to Reasonable and Customary Charges. You may be required to file a Claim form with OptumHealth Behavioral Solutions to apply for reimbursement of eligible expenses under the Program. The reimbursement level will depend on the type of care you receive.

Ambulance
Ground or air transportation by a commercial or municipal Ambulance service that is issued a license or certificate by the appropriate licensing authority.

Annual Enrollment Period
The annual period during which you may change your Retiree Medical Plan Option for the coming year. Annual enrollment is held each summer.

Brand-Name Drug
A prescription medicine that is available only from its original manufacturer or licensee under a recognized brand name. A brand name drug may have a generic equivalent after the original patent expires. Brand-Name Drugs are typically sold at a higher price than Generic Drugs.

Calendar Year
January 1 through December 31. This period is also the "Plan Year" for the purposes of the Retiree Medical Plan.

Capital Accumulation and Retirement Programs
Effective May 1, 2000, Nortel Networks Inc. and certain other Employers introduced and sponsored three Capital Accumulation and Retirement Programs – the Traditional program, the Balanced program and the Investor program. These previously available programs were designed to enable employees, with help from their Employer, accumulate assets through different combinations of pension, retiree welfare, investment and stock purchase plans.

Children
Dependents who are:

- your natural Children,
- Children legally adopted by you or placed with you for adoption
- your step-children,
- your legal foster Children,
- your responsibility as legal guardian,
- Children of your Domestic Partner, or
- Children for whom you are required to provide health coverage, as specified by a Qualified Medical Child Support Order (QMSCO). A QMCSO is an order of judgment from a court that directs a plan administrator to cover a child for benefits under a health care plan

To be eligible for coverage as a child, stepchildren, legally authorized foster Children, Children for whom you the legal guardian and Children of your Domestic Partner must depend on you for support and maintenance and live with you for at least six months of the Calendar Year in a regular, parent-child relationship.

Claim
A request by a covered person for a benefit under a specific plan.

Claims Administrator
The company or third party administrators responsible for processing and paying benefit Claims and other various administrative services.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, you and your Dependents may be eligible to continue certain group health care plan coverages if you lose your benefits under certain circumstances.

Coinsurance
The portion of Covered Expenses paid by your Retiree Medical Plan after you pay your Deductible or Copayment or the specified percentage that you pay when you receive certain services or supplies.

Common Medical Standards
Generally accepted medical practice based on recommendations from the American Medical Association (AMA), the American College of Obstetricians and Gynecologists (ACOG), the American Cancer Society (ACS) and others.

Company
Nortel Networks Inc. (NNI) and any of its Affiliates.

Congenital
A condition present at birth that is not hereditary

Copay, Copayment
The specified dollar amount that you pay when you receive certain services or supplies.

Cosmetic Surgery
Procedures performed mainly to change a person's appearance rather than for the improvement, restoration or correction of normal bodily functions. It includes Surgery performed to treat a mental, psychoneurotic or personality disorder through change in appearance.

Coverage Year
The period for which the Retiree Medical Plan Option election remains in effect. See Annual Enrollment Period. In general, the Effective Date of any Option change is the first of the second month following the month in which the Annual Enrollment Period occurs. Generally, premium changes go into effect with the beginning of the new Coverage Year.

Covered Expense
Charges that may be used as the basis for a Claim under the plan. They are the charges for certain services and supplies to the extent the charges meet the terms specified in the Retiree Medical Plan's "Covered Expenses."

Covered Percent

A percentage of Covered Expenses used to determine the benefits payable for those charges under the coverages. The Covered Percent is not applied to charges used to meet any Deductible or Copayment.

Custodial Care

Care that provides a level of routine maintenance for the purpose of meeting personal needs. Custodial Care includes, but is not limited to: help in walking and getting into and out of bed, help in bathing, dressing and eating, help in other functions of daily living of a similar nature, administration of or help in using or applying Medications, creams and ointments, routine administration of medical gases after a regimen of therapy has been set up, routine care of a patient, including functions such as changes of dressings, diapers and protective sheets and periodic turning and positioning in bed, routine care and maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags and indwelling catheters, routine tracheostomy care, general supervision of exercise programs, including carrying out of maintenance programs or repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

Deductible

The amount of Covered Expenses you and your enrolled Dependents must pay each year before the plan begins to pay benefits.

Dependent

For your medical coverage, Dependents include:

- your spouse, including your common-law spouse as recognized by applicable state law
- your qualified Domestic Partner, (see definition of “Domestic Partner”)
- your unmarried Children and your Domestic Partner’s unmarried Children under the age of 19,
- your unmarried Children and your Domestic Partner’s unmarried Children between the ages 19 and 25 who are full-time students at an accredited school and are primarily supported by you
- your unmarried Children and your Domestic Partner’s unmarried Children of any age who have a mental or physical disability that began before age 19 (or age 25 if they are a full-time student) and who are Wholly Dependent on you for support and maintenance and became dependent before age 19 (or age 25 if a full-time student)

Dispense as Written (DAW)

A phrase prescribers use when writing a prescription to indicate their preference that the pharmacy dispense the Brand-Name Drug ordered rather than a generic substitute. The Doctor may indicate DAW on your prescription if there is a medical reason (such as an allergy to certain drug ingredients) for you to take only a Brand-Name Drug.

