FLEX OVERVIEW

SUMMARY PLAN DESCRIPTION

PLAN YEAR 2012

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INTRODUCTION

The FLEX Benefits Program – or FLEX for short – is a flexible benefits, or "cafeteria style," plan that offers you a choice among different types and levels of benefits. FLEX offers you two kinds of benefits: Core FLEX Benefits and Optional FLEX Benefits. Under FLEX, you may use Core FLEX Benefits and Optional FLEX Benefits to create your own customized benefits package.

Core FLEX Benefits are the foundation of the program, giving you a base on which to build a personalized benefits package. The Company believes that every Employee should have a minimum level of benefits coverage. Therefore, the Company automatically provides Core FLEX Benefits. The cost of Core coverage is fully paid by the Company.

Optional FLEX Benefits are the "building blocks" of the program, offering you the choice of a variety of options for additional coverage. You purchase Optional FLEX Benefits with your Employee Contributions. FLEX Credits (Company-provided benefit dollars) are used to offset your cost of optional medical benefits.

Some FLEX Benefits including medical, dental/hearing, and STD are self-funded. This means that, after discounts are applied, Nortel Networks – not the insurance company – pays employees' claims. The insurance company only provides administrative services such as managing networks and processing claims. Self insurance is less expensive than insured health care plans and allows Nortel to administer consistent plans across different states.

On the following pages, you will find a brief description of the FLEX Benefits Program. Please read it carefully to learn more about how the program works and the options the Company is offering to you.

This information is a summary plan description (SPD) under the terms of the Employee Retirement Income Security Act of 1974 (ERISA). The complete terms of the FLEX Benefits Program can be found in each of the benefit plan summary plan descriptions posted to www.nortel-us.com/.

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

Please note that certain key words are capitalized. You can find these words in the Glossary section of this document.

PLAN HIGHLIGHTS

Core FLEX Benefits

The following Core FLEX Benefits are provided automatically:

Short-Term Disability
- 100% of FLEX Earnings for up to 6 weeks, then 66 2/3%* for up to the next 20 weeks for you only

Long-Term Disability
- 50% of FLEX Earnings up to a monthly maximum of $5000, for you only

Employee Life Insurance
- 1 X FLEX Earnings for you only

Employee Assistance Program
- Provides counseling as well as work life services for employees and their eligible dependents. Expert counseling and access to research and referral for child/elder care, legal/financial assistance, education and more are offered.

*or statutory minimum (if greater)

Optional FLEX Benefits

You can supplement or replace Core FLEX Benefits with choices from the following Optional FLEX Benefits:

Medical (Employee and Eligible Dependents**)
Network Area:
- No Coverage
- Preferred Provider Organization (PPO) Option 80/60
- Preferred Provider Organization (PPO) Option 90/70

Non-Network Area:
- No Coverage
- Out-of-Area Comprehensive Option

Dental, Vision and Hearing Care (Employee and Eligible Dependents**)
- No Coverage
- Comprehensive
- Plus

Life Insurance (Employee and Eligible Dependents**)
- Employee:
  - No Coverage
  - $50,000
  - 1-5 X FLEX Earnings
- Spouse or Domestic Partner:

    - No Coverage
    - $10,000
    - $25,000
    - $50,000
    - $75,000
    - $100,000
- Child(ren):
    - No Coverage
    - $5,000
    - $10,000
    - $15,000

Accidental Death & Dismemberment Insurance (Employee and Eligible Dependents**)

- Employee
    - No Coverage
    - 1 – 5 XFLEX Earnings
- Family
    - No Coverage
    - Family Coverage

** Refer to pages 7 – 8 of this section or page 16 of the Glossary for a definition of eligible Dependents.

ELIGIBILITY

For You

You are eligible for FLEX Benefits 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 FLEX unless specified in the collective bargaining agreement.

For Your Dependents

If you are eligible for FLEX, you may enroll your eligible Dependents for Medical, Dental, Vision and Hearing Care and Dependent Life Insurance coverage under FLEX. Generally, 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, incapable of self-sustaining employment, and unable to engage in the normal activities of a person of the same age, sex and ability by reason of mental or physical handicap 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.

*It should be noted that the definition for 'Dependents' can vary among each of the different benefit plans under FLEX. Refer to the 'Glossary' section of each benefit plan summary plan description to determine how 'Dependents' are defined in each plan.

