NORTEL NETWORKS RETIREE LIFE INSURANCE AND LONG-TERM CARE PLAN

SUMMARY PLAN DESCRIPTION
2011

CONTENTS

INTRODUCTION

The Nortel Networks Retiree Life Insurance and Long-Term Care Plan helps provide financial security to you and your family by providing your survivors with a death benefit if you die and insurance to protect you and your spouse should either of you need long-term care.

This is a brief description of the provisions of the Retiree Life Insurance and Long-Term Care Plan. Please read this information carefully to understand your options.

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 document.

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 Life Insurance and Long-Term Care Plan can be found in the Plan documents. If there are any discrepancies between the information in this summary and the Nortel Networks Retiree Life Insurance and Long-Term Care Plan document, the actual plan document shall, in all cases, govern the details of the benefit coverage and the plan administration. In accordance with each plan or program, Nortel Networks reserves the right to amend or discontinue the plan program described in this summary at any time without prior notice to, or consent by, employees.

This SPD describes the provisions of the Plan that are in effect as of January 1, 2011. If you retired or became a covered dependent of a retired employee under the Plan prior to that date, your eligibility for coverage and your coverage options were determined by the Plan as it existed on your retirement date. You may not make changes in the coverage that you currently have or elect as future coverage.

PLAN HIGHLIGHTS

If you were hired on or after January 1, 2008 or were a member of the previously available Investor Program under CARP there is no retiree life insurance or long-term care benefit available to you.

If you were not age 50 with at least five years of service on July 1, 2006:
Effective January 1, 2008, if you were hired before January 1, 2008, and were a member of the previously available Traditional or Balanced Program of the Capital Accumulation and Retirement Programs (CARP) on December 31, 2007, you will be eligible for a $10,000 retiree life insurance benefit (no long term care available)

upon retirement from the Company provided you meet the eligibility requirements described later in this summary plan description.

If you were age 50 with at least five years of service on July 1, 2006:
Effective January 1, 2008, if you were a member of the previously available Traditional or Balanced Program of the Capital Accumulation and Retirement Programs (CARP) on December 31, 2007 and provided you meet the eligibility requirements described later in this summary plan description, you may choose one of the following coverage options under the Retiree Life Insurance and Long-Term Care Plan:

Option	Coverage	Benefit
Option 1 Available only to retirees who chose the Traditional Program under CARP and were a US based employee	You only	Life Insurance: If your employment began prior to January 1, 1991, you can choose Life Insurance equal to your base pay and commissions as of December 31, 1990. This insurance amount will be reduced by 10% of the initial amount each year for five years. After five years, the life insurance coverage will be equal to one-half of the initial amount with a maximum amount of $50,000. Long-Term Care: No benefit
Option 2	You only	Life Insurance: $35,000 Life Insurance coverage Long-Term Care: No benefit
Option 3	You only	Life Insurance: $10,000 Life Insurance coverage Long-Term Care: Coverage of up to $100 per day up to a lifetime maximum of $180,000
Option 4	You and your spouse	Life Insurance: $10,000 Life Insurance coverage for you only Long-Term Care: Coverage of up to $70 per day for you and your spouse up to a combined lifetime maximum of $125,000
Option 5	You only	Life Insurance: $10,000 Life Insurance coverage Long-Term Care: No benefit

Option 6		Waive Coverage

ELIGIBILITY

For You

For currently Retired Employees:

At the time that you retired, if you were eligible you were provided with information about the Retiree Life Insurance and Long-Term Care Plan that was available to you and you selected a coverage option. After retirement, you may not make changes to your coverage under the Nortel Networks Retiree Life Insurance and Long-Term Care Plan.

For current Employees:

If you were hired on or after January 1, 2008

You are not eligible for Retiree Life or Long Tern Care Benefits.

If you were hired prior to January 1, 2008.

Effective January 1, 2008, your eligibility for the Retiree Life Insurance and Long-Term Care Plan depends upon which of the previously available Capital Accumulation and Retirement Programs you were a member of as of December 31, 2007. Below is a Table outlining the Retiree Life Insurance and Long-Term Care Plan eligibility requirements applicable to each of these programs (Grandfathered, Traditional, Balanced and Investor Programs):

	Traditional Program		Balanced Program	Investor Program
	Grandfathered[1]	Non-grandfathered		
Eligible to participate in the Retiree Life and Long-Term Care Plan	Age: 55 Service: 10 years[2]	Age: 55 Service: 10 years after age 40	Age: 55 Service: 10 years after age 40	No Coverage

[1]If you were at least age 50 and had a 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 Life Insurance and Long-Term Care Plan at age 65 with 1 year of service.

If you retire from Nortel Networks Inc. or another company that has adopted the Nortel Networks Retiree Life Insurance and Long-Term Care Plan ("Employers") or a successor plan, you are entitled to select coverage under this plan provided you:

- were a member of the previously available Traditional or the Balanced Program under the Capital Accumulation and Retirement Programs on December 31, 2007,
- are at least age 55 on your Retirement Start Date,
- have at least ten years of Service after age 40 on your Retirement Start Date, ***and***
- move immediately from actively-at-work status with an Employer to immediate commencement of Retirement under the Early or Normal Retirement provisions of the Nortel Networks Retirement Income Plan.

    - A retiree will still be considered to have moved immediately to retirement status even if there is an intervening period of severance benefits payments under a Nortel Networks Severance Allowance Plan

If you are covered by a collective bargaining agreement that does not specifically provide for participation in this plan, you **are not** eligible to participate in the Retiree Life Insurance and Long-Term Care Plan.

Disability Leave of Absence and Long-Term Care Coverage

Long-term care coverage **is *not*** available if you begin your retirement benefits under the Nortel Networks Retirement Income Plan immediately after a disability leave of absence. However, if you retire from a disability leave of absence and meet all other eligibility requirements described above, you are eligible for Options 1 or 2.