Doctor

A licensed practitioner of the healing arts acting within the scope of his or her license.

Domestic Partner

An individual of either gender who is not your spouse and who is certified by required proof to be:

- not married to anyone else,
- not related to you by blood that would prohibit legal marriage in the state in which you live,
- your sole and exclusive partner whom you publicly represent as your Domestic Partner,
- sharing in your financial obligations,
- living with you and meeting all of the other requirements listed above for at least 12 months immediately before you certify Domestic Partnership,
- mentally competent to consent to a contract, and
- age 18 or older.

To be eligible for medical coverage, your Domestic Partner must be qualified under the Plan rules including your completion of an Affidavit of Domestic Partnership. Contact HR Shared Services at: ESN 355-9351 or 1-800-676-4636. Hearing impaired call (TDD) 919-992-6914.

Durable Medical Equipment

Equipment needed for a medical condition which is able to withstand repeated use, including wheelchairs and Hospital beds.

Effective Date

The date coverage goes into effect under the Plan.

Emergency

A sudden and serious situation that happens unexpectedly and requires immediate medical attention, or an Illness or Injury of such a nature that failure to get immediate medical care could put that person's life in danger or cause serious harm to that person's bodily functions. Some examples of an Emergency are apparent heart attack including, but not limited to, severe, crushing chest pain radiating to the arms and jaw, cerebral vascular Accidents, severe shortness of breath or difficulty in breathing, severe bleeding, sudden loss of consciousness, convulsions, severe or multiple Injuries, including obvious fractures, serious burns, severe allergic reactions, high fever, cyanosis, apparent poisoning. In connection with the pregnancy of a covered person, a term delivery, whether vaginally or by a Cesarean section, is not an Emergency.

Employers

Nortel Networks Inc. and subsidiaries of, or other companies related to, Nortel Networks Inc.(NNI), that have been authorized by the Board of Directors of NNI to provide coverage

for their employees under the Retiree Medical Plan and have adopted the Retiree Medical Plan.

Enrollment Period
The 31-day period after you first become eligible for benefits as a newly Retired Employee or after you experience a Status Change. See “Annual Enrollment Period” also.

ERISA
Employee Retirement Income Security Act of 1974 which regulates the welfare group benefit plans (medical, disability, etc)

Evidence of Insurability (EOI)
Proof of a person’s physical condition verifying good health may be required for his or her acceptance for coverage.

Experimental or Investigational
Services, supplies or treatment not recognized or approved by the relevant standard setting body as accepted medical practice and/or as safe and effective for the diagnosis or treatment of a specific condition. Such standard setting organizations include the American Medical Association (AMA) and the U.S. Food and Drug Administration (FDA).

Explanation of Benefits (EOB)
A statement from your insurance company giving specific details about how and why benefit payments were or were not made. It summarizes the charges submitted and processed, the amount allowed, the amount paid, and the balance you may owe

Formulary
List of preferred brand-name and Generic Drugs that have been selected by prescription benefit Claims Administrator's independent pharmacy and therapeutics committee based on their safety, effectiveness and cost.

Generic Drug
Equivalent version of a Brand-Name Drug produced when the patent on the Brand-Name Drug expires. Generic Drugs have the same active ingredients as Brand-Name Drugs but are less expensive.

HR Shared Services
The service center for the Employer’s benefit plans. By contacting HR Shared Services, you can ask questions about the Retiree Medical Plan, request needed forms or change your employee information, such as your address.

Hemodialysis
The process of filtering the blood and removing from it the toxic urinary substances and other waste products of protein metabolism.

Highest Benefit Level

If your care is certified by OptumHealth Behavioral Solutions and provided by a OptumHealth Behavioral Solutions Network Provider (In-Network Benefits), your benefits will, in most cases, be paid at 100% less any applicable Copayments with no Deductible. (See the "summary of Managed Mental Health and Substance Treatment Abuse Benefits on page 23 for further information.

Hire Date

The date your employment with your Employer began.

Home Delivery Pharmacy Service

All Retiree Medical Plan options offer a mail order prescription drug benefit to be used for long-term or Maintenance Drugs, such as medication for high blood pressure or arthritis.

Home Health Care

A program, prescribed in writing by a person' s physician and administered by a Home Health Care Agency, that provides for the care and treatment of a person's Sickness or Injury in the person's home.

Home Health Care Agency

An organization that meets at least one of the following three requirements:

1. It is established and operated in accordance with applicable licensing and other laws.
2. It is a Home Health Care Agency as defined in Medicare.
3. It administers a Home Health Care plan and meets all of these requirements:
    - It has a full-time administrator.
    - It keeps written records of services and supplies furnished to the patient.
    - Its staff includes at least one registered nurse (RN) or it has access to nursing care by a registered nurse.
    - Its employees are bonded.
    - It maintains malpractice insurance.
    - It has the primary purpose of providing Home Health Care.
    - It has a delivery system for bringing supportive services to the home.

