Nortel Networks Inc.
Life and Accidental Death & Dismemberment Insurance 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 Life and Accidental Death and Dismemberment (AD&D) Insurance Plan that are in effect for the 2012 Calendar Year. It is designed to provide you with a detailed summary of your Life and AD&D insurance 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 - LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE PLAN BENEFITS** describes the provisions of the Life and AD&D Insurance Plan that determine your benefits.
- **SECTION TWO - ADMINISTRATIVE INFORMATION** includes administrative details about the Life and AD&D Insurance Plan, such as how to file Claims and appeal denied Claims, where to get more information, your ERISA rights and how the Company may amend the plans.
- **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 - LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE PLAN BENEFITS

This section describes the provisions of the Life and AD&D Insurance Plan including who is eligible, how participation is elected, what benefits are paid, and when participation ends.

Introduction to Life and AD&D Insurance Plan Benefits

The Life and AD&D Insurance Plan is part of the Nortel Networks 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 Benefits to create your own customized benefits package. Under the Life and AD&D Insurance Plan, you are provided term life insurance coverage as part of your Core FLEX Benefits and, as part of your Optional FLEX Benefits, you can choose optional term life insurance and optional AD&D insurance coverage including coverage for your Dependents. Or you may decline optional coverage.

Your term life insurance benefits help in providing financial security for your family if you die and your AD&D benefits help you or your family if you are Seriously Injured or die in an Accident. The Company has chosen The Prudential Insurance Company of America (Prudential) to insure the Life and AD&D Insurance Plan under a group term life insurance policy.

The complete requirements for payment of Life and AD&D Insurance Plan benefits, including a complete listing of covered services, exclusions and limitations, can be found in the group contracts that govern the plans. A copy of the booklet-certificate that is part of the group contract for the Life and AD&D Insurance Plan can be obtained from the Company. If there is a difference between this summary and the group contracts, the group contracts will control.

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).

PLAN HIGHLIGHTS

Employee Term Life Insurance

Core Employee Term Life Insurance

1 X FLEX Earnings
(rounded up to the next higher $1,000,
up to $1,000,000)

Optional Employee Term Life Insurance

1 X FLEX Earnings
2 X FLEX Earnings
3 X FLEX Earnings
4 X FLEX Earnings*
5 X FLEX Earnings*
(rounded up to the next higher $1,000,
up to a maximum of $3,000,000)

Dependent Term Life Insurance

Core Dependent Term Life Insurance

Not available

Optional Dependent Term Life Insurance

Optional Spousal or Domestic Partner Term Life Insurance:

- $10,000
- $25,000
- $50,000*
- $75,000*
- $100,000*

Optional Child Term Life Insurance:

- $5,000**
- $10,000**
- $15,000**

Note: Under optional child term life insurance, the amount will be the same for each child. If you enroll in optional child term life insurance, your newborn child, age 14 days but less than six months, will automatically be covered in the amount of $1,000.

* Requires Evidence Of Insurability at any time of enrollment regardless of whether you have a Status Change. For more information, see "Evidence Of Insurability."

** Per child coverage (age six months, but less than 19 years; 25 years if a full-time student).

Accidental Death & Dismemberment (AD&D) Insurance

Core AD&D Insurance

Not available

Optional AD&D Insurance

Optional Employee AD&D Insurance:
1 X FLEX Earnings
2 X FLEX Earnings
3 X FLEX Earnings
4 X FLEX Earnings
5 X FLEX Earnings
(rounded up to the next higher $1,000, up to a maximum of $1,000,000, or 5 X FLEX Earnings, if less)

Optional Dependent AD&D Insurance:
The amount of AD&D insurance on each of your Dependents is a percentage of your amount of optional employee AD&D insurance. The percentage that applies is shown below. It is based on the persons who are your Dependents at the time the Claim is incurred.

