Nortel Networks Inc. Dental/Vision/Hearing Care Plan

Summary Plan Description 2012

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ABOUT THIS SUMMARY PLAN DESCRIPTION

This is the Summary Plan Description (SPD) that describes the provisions of the Nortel Networks Dental/Vision/Hearing Care Plan that are in effect for the 2012 Calendar Year. It is designed to provide you with a comprehensive resource providing detailed information about your dental/vision/hearing care benefits and connecting you to other sources of information that could not be described fully in this SPD. It is divided into the following sections:

- **SECTION ONE – DENTAL/VISION/HEARING CARE PLAN BENEFITS** describes the provisions of the Dental/Vision/Hearing Care Plan that determine your benefits.
- **SECTION TWO – ADMINISTRATIVE INFORMATION** includes administrative details about the Dental/Vision/Hearing Care 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 SPD.

In no case does this document indicate or guarantee any right of future employment.

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

SECTION ONE – DENTAL/VISION/HEARING CARE PLAN BENEFITS

This section describes the provisions of the Dental/Vision/Hearing Care Plan, including who is eligible, how participation is elected, what benefits are paid, and when participation ends.

INTRODUCTION TO DENTAL/VISION/HEARING CARE PLAN BENEFITS

The Dental/Vision/Hearing Care Plan is part of the Nortel Networks Health and Benefits Program referred to as FLEX or FLEX Program. The FLEX Program is a flexible benefits or "cafeteria" plan that offers you a choice among different types and levels of benefits. FLEX offers two kinds of benefits: "Core" and "Optional". Under FLEX, you may choose among various Core and Optional FLEX Program benefits to create your own customized benefits package. The Dental/Vision/Hearing Care Plan is an "Optional" benefit under the FLEX Program. Under FLEX, you can choose from two Dental/Vision/Hearing Care options: the Comprehensive Option or Plus Option. Or you may decline coverage.

The information contained in this document is a summary plan description (SPD) under the terms of the Employee Retirement Income Security Act of 1974 (ERISA). The complete terms of the Dental/Vision/Hearing Care Plan consist of:

- this SPD, as well as
- subsequent information that is provided to you about the plan changes from year-to-year, and
- certain information developed and used by the Claims Administrator in evaluating your Claims.

Such information includes the resources listed below.

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 Dental/Vision/Hearing Care Plan, including:

- Connecticut General Life Insurance Company (CIGNA)—regarding the Dental and Hearing Care benefits
- EyeMed—regarding the Vision Care benefits

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, CIGNA Clinical Resource Tools and CIGNA licensed dental consultants
    - Used to determine whether your Claim meets the "common dental standards" that apply under this plan for dental care benefits.

- CIGNA Standard Operating Procedures, CIGNA Clinical Resource Tools, and Milliman & Roberts' Guidelines
    - Used to determine whether your Claim meets the Common Medical Standards and is a Covered Expense under this plan for hearing care benefits.

To request the documents listed above that CIGNA relies upon in the determination of your Claim, send a written request to CIGNA at: CIGNA HealthCare, P.O. Box 188037, Chattanooga, TN 37422-8037 or call member services at 1-800-257-2702.

EyeMed

- Medically Necessary Contact Lens Criteria is used when evaluating whether your claim for medically necessary contact lenses is covered under this plan for vision care benefits.

"To request the documentation that EyeMed relies upon in determination of your Claim, call EyeMed's Member Services at 866-680-1186 or send a written request to EyeMed at: P.O. Box 8504, Mason, OH 45040-7111 Attn: Claims Department.

PLAN HIGHLIGHTS

Description	Comprehensive	Plus
Dental Coverage		
Deductible	$25 per person, $75 per family, for Basic, Major, and Orthodontia Services	$50 per person, $150 per family for Basic, Major, and Orthodontia Services
Preventive Services (such as exams, cleanings and fluoride treatments)	100% of Covered Expenses (No Deductible)	100% of Covered Expenses (No Deductible)
Basic Services (such as fillings, extractions, Periodontics, root canals and oral Surgery)	80% of Covered Expenses	80% of Covered Expenses
Major Services (such as crowns, dentures and fixed bridges)	50% of Covered Expenses	60% of Covered Expenses
Orthodontic (such as braces to correct tooth or bite alignment)	50% of Covered Expenses	50% of Covered Expenses
Annual maximum dental benefit (excludes Orthodontia, includes oral Surgery)	$1,500 per person	$2,000 per person
Lifetime maximum Orthodontia Orthodontic benefit	$1,500 per person	$2,000 per person
Note: Reasonable and Customary (R&C) limits apply to all dental coverage amounts		

Description	Comprehensive	Plus
Vision Coverage		
Copayment for vision care services	$10	$10
Routine exam, frames, and lens benefits from an EyeMed Network Provider [1]	Covered up to plan allowance after copayment	Covered up to plan allowance after copayment
Contact lens benefit from an EyeMed Network Provider [2]	Up to $150/calendar year for elective contact lenses[3]; medically necessary contact lenses are covered in full[4]; contact lenses are in lieu of spectacle lenses. Note: Only one claim per year – see footnote[3] below.	

Description	Comprehensive	Plus
Services from an Out-of-Network Provider:	Reimbursed after copayment **up to** the following under Comprehensive and Plus options. The contact Lens allowance is for Contact Lens materials only.	
Exam	$50	
Spectacle Lenses[5]: Single	$40	
Bifocal	$60	
Trifocal	$80	
Lenticular	$125	
Contact Lenses –Elective[3] (in lieu of spectacle Lenses)	$105	
Contact Lenses -Medically Necessary (in lieu of spectacle Lenses)	$210	
Frames	$45	
Plan pays benefits for: • Exams • Spectacle Lenses [5] • Contact Lenses[6] • Frames	Once every: • Calendar Year • Calendar Year • Calendar Year • 2 Calendar Years	
Laser Vision Correction Discount	When arranged with a participating provider, the discount is 15% off the retail price or 5% off any promotional offer.	

Description	Comprehensive	Plus
Hearing Care Coverage		
Eligible expenses (hearing aids and hearing exams)	80% of Covered Expenses	100% of Covered Expenses
Maximum benefit every two Calendar Years	$750	$1,000

[1]The plan allowance is a retail equivalent amount of at least $115. There is full coverage for approved frames. When deciding on a frame, ask the doctor which ones are covered in full. You may choose a frame outside the plan's coverage and pay **80% of** the difference in cost.

[2]The contact lens exam is a special exam for ensuring proper fit of your contacts and evaluating your vision with the contacts. **Standard fitting costs will not exceed $40, you pay 90% of the premium fitting cost.** Your contact lens allowance is applied to the contact lenses (material). You pay for expenses above the allowance.

[3]This is a one-time benefit per year. You must use the $150 allowance at one time during the year; any unused amount will be forfeited.

[4]Medically necessary contact lenses are for patients who cannot wear prescription glasses. Examples of conditions for prescribing medically necessary contact lenses include **Keratoconus** or to correct extreme visual acuity problems that cannot be corrected with spectacle lenses. Prior authorization is not required but advisable if you're receiving services from an out-of-network provider.

[5]In-network, there are discounts for elective lens options. Out-of-network, expenses for elective lens options are your

responsibility. Examples of elective lens options are tinting, polycarbonates, and progressives. If you have any questions, please contact EyeMed.
[6] In lieu of spectacle lenses

WHO IS ELIGIBILE

You

You are eligible for the Dental/Vision/Hearing Care Plan if you are a regular Employee working 20 or more hours per week.

If you are a member of a bargaining unit, you are not eligible for the Dental/Vision/Hearing Care Plan unless specified in the collective bargaining agreement. If you are a non-payrolled worker or independent contractor you are not eligible for the Dental/Vision/Hearing Care Plan.