Hospice/Hospice Care Program

A health care program directed by a Physician and providing services rendered at home, in outpatient settings or in institutional settings for covered persons suffering from a terminal illness. A Hospice must have a team of personnel that includes at least one Physician and one registered nurse. It must also:

- maintain central clinical records on all patients

- meet the standards of the National Hospice Organization (NHO) and applicable state licensing certification or registration requirements
- have care available 24 hours a day, seven days a week
- be approved by the Claims Administrator.

In addition to the Physician and registered nurse, Hospice personnel may include a social worker, a clergyman/counselor, volunteers, a clinical Psychologist, a physiotherapist or an occupational therapist, and provide care to:

- reduce pain or other symptoms of mental or physical distress
- meet the special needs arising out of the stresses of the terminal Illness, dying and bereavement.

Hospice Room and Board

Charges made by a Hospice for room and meals and for all general services and activities needed for the care of registered bed patients.

Hospital

An institution that meets either of these two tests:

1. It is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission of Accreditation of Health Care Organizations (JCAHO).
2. It is legally operated, has 24 hour a day supervision by a staff of Physicians, has 24 hour a day nursing service by registered nurses and complies with one of the following conditions:
   - It mainly provides general Inpatient medical care and treatment of ill and injured persons through the use of medical, diagnostic and major surgical facilities. All such facilities are in it or under its control.
   - It mainly provides specialized Inpatient medical care and treatment of ill or injured persons through the use of medical and diagnostic facilities (including x-ray and laboratory). All such facilities are in it, under its control or available to it under a written agreement with a Hospital (as defined above) or with a specialized provider of those facilities.

Hospital does not include nursing homes or institutions, or parts of institutions that:

- are used mainly as a place for convalescence, rest, nursing care or for the aged
- furnish mainly Custodial Care or training in the routines of daily living
- are mainly like schools.

Hospital Inpatient Stay

A hospital stay for which a room and board charge is made by the Hospital.

Hospital Outpatient Stay
A hospital stay for which no room and board charge is made by the Hospital.

Illness
Any disorder of the body or mind of a covered person, but not an injury or pregnancy, including abortion, miscarriage or childbirth.

Imputed Income
According to the IRS, Imputed Income is the value of certain types of Employer-paid benefits. If your Domestic Partner is enrolled in the Nortel Networks Retiree Medical Plan, the value of coverage for your Domestic Partner that is paid for by your Employer may be considered Imputed Income to you. (See Domestic Partner, pages 8 and 9.)

Injury
A condition that results in damage to the covered person's body, independently of illness.

In-Network Benefits
The level of benefits you receive when you use Network Providers for your medical care. For instance, the Retiree Medical Plan's PPO options pay In-Network Benefits at a higher rate than Out-of-Network Benefits for most medical care. For mental health and substance abuse treatment, you receive a higher level of benefit when your care is provided by a OptumHealth Behavioral Solutions Network Provider.

In-Network Providers
See "Network Providers."

Inpatient
A person admitted to an accredited facility as a registered bed patient for medical care and charges.

Intermediate Care is made up of residential, partial, and intensive out-patient programs as defined below:

- Partial Hospital Program (PHP): A structured ambulatory program that may be freestanding or hospital-based and that provides services for at least 5 hours per day and at least 4 days per week. Partial hospital programs are used as a step up from routine or intensive outpatient services, or as a step down from acute Inpatient or residential care. Partial hospital programs can be used to treat mental health conditions or Substance-Use Disorders, or can specialize in the treatment of co-occurring mental health conditions and Substance-Use Disorders. Also known as a **Day Treatment Program**.
- Residential Rehabilitation: Acute overnight services that are typically provided in a freestanding Residential Treatment Center for the care of a Substance-Use Disorder. A residential rehabilitation program is appropriate when a member lacks the motivation

or social support system to remain abstinent, but does not require the structure and the intensity of services provided in a hospital.

- Residential Treatment Center (RTC): Facility-based or freestanding program that provides overnight mental health services for patients who do not require acute care. Intensive Outpatient Program (IOP): A structured outpatient program that may be freestanding or hospital-based and that provides services for at least 3 hours per day, 2 or more days per week. IOPs encompass half-day partial hospital programs. Intensive outpatient programs are used as a step up from routine outpatient services, or as a step down from acute Inpatient, residential care or a partial hospital program. Intensive outpatient programs can be used to treat mental health conditions or Substance-Use Disorders, or can specialize in the treatment of co-occurring mental health conditions and Substance-Use Disorders.

Intermediate Care Facility

An institution that provides care and treatment of mental, psychoneurotic and personality disorders, alcoholism or substance abuse through one or more specialized programs and meets all three of the following conditions:

1. It must be staffed by registered nurses and other mental health professionals.
2. It must provide for the clinical supervision of such specialized programs by Physicians who are licensed in the state in which the facility is located.
3. Each specialized program provided through the institution must:
   - provide treatment for no less than three hours and no more than 12 hours per day
   - furnish a written, individual treatment plan that states specific goals and objectives
   - maintain, at a minimum, weekly progress notes which demonstrate periodic review and direct patient evaluation by the attending Physician, and
   - meet either of these two tests:
     - be accredited by the Joint Commission of Accreditation of Health Care Organizations (JCAHO)
     - be licensed, accredited or approved by the appropriate agency in the state in which the facility is located to provide the type of specialized program described above.