For Your Eligible Spouse

Your spouse as of your Retirement Start Date is eligible for long-term care coverage if you retire after age 55 with at least 10 years of service after age 40 and enroll for Option 4 (see chart on page 4) within the specified time frame.

Special Eligibility Rules

If You and Your Spouse Both Retire from Nortel Networks

If you and your spouse are both eligible to participate in the Retiree Life Insurance and Long-Term Care Plan, then special rules apply for enrolling in the Plan. You may enroll as a Retiree or a spouse but not both.

If Your Spouse is in the Armed Forces

Your spouse is not eligible for coverage while on Active Duty in the armed forces of any country.*

*Contact HR Shared Services if your Spouse is on Active Duty at the time of your retirement start date (1-800-676-4636 or 919-905-9351).

PARTICIPATION

Retiree Life Insurance and Long-Term Care coverage are available to you when you become a Retired Employee provided you meet the eligibility requirements (see page 5). Prior to your Retirement Start Date, HR Shared Services will send you information and forms to complete regarding your participation in the Retiree Life Insurance and Long-Term Care Plan. This information will be included with material regarding your benefits under the Nortel Networks Retirement Income Plan. With this information, you will be able to determine which plan option best meets your needs.

For your Retiree Life and Long-Term Care benefits to begin, you must complete the necessary election forms within 31 days after your Retirement Start Date. **If you choose not to enroll in the Retiree Life and Long-Term Care Plan at that time, you will not be eligible for enrollment in the Plan later.**

WHEN COVERAGE BEGINS

Provided you meet the eligibility requirements and elect coverage, your Retiree Life Insurance and Long-Term Care Plan coverage will begin on your Retirement Start Date for you and your eligible spouse (if coverage for your spouse is selected).

WHEN COVERAGE MAY BE DELAYED

FOR SPOUSAL LONG-TERM CARE COVERAGE

If your spouse is not covered by the Nortel Networks Medical Plan and is confined for medical care or treatment in any institution on your Retirement Start Date, coverage will be delayed. The Coverage will take effect upon the spouse's final release by his or her physician when he/she is no longer confined

COST OF COVERAGE

Premiums are determined by the Plan Administrator for this plan and totally paid by your Employer on your behalf. The life insurance coverage is fully-insured, while the long-term care coverage is self-insured.

RETIREE LIFE INSURANCE

If you die while covered under the Retiree Life Insurance Plan, the Plan will pay a benefit (based on the option you elect) to your Beneficiary as outlined in the chart above. The benefit is payable when the Plan Administrator receives written proof of death.

BENEFICIARIES

You have the right to choose a Beneficiary(ies) who will receive any benefits paid from the Nortel Networks Retiree Life Insurance under your coverage.

You can name anyone you wish as your Beneficiary. You can name one person or several people. If more than one person is named, you must indicate the percentage of the total benefit each person should receive. If you do not indicate each person's share, they will share equally in the benefit. You can change your Beneficiary at any time by completing a new Beneficiary form and returning your completed form to HR Shared Services. Once received by HR Shared Services, the change will take effect on the date you signed the form. To obtain a Beneficiary form, contact HR Shared Services. However, it will not apply to any amount paid by the Plan Administrator before it receives the form.

If you do not designate a Beneficiary, benefits will be paid in total to whoever is in the first order of priority as per the following order:
1. widow or widower
2. surviving children
3. surviving parent(s)
4. surviving brother(s) and sister(s)
5. executor(s) or administrator(s) of your estate

If a Beneficiary dies before you, that Beneficiary's interest will end. It will be shared equally by any remaining Beneficiaries, unless the Beneficiary form states otherwise.

HOW BENEFITS ARE PAID

Normally, your Beneficiary receives benefits in a lump sum payment. However, if your Beneficiary chooses, alternate methods of payment, such as monthly installments, can be used.

If your Beneficiary prefers benefits to be paid in installments, your Beneficiary should contact HR Shared Services for more information.

FILING CLAIMS UNDER THE LIFE INSURANCE COVERAGE

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 Life Insurance Coverage of the Nortel Networks Retiree Life Insurance and Long-Term Care 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.

Your Beneficiary should file a Claim for benefits with Prudential after your death. This process can be initiated by calling HR Shared Services (1-800-676-4636 or 919-905-9351). A death certificate will be required. There is not a specific time limit for submitting a claim for life insurance benefits.

Determination of Benefits

Prudential will notify your Beneficiary of the Claim determination within 45 days of the receipt of the Claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide the Claim, will be furnished to your Beneficiary within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on the Claim, will be furnished to your Beneficiary within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your Beneficiary's failure to submit information necessary to decide the Claim, the period for making the benefit determination by Prudential will be tolled from the date on which the notification of the extension is sent to your Beneficiary until the date on which your Beneficiary responds to the request for additional information.

If the Claim for benefits is denied, in whole or in part, your Beneficiary or your Beneficiary's authorized representative will receive a written notice from Prudential of the denial. The notice will be written in a manner calculated to be understood by your Beneficiary and will include:

a. the specific reason(s) for the adverse determination,
b. references to the specific plan provisions on which the benefit determination was based,
c. a description of any additional material or information necessary for your Beneficiary to perfect a Claim and an explanation of why such information is necessary, and
d. a description of the Prudential's appeals procedures and applicable time limits, including a statement of your Beneficiary's right to bring a civil action under section 502(a) of ERISA following your appeals.