If you are a long-term expatriate Employee on international assignment for the Company (as defined by the Company), you are not eligible for the Dental/Vision/Hearing Care Plan. You will be eligible for health care coverage including dental, vision, and hearing care under the International Health Services Plan. If you are a long-term expatriate Employee on international assignment for the Company (as defined by the Company) and your eligible Dependents accompany you on the assignment, they will also be eligible for coverage under the International Health Services Plan. If you are a short-term expatriate Employee on international assignment for the Company (as defined by the Company) and your eligible Dependents do not accompany you on the assignment, you are eligible to continue your Dental/Vision/Hearing Care Plan coverage under this Plan for your eligible Dependents. If this situation applies to you, you will be given additional information about your benefits.

Your Dependents

If you are eligible for and enrolled in the Dental/Vision/Hearing Care Plan, you may enroll your eligible Dependents. Eligible Dependents include:

- your spouse, including your common-law spouse (under state law) or Domestic Partner (qualified under plan rules),
- your Child(ren) and/or Domestic Partner's Child(ren) under age 26 without access to employer coverage. "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. and,
- your eligible, physically or mentally disabled Child(ren) and/or Domestic Partner's Child(ren) age 26 or over who are Wholly Dependent on you for support and maintenance and became disabled and Dependent before

age 26. You must provide a notice of the disability to HR within 31 days of your child turning age 26 for that child to be considered an eligible Dependent. If the child is over age 26, the child must have become incapacitated before age 26 *and* while covered under the plan to be considered an eligible Dependent.

Qualified Medical Child Support Order

Your Children will be eligible for the Dental/Vision/Hearing Care 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. A copy of the written procedure will be provided to you without charge.

Your Domestic Partner and His or Her Child(ren)

You may enroll your Domestic Partner in the Dental/Vision/Hearing Care Plan, when your relationship with that person meets the plan's eligibility requirements and when the Company has given you written approval of the Affidavit of Domestic Partnership. You may also enroll Child(ren) of your Domestic Partner if they meet the definition of an eligible Dependent as described under "Your Dependents" in this "WHO IS ELIGIBLE" section.

However, you may wish to consult with a tax or legal advisor before enrolling because special tax and legal considerations apply when covering a Domestic Partner and/or your Domestic Partner's Child(ren). For example, the cost of the coverage for your Domestic Partner and/or Domestic Partner's Child(ren) must be paid on an After-Tax basis and the Company's cost is added to your gross earnings for tax purposes (this is considered imputed income) unless your domestic partner and/or domestic partner's child(ren) qualify as your tax dependent under Internal Revenue Code (IRC) Section 152. If the later is the case, benefit premiums will be paid on a pre-tax basis and you will not incur imputed income if you alert HR and provide them with a copy of your most recent federal income tax return in order to prove that your qualifying dependents meet IRC Section 152 criteria.

About Domestic Partners

To be eligible for Domestic Partner coverage under the Dental/Vision/Hearing Care Plan, you and your Domestic Partner must satisfy the following guidelines:

1. For the 12-month period before you sign the Affidavit of Domestic Partnership, you and your Domestic Partner must have:
   --lived in the same residence
   --shared financial obligations (including basic living expenses)
   --been each other's sole and exclusive partner

--publicly represented yourself as Domestic Partners

--intended to continue this relationship in this manner indefinitely

2. Neither you, nor your Domestic Partner, may be married to anyone else.
3. You may not be related to your Domestic Partner by blood or marriage to a degree that would prohibit a legal marriage in the state where you live.
4. You and your Domestic Partner must be at least 18 years old.
5. You and your Domestic Partner must be mentally competent to consent to a contract.

You may add your Domestic Partner to health coverages within 31 days of a Status Change (including an establishment of a domestic partnership) or during an Annual Enrollment Period.

If you make false statements on the Affidavit of Domestic Partnership, the Company or its agent(s) may take civil action to recover direct or indirect losses (including benefits paid under this Dental/Vision/Hearing Care Plan) and attorney's fees, and may discipline you up to and including terminating your employment (and your Domestic Partner's employment, if employed by the Company).

Enrolling Your Domestic Partner

If you are interested in enrolling your Domestic Partner for the first time, call HR within 31 days of your qualifying event to give notice of your intent to add a Domestic Partner. HR will contact you with instruction on how to enroll. Enrollment can be completed online or if preferred, you may submit via mail. You must be able to present two supporting documents when requested. Such documents will be requested periodically for audit purposes. The supporting documents must clearly refer to you and your Domestic Partner, and at least two documents must show that your relationship existed for at least the 12 months prior to the initial approval of your Domestic Partnership status by the Company and at all times afterward. Each of the 2 documents must come from separate categories among the following options:

--Domestic Partnership Agreement

--Registration of domestic partnership with local government where you live

--Joint mortgage or lease or other evidence of joint ownership of real estate

--Designation of Domestic Partner as primary Beneficiary in your will, life insurance or IRA accounts (for these purposes only, primary Beneficiary means a person to whom you have allocated 50% or more of your estate, life insurance or IRA accounts as applicable)

--Durable power of attorney for property or health care

--Evidence of joint ownership of a motor vehicle

--Evidence of joint checking, savings or credit accounts

The Company and its designated agent(s) will determine if the documents are sufficient proof of domestic partnership. Once approved, you may then enroll your Domestic Partner in Dental/Vision/Hearing Care Plan coverage. You may enroll your Domestic Partner's Children in Dental/Vision/Hearing Care coverage.

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Changes in Circumstances

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

If your domestic partnership ends, you must file a Termination of Domestic Partnership Statement with HR 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.
- You will not be eligible to file or be designated a Domestic Partner on another Affidavit of Domestic Partnership for another 12 months after your last Domestic Partnership ended.. This 12-month limitation also applies to your Domestic Partner if he/she also works for the Company.
- 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 continue to pay premiums for their coverage until the start of the next Plan Year, even though your Domestic Partner and his/her child(ren) are ineligible for coverage.

Special Eligibility Rules

If Both You and Your Spouse (or Domestic Partner) Work for the Company

If both you and your spouse (or Domestic Partner) are eligible to participate in the Dental/Vision/Hearing Care Plan, then special rules apply for enrolling in the plan. You may enroll as an Employee or as a Dependent, but not both. Only one of you may enroll your eligible Children as Dependents.

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 this plan as an Employee.

If Your Eligible Dependent is in the Armed Forces

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

HOW TO ENROLL

You may choose to enroll for Dental/Vision/Hearing Care Plan benefits:

- Within 31 days of your Hire Date or the day you become eligible if you are not eligible on your Hire Date,
- During an Annual Enrollment Period, or
- When you experience a Status Change.

To enroll, you must complete the enrollment process and pay the applicable Employee contributions. The Dental/Vision/Hearing Care Plan options you are eligible to choose from and your costs for these options are shown on the FLEX online enrollment tool (or your Personalized Enrollment Worksheet if you do not have intranet access).

You will automatically be provided with materials to help you make your decision when you are hired and prior to the Annual Enrollment Period. However, you must contact HR and report your Status Change to receive information and make new elections following a Status Change.

To report a Status Change or to obtain information about enrollment in the Dental/Vision/Hearing Care Plan upon your hire or during the Annual Enrollment Period, contact HR at: 1-800-676-4636. You may not enroll in the Dental/Vision/Hearing Care Plan or change your coverage by contacting any of the Claims Administrators that process benefit Claims under the Plan; you must contact HR to obtain information about enrollment and report a Status Change.
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Dental/Vision/Hearing Care Plan Options under FLEX

You may select from the following options for Dental/Vision/Hearing Care Plan benefits under the FLEX Program:

- No Coverage
- Comprehensive
- Plus

If you choose to enroll, you may select one of the following Dependent coverage levels:

- You only
- You and your Child(ren) (and/or your Domestic Partner's Child(ren))
- You and your Spouse (or Domestic Partner)
- You and your Spouse (or Domestic Partner) and Child(ren) (and/or your Domestic Partner's Child(ren))

WHEN COVERAGE BEGINS

If you select Dental/Vision/Hearing Care Plan FLEX Benefits, your coverage will begin as follows:

If you enroll and pay the required contribution	**Your coverage will be effective on …**
As a new employee within 31 days after your Hire Date	The day HR receives your selections.
Within 31 days of a Status Change event	The date the Status Change event occurs.