Lifetime Maximum

The total of all medical benefits paid under the Comprehensive and Indemnity Options and out-of-network medical services in the PPO Options, excluding prescription drug benefits and mental health and substance abuse treatment benefits. Mental health and substance abuse treatment benefits are subject to a separate lifetime maximum.

Maintenance Drug/Medications

A Prescription Drug used for the treatment of chronic medical conditions including, but not limited to: chronic obstructive pulmonary disease, clotting disorders, congestive heart failure, coronary artery disease (angina), diabetes (oral agents only), glaucoma, hypertension, thyroid disease or seizure disorders.

Maintenance of Benefits
A provision that applies to your medical coverage if you (or your eligible Dependents) have coverage from more than one source. If you're in a plan that covers less than 100% of eligible expenses, and you've already received that amount (or more) from another plan, the Nortel Networks plan will pay only up to the level it would pay if it were the only plan. For example, if you're in a medical option that covers 80% of eligible expenses and you've already received that 80% of eligible expenses for a Dependent through your spouse's plan, the Nortel Networks plan will not make up the additional 20%.

Managed Care
A type of health plan that negotiates fees with Hospitals, Doctors and other health care professionals in advance. These Providers then form a Managed Care network. Generally, when you use the Providers who have an agreement with the Managed Care network, you receive the highest benefit coverage level applicable under the plan. Managed Care options under the Nortel Retiree Medical Plan include 80/60 and 90/70 Preferred Provider Organizations (PPO)

Medical Plan
The Retiree benefit plan described in this Summary Plan Description which is a plan that provides medical benefits for you and your enrolled Dependents.

Medical Plan ID Card
Wallet card which identifies you as a member of a particular Medical Plan and includes your group number and identification number on a plan. Abbreviated benefits information is usually included regarding copays and where to file Claims.

Medicaid
Title XIX (Grants to States for Medical Assistance Programs) of the Federal Social Security Act, as amended from time to time.

Medically Necessary Leave of Absence
A leave of absence from a post-secondary educational institution or any change of enrollment at that institution that:

- Begins while the student is suffering from a severe illness or injury;
- Is Medically Necessary; and
- Causes the loss of full-time student status under the plan.

Written documentation from a medical professional explaining the need for a temporary medical leave will be required by the claims administrator (CIGNA or OptumHealth Behavioral Solutions)

Medically Necessary, Medical Necessity

Services and supplies, including tests and check-up exams rendered by a Provider that are:

- necessary and appropriate for, and consistent with, the symptoms and diagnosis for direct care and treatment of the Illness or Injury
- within the standards of good medical practice in accordance with all the applicable professional and legal standards
- the most appropriate supply or level of service
- provided in the most appropriate setting
- not primarily for the convenience of the covered person, his/her family members or the provider(s) of the service
- necessary for the diagnosis of an Illness or Injury.

To be considered necessary, a service or supply must meet all of these tests:

- it is ordered by a Physician
- it is recognized throughout the Physician's profession as safe and effective, is required for the diagnosis or treatment of the particular Illness or Injury and is employed appropriately in a manner and setting consistent with generally accepted U.S. medical standards, and
- it is not Educational, Experimental or Investigational in nature.

Your Employer may require proof in writing that any type of service or supply is Medically Necessary, and Medical Necessity will be determined solely by your Employer. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, in itself, make this service or supply Medically Necessary.

Medical Necessity does not include a repeated test that is not necessary, experimental service or supply, services or supplies provided for psychological support, education or vocational training of the covered person, or implant of any artificial organ for any reason whatsoever. The Plans do not cover all Medically Necessary procedures, services and supplies, as some specific exclusions and limits on coverage may apply.

Medicare

Title XVIII (Health Coverage for the Aged and Disabled) of the Federal Social Security Act, as amended from time to time.

Member Services

Customer service centers staffed with representatives who can answer questions concerning coverage and Claims, provide information about Network Providers, send you a Provider directory, identification cards and provide other administrative services.

Network

A group of Hospitals, Doctors and other health care professionals who have an agreement with a Medical Plan or insurance carrier or third party administrator to provide health care

services at a negotiated rate. The Providers agree to accept negotiated fees as payment in full.

Network Provider
Providers including Hospitals, Physicians, other health care providers and pharmacies who have entered into an agreement to participate in a network.

Newborn
An infant from the date of birth until the initial Hospital discharge or until the infant is 31 days old, whichever occurs first.

Non-odontogenic
Conditions that do not arise from disorders of the teeth.

Non-preferred Brand Drug
These are Brand-Name Drugs not included on the Formulary of the prescription benefit Claims Administrator that may have one or more Formulary alternatives.

Ophthalmologist
A medical Doctor who specializes in the treatment of disorders of the eye.

Optometrist
A Doctor of Optometry trained and legally qualified to perform eye examinations and prescribe Lenses.