If the written notice indicates that the Claim is denied due to a participation eligibility issue, you or your Beneficiary (depending on when the Claim is raised) will be directed to address any appeal to Nortel's HR Shared Services as explained under the "WHAT TO DO IF YOU ARE DENIED THE RIGHT TO PARTICIPATE IN THE RETIREE LIFE INSURANCE PLAN" section below. Otherwise, your Beneficiary will need to follow the procedure described in the next section, "WHAT TO DO IF THE LIFE INSURANCE CLAIM IS DENIED BY PRUDENTIAL", to file an appeal.

WHAT TO DO IF THE LIFE INSURANCE CLAIM IS DENIED BY PRUDENTIAL

Appeals of Adverse Benefit Determination to Prudential

If your Beneficiary's Claim for benefits is denied (for a reason other than your ineligibility to participate in the Life Insurance Plan or your ineligibility for the coverage level that is claimed) or if your Beneficiary does not receive a response to the Claim within the appropriate time frame (in which case the Claim for benefits is deemed to have been denied), your Beneficiary or your Beneficiary's representative may appeal the denied Claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such Claim is denied. Your Beneficiary may submit with the appeal any written comments, documents, records and any other information relating to the Claim. Upon your Beneficiary's request, your Beneficiary will also have access to, and the right to obtain copies of, all documents, records and information relevant to the Claim free of charge. 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 regardless of whether such statement was relied upon in making the benefit determination.

A full review of the information in the Claim file and any new information submitted to support the appeal will be conducted by the Prudential Appeals Review Unit. The Claim decision will be made by a member of the Prudential Claims Management Team. The Prudential Appeals Review Unit and Claims Management Team members are made up of individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

The Prudential Appeals Review Unit will make a determination on the Claim appeal within 45 days of the receipt of the appeal request. This period may be extended by up to 90 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Prudential Appeals Review Unit expects to render a decision will be furnished to your Beneficiary within the initial 45-day period. However, if the period of

time is extended due to your Beneficiary's failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to your Beneficiary until the date on which your Beneficiary responds to the request for additional information.

If the Claim on appeal is denied in whole or in part, your Beneficiary will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include:

(a) the specific reason(s) for the adverse determination,
(b) references to the specific plan provisions on which the determination was based,
(c) a statement that your Beneficiary is entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit Claim upon request,
(d) a description of Prudential's review procedures and applicable time limits,
(e) a statement that your Beneficiary has the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
(f) a statement describing any appeals procedures offered by the plan, and your Beneficiary's right to bring a civil suit under section 502(a) of ERISA following the appeals.

If a decision on appeal is not furnished to your Beneficiary within the time frames mentioned above, the Claim will be deemed denied on appeal.

If the appeal of your Beneficiary's benefit Claim is denied or if your Beneficiary does not receive a response to the appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), your Beneficiary or your Beneficiary's representative may make a second appeal of the denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such Claim is deemed denied. Your Beneficiary may submit with the second appeal any written comments, documents, records and any other information relating to the Claim. Upon your Beneficiary's request, your Beneficiary will also have access to, and the right to obtain copies of, all documents, records and information relevant to the Claim free of charge.

Upon receipt of a second appeal, the Prudential Appeals Review Unit will again conduct a full review of the Claim file and any additional information submitted. The Claim decision will be made by a member of the Prudential Senior Claims Management Team. The Appeals Unit and Senior Claims Management Team member would not have been involved in the initial benefit determination or in the first appeal.

The Prudential Appeals Review Unit will make a determination on the second Claim appeal within 45 days of the receipt of the appeal request. This period may be extended by up to 90 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which the Appeals Review Unit expects to render a

decision will be furnished to your Beneficiary within the initial 45-day period. However, if the period of time is extended due to your Beneficiary's failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to your Beneficiary until the date on which your Beneficiary responds to the request for additional information.

If the Claim on appeal is denied in whole or in part for a second time, your Beneficiary will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to your Beneficiary within the time frames mentioned above, the Claim will be deemed denied upon appeal.

This Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under your Employer's ERISA plan(s). The Prudential Insurance Company of America as Claims Administrator has the sole discretion to interpret the terms of the Group Contract, to make findings, and to determine eligibility for benefits. The decision of the Claims Administrator will not be overturned unless arbitrary and capricious.

WHAT TO DO IF YOU ARE DENIED THE RIGHT TO PARTICIPATE IN THE RETIREE LIFE INSURANCE PLAN

The Company retains the exclusive right to interpret and administer the participation provisions of the plans.

First Level Participation Appeals

For appeals regarding denial of your eligibility to participate under the Nortel Networks Retiree Life Insurance coverage and the Effective Date of enrollment in the plan, you should first appeal to HR Shared Services at the address below:

HR Shared Services
Nortel Networks
PO Box 13010
Research Triangle Park, NC 27709

You have the right to:

1. Submit written comments, documents, records and other information relating to the participation appeal.
2. Request free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your participation appeal. For this purpose, a document, record or other information is treated as "relevant" to your participation appeal 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.

3. A review that takes into account all comments, documents, records and other information submitted by you relating to the appeal, regardless of whether such information was submitted or considered in the prior appeal determination.
4. A review that does not defer to the prior adverse appeal determination and that is conducted by the Plan Administrator of the plan who is neither the individual who made the adverse determination nor that person's subordinate.

HR Shared Services' notice of an adverse benefit determination regarding participation issues on appeal will contain all of the following information:

1. The specific reason(s) for the adverse appeal determination.
2. Reference to the specific plan provisions on which the appeal determination is based.
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your appeal.
4. Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse appeal determination or notice that a 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.
5. A statement of your right to bring an action under ERISA.

You will be notified by HR Shared Services of their decision within 60 days from receipt of a request for appeal of a denied Claim.

Second Level Participation Appeals

If you are not satisfied with the first level appeal decision of HR Shared Services, you have the right to request a second level appeal from the Employee Benefits Committee (EBC) of Nortel Networks Inc.