During the Annual Enrollment Period The first day of the next Plan Year, normally January 1

If you do not enroll under any of the above circumstances for Dental/Vision/Hearing Care coverage, you will have to wait until the next Annual Enrollment Period (or the date you experience a Status Change) to make a Dental/Vision/Hearing Care Plan selection.

During the New Hire Enrollment Period

You have 31 days from your Hire Date to enroll in the Dental/Vision/Hearing Care Plan. If you enroll within 31 days of your Hire Date, your Dental/Vision/Hearing Care coverage will be effective on the date HR receives your selections. Some benefits under FLEX are provided automatically during the first 31 days of your employment, without any action on your part. That is not true with respect to the Dental/Vision/Hearing Care Plan. You will not have coverage under any Dental/Vision/Hearing Care Plan option until you enroll in the Plan. The Effective Date of the enrollment is explained above.

If You Do Not Enroll

If you don't enroll for Dental/Vision/Hearing Care coverage within 31 days of your Hire Date, YOU AND YOUR DEPENDENTS WILL HAVE NO COVERAGE UNDER THE DENTAL/VISION/HEARING CARE PLAN until the next Plan Year (if you elect coverage during the next Annual Enrollment Period) or unless you experience a Status Change that allows enrollment in the Dental/Vision/Hearing Plan.

During the Annual Enrollment Period

Each year during the Annual Enrollment Period (generally in the fall), you will make your FLEX selections, including your choices among the Dental/Vision/Hearing Care Plan options, for the next Plan Year. Before the Annual Enrollment Period begins, you will receive materials to help you make your decisions, as well as instructions on how to enroll. The FLEX selections you make during the Annual Enrollment Period will go into effect on the first day of the following Plan Year and remain in effect through the end of the Plan Year unless you make a new selection due to a Status Change.

If You Do Not Enroll

If you do not enroll during the Annual Enrollment Period, the option and coverage level in which you were enrolled during the prior year will continue into the next year. For example, if you did not enroll during the 2011 Annual Enrollment Period and you chose the Comprehensive option for the 2010 Plan Year, then the Comprehensive option was continued for you for the 2011 Plan Year since the Comprehensive option was still offered in 2011. If you were enrolled in an option that is discontinued and do not enroll during the Annual Enrollment Period YOU AND YOUR DEPENDENTS WILL HAVE NO COVERAGE UNDER THE DENTAL/VISION/HEARING CARE PLAN for the upcoming Plan Year. You will be able to enroll during the next Annual Enrollment Period (for the following Plan Year) or during the year for the remainder of the Plan Year if you experience a Status Change that allows enrollment in the Dental/Vision/Hearing Plan.

Changing Your Selections

Your FLEX Benefits selection remains in effect through the end of the Plan Year (usually December 31). You generally cannot change your selections until the next Annual Enrollment Period, unless you experience a Status Change that permits it.

You can make certain changes in your FLEX Benefits choices during the 31-day period after you experience one of the following Status Changes. The list of Status Changes includes but is not limited to:

- Marriage,
- Domestic Partner relationship becoming qualified for eligibility, and verified by HR,
- Divorce, annulment, or legal separation,
- Rescinded divorce,
- Birth, adoption, placement for adoption or change in legal custody of a Dependent child,
- Death of a spouse, enrolled Domestic Partner or Dependent child,
- Change in your employment status affecting benefit eligibility (such as from or to part-time or full-time),
- Change in your spouse's or enrolled Domestic Partner's employment status affecting benefits eligibility (such as from or to part-time or full-time),
- Beginning or end of your spouse's or enrolled Domestic Partner's employment,
- Loss of spouse's or Domestic Partner's dental, vision and hearing coverage,
- Covered child's loss of Dependent status (i.e., has access to employer coverage),
- Dependent child becomes eligible (i.e., loss of coverage),
- Benefits plan year of a spouse's or Domestic Partner's benefit plan differing from the Company Play Year (e.g., your spouse's or Domestic Partner's benefits are effective on July 1 and yours are effective on January 1).
- You, your spouse or enrolled Domestic Partner becomes eligible for Medicare or Medicaid

If you make changes to your benefit selections due to a Status Change, the change must be consistent with the Status Change. For example, if you experience the birth of a Dependent child, you may add coverage for your child under your Dental/Vision/Hearing Care Plan.

To make a change to your benefit selection, you must contact HR within 31 days of the Status Change. HR will initiate the Status Change in the FLEX online enrollment tool, which will allow you to go online to make your benefit changes. Changes submitted within 31days of the Status Change event will be effective the date of the event.

Alternatively, you may ask to change your benefit selections by fax or mail. Contact HR for a Personalized Enrollment Worksheet and an affidavit, which you must complete and return to HR within 31 days of the Status Change.

When you request to change your benefit selections due to a Status Change, HR may ask you to provide supporting documentation (such as a marriage or birth certificate, or a divorce decree). Such a request may either be made at the time you report your Status Change or at a later date for audit purposes.

If you submit your changes (either online or by notarized affidavit) more than 31 days after the date your Status Change occurred, you cannot change your Dental /Vision/Hearing Care Plan option, for example from Comprehensive to Plus) until the next Annual Enrollment Period. However, you may change your Dependent coverage level (e.g., Employee and spouse, Employee and child) for the Dental/Vision/Hearing Care plan. Your Dependent coverage level change will be effective on the date HR receives all documents (i.e., via fax or mail, or via online affidavit). This type of change must be completed within 12 months of the date the Status Change occurred *and* within the Calendar Year in which the 31-day Enrollment Period following the Status Change ended. No other changes to your Dental/Vision/Hearing Care Plan benefits are permitted outside the 31-day Enrollment Period.

Please note: Coverage for Dependents who become ineligible will be terminated back to the date of the Status Change event that made them ineligible.

WHAT COVERAGE COSTS

You and the Company share the cost of Dental/Vision/Hearing Care Plan coverage. The cost of coverage is determined by the Company each year. The Company reserves the right to change the cost of coverage as necessary. Each of the Dental/Vision/Hearing Care Plan options has a different price, based on the level of coverage under the Plan. If you select the Dental/Vision/Hearing Care Plan, your Employee contributions are deducted from your paycheck each pay period on a Before-Tax basis.

The cost of coverage for a Domestic Partner and a Domestic Partner's Child(ren) is paid with After-Tax contributions unless your domestic partner and/or domestic partner's child(ren) qualify as your tax dependent under Internal Revenue Code (IRC) Section 152. If the later is the case, benefit premiums will be paid on a pre-tax basis and you will not incur imputed income if you alert HR and provide them with a copy of your most recent federal income tax return in order to prove that your qualifying dependents meet IRC Section 152 criteria. When you pay for benefits Before-Tax, it means that the cost of coverage is deducted from your pay before Federal taxes are taken out (as well as most state and local taxes, except in New Jersey and Pennsylvania). Because your taxable income is effectively lowered, therefore, you pay less in taxes. You do not pay FICA (Social Security) tax on these benefits, so your Social Security benefits may be reduced slightly in the future. These Before-Tax Contributions will not affect the amount of your other benefits (like life insurance), which are calculated based on your FLEX Earnings.

WHEN CONTRIBUTIONS BEGIN

Contributions for Dental/Vision/Hearing Care FLEX Benefits begin with the first full pay cycle following the Effective Date.