Qualified Medical Child Support Order

Your children or your Domestic Partner's Child(ren) will be eligible for the Medical Plan, and the Dental, Vision and 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 QMSCO will not become effective until the Plan Administrator determines that the order is a QMCSO. A QMCSO 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.

For Your Domestic Partner and His or Her Child(ren)

You may enroll your Domestic Partner in the Medical and Dental, Vision and Hearing Care and the Life Insurance and Accidental Death and Dismemberment plans 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 on page 7.

It is strongly recommended you consult with a tax or legal advisor before enrolling your Domestic Partner and his/her Child(ren) because special tax and legal considerations apply. 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.

Refer to the Administrative Information section of each benefit plan's summary plan description for details about the requirements for enrolling your Domestic Partner and/or your Domestic Partner's Children.

SPECIAL ELIGIBILITY RULES

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

If you and your spouse (or Domestic Partner) are both eligible to participate in FLEX, special rules apply for enrolling in Medical, Dental, Vision and Hearing Care and Life Insurance and AD&D Insurance coverage. You may enroll as an Employee or a spouse (or Domestic Partner), but not both. In addition, both you and your spouse (or Domestic Partner) must select the same medical plan in order for your combined expenses to apply to the family Deductible or family Out-of-Pocket Maximum.

If you and your spouse (or Domestic Partner) have Children together, only one of you may enroll your eligible Dependent Children. If your spouse (or Domestic Partner) has Children who are not your Children, see "For your Dependents" on page 7 for information on who may enroll those Children.

If you and Your Child (or your Domestic Partner's child) Both Work for the Company

Your child (or your Domestic Partner's child) will not be considered an eligible Dependent if your child is covered under the plans 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.

PARTICIPATION

When You are First Hired

All benefits are available on your Hire Date, provided you complete the enrollment process as required and make the applicable Employee contributions.

You are immediately eligible for Core FLEX Benefits, but you do not need to enroll in order to participate. You are also immediately eligible for Optional FLEX Benefits, may be subject to medical evidence requirements, but you must enroll to participate in these benefits. You will receive enrollment information including a Personalized Enrollment Worksheet or directions on how to enroll on-line from HR.

As a new employee, for the first 31 days or up to the date you make an enrollment selection, whichever is first, you will have company-paid medical coverage for you and your eligible Dependents under the Medical Plan.

If you enroll as a new employee on or before your date of hire, any optional coverage you choose will be effective on your date of hire. If you enroll later but within 31 days of your date of hire, any optional coverage you choose will be effective on the date HR received your elections. Deductions reflecting your choices will begin with the next pay cycle following the effective date of coverage.

If You Do Not Enroll

If you do not enroll for FLEX within 31 days of your date of hire (or eligibility date), you will not have Optional FLEX Benefits, except for the Medical Plan, where you will be defaulted to coverage for you only. You must wait until an Annual Enrollment period, or until you experience a qualified Status Change to enroll in Optional FLEX Benefits.

Your Core FLEX Benefits include:

- Short-Term Disability (100% of FLEX Earnings for up to the first 6 weeks, then 66 2/3% for up to the next 20 weeks)
- Long-Term Disability (50% of FLEX Earnings up to a monthly maximum of $5000)*
- Employee Life Insurance (1 X Flex Earnings)
- Employee Assistance Program

If you are a newly hired Employee, you will not be covered by LTD benefits if Total Disability occurs within 12 months after your LTD coverage is initially effective and if the disability is caused or in any way related to a "Preexisting Condition" that existed within 90 days of your coverage Effective Date.

The Preexisting Condition exclusion will not apply to employees who become covered under the Nortel Networks FLEX program due to the acquisition of their employer by the Company and their employer's subsequent election to cover its employees under the LTD plan as an Affiliate.

During the Annual Enrollment Period

Each year during the Annual Enrollment period (generally in the fall), you will make your FLEX selections 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 qualified Status Change.

Evidence of Insurability

You may be required to provide Evidence of Insurability (EOI) when you enroll for certain benefit plans during the Annual Enrollment Period, when you change coverage because of a qualified Status Change or as a new hire. Refer to each benefit plan summary plan description for more details and requirements about evidence of insurability.

CHANGING YOUR SELECTIONS

Most of your FLEX selections remain in effect the entire Plan Year (usually January 1 through December 31) and may not be changed.