Persons who are your Dependents:	Amount of Insurance on each Dependent, as a percentage of your AD&D Insurance:
Your spouse/Domestic Partner	60% on your spouse/Domestic Partner
Your Child/Child(ren) only	20% on each Child
Your spouse/Domestic Partner and Child(ren)	50% on your spouse/Domestic Partner and 15% on each Child

WHO IS ELIGIBLE

You

You are eligible for the Life and AD&D Insurance 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 Life and AD&D Insurance Plan unless specified in the collective bargaining agreement. If you are a non-payrolled worker or independent contractor, you are not eligible for the Life and AD&D Insurance Plan.

Your Dependents

You may enroll your eligible Dependents for dependent term life insurance coverage. In addition, you may choose to cover your eligible Dependents for AD&D insurance coverage. Eligible Dependents include:

- your spouse, including your "common-law spouse" (as defined under applicable state law) or your qualified Domestic Partner
- your unmarried Children who are at least 14 days but less than 19 years old. "Child(ren)" include:
  your natural or legally adopted (or placed for adoption) Child(ren
  - your step-Child(ren), legally authorized foster Child(ren), and any child for whom you are legal guardian, if these Child(ren) depend on you for support and maintenance and live with you in a regular, parent-child relationship for at least six months of the Calendar Year.
- your unmarried Child(ren) under age 25 who are registered full-time students at an accredited school and are primarily supported by you, and
- your eligible, unmarried, physically or mentally disabled Child(ren) age 19 or over who are Wholly Dependent on you for support and maintenance and became disabled and Dependent before age 19 (or before age 25 if a full-time student). You must provide notice of the disability to HR within 31 days of your child turning age 19 for that child to be considered an eligible Dependent. If the child is over age 19, the child must have become incapacitated before age 19 *and* while covered under the plan to be considered an eligible Dependent.

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 work for the Company and if you are both eligible to participate in the Life Insurance and AD&D Insurance Plan, then special rules apply for enrolling in the plan.

- You may enroll as both an Employee and as a Dependent.
- You both may enroll for Dependent Child coverage.

If Both You and Your Child Work for the Company

Your child will not be considered an eligible Dependent if your child is covered under this plan as an Employee.

If Your Spouse, Domestic Partner or Child is in the Armed Forces

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

HOW TO ENROLL

You may choose to enroll for optional life insurance and optional AD&D plan benefits:

- Within 31 days of your Hire Date or the date 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 Life and AD&D Insurance 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 Life and AD&D Insurance Plan upon your hire or during the Annual Enrollment Period, contact HR at: 1-800-676-4636. You may not enroll in the Life and AD&D Insurance Plan or change your coverage by contacting any of the Claims Administrators that process benefit Claims under the Plan; you must contact HR to do that.

You may increase the amount of your core Employee term life insurance coverage by selecting optional Employee term life insurance during the FLEX enrollment process. You may also choose coverage for your spouse, Domestic Partner or Child(ren) by selecting optional Dependent term life insurance even if you do not select optional Employee term life insurance coverage for yourself. In addition, you may select optional AD&D insurance coverage for yourself only or for yourself and your eligible Dependents by selecting optional AD&D insurance coverage. In order to enroll in optional Dependent AD&D insurance, you must also be enrolled in optional Employee AD&D insurance coverage.

Life Insurance Plan Options under FLEX

Core FLEX Benefits

You are eligible for core Employee term life insurance on your Hire Date. You do not need to enroll for core Employee term life insurance coverage in order to participate. The amount of core Employee term life insurance available is described above.

Optional FLEX Benefits

You may select from the following options for life insurance plan benefits under the FLEX Program:

- No Coverage
- Optional Employee Term Life Insurance

- Optional Dependent Term Life Insurance
    - Optional Spousal or Domestic Partner Term Life Insurance
    - Optional Child Term Life Insurance

If you choose to enroll in optional benefits, you may select coverage as follows:

- You only
- Your spouse or Domestic Partner only
- Your Child(ren)only
- You and your spouse or Domestic Partner
- You and your Child(ren)
- You and your Spouse or Domestic Partner and Child(ren)

The amount of optional life insurance coverage available is described below.