Out-of-Network Benefits
The level of benefits you receive under a managed medical plan option or coverage under a medical plan option that is managed (e.g., the Mental Health and Substance Abuse Treatment Benefit and Prescription Drug Benefit under all the Nortel Networks Retiree Medical Plan options) when you use a health care provider who does not participate in the network.

Out-of-Pocket Maximum
The maximum dollar amount you pay annually out of your pocket for covered medical expenses, excluding Deductibles, Copayments and any amounts over reasonable and customary limits. This amount also excludes mental health and substance abuse treatment benefits and prescription drug benefit expenses. The plan pays 100% of any Covered Expenses (except outpatient treatment for mental Illness, alcohol or substance abuse) after the maximum is reached, up to the Retiree Medical Plan's maximum benefit.

Pay-the-Difference
The Pay-the-Difference feature is designed to provide higher coverage for lower-cost alternatives to Brand-Name Drugs. Whenever you buy a Brand-Name Drub that has a

lower-cost generic equivalent, whether through a retail pharmacy or through the Home Delivery Service, you'll pay the applicable Brand-Name Copayment/Coinsurance plus the difference between the cost of the generic equivalent and the cost of the Brand-Name Drug. This includes anytime your Doctor indicates that the prescription should be "Dispensed As Written".

Pension Service Plan

The Nortel Networks Pension Service Plan that became effective on January 1, 1999, and became part of the Traditional program within the previously available Capital Accumulation and Retirement Program that was introduced May 1, 2000.

Physician
See "Doctor."

Plan Administrator
Nortel Networks Inc. (NNI) acting by and through its Board of Directors.

Plan Year
For Deductibles, Calendar Year Out-of-Pocket Maximums, and EAP visits the Plan Year for the Retiree Medical Plan is January 1 to December 31.

Precertification
A process where the need for Hospital admission and certain outpatient procedures is verified prior to admittance. For inpatient admissions, your length of stay is also reviewed.

Predetermination Review
A process through which a proposed Durable Medical Equipment purchase is reviewed and an estimate of benefits considered eligible for payment under the plan is provided by the Claims Administrator before the equipment is purchased

Preexisting Condition
Any condition for which you:

- receive treatment or services,
- incur expense,
- receive diagnosis, or
- take prescribed medication before coverage begins.

Preferred Brand-Name Drug
These are Brand-Name Drugs that are included on the Formulary of the prescription benefit Claims Administrator. These drugs may offer greater discounts than non-preferred Brand-Name Drugs, which reduces both your and the Company's costs.

Preferred Provider Organization (PPO)
A Managed Care network Medical Plan option that pays benefits when you see health care professionals within the preferred provider network. If you go to a provider who is not a member of the network, the PPO option still pays benefits, but at the lower Out-of Network Benefit Level

Prescription Drug
For Prescription Drugs payable under the Retiree Medical Plan, this means only:

1. A medicinal substance that, by law, can be dispensed only by prescription
2. A compound medication that includes a substance described in (1) or

3. Prescribed oral and injectable insulin and insulin syringes.

It does not include experimental drugs, allergy and biological sera, therapeutic devices or appliances and injectables, other than prescribed injectable insulin

Preventive Care

For purposes of your Retiree Medical Plan, Preventive Care includes services such as well baby care, annual physicals rendered solely for health maintenance and not for Illness or Injury, routine OB/GYN diagnostic care, routine mammogram and sigmoidoscopy. Limitations apply.

Prior Plan

The Northern Telecom Inc. Retirement Plan for Employees as in effect prior to January 1, 1999.

Provider

A person or organization, such as a Physician, Hospital or pharmacy, that provides health care services.

Provider Directory

A listing of Doctors, Hospitals and other health care professionals who belong to a Managed Care Network.

Psychologist

A person who is licensed or certified as a clinical Psychologist or who is considered qualified as a clinical Psychologist by a recognized psychological association.

Qualified Medical Child Support Order (QMCSO)

An order or judgment from a court that directs the Plan Administrator to cover a child for benefits under a group health plan, as required under Section 609 of the Employee Retirement Income Security Act of 1974.

Reasonable and Customary Charge

A charge for a Covered Expense under the Medical Plan that is the normal charge made by a licensed practitioner for a similar service and does not exceed the normal charge made by most providers in the geographic area where the service is provided.

Retirement

Moving from actively at-work status with an Employer to “Early Retirement,” “Normal Retirement” or “Late Retirement” status, as defined according to the terms of the previously available Nortel Networks Retirement Income Plan that apply to the Retiree as a Traditional or Balanced program member. With respect to an Investor program member, “Retirement” means moving from actively at-work status with an Employer to retirement status after reaching age 55. If there is a period of time during which an employee is receiving Nortel Networks standard severance benefits from the Employer between

actively-at-work status and retirement status, the employee will be considered to have retired directly from Company service. Retirement from Company service does not include any employee who moves from disability status to retirement status.

Retirement Start Date
The date a Retiree's Retirement from Employer service is effective according to the terms of the previously available Nortel Networks Retirement Income Plan.

Retired Employee, Retiree
An employee of the Employers who has retired from the active service of the Employers according to the provisions of the previously available Nortel Networks, Inc., Retirement Plan

Retiree Medical Plan
The plan described in this summary that provides medical benefits to Retired Employees and their eligible and enrolled Dependents.