MAINTENANCE OF BENEFITS PROVISION

All of the Dental/Vision/Hearing Care Plan options contain the Maintenance of Benefits provision, which coordinates benefits available from more than one plan. If both you and your spouse (or your Domestic Partner) are working, you and your eligible Dependents may be covered under both the Company plan and your spouse's (or Domestic Partner's) plan. The Maintenance of Benefits provision coordinates benefits provided under all dental, vision and hearing care programs so that you can receive up to — but no more than — the amount that would have been covered by the Company plan.

A dental, vision, hearing care program is defined as any of these which provide benefits or services for, or by reason of, dental/vision/hearing care or treatment.

- 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 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:
  1. school accident-type coverage for grammar school or high school students, or
  2. 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, 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 payment provisions of an automobile insurance contract.

The Maintenance of Benefits provision reduces the advantages of double coverage, so you should decide whether you wish to be covered by the Company Dental/Vision/Hearing Care Plan or by your spouse's (or Domestic Partner's) employer's dental, vision and hearing care plan.

Here is 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 Company's Dental/Vision/Hearing Care 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 Dental/Vision/Hearing Care Plan if the primary plan pays benefits that are equal to or greater than the benefits this plan would normally pay.

Determination of which plan is primary is as follows:

- Coverage as an Employee 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 unless the Dependent child's parents are separated or divorced. Then the following applies:
  1. The plan of the parent with custody pays first.
  2. The stepparent's plan 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 both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which 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 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.

If you select your spouse's (or Domestic Partner's) dental, vision and hearing care coverage and that coverage ends during the Calendar Year as the result of a Status Change, you may return to the Company Dental/Vision/Hearing Care Plan option of your choice within 31 days of the loss of coverage, with no Evidence of Insurability required. However, you will be required to provide proof of the loss of coverage.

DENTAL CARE BENEFITS

The plan pays benefits for eligible charges incurred for dental care services. The following is a summary of these benefits.

Reimbursement Levels

Dental benefits are paid based on the coverage category in which the expense falls, up to the plan maximum and subject to the Alternate Benefit Provision. The plan pays a percentage of the Reasonable and Customary Charges for Covered Expenses in each coverage category as indicated in the "Plan Highlights." Deductibles may apply based on the coverage category and type of service.

Benefits for Orthodontia expenses under the Comprehensive or Plus Options will be paid beginning when the appliances are first inserted, and will continue every three months for the estimated duration of treatment as long as the patient remains covered. The payments will be in equal installments, except that the first payment will be limited to the orthodontist's initial charge, up to the maximum Orthodontia benefit. Payments are made every three months even if you are billed in full at your first visit. Charges for Orthodontia treatment that started before you were covered under this plan are excluded.

Passive Network Benefit

The dental benefit also includes a "passive" network. Even though there are no In-Network and Out-of-Network Benefit levels in your dental coverage, services are provided at a discounted rate when you go to dental care Providers who are in the CIGNA Preferred Provider Organization (PPO) dental plan network. To receive a dental PPO directory, contact CIGNA Member Services at 1-800-257-2702 or by visiting www.myCIGNA.com.

Annual Maximum Benefit

The maximum amount the plan will pay for eligible dental expenses, except Orthodontia, per person is $1,500 annually for the Comprehensive Option and $2,000 annually for the Plus Option.

Orthodontia Lifetime Maximum Benefit

The maximum lifetime benefit the plan will pay for eligible Orthodontia expenses per person is $1,500 for the Comprehensive Option and $2,000 for the Plus Option. Please note that this limit is a *Lifetime* Maximum. If you change your Dental/Vision/Hearing Care plan option, any orthodontic benefits already paid are applied toward your Lifetime Maximum in any future subsequent plan options in which you enroll; benefits already paid toward the Lifetime Maximum transfer when you change options.

What Is Covered

Dentist's charges for non-occupational disease or Injury are covered (up to Reasonable and Customary Charges) if they are necessary for the care of your teeth and if they start and are completed while the patient is covered under this plan. A dental service starts when the actual performance of the service starts except:

If the service is …	*the service starts …*
▪ fixed bridgework	when the first impressions are taken and full or partial dentures and/or teeth are fully prepared
▪ crown, inlay or onlay	the first date the tooth is prepared
▪ root canal therapy	when the pulp chamber is opened

Preventive Care

Eligible expenses in the Preventive Care category include:

- bite-wing x-rays, up to twice per Calendar Year (full-mouth or panorex, once every three Calendar Years)
- routine cleaning of teeth, up to twice per Calendar Year (two periodontal cleanings may be covered when the condition of the gums and other tissue supporting the teeth justify these procedures)
- routine exams, up to twice per Calendar Year
- sealants for Dependents under age 14, limited to one treatment per permanent tooth every 36 months
- topical fluoride treatment for Dependents under age 19, limited to twice per Calendar Year
- space maintainers for Dependents under age 14 limited to non-orthodontic treatment
- emergency treatment of dental pain when no other definitive dental services are performed (any x-ray taken in connection with such treatment is a separate dental service)

Basic Services

Eligible expenses in the Basic Services category include:

- anesthetics
- endodontic treatment, including root canal therapy
- extractions of fully erupted teeth
- fillings
- oral Surgery; eligible expenses include:
  - excision of partially or completely unerupted teeth, including impacted teeth
  - excision of a tooth root without the extraction of the entire tooth (not including root canal therapy)
  - other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction of teeth
- treatment of periodontal disease and other diseases of the gums and tissues of the mouth
- re-cementing of bridges, crowns, inlays and onlays

- denture adjustment and repair
- osseous surgery
- root planing and restoration

Major Services

Eligible expenses in the Major Services category include:

- crowns, onlays and inlays
- initial installation of prosthesis, including dentures and fixed bridges for replacement of one or more natural teeth extracted while covered under this benefit
- maintenance of prosthesis, including dentures that have been installed for more than six months
- replacement of crowns, fixed bridges, full and partial dentures more than five years old
- surgical implants, including prosthetic device attached to it

Orthodontia

Eligible expenses in the Orthodontia category include:

- all active treatment and retention appliances
- fixed or removable appliances
- one appliance per arch per person for tooth guidance
- one appliance per person to control harmful habits
- preliminary study, including x-rays, diagnostic casts and treatment plan

Predetermination Review

Predetermination Review lets you know what services are covered and what payments may be made for treatment before the work is done. Whenever your Dentist recommends extensive dental work (such as a root canal or crown), your Dentist should complete a Claim form describing the type and expected cost of the treatment. This form should be sent to the Claims Administrator before the work is scheduled to be done. Any subsequent major changes in the treatment plan should also be sent to the Claims Administrator for review. By reviewing the proposed dental treatment and expected charges, the Claims Administrator will be able to provide you and your Dentist with a detailed description and estimate of amounts considered for payment for the particular covered services.

When there has not been a Predetermination Review, the Claims Administrator will determine the expenses that will be included as Covered Expenses at the time the Claim is received.

Predetermination Review does not guarantee payment. The estimate of benefits payable may change due to certain factors such as what benefits are available at the time services are completed.

Alternate Benefit Provision

When more than one dental service could provide suitable treatment based on common dental standards the Claims Administrator will determine the dental service on which payment will be based and the expenses that will be included as Covered Expenses. Benefits will be provided for the treatment that is determined to be most adequate, appropriate and cost effective. You and your Dentist are free to apply this benefit payment to the treatment of your choice; however, if you select a treatment method that is more expensive than an alternate method that would achieve the medically required result, benefits are limited to the Reasonable and Customary Charge for the less expensive method. For this reason, you should file a Predetermination Review when extensive dental services are needed so that you and your Dentist know in advance what the benefit plan may cover before any treatment begins.