Your second level appeal request must be submitted to the EBC, at the address below, within 60 days from receipt of the first level appeal decision. The EBC has the final discretionary authority to construe and to interpret the Plan with regard to your benefit to participate in the Plan and the Effective Date of enrollment in the Plan.

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

You have the right to:

1. Submit written comments, documents, records and other information relating to the participation appeal.
2. Request free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your participation appeal. For this purpose, a document, record or other information is treated as "relevant" to your participation appeal 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.
3. A review that takes into account all comments, documents, records and other information submitted by you relating to the appeal, regardless of whether such information was submitted or considered in the prior appeal determination.
4. A review that does not defer to the prior adverse appeal determination and that is conducted by the Plan Administrator of the plan who is neither the individual who made the adverse determination nor that person's subordinate.

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 Committee 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 Committee meets monthly). 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 Committee 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 Committee 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 Committee sends you the extension notification until the date you respond to the request for additional information.

The Committee 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 Employee Benefits Committee's notice of an adverse benefit determination regarding participation issues on appeal will contain all of the following information:

1. The specific reason(s) for the adverse appeal determination.
2. Reference to the specific plan provisions on which the appeal determination is based.
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your appeal.
4. Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse appeal determination or notice that a 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.
5. A statement of your right to bring an action under ERISA.

General Information about Retiree Life Insurance Participation Appeals

Following a final adverse benefit decision, you have the right to bring a civil action under ERISA section 502(a). You and your plan may have other voluntary alternative options, such as mediation. One way to find out what may be available to you is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

See the Plan Administration section of this booklet for further details about submitting Claims. To request a Claim form, contact HR Shared Services at 1-800-676-4636.

CONVERSION PRIVILEGE

The conversion privilege gives you the option to convert your Life Insurance coverage under the plan to an individual policy if your group coverage ends. You will not have to provide Evidence of Insurability for this coverage.

To convert coverage, you must submit an application and pay the first premium within 31 days after your group coverage ends or within 15 days after you receive written notice of the conversion privilege, whichever is later. However, under no circumstances may you convert your coverage to an individual policy if you do not apply for individual coverage and pay the first premium within 92 days after your group coverage ends.

You cannot convert more than the amount of your group coverage at the time coverage ends. If all insurance under the policy is canceled for Retirees and you have been covered for at least five years, you may convert the lesser of:

- the amount of your group coverage in excess of the amount of group Life Insurance for which you are or become eligible during the 31-day conversion period, or
- $2,000.

Your individual coverage will become effective at the end of the 31-day conversion period.

For information about Life Insurance conversion, contact Prudential Group Insurance at (800) 524-0542.

DEATH BENEFIT DURING CONVERSION PERIOD

A death benefit is payable if you die:

(1) within 31 days after you cease to be a covered person; and

(2) while entitled to convert your Retiree Life Insurance to an individual contract.

The amount of the benefit is equal to the amount of Retiree Life Insurance under this Coverage you were entitled to convert. It is payable even if you did not apply for conversion. It is payable when Prudential receives written proof of death.

LIMITS ON ASSIGNMENTS

Benefits under the plan may be assigned only as a gift assignment. Prudential will not:

- be responsible for determining the validity of a purported gift assignment or
- be held accountable in knowing about an assignment unless Prudential has received a copy of it.

For more information on limits of assignments or how to assign benefits as a gift, contact your legal or tax advisor or Prudential.

RETIREE LONG-TERM CARE COVERAGE

Nortel Networks offers Long-Term Care coverage which is designed to pay benefits for certain services not covered by Medicare, the Nortel Networks Retiree Medical Plan or other insurance plans if you or your covered spouse needs long-term care.

To receive Long-Term Care benefits, the following must occur:

- You or your covered spouse is:
  - dependent on others to manage two or more of the following five Activities of Daily Living as determined by the Claims Administrator
  - bathing
  - dressing
  - toileting
  - eating

  - transferring from bed to chair, OR
  - has been assessed by Care Managers to be severely cognitively impaired.

- A 60-day waiting period must be completed before benefits begin. The waiting period begins as of the date the Claims Administrator assesses the covered person is eligible to receive benefits.

  Since the Claims Administrator can only begin the assessment process when they are made aware of a claim, it is best to file claims as soon as expenses for eligible charges are incurred. This will ensure that the waiting period begins as early as possible.

  Additionally, after a period of dependency has been established for a covered person, if that person is not confined to a Nursing Home or has not received Home Health Care Visits or Adult Day Care services for a period of six consecutive months, a new waiting period must be established unless Care Managers have verified continued Activities of Daily Living dependency during that six-month period.

ELIGIBLE CHARGES

In general, benefits are payable for eligible charges incurred for your or your spouse's Long Term Care. The Benefit Amount Payable is an amount equal to the covered percent of the eligible charges shown in Benefit Amounts, page 21, incurred for services and supplies furnished to a covered person, subject to the Maximum Daily Benefit and Lifetime Benefit Maximum shown under Benefit Amounts.

A charge is an eligible charge if all of these conditions are met:

(1) It is made for a covered service or supply furnished to you or your covered spouse.

(2) The service or supply is determined by Care Managers to be required because a covered person's physical or mental impairment either:

  (a) causes the covered person to be dependent on others for assistance in two or more of the Activities of Daily Living; or

  (b) results in an assessment by Care Managers that the covered person is severely cognitively impaired.

(3) The person has completed the waiting period

(4) The person is a covered person when the charge is incurred. A charge is considered incurred on the date of the service or supply for which the charge is made.

A charge, or part of a charge, is not an eligible charge if it is excluded. It is excluded to the extent it is described in Services Not Covered, page 19.