You can make certain changes in your FLEX Benefits choices during the 31-day period after you experience one of the following life events. Other than Annual Enrollment, these are the only times you can change your FLEX choices. The list of qualified 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,
- Disability of a spouse, enrolled Domestic Partner or 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 or a paid leave of absence),
- 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 or a paid leave of absence),
- Beginning or end of your spouse's or enrolled Domestic Partner's employment,
- You, your spouse or enrolled Domestic Partner takes an unpaid leave of absence,
- Relocations affecting a Medical Plan network availability,
- Loss of spouse's or Domestic Partner's medical or dental, vision and hearing coverage,
- You, your spouse or enrolled Domestic Partner become eligible for Medicare or Medicaid,
- Shift change,
- Loss of other group health plan coverage (for the employee who declined coverage due to having other coverage but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause),
- Loss of employer contribution toward other group health plan coverage (for the employee who declined coverage due to having other coverage),
- Covered child's loss of Dependent status,
- Dependent child becomes eligible,
- Termination of your relationship with an enrolled Domestic Partner, or
- Loss of other group health plan coverage when the other coverage was COBRA and the maximum COBRA coverage period ends.
- Benefits plan year of a spouse's or Domestic Partner's benefit plan differing from the Company Plan Year (e.g. your spouse's or Domestic Partner's benefits are effective on July 1 and yours are effective on January 1.)

The benefit selections you may make must be consistent with the qualified Status Change. For example, if you have a baby, you may add coverage for the child under your Medical, Dental, Vision and Hearing Care plans, select Optional Dependent Life Insurance for your child, and or increase your Optional Employee Life Insurance.

You must request the change, document the qualifying event and HR must receive your FLEX Enrollment Change form within 31 days of the occurrence. A qualified Status Change Affidavit, which proves that the event occurred, is required.

If you return your required documentation within 31 days after your event occurred, your coverage will not become effective until all documentation is received (i.e., via fax, mail, or online) by HR.

If more than 31 days has elapsed since the date of your Status Change, you may change options in which you are currently enrolled only at the next Annual Enrollment period or your next qualified Status Change. The FLEX Plan does provide for you to request an

addition or deletion of dependent coverage for your current medical and/or dental, vision and hearing care options. However, this must be done within 12 months after the Life Event occurred and within the Calendar Year in which the 31-day enrollment period ended. No other changes to Optional FLEX Benefits are permitted outside the 31-day enrollment period.

Please note:

- Coverage for Dependents who become ineligible is terminated back to the date of the event that made them ineligible

COST OF COVERAGE

FLEX Credits

Each option under FLEX has its own price tag; the more extensive the coverage, the higher the cost. The Company helps you purchase optional medical benefits by giving you FLEX Credits. If you choose more coverage than your FLEX Credits will buy, you will pay the difference with Payroll Deductions each pay period. On the other hand, if you choose a Medical Plan option that costs less than your FLEX Credits you will receive the balance as taxable income.

All full-time and part-time Employees receive the same number of FLEX Credits. Each year, the Company will evaluate the amount of FLEX Credits provided to Employees and the FLEX Plan prices. Adjustments may be made from year to year.

Your Contributions

You make Before-Tax Contributions for the following plans:

- Medical*
- Dental, Vision and Hearing Care*

The cost of health care coverage for a Domestic Partner and a Domestic Partner's Child(ren) is after- tax unless your Domestic Partner and/or Domestic Partner's child(ren) qualify as your tax dependent under Internal Revenue Code (IRC) Section 152.

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, 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.

You make After-Tax Contributions for the following benefits:

- Optional Employee Life
- Optional Dependent Life
- Optional AD&D Insurance

FLEX EARNINGS

FLEX Earnings equal your base salary. If you are a part-time Employee regularly scheduled to work 20 to 34.5 hours per week, your FLEX Earnings are based on a 25-hour work week.* If you are a part-time Employee regularly scheduled to work 35 to 37.5 hours per week, your FLEX Earnings are based on a 40-hour work week. 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). Your FLEX Earnings are determined on the following dates:

* Refer to the Short-Term Disability Plan summary plan description for special provisions regarding part-time FLEX Earnings and disability benefits.

If you are enrolling:	***Your Flex Earnings are your base salary as of:***
For Annual Enrollment	January 1 of the plan year
As a new hire	Your hire date
Part-time to full-time or vice versa	Effective date of employment status change

FLEX Earnings do *not* include:

- Overtime pay,
- Shift differentials,
- Relocation payments or
- Bonuses.