What Is Not Covered

No benefit payment will be made for expenses incurred for:

1. an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered
2. bite registrations, precision or semi-precision attachments or splinting
3. cosmetic dentistry, including personalization or characterization of dentures, unless for accidental Injury and provided such treatment commences within 90 days of the Accident
4. dental services that do not meet common dental standards
5. the first installment of dentures and bridgework (including crowns and inlays forming the abutments), when charges are for the replacement of Congenitally missing teeth, or for replacement of natural teeth all of which were lost while the patient was not covered for this benefit
6. any generally excluded charge
7. infection control
8. instruction in plaque control, dental hygiene and diet
9. an orthodontic procedure for which an active appliance was installed before the person was covered by the plan, except when the person is:
    - a transfer from another Nortel Networks entity (e.g., an employee of Nortel Networks Limited who transfers to Nortel Networks, Inc.), or
    - an individual joining the plan as a result of an acquisition or joint venture where the Company's transaction agreement stipulates the exception.
10. procedures, appliances or restorations (except full dentures) whose main purpose is to change vertical dimension, diagnosis or treatment of conditions or dysfunction of the Temporomandibular Joint (TMJ), stabilize periodontically involved teeth, or restore occlusion
11. prosthetic devices that were ordered before you or your eligible Dependent became eligible or which were ordered while you or your eligible Dependent were covered but were installed more than 30 days after termination of eligibility
12. replacement of bridges, crowns or dentures unless one or more of the following applies:

– the replacement or addition of teeth is required to replace one or more natural teeth extracted while the person was covered for this benefit, or

– the bridge, crown or denture was installed at least five years before its replacement and cannot be made serviceable, or

– the existing denture is temporary and the replacement by a permanent denture is required and done within 12 months of the temporary denture

13. the replacement of a lost, stolen or missing prosthetic device
14. services or supplies covered under the Medical Plan
15. services or supplies received from a Hospital
16. services not listed as Covered Expenses in this plan
17. treatment by anyone except a Dentist, except for cleaning or scaling of teeth by a licensed dental hygienist supervised by a Dentist
18. veneers or similar properties of crowns and bridgework on or replacing the upper and lower first, second and third molars
19. services preformed at an after hours visit with no other visit
20. experimental or investigational procedures and treatment
21. prescription drugs

VISION CARE BENEFITS

The plan pays benefits for eligible charges incurred for Vision Services. The following is a summary of your vision care benefits.

Reimbursement Levels

The Comprehensive and Plus Options pay 100% of the charges for eligible vision care expenses when you use an EyeMed Network Provider -- minus any Copayment required and non-covered options. Certain In-Network Benefits are limited to the amount listed under "Maximum Benefit." If you use an Out-of-Network Provider, you will be reimbursed according to the out-of-network schedule listed under "Maximum Benefit."

There is no Deductible for vision care benefits. There is a Copayment of $10 for the Comprehensive Option. There is no Copayment for the Plus Option. You pay one plan Copayment for all services, including eye examinations, Lenses and frames.

EyeMed Member Discounts

The vision care benefits features the following two discount programs:

- Additional pairs of prescription eyeglasses (eyeglasses purchased separately from the plan's regular benefits) will be discounted 40% from the Doctor's reasonable and customary retail charges. This service must be from the same EyeMed Doctor who provided your eye exam and materials.
- EyeMed member Doctors offer a 15% discount for professional services above the $150 allowance for conventional contact Lenses (includes evaluation, fitting and follow-up). EyeMed member Doctors offer a 20% discount off the amount of the cost of frames that exceed the plan's frame allowance.

Important Notes about Network Vision Benefits

When you make an appointment with an EyeMed Doctor, identify yourself as an EyeMed member. If you do not identify yourself as an EyeMed member, you will not receive In-Network Benefits and additional EyeMed negotiated discounts. The Doctor will ask for your Member ID number and your Company name to verify your coverage. At the time of service, you pay any required Copayment. The Doctor bills EyeMed directly, so there are no Claim forms to complete and file.

If you go to an Out-of-Network Provider, you pay the bill in full. Then you can file a Claim by submitting a Claim form and itemized statement to EyeMed. You will be reimbursed up to the covered amount shown in the "Plan Highlights" chart of this section.

Maximum Benefit

When you use an EyeMed Network Provider, there is no maximum amount the plan will pay for most services. However, there is a $150 maximum for elective contact Lenses. Other maximums include:

- Examinations – every Calendar Year
- Lenses – every Calendar Year
- Frames – every two Calendar Years
- Contact Lenses – up to $150 every Calendar Year (in lieu of spectacle Lenses)

The maximum amount the plan will pay when you go out-of-network for services is:

- Exams – $50; every Calendar Year
- Spectacle Lenses – up to $40 single; $60 bifocal; $80 trifocal; $125 lenticular; every Calendar Year
- Frames – up to $45; every two Calendar Years
- Contact Lenses – up to $105 for Elective Contact Lenses and $210 for Medically Necessary contact Lenses when EyeMed Network Provider obtains prior authorization; every Calendar Year (in lieu of spectacle Lenses)

What Is Covered

Eligible vision care expenses include:

- Vision Examination by a Doctor, limited to one exam every Calendar Year
- Eyeglass frames ordered from a Doctor or Optician (within plan allowance)
- Lenses (contact Lenses or spectacle Lenses) prescribed by a Doctor and ordered from a Doctor or Optician (within plan allowance)
- Medically Necessary contact Lenses (maximum allowance of $400 per calendar year and in lieu of spectacle lenses) ordered from a Doctor with prior approval for certain conditions including, but not limited to cataract Surgery, or to correct extreme visual acuity problems
- Allowance for contact Lenses is in lieu of spectacle Lenses

Note: Additional vision care expenses may be eligible under the Medical Plan.

What Is Not Covered

No payment will be made for expenses incurred for:

1. any generally excluded charge
2. services or supplies covered under the Medical Plan
3. services or supplies in connection with medical or surgical treatment of the eye
4. services or supplies for special treatment, such as:
   - orthoptics
   - subnormal vision aids
   - vision training
   - tonography
5. services or supplies not listed as Covered Expenses in this plan
6. services or supplies that are not Medically Necessary and are not prescribed by an Optometrist or an Ophthalmologist

EyeMed Doctor Directory

EyeMed's Doctor Directory is a listing of Doctors participating in the EyeMed Network. You can obtain a copy of the EyeMed Doctor Directory from the EyeMed member website at www.eyemedvisioncare.com (members must register to use the site) or by calling (toll free) 866-680-1186.
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HEARING CARE BENEFITS

The plan pays benefits for eligible charges incurred for hearing care services. This is a summary of these benefits.

Reimbursement Levels

The Comprehensive Option pays 80% of the Reasonable and Customary Charges for eligible hearing care expenses. The Plus Option pays at 100% of the Reasonable and Customary Charges for eligible hearing care expenses. There is no Deductible or Copayment for hearing care benefits.