COVERED SERVICES

Nursing Home Services

- **Nursing home stays** are covered provided:

    - the nursing home is a qualified nursing home
    - a Room and Board charge was made by the nursing home ***and***
    - the nursing home stay began after you became eligible under this Plan.

  A qualified nursing home is a facility that:
  - Is approved by Medicare as a provider of skilled nursing care services ***or***
  - Is licensed by the state in which the institution is located as a skilled nursing home or as an intermediate care facility ***or***
  - Meets ***all*** of the following:
    - It is licensed as a nursing home by the state in which the institution is located
    - Its main function is to provide skilled, intermediate or custodial nursing care
    - It is engaged in providing continuous room and board accommodations to three or more persons
    - It is under the supervision of a registered nurse or licensed practical nurse
    - It maintains a daily medical record of each patient
    - It maintains control and records for all medications dispensed

- **Other services and supplies** furnished by the nursing home for care in it during a qualified nursing home stay are also covered services.

Home Health Care

Coverage is provided for visits by a member of a home health care agency, if the agency meets at least one of the following:

- It is licensed as a home health care agency in the jurisdiction in which the home health care is delivered ***or***

- It is a home health care agency as defined by Medicare ***or***

- It is an agency or organization which provides a program of home health care that meets ***all*** of the following:

- It is licensed to provide the services in the program of home health care - Home Health Care: A program, prescribed in writing by a person's doctor 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.
- It is certified by the Claims Administrator as an appropriate provider of home health care
- It has a full-time administrator
- It maintains written records of services provided to the patient
- Either its staff includes at least one registered nurse or nursing care by a registered nurse is available to it.

Adult Day Care

Coverage is provided for visits to an adult day care facility, if the facility meets the following two criteria:

- If the state in which the facility is located licenses adult day care facilities, the facility must be state licensed, ***and***

- The facility must:
  - Provide or be able to arrange for nursing care under the supervision of a registered nurse (RN)
  - Have a staff-to-patient ratio of no less than one to eight
  - Provide necessary assistance in Activities of Daily Living ("ADL")
  - Provide or arrange for physical and restorative therapy
  - Provide planned therapeutic, social and educational activities
  - Provide social services, such as case management and counseling
  - Provide nutritional services and counseling
  - Maintain written records of services provided to each patient
  - Have a full-time administrator.

SERVICES NOT COVERED

The following services are not covered under Long-Term Care coverage:

- Charges for which benefits are payable under any governmental plan, including Medicare, to the extent permitted by law.

- Stays in a nursing facility or other institution owned or operated by the United States Government or any of its agencies, unless payment is legally required.

- Stays or visits for injury or sickness caused by or resulting from:
  - Any war or act of war, even if war is not declared;
  - Committing or attempting to commit a felony;
  - Engaging in an illegal occupation; or
  - Participation in a riot or insurrection.

- Stays or visits due to mental, psychoneurotic or personality disorders of an inorganic nature, (i.e., schizophrenia, manic depression/depression, neuroses, and psychoses). Alzheimer's disease, organic brain syndrome, chronic brain syndrome and senile dementia are considered organic and are covered.

- Stays or visits outside the United States and its possessions.

- Stays or visits caused wholly or partly by intentionally self-inflicted injury or attempted suicide, while sane or insane.

- Stays or visits due to chronic alcoholism or chemical dependency.

- Stays or visits for which no charges would be made in the absence of insurance.

- Charges for a service or supply furnished by a Close Relative

- Charges not considered reasonably necessary

  Charges for services not deemed to be reasonably necessary, or not customarily performed, for the long term care of the person are excluded from coverage.

  To be considered "reasonably necessary", a service must meet all of these tests:
  (a) It is commonly and customarily recognized as appropriate for long term care.
  (b) It is neither educational nor experimental in nature.
  (c) It is not furnished mainly for the purpose of medical or other research.

- Services which are covered under another plan or program.

CASE MANAGEMENT

If you have Long-Term Care coverage, you will be assessed by a Care Manager for benefit eligibility and determination of long-term care needs as well as the most appropriate source and amount of care required to meet those needs.

Your eligibility for benefits will be based on your degree of physical and/or mental impairment. These dimensions of functioning will be assessed through the use of methods consistent with accepted practices in assessing the ability to perform Activities of Daily Living.

Upon certification of benefits, the Care Manager will be responsible for:

- Developing a long-term care plan in conjunction with you and other relevant resources,

- Authorizing qualified services,
- Monitoring and modifying the plan of care and needed services,
- Providing benefits counseling, and
- Conducting scheduled recertifications.

Once you are certified for benefits under the Plan, you must submit claims demonstrating that eligible services were received in order to receive benefits.

BENEFIT AMOUNTS

The maximum benefits available under the Nortel Networks Retiree Long-Term Care Coverage are as follows:

	You Only (Option 3)	You and Your Spouse (Option 4)
Maximum Daily Amount (MDA)	$100/day	$70/day per person
Nursing Home Services	up to full MDA ($100/day)	up to full MDA ($70/day per person)
Home Health Care	up to half the MDA ($50/day)	up to half the MDA ($35/day per person)
Adult Day Care	up to half the MDA ($50/day)	up to half the MDA ($35/day per person)
Lifetime Maximum Benefit	$180,000	$125,000 (you and your spouse combined)

COVERED PERCENT

- 100% of the daily charges for qualifying nursing home services, up to the Maximum Daily Amount (MDA);
- 100% of the per-visit charges for qualifying home health care services, up to one half the MDA; and
- 100% of the daily charge for adult day care services, up to one half the MDA.
- If multiple services are provided on a single day, the maximum benefit shall be limited to the MDA if the covered individual is a resident in a qualifying nursing home, and otherwise shall be limited to one half the MDA.