Accidental Death and Dismemberment (AD&D) Insurance Plan Options under FLEX

Core FLEX Benefits

There is no core AD&D insurance coverage available under the FLEX Program.

Optional FLEX Benefits

You may select from the following options for AD&D insurance plan benefits under the FLEX Program:

- No Coverage
- Optional AD&D Insurance
    - Optional Employee AD&D Insurance
    - Optional Dependent AD&D Insurance

If you choose to enroll, you may select coverage as follows:

- You only
- Your Dependent(s) only
- You and Your Dependent(s)

The amount of optional AD&D insurance coverage available is described below.

Evidence Of Insurability for the Life Insurance Plan

You will be required to provide acceptable Evidence Of Insurability, or EOI, if you select certain levels of optional Employee term life insurance or optional Dependent term life insurance coverage.

To provide EOI, you will have to submit a completed medical questionnaire to the Claims Administrator and you may have to provide additional information. For example, you may be asked to have a physical exam or laboratory work, at your expense. (If you participate in a Managed Care option under the Nortel Networks Medical Plan, these medical expenses may be covered at in-network rates when you use your Primary Care Physician (PCP), if a PCP is applicable under your Medical Plan option, and submit a Claim form. Any charges for completing paperwork will be at your expense.)

EOI must be satisfactory to the Claims Administrator before coverage can be approved. The Claims Administrator uses its standard underwriting rules and procedures for reviewing applications and has the sole authority to approve or reject any application on the basis of health. Coverage will be provided at the current level while the decision on your EOI is pending. If not approved, your coverage will continue at the current level.

Special Note: If you have a Status Change (as described under "Changing Your Selections"), you may be able to increase your optional Employee term life insurance coverage by one level without providing Evidence Of Insurability. However, EOI is required for increases to four or five times FLEX Earnings, whether or not you have a Status Change.

You will be required to provide acceptable Evidence Of Insurability … if you select certain levels of optional Employee term life insurance or optional Dependent term life insurance coverage.

For You

You must provide EOI if:

- you increase your current optional Employee term life insurance coverage
- you select optional Employee term life insurance coverage of four or five times your annual FLEX Earnings

You must also provide EOI in any of the following situations:

(1) You enroll for optional life insurance after any insurance under the group contract ends because you did not pay a required contribution.
(2) You have not met a previous requirement for Evidence Of Insurability to become insured under any Prudential group contract for Employees.
(3) You wish to enroll for optional life insurance and have an individual life insurance contract which you obtained by converting your term life insurance under the plan. If you have an individual life insurance contract which you obtained by converting your term life insurance under the plan, it is your responsibility to identify yourself as having converted your term life insurance to an individual policy. If you fail to notify HR of your conversion *prior* to your enrollment in optional life insurance, you or your Beneficiaries could be denied term life insurance benefits under the plan in the future.

For Your Dependents

You will be required to provide EOI for your spouse or Domestic Partner if you select optional term life insurance for your spouse or Domestic Partner in a coverage amount of $50,000, $75,000 or $100,000. However, you will not have to provide EOI for your spouse or Domestic Partner if you select optional spousal or Domestic Partner term life insurance of $10,000 or $25,000, or if you select optional Child term life insurance, provided you enroll within 31 days of first becoming eligible, during an Annual Enrollment Period or within 31 days of a Status Change (as described under "Changing Your Selections").

You must also provide EOI for your spouse or Domestic Partner in any of the following situations:

(1) You enroll for optional spousal or Domestic Partner term life insurance after any insurance under the group contract ends because you did not pay a required contribution.

(2) Your spouse or Domestic Partner is a person for whom a previous requirement for Evidence Of Insurability has not been met. The evidence was required for your spouse or Domestic Partner to become covered for insurance, as a Dependent or an Employee. That insurance is or was under any Prudential group contract for Employees.

WHEN COVERAGE BEGINS

Core Life Insurance Plan Benefits

Core Employee term life insurance coverage is automatically effective on your date of hire as a new Employee. Refer to "Plan Highlights" for more information about this coverage.