Maximum Benefit

The maximum amount the plan will pay for Covered Expenses for hearing care every 2 Calendar Years is:

Comprehensive	$750
Plus	$1,000

What Is Covered

Eligible hearing care expenses include:

- hearing aids
- hearing exams for fitting hearing aids

What Is Not Covered

The following hearing care expenses are not eligible:

1. ear molds
2. any generally excluded charge
3. hearing aid batteries
4. hearing tests for the diagnosis of hearing deficiencies or illness
5. replacement of a lost, stolen or missing hearing aid
6. services or supplies covered under the Medical Plan
7. services or supplies that are not Medically Necessary and not prescribed by a Doctor
8. services and supplies received from a Hospital
9. services or supplies not listed as Covered Expenses in this plan
10. Surgery

GENERAL DENTAL, VISION AND HEARING CARE PLAN EXCLUSIONS

Expenses for the following services and supplies are not covered under any Dental/ Vision/ Hearing Care Plan option:

1. Charges for services which do not meet Common Medical Standards
2. Charges for personal comfort and convenience items and services
3. Educational, Experimental or Investigational services
4. Charges above Reasonable and Customary Charges or plan allowance
5. Services or supplies furnished by or for the U.S. Government or any other government, unless payment of the charge is required by law
6. Charges paid or payable under any no-fault automobile insurance law or uninsured motorist insurance law
7. Charges for which the patient is not legally required to pay
8. Services ordered by someone other than a Doctor or Dentist
9. Services performed by you, the Company, a family member or someone who lives in your household, including your spouse (or Domestic Partner), a child, brother, sister, your parent or the parent of a spouse (or Domestic Partner).
10. Charges for Illness or Injury due to war or any act of war
11. Work-related Injury or Illness for which Workers' Compensation, any occupational disease law or similar law is payable

WHEN COVERAGE ENDS

For You

Dental/ Vision/ Hearing Care Plan coverage for you will end on the last day of the month in which one of the following occurs:

- the date your employment ends or you stop qualifying for coverage,
- the date the part of the plan providing the coverage ends, or
- the date you fail to pay any required contribution

For Your Dependents

Dental/Vision/Hearing Care coverage for your eligible Dependents will end on the last day of the month in which one of the following occurs:

- the date your employment ends or your covered Dependent stops qualifying for coverage,
- the date the part of the plan providing the coverage ends, or
- the date you fail to pay any required contribution

Continuing Coverage

If you stop Active Work for any reason, you should contact HR at once to determine what arrangements, if any, can be made to continue any of your coverage.

COBRA

You and your covered Dependents may continue Dental/ Vision/ Hearing Care Plan coverage under certain circumstances under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). See the information about COBRA in **"SECTION TWO – ADMINISTRATIVE INFORMATION."**

SECTION TWO - ADMINISTRATIVE INFORMATION

This Administrative Information section provides further administrative details about this plan, such as identifying information about the Plan that is required under ERISA, how to file Claims and appeal denied Claims, where to get more information, your ERISA rights and how the Company may amend the plan.

IDENTIFYING INFORMATION

Plan Type under ERISA: Welfare Plan

Plan Number: 508

Funding Method: Self-funded with contributions held in trust

Contribution Source: the Companies that sponsor the Plan and participating Employees 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.

The address for Nortel Networks Inc. is: Nortel Networks Inc.

4001 E. Chapel Hill-Nelson Highway
Research Triangle Park, NC. 27709

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):

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

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 at 1-800-676-4636 if you cannot locate the information you need in the list that follows. For Claims filed on or after January 1, 2003, the ultimate decision about your eligibility for benefits under the plan is made by the named ERISA "claims fiduciary" who has responsibility for the determination of your Claim. (See the Administrative Information SPD corresponding to the year in which the claim was incurred for information on appeal procedures for claims incurred prior to 1/1/2003.) 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 Dental/Vision/Hearing Care Plan are noted in the list below.

Claims Administrator	Address	Phone Number

1. Dental Benefits

All Claims and appeals of denied Claims for dental benefits as described in this Summary Plan Description other than eligibility to participate in the plan, cost of coverage and COBRA should be filed with the applicable entity listed below, based on the coverage you selected.

Claims Administrator	**Address**	**Phone Number**
CIGNA	PO Box 188037 Chattanooga, TN 37422-8037	1-800-257-2702

2. Vision Benefits

All Claims and appeals of denied Claims for Vision benefits as described in this Summary Plan Description other than eligibility to participate in the plan, cost of coverage issues and COBRA should be filed with the applicable entity listed below.

Claims Administrator	**Address**	**Phone Number**
Eye Med Vision Care	4000 Lurottica Place Mason, OH 45040	1-866-680-1186

3. Hearing Care Benefits

All Claims and appeals of denied Claims for hearing benefits as described in this Summary Plan Description other than eligibility to participate in the plan, cost of coverage and COBRA should be filed with the applicable entity listed below, based on the coverage you selected.

Claims Administrator	**Address**	**Phone Number**
CIGNA	PO Box 33668 Charlotte, NC 28233-3668	1-800-257-2702

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

Initial Claims regarding eligibility to participate in the Dental/Vision/Hearing Care Plan; enrollment of Dependents in the Dental,/ Vision,/ Hearing Care Plan; disputes about the coverage option elected; the Effective Date of your enrollment in the Dental/ Vision,/ Hearing Care Plan; and COBRA eligibility should be filed with HR. 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 and the EBC follows:

HR	c/o Nortel Networks Mailstop: 570 02 0C3 PO Box 13010 Research Triangle Park, N.C. 27709-3010	Toll-free: 1-800-676-4636 Direct: 919-905-9351
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) Toll-free: 1-800-877-7994
3201 34th Street South
St. Petersburg, FL 33711

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 Dental/Vision/ Hearing Care Plan. These procedures are intended to comply with the requirements of ERISA and will be interpreted in accordance with ERISA requirements.

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 30-31 for a complete list of all Claims Administrators, their respective addresses and phone numbers. Claim forms are available on www.nortel-us.com/ and from HR. 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 (Dental,/ Vision,/ Hearing Care 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. 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.
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 Dental/Vision/ Hearing Care Plan condition receipt of the benefit on approval of the benefit prior to receiving dental, vision, or hearing 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 dental, vision, or hearing 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 Dental/ Vision/Hearing Care plan condition receipt of the benefit on approval of the benefit in advance of obtaining dental, vision or hearing 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

A Concurrent Care Claim is considered a request for treatment at the time the procedure is being rendered. It is not applicable to dental and hearing care Claim administration

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 dental, vision or hearing 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 above) -

- 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 above)

- 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 Dental/ Vision/ Hearing Care Plan.

- The first level appeal will be conducted and you will be notified by HR, the Claims Administrator, of the decision within 60 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 Employee Benefits Committee, 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.
- 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 appeal for determining your eligibility to participate in the Dental, Vision, Hearing Care Plan, the enrollment of your Dependents in the Dental/ Vision/ Hearing Care 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 monthly 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. 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.

Final Note on Dental/ Vision/ Hearing Care 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 above.*

YOUR RIGHTS UNDER COBRA

You, your Dependents and your Domestic Partner 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 certain health care benefits (identified under the "COBRA Participation" section below) would otherwise end. This is called COBRA coverage. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. To be eligible for COBRA coverage continuation you must first be enrolled in the health plan you wish to continue on the day before you become ineligible.

COBRA Participation

If one of the qualifying events listed in the COBRA Continuation Period chart causes you, your Dependent or your Domestic Partner to lose health care coverage, you may continue coverage in the plan for yourself and/or your eligible Dependents (as applicable).

Continued coverage is normally available for a maximum of 18 or 36 months, depending on the event outlined in the chart. If you are disabled on the date of the Qualifying Event, or within 60 days of COBRA coverage, you may be eligible to extend an 18-month COBRA continuation period for an additional 11 months. Verification by the Social Security Administration must be submitted to the COBRA Administrator within 60 days of the date disability is approved in order to extend coverage from 18 to 29 months. The continuation premium for the additional 11 months will be increased from 102% to 150% of the full group rate per person. The maximum continuation period if multiple events should occur that cause a loss of group health coverage is a total of 36 months. For example, if you terminate and then die while covered by the plan, your Dependents' coverage may continue for a maximum of 36 months.