Room and Board
Charges made by a Hospital for room and meals and for all general services and activities needed for the care of registered bed patients.

Second Surgical Opinion
An opinion secured by a Physician who:

- is not in practice with or related to the Physician who gave the original recommendation for Surgery, and
- whose practice would normally include treatment of the condition for which Surgery was originally recommended.

The second surgical opinion may not be rendered by the physician selected to perform the Surgery.

Semi-Private
A class of accommodations in a hospital or skilled nursing facility in which at least two patient beds are available per room.

Short-Term Rehabilitation
Therapy that is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function) which has been lost or impaired due to an Injury, disease or Congenital defect.

Sickness
See "Illness."

Skilled Nursing Facility
An institution that meets all of these tests:

- it is legally operated.
- it mainly provides short-term nursing and rehabilitation services for persons recovering from Illness or Injury. The services are provided for a fee from its patients, and include both:
    - Room and Board, and
    - twenty-four hour a day skilled nursing service.
- it provides the services under the full-time supervision of a Doctor or registered nurse (RN).
- it keeps adequate medical records.
- if not supervised by a Doctor, it has the services of one available under a fixed agreement.

"Skilled Nursing Facility" does not include an institution or part of one that is used mainly as a place for rest or for the aged.

Specialist
A Physician whose practice is limited to a particular branch of medicine or Surgery other than general practice, internal medicine, pediatrics, or family practice.

Status Change
You can make certain changes in the Dependents who are covered and your Dependent coverage level under the Nortel Networks Retiree Medical Plan during the 31-day period after you or your covered Dependent(s) experiences certain events. Please see Section "Changing Your Selection" for details concerning Status Changes.

Surgery
Generally recognized and accepted Medically Necessary operative procedures for the treatment, diagnosis or evaluation of an Illness or Injury.

Temporomandibular Joint Dysfunction (TMJ)
A malfunction of the joint between the lower jawbone and the temporal bone.

Terminally Ill
The medical prognosis of a person with a chronic, progressive illness that has been designated not curable by the covered person's attending physician. Expected survival must be six months or less at the time of referral to a hospice.

Termination Date
The last day you work for the Employer.

Termination of Domestic Partnership Statement
A Nortel form which notifies the Company that a Domestic Partnership has dissolved.

Total Disability
For determination of benefits under the Nortel Networks Retiree Medical Plan, the inability to engage in the normal activities of a person of the same age, sex, and ability or, in the case of a Dependent who normally works for wage and profit, his inability to work for wage or profit. Medicare standards for determination of total disability may differ from those used by the Retiree Medical Plan.

Wholly Dependent
Complete dependency for the full care, support and maintenance of a physically or mentally disabled individual, including services necessary to maintain life, such as room and board, health and comfort of the Dependent.

Workers' Compensation Benefits
Benefits covered under Workers' Compensation law.

Years of Service
A year of Vesting Service under Section 3.2 of the previously available Nortel Networks Retirement Income Plan.

Further, for non-grandfathered Traditional and Balanced Program members, the year in which the member becomes 40 years of age is counted as a full year of service for the purpose of determining years of service for the Retiree Medical Plan, if such year would not otherwise be counted as a Year of Service." Also, the year in which the non-grandfathered Traditional or Balanced Program member retires is counted as a full year of service for the purpose of determining years of service for the Retiree Medical Plan and if such year would not otherwise be counted as a Year of Service.

APPENDIX A

Claims Administrator Information Used In Claim Determinations

The following is a list of the resources relied upon in Claims determination by the Claims Administrators for the Medical Plan, including:

- Connecticut General Life Insurance Company (CIGNA)
- Medco Health (Medco)
- OptumHealth Behavioral Solutions

You can obtain information on the criteria the Claims Administrator relies upon in determination of your Claim as described below.

CIGNA

- CIGNA Standard Operating Procedures
  - Used to determine whether your Claim meets the following standards that apply under this plan: Common Medical Standards; Educational, Experimental or Investigational; and Medically Necessary services, supplies and treatments.

- CIGNA Clinical Resource Tools
  - Used to determine whether your Claim meets the following standards that apply under this plan: Common Medical Standards; Educational, Experimental or Investigational; and Medically Necessary services, supplies and treatments.

- Milliman & Roberts' Guidelines
  - Used to determine whether your Claim meets the following standards that apply under this plan: Common Medical Standards; Educational, Experimental or Investigational; and Medically Necessary services, supplies and treatments. Provides independent medical guidelines.

- Ingenix's Prevailing Healthcare Charges System
  - Used to determine whether your Claim meets the following standards that apply under this plan: Reasonable and Customary Charges.

To request the documents listed above that CIGNA relies upon in determination of your Claim, send a written request to CIGNA at the Claim office address on your Medical Plan ID Card.