COORDINATION OF BENEFITS

The Retiree Long-Term Coverage includes a Coordination of Benefits provision that coordinates benefits available from more than one program. The purpose of a group health care program is to help you pay for covered expenses, but not to result in total benefits greater than the covered expenses incurred. Thus, the group plan's benefits that, without these rules, would be payable for your or your spouse's long term care expenses may be reduced so that the total benefits from this and all of the other programs (defined below) will not be more than the total Allowable Expenses. This coordination with other programs helps to control the cost of benefits for everyone.

Programs: Any of the following that provide benefits or services for, or by reason of, long term care or treatment:

(a) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid or any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

(b) Group insurance or other coverage for persons in a group, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.

For the purposes of these rules, a Long Term Care Program is one that provides benefits or services for care furnished during a Nursing Home Stay, Home Health Care Visits, Adult Day Care Visits, as defined is this coverage.

HOW COORDINATION OF BENEFITS WORKS

When the sum of the benefits in (a) and (b) below for yours or your spouse's Allowable Expenses in a Claim Determination Period would be more than those Allowable Expenses, the benefits of this program will be reduced so that the benefits of this program and the benefits of other programs ("b" below) do not total more than the Allowable Expenses.

(a) The benefits that would be payable for the Allowable Expenses under this program in the absence of the coordination of benefits.

(b) The benefits that would be payable for the Allowable Expenses under all other Programs of the same type as this program, in the absence of coordination of benefits rules, whether or not claim is made. But this (b) does not include the benefits of a Program if:

(i) It has rules coordinating its benefits with those of this program; **and**

(ii) Those rules have a Claim Determination Period and Facility of Payment items similar to those in these rules; **and**

(iii) Its rules and this program's rules both require this program to determine benefits before it does.

This Program's Rules for the Order in which Benefits are Determined: When yours or your spouse's long term care is the basis for a claim:

(a) **Active/Inactive Employee:** The benefits of a program which covers a person as an employee are determined before those of a program which covers that person as that employee's spouse. If the other program does not have this rule, and if, as a result, the programs do not agree on the order of benefits, this rule (c) is ignored.

(b) **Longer/Shorter Length of Coverage:** If none of the above rules determine the order of benefits, the benefits of the program which covered a person longer are determined before those of the program which covered that person for the shorter time.

When these rules reduce this program's benefits, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this program.

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 Long-Term Care Coverage of the Nortel Networks Retiree Life and Long-Term Care 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, 2011

You or your spouse should file a Claim with Prudential in writing for benefits after Long-Term Care expenses are incurred (see page 34 for address). Prudential must be given written proof of the loss when a Claim is filed. This proof must cover the occurrence, character and extent of loss and must be furnished within 90 days after the date of loss.

A Claim will not be considered valid unless the proof is furnished within these limits. However, it may not be reasonably possible to do so. In that case, the Claim will still be considered valid if the proof is furnished as soon as reasonably possible. The definition of reasonably possible is determined by Prudential.

Benefits are paid when Prudential receives written proof of the loss, provided the waiting period has been satisfied.

A benefit unpaid at your death will be paid to your estate. But this does not apply if the coverage or the Limits on Assignments section on an earlier page states otherwise.

Determination of Benefits

Prudential will notify you of the Claim determination within 45 days of the receipt of your Claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your Claim, will be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your Claim, will be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the Claim, the period for making the benefit determination by Prudential will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your Claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and will include:

a. the specific reason(s) for the adverse determination,
b. references to the specific plan provisions on which the benefit determination was based,
c. a description of any additional material or information necessary for you to perfect a Claim and an explanation of why such information is necessary,
d. a description of the Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals, and
e. if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

WHAT TO DO IF YOUR LTC CLAIM IS DENIED BY PRUDENTIAL

Appeals of Adverse Benefit Determination to Prudential

If your Claim for benefits is denied or if you do not receive a response to your Claim within the appropriate time frame (in which case the Claim for benefits is deemed to have been denied), you or your representative may appeal your denied Claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such Claim is denied. You may submit with your appeal any written comments, documents, records and any other information relating to your Claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your Claim free of charge. 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 regardless of whether such statement was relied upon in making the benefit determination.

A full review of the information in the Claim file and any new information submitted to support the appeal will be conducted by the Prudential Appeals Review Unit. The Claim decision will be made by a member of the Prudential Claims Management Team. The Prudential Appeals Review Unit and Claims Management Team members are made up of individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

The Prudential Appeals Review Unit will make a determination on your Claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to 90 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Prudential Appeals Review Unit expects to render a decision will be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the Claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include:
(a) the specific reason(s) for the adverse determination,
(b) references to the specific plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit Claim upon request,
(d) a description of Prudential's review procedures and applicable time limits,
(e) a statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
(f) a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under section 502(a) of ERISA following your appeals.

If a decision on appeal is not furnished to you within the time frames mentioned above, the Claim will be deemed denied on appeal.

If the appeal of your benefit Claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such Claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your Claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your Claim free of charge.

Upon receipt of a second appeal, the Prudential Appeals Review Unit will again conduct a full review of the Claim file and any additional information submitted. The Claim decision will be made by a member of the Prudential Senior Claims Management Team. The Appeals Unit and Senior Claims Management Team member would not have been involved in the initial benefit determination or in the first appeal.

The Prudential Appeals Review Unit will make a determination on your second Claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to 90 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which the Appeals Review Unit expects to render a decision will be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the Claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the Claim will be deemed denied upon appeal.