COBRA Continuation Period

CIRCUMSTANCES	MAXIMUM CONTINUATION PERIOD		
	You	**Spouse or Domestic Partner**	**Children or Domestic Partner's Children**
You lose coverage because of			
reduced work hours	18 months	18 months	18 months
You terminate for any reason except (gross misconduct)	18 months	18 months	18 months
You are disabled as defined by Social Security) when you terminate or lose coverage due to reduced work hours or you become disabled within 60 days of commencement of COBRA coverage	29 months	29 months	29 months
You die	N/A	36 months	36 months
You and your spouse divorce	N/A	36 months	36 months
You and your Domestic Partner terminate your relationship	N/A	36 months	36 months
You become entitled to Medicare	N/A	36 months	36 months
Your or your Domestic Partner's child no longer qualifies as a Dependent	N/A	N/A	36 months
Your spouse or Domestic Partner is disabled (as defined by Social Security) when you terminate or lose coverage due to reduced work hours or your spouse becomes disabled within 60 days of commencement of COBRA coverage	29 months	29 months	29 months
Your or your Domestic Partner's child is disabled (as defined by			

Social Security) when you terminate or lose coverage due to reduced work hours or becomes disabled within 60 days of commencement of COBRA coverage	29 months	29 months	29 months

Notification

The COBRA Administrator, Ceridian COBRA Continuation Services (COBRAServ), will notify you by mail of your COBRA election rights when the qualifying event is a reduction in hours or termination of employment. You will receive instructions on how to continue your health care benefits under COBRA within 14 days of the date that COBRAServ received notification from the Company that one of these events has occurred.

If you have a divorce or a Dependent ceases to qualify as a "Dependent" due to a change in status that will automatically result in loss of coverage under the Plan for your former spouse or Domestic Partner or the affected Dependent. In that event, you (or the affected Dependent or a person acting for the affected Dependent) must notify HR within 60 days of the event so that COBRA can be offered and their election rights can be mailed to the spouse or other Dependent who lost coverage. COBRAServ will send you instructions on how to continue your health care benefits within 14 days after they receive notification from the Company that one of these events has occurred. If you or the affected Dependent (or someone acting for the Dependent) do not notify HR within 60 days of the event, no COBRA benefits will be available at any time to any Dependent who loses coverage due to the event.

Election

The COBRA Administrator (COBRAServ) will generate a qualifying event package within 14 days of notification from HR of your qualifying event. You have 60 days from the later of the date that you lose coverage and the date the notice of the qualifying event is sent (postmarked) to make your COBRA election. You will then have an additional 45-day period from the date of your COBRA election to pay any premiums that are due. Each subsequent monthly premium payment must be postmarked no later than the grace period end date to keep your coverage(s) in active status.

If you fail to elect the COBRA coverage within 60 days of the later of the date you lose coverage and the date you are sent the qualifying event package, you will not be eligible to elect COBRA at any later date.

If you elect COBRA continuation:

- Initially, you may keep the same level of coverage you had at the time of the event or choose a lower level of coverage (e.g., you only, you and your Children and/or Domestic Partner's Children, you and your spouse (or Domestic Partner) or you and your family).
- Coverage will be effective as of the date of the qualifying event.
- You may change coverage during the Annual Enrollment Period or if you experience a Status Change, as described in **"SECTION ONE –**under "Changing Your Selections."
- You may enroll any newly eligible spouse or child under the usual plan rules.

COBRA participants are held to similar guidelines concerning their health insurance as active Employees. Changes in your health plans once enrolled in COBRA can only be made during the Annual Enrollment Period, typically occurring in the fall, or within 31 days of a Status Change (as described in "Changing Your Selections").

Cost of Participation

COBRA participants must pay monthly premiums for their coverage:

- For Dental/Vision/Hearing Care coverage, premiums are based on the full group rate per covered person set at the beginning of the Plan Year, plus 2% to cover administrative costs.
- Regular monthly premiums are due to the COBRA Administrator (COBRAServ) by the first of each month.
- If you are disabled under the Social Security definition, COBRA premiums for months 19–29 reflect the full group cost per person, plus 50%.

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, after the date of COBRA election, not offered by the Company (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 the limitation expires. You are entitled to receive credit equal to the period of your 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.
- you or your eligible Dependents become entitled to Medicare after the date of COBRA election,. Covered Dependents who are not entitled to Medicare can continue coverage under COBRA until the maximum continuation period is reached. If you become entitled to Medicare within 18 months before the termination of your employment (or a reduction in your work hours) that entitles you to COBRA continuation coverage, your qualified Dependents will be eligible for COBRA coverage for up to 36 months from the date you became entitled to Medicare.
- you or your eligible Dependents have met 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 Company ceases to provide Dental/Vision/ Hearing Care Plan benefits to all Employees.

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.

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, 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 Public Disclosure Room of the Pension and Welfare Benefit Administration.
- 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 yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for Preexisting Conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

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 Administratin (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administratin (EBSA),, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administratin (EBSA),.

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 Dental/Vision/Hearing Care Plan 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 it 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
Nortel Networks
PO Box 13010
Research Triangle Park, N.C. 27709-3010
Toll-free: 1-800-676-4636
Direct: 919-905-9351

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 "pre-existing condition exclusions." A pre-existing 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 pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing 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 pre-existing 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 *L*aws, or http://www.cms.hhs.gov/hipaa1.

FUTURE OF THE PLAN

Although the benefits currently available (in the 2012 Plan Year) are described in this summary for the Company's Dental/Vision/Hearing Care 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 without prior notice to Plan participants.

The Company's practices, polices, and benefits are outlined here for your information as required by law. However, this does not constitute an implied or expressed contract or guarantee of employment.

SECTION THREE – GLOSSARY

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.

Active Duty
Currently enlisted in the Unites States armed forces and called upon to serve.

Active Work, Actively at Work
You will be considered Actively at Work on any of the Company's scheduled work days if you are performing the regular duties of your job on that day in accordance with your regularly scheduled hours, either at a Company defined place of business or at some location to which you are required to travel for Company business.

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.

After-Tax Contribution
A contribution for benefits coverage that is deducted from your pay after federal income, FICA (Social Security), and most state and local income taxes have been deducted.

Annual Enrollment Period
The period during which you may enroll yourself and/or your eligible Dependents for benefits under the FLEX Program and related benefit plans for the next Calendar Year. The FLEX Annual Enrollment Period is held each fall. Benefits selected during the Annual Enrollment Period are generally effective the following January 1.

Basic Services
Under your dental coverage, basic services include:

- fillings,
- extractions,
- anesthesia,
- Periodontics (treatment of the gums and mouth tissue),
- oral Surgery,
- endodontics, and
- minor restorations.

Before-Tax Contribution
A contribution for benefits coverage that is deducted from your pay before federal income, FICA (Social Security), and most state and local income taxes are deducted, reducing your taxable income.

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

Calendar Year
January 1 through December 31. This period is also known as the Plan Year for the purposes of all Company health care plans.

Children
Dependents who are:

- your natural children,
- children legally adopted by you or placed with you for adoption,
- your stepchildren,
- your legal foster children,
- your responsibility as a legal guardian,
- children of your Domestic Partner
- children for whom you are required to provide health coverage, as specified by a Qualified Medical Child Support Order (QMCSO). 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, stepchildren, legally authorized foster children, children for whom you are the legal guardian and children of your Domestic Partner must depend on you for support and maintenance and live with you 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 the Dental/Vision/Hearing Care 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), as amended. 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.

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

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 and others.

Congenitally
A condition present at birth that is not hereditary.

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

Core FLEX Program Benefits
Benefits fully paid by the Company. You are automatically enrolled in the following core coverage and have no choices to make in order to have coverage in these benefits:

- Short-Term Disability coverage at 100% of your pre-disability base salary (called FLEX Earnings - see this glossary for more on what is and isn't included in this amount) for six weeks, then 66 2/3% of your pre-disability FLEX Earnings for up to 20 additional weeks,
- Long-Term Disability coverage at 55% of your pre-disability FLEX Earnings after you have been disabled for 26 consecutive weeks,
- Employee Life Insurance equal to one times your FLEX Earnings,
- Employee Assistance Program provides free confidential counseling for up through the first 8 visits.