Medco

- Medco Plan ESM Plan Design Document is used for retail Claims to determine:
    - Covered Expenses,
    - treatments that require prior authorization, and
    - exclusions, and limits, including dispensing limits

- Medco Plan ESN Plan Design Document is used for home delivery Claims to determine:
    - Covered Expenses,
    - quantity per Copayment requirements,
    - treatments that require prior authorization, and
    - exclusions, and limits, including dispensing limits

See "Appendix B" of this SPD for the above Medco documents.

- Medco clinical information is used when prescription Medications require prior authorization. Medco refers to its clinical information in evaluating whether your prescription medication is covered under the plan.

To request the clinical information document that Medco relies upon in determination of your Claim, call Medco member services at 1-800-711-3460.

OptumHealth Behavioral Solutions

- Level of Care Guidelines, including:
  OptumHealth Behavioral Solutions Level of Care Guidelines - Introduction
  a. Mental Health Guidelines: Introduction
     MH Level Of Care Criteria: Crisis Assessment
     MH Level Of Care Criteria: 23-Hour Observation
     MH Level Of Care Criteria: Acute Inpatient
     MH Level Of Care Criteria: Subacute Inpatient
     MH Level Of Care Criteria: Residential Treatment
     MH Level Of Care Criteria: Partial Hospital/Day Treatment
     MH Level Of Care Criteria: Intensive Outpatient
     MH Level Of Care Criteria: Home Health
     MH Level Of Care Criteria: Outpatient
     MH Level Of Care Criteria: Outpatient Termination Guidelines
     Mental Health Continued Stay Criteria
  b. Substance Abuse Guidelines: Introduction
     SA Level Of Care Criteria: Crisis Assessment Services
     SA Level Of Care Criteria: 23-Hour Observation
     SA Level Of Care Criteria: Inpatient Detoxification
     SA Level Of Care Criteria: Inpatient Rehabilitation
     SA Level Of Care Criteria: Residential Rehabilitation
     SA Level Of Care Criteria: Chemical Dependence Halfway House
     SA Level Of Care Criteria: Partial Hospital/Day Treatment

SA Level Of Care Criteria: Intensive Outpatient Program
SA Level Of Care Criteria: Outpatient
SA Level Of Care Criteria: Outpatient Discharge Guidelines
Substance Abuse Continued Stay Criteria

c. Mental Health LOC Guidelines Summary
d. Substance Abuse LOC Guidelines Summary
e. Dual Diagnosis LOC Guidelines Summary

You may access the OptumHealth Behavioral Solutions Level of Care Guidelines at the following website:
https://www.ubhonline.com/html/guidelines/levelOfCareGuidelines/index.html

- Ingenix's Prevailing Healthcare Charges System (used to determine whether your Claim meets the plan's standard for: Reasonable and Customary Charges)

APPENDIX B

Prescription Benefits
Medco Information Used In Claim Determination

Retail Plan (ESM Plan Design Document)

Covered Drugs:

The following are covered benefits unless listed as an exclusion below

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes
- OTC Diabetic Supplies (except Blood Glucose Testing Monitors)
- Oral Contraceptives
- Legend Contraceptive devices and injections
- Retin-A/ Avita through age 35
- Yohimbine
- Anabolic Steroids

Managed Care Prior Authorization:

- Drugs to treat Impotency (i.e. Caverject, Edex, Muse) limited to a 6 day supply or 6 units, whichever is lesser per Claim
- IVR - Viagra limited to a 6 day supply or 6 tablets whichever is lesser per Claim
- IVR – Retin-A/ Avita age 36 and older

Exclusions:

The following are excluded from coverage unless specifically listed as a benefit under "Covered Drugs".

- Non-Federal Legend Drugs
- OTC Contraceptive jellies, creams, foams, or devices
- Contraceptive implants
- Gamma Globulin
- Ostomy Supplies
- Blood Glucose Testing Monitors
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth (i.e. Rogaine®, Propecia®) or for cosmetic purposes only (i.e. Renova®).
- Allergy Sera
- Biologicals, Immunization agents or Vaccines

- Blood or blood plasma products
- Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.

Dispensing Limits:

- The amount of drug which is to be dispensed per prescription or refill will be in quantities prescribed up to a 90 day supply.

Home Delivery (Mail-Order) Plan (ESN Plan Design Document)

Covered Drugs:

The following are covered benefits unless listed as an exclusion below

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes
- OTC Diabetic Supplies (except Blood Glucose Testing Monitors)
- Oral Contraceptives
- Legend Contraceptive devices and injections
- Retin-A/ Avita through age 35
- Anabolic Steroids

Quantity Per Copayment:

- Drugs to treat Impotency (except Viagra) for males age 18 and over limited to a 90 day supply or 18 units, whichever is lesser per Claim

Managed Care Prior Authorization:

- IVR - Viagra limited to a 90 day supply or 18 tablets whichever is lesser

Exclusions:

The following are excluded from coverage unless specifically listed as a benefit under "Covered Drugs".

- Non-Federal Legend Drugs
- OTC Contraceptive jellies, creams, foams, or devices
- Contraceptive implants
- Gamma Globulin
- Retin-A/ Avita age 36 and over
- Ostomy Supplies
- Blood Glucose Testing Monitors
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth (i.e. Rogaine®, Propecia®) or for cosmetic purposes only (i.e. Renova®).
- Allergy Sera
- Biologicals, Immunization agents or Vaccines
- Blood or blood plasma products
- Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.