APPEALING A LONG-TERM CARE CLAIM AFTER A FINAL DENIAL FROM PRUDENTIAL

If Prudential, the Claims Administrator, makes a second denial decision on all or part of your Claim, you will be notified in writing as described above. You or your authorized representative may review all documents related to any denial of benefits. If you disagree with the Claims Administrator's decision, you have 60 days from the receipt of the denial to request a final review. This request should be made in writing and sent to the Nortel Networks Inc. Employee Benefits Committee (EBC). Their address is:

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

You have the right to:

1. Submit written comments, documents, records and other information relating to the participation appeal.
2. Request free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your participation appeal. For this purpose, a document, record or other information is treated as "relevant" to your participation appeal 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.
3. A review that takes into account all comments, documents, records and other information submitted by you relating to the appeal, regardless of whether such information was submitted or considered in the prior appeal determination.
4. A review that does not defer to the prior adverse appeal determination and that is conducted by the Plan Administrator of the plan who is neither the individual who made the adverse determination nor that person's subordinate.

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 Committee 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 Committee 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 Committee 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 Committee 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 Committee sends you the extension notification until the date you respond to the request for additional information.

The Committee 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 Employee Benefits Committee's notice of an adverse benefit determination regarding participation issues on appeal will contain all of the following information:

1. The specific reason(s) for the adverse appeal determination.
2. Reference to the specific plan provisions on which the appeal determination is based.
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your appeal.
4. Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse appeal determination or notice that a 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.
5. A statement of your right to bring an action under ERISA.

General Information about Retiree Long-term Care Coverage Appeals

Following a final adverse benefit decision, you have the right to bring a civil action under ERISA section 502(a). You and your plan may have other voluntary alternative options, such as mediation. One way to find out what may be available to you is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

WHAT TO DO IF YOU ARE DENIED THE RIGHT TO PARTICIPATE IN THE NORTEL LTC PLAN

The Company retains the exclusive right to interpret and administer the participation provisions of the plans.

First Level Participation Appeals

For appeals regarding denial of your eligibility to participate under the Nortel Networks Long Term Care Plan and the Effective Date of enrollment in this Plan, you should first appeal to HR Shared Services. See page 33 for address.

You have the right to:

1. Submit written comments, documents, records and other information relating to the participation appeal.
2. Request free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your participation appeal. For this purpose, a document, record or other information is treated as "relevant" to your participation appeal 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.
3. A review that takes into account all comments, documents, records and other information submitted by you relating to the appeal, regardless of whether such information was submitted or considered in the prior appeal determination.
4. A review that does not defer to the prior adverse appeal determination and that is conducted by the Plan Administrator of the plan who is neither the individual who made the adverse determination nor that person's subordinate.

HR Shared Services' notice of an adverse benefit determination regarding participation issues on appeal will contain all of the following information:

1. The specific reason(s) for the adverse appeal determination.
2. Reference to the specific plan provisions on which the appeal determination is based.
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your appeal.
4. Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse appeal determination or notice that a 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.
5. A statement of your right to bring an action under ERISA.

You will be notified by HR Shared Services of their decision within 60 days from receipt of a request for appeal of a denied Claim.

Second Level Participation Appeals

If you are not satisfied with the first level appeal decision of HR Shared Services, you have the right to request a second level appeal from the Employee Benefits Committee (EBC) of Nortel Networks Inc.

Your second level appeal request must be submitted to the EBC, at the address below, within 60 days from receipt of the first level appeal decision. The EBC has the final discretionary authority to construe and to interpret the Plan with regard to your benefit to participate in the Plan and the Effective Date of enrollment in the Plan.

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

You have the right to:

1. Submit written comments, documents, records and other information relating to the participation appeal.
2. Request free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your participation appeal. For this purpose, a document, record or other information is treated as "relevant" to your participation appeal 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.
3. A review that takes into account all comments, documents, records and other information submitted by you relating to the appeal, regardless of whether such information was submitted or considered in the prior appeal determination.
4. A review that does not defer to the prior adverse appeal determination and that is conducted by the Plan Administrator of the plan who is neither the individual who made the adverse determination nor that person's subordinate.

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 Committee 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 Committee 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 Committee 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 Committee 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 Committee sends you the extension notification until the date you respond to the request for additional information.

The Committee 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 Employee Benefits Committee's notice of an adverse benefit determination regarding participation issues on appeal will contain all of the following information:

1. The specific reason(s) for the adverse appeal determination.
2. Reference to the specific plan provisions on which the appeal determination is based.
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your appeal.
4. Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse appeal determination or notice that a 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.
5. A statement of your right to bring an action under ERISA.

General Information about Retiree Long-term Care Coverage Participation Appeals

Following a final adverse benefit decision, you have the right to bring a civil action under ERISA section 502(a). You and your plan may have other voluntary alternative options, such as mediation. One way to find out what may be available to you is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

WHEN COVERAGE ENDS

Your Nortel Networks Retiree Life Insurance and Long-Term Care Coverage will end when the first of these occurs:

- Your membership in the Covered Classes for the insurance ends.
  (For example, you are rehired by Nortel Networks as an active employee.)
- The part of the Group Contract providing the insurance ends.

PLAN ADMINISTRATION

This section contains information on the administration of Nortel Networks Retiree Life and Long-Term Care 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 at the end of this booklet.

Plan Year

The Plan Year is January 1 to December 31. The Plan Year may change from time to time as determined by the Plan Administrator prior to the first day of the Plan Year.

Prudential

"Prudential" in this document means the Prudential Insurance Company of America who is the ERISA Plan Administrator, i.e. makes the final decision regarding eligibility for benefits after you appeal a denied Claim, for the Retiree Life Insurance coverage of the Nortel Networks Retiree Life and Long-Term Care Plan. Prudential is the Claims Administrator, i.e. makes the initial decision about your entitlement to a benefit when you file a Claim, for the Retiree Long-Term Care coverages of the plan.

Prudential has been contracted to provide administrative services as well as process Claim reimbursements.