You can supplement your Core FLEX Program benefits by purchasing Optional FLEX Program benefits with FLEX Credits provided by the Company and with Before-Tax and After-Tax Contributions.

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 plan's "Covered Expenses."

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

Dentist
A person legally licensed to practice dentistry or a Physician authorized by his or her license to perform the particular procedures rendered by him or her.

Dependent
For your Dental/Vision/Hearing Care Plan coverage, Dependents include:

- your spouse, including your common-law spouse as recognized by applicable state law,
- your qualified Domestic Partner, (see definition Domestic Partner),
- your children and your Domestic Partner's children under the age of 26 without access to employer coverage, (see definition Children), and
- your and your Domestic Partner's, physically or mentally disabled Children age 26 or over who are Wholly Dependent on you for support and maintenance and became disabled and Dependent before age 26. You must provide notice of the disability to HR within 31 days of your Child turning age 26 for that Child to be considered an eligible Dependent. If the Child is over age 26, the Child must have become incapacitated before age 26 *and* while covered under the plan to be considered an eligible Dependent.

Your spouse or child may not be considered a Dependent under the Dental/Vision/Hearing Care Plan while on Active Duty in the armed forces of any country. In addition, your spouse or child may not be considered a Dependent under the Dental/Vision/Hearing Care Plan if he or she is covered as an Employee.

Doctor
A licensed practitioner of the healing arts acting within the scope of the license. For the vision care benefits, "Doctor" means an Ophthalmologist or Optometrist.

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

Domestic Partner
An unmarried individual of either gender 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 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 health coverage, your Domestic Partner must be qualified under the FLEX Program rules including your completion of an Affidavit of Domestic Partners available on www.nortel-us.com/ or completing the affidavit online at the time of benefit selection. Contact HR for more information.

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

Employee
A person employed by the Company or any of its Affiliates on a permanent basis; the term also applies to that person for any rights after coverage ends. The term specifically excludes independent contractors and all other workers providing services to the Company or an Affiliate who are not recorded as Employees on the payroll records of the Company or an Affiliate, including any such individual who is subsequently reclassified by a court of law or a regulatory body as a common law Employee of an Employer.

Enrollment Period
See "Annual Enrollment." The FLEX Program benefits, including the Dental/Vision/Hearing Care Plan, may be selected during the Annual Enrollment Period, during the 31-day enrollment period following your commencement of employment as a new Employee or after you experience a Status Change.

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 evidence of good health affecting his or her acceptance for coverage.

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

FLEX Program
One of the Company's benefit programs, which offers you the flexibility to choose from different types and levels of welfare plan benefits. Through the FLEX Program or "FLEX" you can design the welfare plan benefits program that is best for you and your family.

FLEX Credits
Company-provided benefit dollars you may use to purchase Optional FLEX Program benefits.

FLEX Earnings
Your base salary. FLEX Earnings do not include other types of pay, including but not limited to, overtime, shift differentials, relocation payments or bonuses. If you are eligible for sales incentives, your FLEX Earnings include your base salary and target incentives, as defined each year by the Company (excluding bonuses).

HR
Nortel's Human Resources. By contacting HR, you can request needed forms or change your Employee information, such as your home address.

Hire Date
The date your employment with the Company begins.

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, or
- are mainly like schools.

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

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 vision care.

Lens, Lenses
A corrective device for the eyes made out of either glass or plastic designed to be either fitted into a frame (glasses) or worn directly over the cornea of the eye (contact Lenses).

Maintenance of Benefits
A provision that applies to your Dental, Vision and Hearing Care coverage if you (or your enrolled 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 Dental/Vision/Hearing Care Plan 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%.

Major Services
A category of dental services that includes:

- crowns, onlays and inlays
- initial installation of prosthesis, including dentures and fixed bridges for replacement of one or more natural teeth extracted while covered under this benefit
- maintenance of prosthesis, including dentures that have been installed for more than six months
- replacement of crowns, fixed bridges, full and partial dentures more than five years old
- surgical implants, including prosthetic device attached to it

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

Medical Plan
A plan that provides medical benefits for you and your enrolled Dependents.

Medically Necessary - Dental, Vision and Hearing Care Plan
For dental and hearing benefits, any generally accepted medical or dental service or supply provided by or under the supervision of a licensed doctor that is required to diagnose or treat an illness or injury.

For vision benefits: Medically Necessary contact Lenses are for patients who cannot wear prescription glasses. Medically Necessary contact Lenses must be prescribed by an EyeMed Doctor for certain conditions, such as following cataract Surgery or to correct extreme visual acuity problems that cannot be corrected with spectacle lenses. An EyeMed Doctor must obtain prior approval from EyeMed for Medically Necessary contact Lenses.

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 for Managed Care networks that can answer questions about Providers and send you a Doctor Directory.

Network
A group of Hospitals, Doctors and other health care professionals who have an agreement with a health plan or insurance carrier to provide services at a negotiated rate. The Providers agree to accept negotiated fees as payment in full.

Network Providers
Dental, Vision and Hearing Care Plan Providers including Hospitals, Physicians, other health care Providers and pharmacies who have entered into an agreement to participate in a network.

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

Optician
A person legally qualified to supply eyeglasses and contact Lenses according to prescriptions written by an Ophthalmologist or Optometrist.

Optional FLEX Program Benefits
Benefits you pay for with FLEX Credits, Before-Tax Contributions or After-Tax Contributions. Optional FLEX Program benefits supplement Company paid Core FLEX Program benefits.

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

Orthodontia/Orthodontic
Dental services that include straightening of teeth and fitting of braces.

Out-of-Network Benefits
The level of benefits you receive under the vision care benefits portion of the Plan when you use a health care Provider who does not participate in a network.

Out-of-Network Provider
Dental, Vision and Hearing Care Plan Providers who have not entered into an agreement to participate in a Network.

Periodontics
Dental services involving the treatment of diseases of the gums, bones and membranes that surround and support the teeth.

Physician
See "Doctor".

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

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.

Predetermination Review
A process through which proposed extensive dental treatment is reviewed and a detailed description and estimate of benefits considered for payment is provided by the Claims Administrator before the work is done.

Preexisting Condition
Any condition for which you:

- receive treatment or services,
- incur expense,
- receive diagnosis, or
- take prescribed medication

before coverage begins.

Preventive Care
Preventive Care includes services that help promote and maintain good dental health, such as:

- bite-wing x-rays, up to twice per Calendar Year (full-mouth or panorex, once every three Calendar Years)
- routine cleaning of teeth, up to twice per Calendar Year (two periodontal cleanings may be covered when the condition of the gums and other tissue supporting the teeth justify these procedures)
- routine exams, up to twice per Calendar Year
- sealants for Dependents under age 14, limited to one treatment per permanent tooth every 36 months
- topical fluoride treatment for Dependents under age 19, limited to twice per Calendar Year
- space maintainers for Dependents under age 14 limited to non-orthodontic treatment

- emergency treatment of dental pain when no other definitive dental services are performed (any x-ray taken in connection with such treatment is a separate dental service)

Limitations apply.

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

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 Dental/Vision/Hearing Care 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.

Sickness
See "Illness".

Status Change
A life event that you experience which may allow you to make certain changes in your FLEX Benefits choices. Other than the Annual Enrollment Period, the occurrence of a Status Change is the only time you can change your FLEX choices. You must notify HR during the 31-day period after you experience a Status Change in order to change your benefits.

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.

Vision Examination
An examination performed by an Ophthalmologist or Optometrist to check your eyes and prescribe treatment if needed. The examination usually includes, but is not limited to, history, external examination of the eye, determination of refractive status, binocular measurement and examination of the interior of the eye, by instrument, and the prescribing of Lenses, if needed.

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.