Dispensing Limits:

The amount of drug which is to be dispensed per prescription or refill will be in quantities prescribed up to a 90 day supply.

Specialty Drugs

The following is a list of drugs classified by Medco as Specialty Drugs. Specialty drugs are available through Accredo Health Group, a subsidiary of Medco Health. Coverage for these medications may vary. To confirm plan coverage and to order, call toll-free 1-800-501-7260 between 8:00 a.m. and 8:00 p.m., Eastern Standard Time, Monday through Friday — or just have your doctor contact Medco at 1-800-987-4904.

RARE DISEASE

Adagen® (pegademase bovine)
Advate® (antihemophilic factor [recombinant])
Aldurazyme® (laronidase)
Alphanate® (antihemophilic factor [human])
AlphaNine® SD (coagulation factor IX [human])
Aralast® (alpha[1]-proteinase inhibitor [human])
Bebulin® VH (factor IX complex)

BeneFIX® (coagulation factor IX [recombinant])
Carimune® NF (immune globulin intravenous [human])
Cerezyme® (imiglucerase)
*Elaprase*TM (idursulfase)
Fabrazyme® (agalsidase beta)
Feiba® VH (anti-inhibitor coagulant complex)
Flebogamma® (immune globulin intravenous [human])
Flolan® (epoprostenol sodium)
Gammagard® Liquid (immune globulin intravenous [human])
Gammagard® S/D (immune globulin intravenous [human])
Gamunex® (immune globulin intravenous [human])
Helixate® FS (antihemophilic factor [recombinant])
Hemofil®M(antihemophilic factor [human])
Humate-P® (antihemophilic factor/vonWillebrand factor complex [human])
Hyate:C® (antihemophilic factor [porcine])
Koate®-DVI (antihemophilic factor [human])
Kogenate® FS (antihemophilic factor[recombinant])
*Letairis*TM (ambrisentan)
*Monarc-M*TM (antihemophilic factor [human])
Monoclate-P® (antihemophilic factor [human])
Mononine® (coagulation factor IX [human])
Myozyme® (alglucosidase alfa)
Naglazyme® (galsulfase)
NovoSeven® (coagulation factorVIIa [recombinant])
Octagam® (immune globulin intravenous [human])
Orfadin® (nitisinone)
Polygam® S/D (immune globulin intravenous [human])
Profilnine® SD (factor IX complex [human])
Proplex® T (factor IX complex)
*Recombinate*TM (antihemophilic factor [recombinant])
ReFacto® (antihemophilic factor [recombinant])
Remodulin® (treprostinil sodium)
Revatio® (sildenafil citrate)
*Soliris*TM (eculizumab)
Stimate® (desmopressin acetate)
Tracleer® (bosentan)
Ventavis® (iloprost)

SELF-ADMINISTERABLE

Actimmune® (interferon gamma-1b)
Apokyn® (apomorphine hydrochloride)
Avonex® (interferon beta-1a)
Betaseron® (interferon beta-1b)
Bravelle® (urofollitropin)
Cetrotide® (cetrorelix acetate)
Chorex-10™ (chorionic gonadotropin)

Chorionic gonadotropin (generic)
Copaxone® (glatiramer acetate)
Enbrel® (etanercept)
Follistim AQ™ (follitropin beta)
Forteo® (teriparatide [rDNA origin])
Fuzeon® (enfuvirtide)
Ganirelix acetate (formerly *Antagon*™)
Genotropin® (somatropin [rDNA origin])
Gonal-f® (follitropin alfa)
Gonal-f® *RFF* (follitropin alfa)
Humatrope® (somatropin [rDNA origin])
Humira™ (adalimumab)
Increlex® (mecasermin [rDNA origin])
Infergen® (interferon alfacon-1)
Intron® *A* (interferon alfa-2b)
Kineret® (anakinra)
Luveris® (lutropin alfa)
Menopur® (menotropins)
Norditropin® (somatropin [rDNA origin])
Norditropin/NordiFlex® (somatropin [rDNA origin])
Novarel® (chorionic gonadotropin)
Nutropin® (somatropin [rDNA origin])
Nutropin AQ® (somatropin [rDNA origin])
Omnitrope™ (somatropin [rDNA origin])
Orfadin® (nitisinone)
Ovidrel® (choriogonadotropin alfa)
Pegasys® (peginterferon alfa-2a)
PEG-Intron® (peginterferon alfa-2b)
PEG-Intron® *Redipen*® (peginterferon alfa-2b)
Pregnyl® (chorionic gonadotropin)
Profasi® *HP* (chorionic gonadotropin)
Pulmozyme® (dornase alfa)
Raptiva® (efalizumab)
Rebif® (interferon beta-1a)
Repronex® (menotropins)
Saizen® (somatropin [rDNA origin])
Sensipar® (cinacalcet hydrochloride)
Serostim® (somatropin [rDNA origin])
Tev-Tropin® (somatropin [rDNA origin])
Tobi® (tobramycin)
Zorbtive® (somatropin [rDNA origin])