If your FLEX Earnings and FLEX Credits change during the Plan year (except due to an employment status change – e.g., full-time to part-time), related FLEX Payroll deductions and credits will not change during the year since these deductions are based on your FLEX Earnings as of January 1 of the plan year. If your FLEX Earnings *increase* during the year, pay-related benefits (e.g., disability, life insurance, etc.) will be based on your FLEX Earnings at the time of your disability, dismemberment or death. However, if your FLEX Earnings *decrease* during the year, pay-related benefits (except

due to an employment status change – e.g., full-time to part-time) will be based on your FLEX Earnings as of January 1 of the plan year.

ADDITIONAL INFORMATION

For more detailed information, please refer to the summary plan description(s) for each of the respective benefit plans. These documents are posted on www.nortel-us.com/.

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.

Sometimes, to describe a benefit plan accurately, some technical terms must be used. Here, to help you understand them, are brief definitions in alphabetical order.

Active Duty
Currently enlisted in the armed forces of any country 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 in the coming year. The FLEX Annual Enrollment Period is held each fall. Benefits selected during the Annual Enrollment Period are generally effective the following January 1.

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 and saving you money in taxes.

Calendar Year
January 1 through December 31. This period is also known as the Plan Year for the purposes of all 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, or
- 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.

* The above definition may vary by plan. Refer to each benefit plan summary plan description to determine the definition under each plan.

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

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

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

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

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

Core FLEX 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 50% of your pre-disability FLEX Earnings (up to monthly maximum of $5000) after you have been disabled for 180 days.
- Employee Life Insurance equal to one times your FLEX Earnings,
- Employee Assistance Program provides free confidential counseling for up through the first 8 visits.

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.

Dependent*
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 of 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 Shared Services 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 Medical 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 Medical plan if he or she is covered as an Employee.

* The above definition may vary by plan. Refer to each benefit plan summary plan description to determine the definition under each plan.

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 Benefits may be selected during a 31-day enrollment period when you first become eligible for benefits as a new employee or after you experience a Status Change.

Evidence of Insurability (EOI)
Proof of a person's physical condition verifying evidence of good health affecting his or her acceptance for coverage.

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

FLEX Credits
Company-provided benefit dollars used to offset the cost of Optional FLEX Medical 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). Part-time employees' premium calculations under the FLEX Disability, Life and AD&D plans are based on a 25-hour work week if the employee regularly works 20-34.5 hours per week, and on a 40-hour work week if the employee regularly works more than 35 hours per week. Claim calculations on these benefits are based on the number of hours worked that a part-time employee has averaged over the 12 weeks immediately preceding the event which caused a Claim for benefits to be filed.

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

Hire Date
The date your employment with the Company begins.

In-Network Benefits
The level of benefits you receive when you use Network Providers for your medical care. For instance, the Medical Plan's PPO options pay In-Network Benefits at a higher rate than Out-of-Network Benefits.

In-Network Providers
See "Network Providers".

Maintenance of Benefits
A provision that applies to your Medical 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 FLEX medical option that covers 80% of eligible expenses and you've already received that 80% of eligible expenses for a Dependent through your spouse's plan, the Nortel Networks plan will not make up the additional 20%.

Managed Care
A type of health plan that negotiates fees with hospitals, doctors and other health care professionals in advance. These providers then form a Managed Care network. Generally, when you use the providers who have an agreement with the Managed Care network, you receive the highest benefit coverage level applicable under the plan.

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

Optional FLEX Benefits
Benefits that can be purchased to supplement Company paid Core FLEX Benefits. They include:

- Medical coverage for yourself or yourself and your eligible Dependents,
- Dental/Vision/Hearing Care coverage for yourself or yourself and your eligible dependents,

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

Payroll Deduction
Contributions taken from your pay either before or after federal income, FICA (Social Security) and most state and local income taxes are deducted.

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.

Preexisting Condition
Any condition for which you:
- receive treatment or services,
- incur expense,
- receive diagnosis, or
- take prescribed medication before coverage begins.

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

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.

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 Shared Services during the 31-day period after you experience a Status Change in order to change your benefits.

Termination Date
The last day you work for the Company.

Total Disability, Totally Disabled
For the Short-Term Disability plan, the inability to perform the work you normally perform due to Illness or accidental Injury, as certified by a Physician.
For the Long-Term Disability plan, during the first 12 months, the inability to perform the work you normally perform. After the first 12-month period, you will be considered Totally Disabled if you are unable to perform any job you are or could become qualified to do with your education, training or experience.

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.