Optional Life Insurance Plan and Optional AD&D Insurance Plan Benefits

If you select any optional term life insurance or optional AD&D insurance during your election of 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. Note: some events allow for a choice in coverage Effective Date. Contact HR if you have questions.
During the Annual Enrollment Period	The first day of the next Plan Year, normally January 1

***** If you are required to provide Evidence Of Insurability (as described under "How To Enroll") your new optional coverage will begin when EOI is approved by the Claims Administrator.

During the New Hire Enrollment Period

You have 31 days from your Hire Date to enroll in the optional benefits provided under the Life and AD&D Insurance Plan. If you enroll within 31 days of your Hire Date, your optional Life and AD&D Insurance Plan coverage will be effective on the date HR receives your selections. You will not have coverage under any optional Life and AD&D Insurance Plan benefits until you enroll in the Plan. The Effective Date of the enrollment is explained above.

If You Do Not Enroll

If you do not enroll under any of the above circumstances, you will be covered under core life insurance only. YOU WILL HAVE NO AD&D INSURANCE COVERAGE AND YOUR DEPENDENTS WILL HAVE NO LIFE AND AD&D INSURANCE COVERAGE until the next Plan Year (if you elect coverage during the next Annual Enrollment Period) or until you elect coverage following an applicable Status Change.

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 Life and AD&D Insurance 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. The Effective Date of the enrollment is explained above.

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 in 2011 will continue in 2012.

Delay of Effective Date

If you are not Actively at Work on the day your enrollment or change in coverage would otherwise be effective, the Effective Date will be delayed until you return to Active Work status, regardless of the reason for your absence. In addition, if an eligible Dependent is confined for medical treatment at home or elsewhere on the date coverage would otherwise be effective, the Dependent will not be covered until they are released by their Physician and are no longer confined. However, this rule does not apply to your eligible newborn child who is at least 14 days old if:

- the newborn is your first eligible Dependent, or
- you already have Dependent coverage for other eligible Dependents

Changing Your Selections

Your FLEX Benefits selection remains in effect through the end of the Plan Year (usually December 31st). 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,

- Covered child's loss of Dependent status (e.g., no longer a full-time student),
- Dependent child becomes eligible (e.g., becomes a full-time student),

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 select optional Dependent term life insurance for your Child and increase your optional Employee term life insurance.

To make a change to your benefit selections, 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.

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.

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 falsely report a Status Change and request benefit selection changes related to such a change, you will be subject to discipline by the Company (up to and including employment termination), a requirement to return any benefits obtained with respect to the benefit selection changes and legal action that is appropriate with regard to any fraud or misrepresentation that has occurred if such a Status Change has not actually occurred,

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 any FLEX Benefit Program options (e.g., medical, life insurance or disability coverage) until the next Annual 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

Core Employee term life insurance coverage is provided at no cost to you. You and the Company share the cost of optional Employee term life insurance and optional Dependent term life insurance coverage and you pay the full cost of optional AD&D insurance coverage. The cost of coverage is determined by the Company and/or the insurer each year. The Company reserves the right to change your cost of coverage as necessary.

If you select optional Employee term life insurance, optional Dependent term life insurance or optional AD&D insurance coverage, your Employee contributions are deducted from your paycheck each pay period on an After-Tax basis or you may be able to use FLEX Credits to pay some of the cost if you do not use your FLEX Credits to pay for other benefits. The Company makes available FLEX Credits which may be used to pay for Optional FLEX Benefits under the FLEX Program. (More information about FLEX Credits is provided in the SPD for the FLEX Program, located on www.nortel-us.com/.)All full-time and part-time Employees who are eligible to participate in the Plan receive the same number of FLEX Credits. The amount of FLEX Credits you receive as well as your cost for each of the options available under FLEX is shown on the FLEX online enrollment tool or your Personalized Enrollment Worksheet (if you don't have intranet access). The Amount of FLEX Credits may also be changed by the Company.