Nortel

"Nortel" in this booklet means Nortel Networks Inc. Nortel Networks Inc. is the Plan Administrator for the Retiree Long-Term Care coverage of the Nortel Networks Retiree Life and Long-Term Care Plan. Nortel Networks Inc. 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. The Employee Benefits Committee (EBC) is the final authority to review denied Long-Term Care Claims. Prudential Insurance Company is the final authority to review denied Life Insurance Claims. Should you need to contact the Nortel Networks Plan Administrator, use the following address:

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

To contact the Employee Benefits Committee, use the following address:

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

For general questions regarding the plan, please contact HR Shared Services at ESN 355-9351 or 800-676-4636. Hearing impaired call (TDD) 919-992-6914.

To contact HR Shared Services, use the following address:

HR Shared Services
Nortel Networks Inc.
PO Box 13010
Research Triangle Park, NC 27709

Employer Identification Number

The employer identification number assigned to Nortel Networks Inc. by the IRS is #04-2486332. Certain subsidiary companies of Nortel Networks Inc. also provide this plan to their Employees. For a complete list of these subsidiary companies, you may contact HR Shared Services.

Agent for Service of Legal Process

The agent for service of legal process is:

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

Legal process may also be served upon the trustee of any trust that funds benefits under the plans. The trustee of the Nortel Networks Inc. Health & Welfare Benefits Trust (which funds benefits under the plans) is Bank of America, Illinois. Bank of America can be contacted at the following address:

Retirement Services Group
Bank of America
231 South LaSalle Street, 13th Floor
Chicago, IL 60604
800-432-1000

PLAN IDENTIFICATION

The following chart is designed to provide you with some specific information regarding each plan and plan type that the Employers sponsor. The plan number refers to the number that has been assigned to the specific plan by the Employers. The funding method describes the party(ies) responsible for funding the plan. The Claims Administrator identifies who provides daily administrative services required to maintain each plan. The contribution source states how premiums/costs for each plan are distributed between Nortel Networks Inc. and/or plan participants. This chart is not designed to inform you of all specifics surrounding all plans. Additional information can be obtained by contacting the Claims Administrator at the respective address and phone number that are provided on the chart below.

Formal Plan Name	Plan Type	Plan Number	Funding Method	Claims Administrator	Contribution Source
Retiree Life Insurance and Long-term Care Coverage Plan	Welfare	518			Employers
Life Insurance Coverage			Insured	The Prudential Insurance Company of America Life Claim Division PO Box 8517 Philadelphia, PA 19176 800-524-0542	
Long-Term Care Coverage			Self-insured	The Prudential Long-Term Care Division. PO Box 8526 Philadelphia, PA 19176 800-732-0416	

YOUR RIGHTS UNDER ERISA

As a participant in the Company's employee benefit plans, 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:

- examine, without charge, at the Plan Administrator's office or your work location, during normal working hours, all plan documents, including insurance contracts, and copies of all documents filed by the plans with the U.S. Department of Labor, such as annual reports and plan descriptions.
- obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may request a reasonable charge for the copies.
- receive a summary of the plans' annual financial reports. The Plan Administrator is required by law to furnish each participant with a summary of these annual reports.

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

The people who supervise the operation of your plans, called "fiduciaries," have a duty to do so prudently and solely 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 benefit or exercising your rights under ERISA.

If your Claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your Claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may seek assistance from the U.S. Department of Labor or 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.

If it should happen that a plan fiduciary misuses plan 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. 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 pages 25-31.*

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.

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.

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.

Activities of Daily Living
Under the Life Insurance and Long-Term Care Plan, activities of daily living include: bathing, dressing, toileting, eating and transferring from bed to chair. To receive benefits under the Plan, you or your covered spouse must be dependent on others to manage two or more of these activities of daily living.

Allowable Expense
The reasonably necessary charge for a needed service or supply, when the charge, service or supply is covered at least in part by one or more Long Term Care Programs covering the person for whom claim is made.

Beneficiary
The person or persons you have chosen to receive benefit payments in the event of your death.

Care Manager
Registered nurses or social workers who assess your needs for care, the most appropriate source of care and the amount of care required to meet your needs.

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

Claim Determination Period
A calendar year, but, for you or your spouse, this does not include any part of a calendar year while you or your spouse has no coverage under the Nortel Networks Retiree Long-Term Care Coverage or any part of the year before the date these or similar rules take effect.

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

Close Relative
A spouse, child, grandchild, brother, sister parent or spouse's parent.

Effective Date
The date coverage goes into effect under the Plan.

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

Facility of Payment
A payment made under another program may include an amount which should have been paid under this Program. If it does, Prudential may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Program. Prudential will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case the payment made shall be deemed to be the reasonable cash value of any benefits provided in the form of services.

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

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

Plan Year
January 1 to December 31. The Plan Year may change from time to time as determined by the Plan Administrator prior to the first day of the Plan Year.

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 Nortel Networks Retirement Income Plan. With respect to an individual who is not a member of the Nortel Networks Retirement Income Plan, "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 Nortel Networks Retirement Income Plan.

Retired Employee
An employee of the Employer who has retired from the active service of the Employer according to the provisions of the Nortel Networks Inc. Retirement Income Plan.

Room and Board
Charges made by a facility for room, meals, and general services and activities needed for the care of registered patients.

Year of Service
A year of Vesting Service as described in the Nortel Networks Retirement Income Summary Plan Description.

Further, for non-grandfathered Traditional and Balanced Program members of the previously available CARP, 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 Life and Long-Term Care 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 of the previously available CARP retires is counted as a full year of service for the purpose of determining years of service for the Retiree Life and Long-Term Care Plan and if such year would not otherwise be counted as a Year of Service.