Each of the life insurance plan options has a different price based on the level of coverage under the Plan. The cost of optional Employee term life insurance coverage is based on your FLEX Earnings, the coverage level selected, your age and on whether you are a smoker or a non-smoker. Your age is your age on December 31 of the year for which you have

enrolled. You are eligible for discounted non-smoker rates only if you have not smoked a cigarette or used any tobacco products for 12 continuous months. Once you have completed 12 months without using any tobacco product, you will be eligible to apply for non-smoker rates during the next Annual Enrollment Period.

The cost of optional spousal or Domestic Partner term life insurance coverage is based on the coverage level selected and your spouse's or Domestic Partner's age as of December 31 of the year for which you have enrolled. The cost of optional Child term life insurance coverage is fixed regardless of the number of Children covered.

The cost of optional AD&D insurance coverage is applied on a rate per $1,000 basis of your selection, and is based on either single or family rates.

WHEN CONTRIBUTIONS BEGIN

Contributions for Life and AD&D Insurance Plan benefits begin with the first full pay cycle following the Effective Date.

Core Employee term life insurance coverage is provided at no cost to you. You will pay for optional Employee term life insurance, optional Dependent term life insurance and optional AD&D insurance coverage with after-tax dollars. Contributions are deducted from your paycheck each pay period.

FLEX EARNINGS

FLEX Earnings equal your base salary. If you are eligible for sales incentives, your FLEX Earnings include your target incentives, as defined each year by the Company (excluding bonuses). Your FLEX Earnings are determined on the following dates:

If you are enrolling:	Your FLEX Earnings are your base salary as of:
For 2012 annual enrollment	January 1, 2012
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 change during the Calendar Year (except due to an employment Status Change - e.g., full-time to part-time), related FLEX Payroll Deductions will not change during the year since these deductions are based on your FLEX Earnings as of January 1 and the amount of coverage selected... If your FLEX Earnings *increase* during the year, pay-related benefits (e.g., disability, term 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 (except due to an employment Status Change - e.g., full-time to part-time), pay-related benefits will be based on your FLEX Earnings as of January 1.

FLEX Earnings are your annual base salary. 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).

BENEFICIARY

Your Beneficiary is the person who receives plan payments in the event of your death. You can name anyone you wish as your Beneficiary. You can name one person or several people. If more than one person is named, you must indicate the percentage of the total benefit each person should receive. If you do not indicate each person's share, they will share equally in the benefit.

You can change your Beneficiary at any time by completing a new Beneficiary designation form and returning your completed form to HR. Once received by HR, the change will take effect on the date you sign the form. To obtain a Beneficiary designation form, you can visit the www.nortel-us.com/ web site or contact HR.

If you do not designate a Beneficiary, benefits will be paid in total to whoever is in the first order of priority as per the following order:

1. widow or widower
2. surviving Child/Child(ren)
3. surviving parent(s)
4. surviving brother(s) and sister(s)
5. executor(s) or administrator(s) of estate

If you purchase optional Dependent term life insurance and optional AD&D insurance coverage, you are automatically the Beneficiary for any benefits paid due to the death of a covered family member. If you are not living at the death of a Dependent, the benefit is payable to the Dependent's estate or, at the Claim Administrator's option, to any one or more of these surviving relatives of the Dependent: wife; husband; mother; father; Child/Child(ren); brothers; sisters.

Your Beneficiary is the person who receives plan payments in the event of your death. You can name anyone you wish as your Beneficiary. If more than one person is named, you must indicate the percentage of the total benefit each person should receive. If you do not indicate each person's share, they will share equally in the benefit.

REMEMBER: Benefits will be payable to the Beneficiary you have designated. Make sure your designation is current.

EMPLOYEE TERM LIFE INSURANCE

If you die while covered under the life insurance plan, the plan will pay benefits to your Beneficiary(ies). Benefits under core Employee term life insurance and optional Employee term life insurance are based on a multiple of your annual FLEX Earnings.

Core FLEX Benefit Amount

Core Employee term life insurance coverage is equal to one times your annual FLEX Earnings. This number is rounded up to the next higher $1,000.

Optional FLEX Benefit Amount

Optional Employee term life insurance coverage is available in the following amounts:

- No coverage
- 1 X FLEX Earnings
- 2 X FLEX Earnings
- 3 X FLEX Earnings
- 4 X FLEX Earnings*
- 5 X FLEX Earnings*

To determine your optional Employee term life insurance coverage amount, first multiply your FLEX Earnings by the option you have selected. If the result is not an even multiple of $1,000, round the amount to the next $1,000. Here is an example, using FLEX Earnings of $22,400:

Multiple	Benefit Amount
1 X FLEX Earnings = $ 22,400	$ 23,000
2 X FLEX Earnings = $ 44,800	$ 45,000
3 X FLEX Earnings = $ 67,200	$ 68,000
4 X FLEX Earnings = $ 89,600	$ 90,000
5 X FLEX Earnings = $112,000	$112,000

* Requires Evidence Of Insurability at any time of enrollment regardless of whether you have a Status Change.

Benefits under core Employee term life insurance and optional Employee term life insurance are based on a multiple of your annual FLEX Earnings.

Maximum Benefit Amount

The maximum coverage under core Employee life insurance is $1,000,000 or one times your FLEX Earnings, whichever is less. The maximum coverage under optional Employee term life insurance is $3,000,000 or five times your annual FLEX Earnings, whichever is less. Under no circumstances could you have Employee term life insurance coverage in excess of $4,000,000 or six times your FLEX Earnings, whichever is less.

Tax Implications

Federal law requires you to pay income tax on the cost of Company-paid Employee term life insurance coverage that exceeds $50,000. If your core Employee term life insurance coverage is greater than $50,000, an additional amount of income equal to the Company cost of your coverage over $50,000 will be added as taxable earnings on your W-2 form at the end of the year. This amount is called "Imputed Income."

To avoid this taxation, you may select to cap your core Employee term life insurance at $50,000 of coverage when you first enroll, when you have a Status Change or during an Annual Enrollment Period. If you do so, you will not be eligible to select any optional Employee term life insurance coverage.

Federal law requires you to pay income tax on the cost of Company-paid employee term life insurance coverage that exceeds $50,000. This amount is called "Imputed Income."

Accelerated Benefit Payment

If you become Terminally Ill with six months or less to live, you can apply to have a portion of your Employee term life insurance benefits paid directly to you. You must furnish satisfactory proof of your Illness to the Claims Administrator before any benefits can be paid.

You can receive up to 50% of the amount of your Employee term life insurance coverage, but not more than $50,000. Benefits will be paid in a single lump sum or, if you choose, in six equal monthly installments.

If you elect monthly installments and you die before all payments have been made, the Claims Administrator will pay your Beneficiary or Beneficiaries in one sum. That sum will be the total of the payments that remain.

Your right to be paid under this option is subject to these terms:

1. You must choose this option in writing in a form that satisfies the Claims Administrator.
2. You must furnish proof that satisfies the Claims Administrator that your life expectancy is 6 months or less, including certification by a Doctor.
3. Your Employee term life insurance must not be assigned.
4. Accelerated benefit payments will be made available to you on a voluntary basis only. Therefore:
    a. if you are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise, you are not eligible for this benefit.
    b. if you are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement, you are not eligible for this benefit.

Accelerated benefit payments are non-taxable and may affect your eligibility for certain government benefits. In addition, the amount of benefits payable to your Beneficiary upon your death will be reduced by the amount of accelerated benefits that you receive. Also, any amount you could otherwise have converted to an individual contract will be reduced by these accelerated benefit payments.

If you wish to apply for accelerated benefits, please contact HR for forms and instructions.

If you become Terminally Ill with six months or less to live, you can apply to have a portion of your Employee term life insurance benefits paid directly to you. You must furnish satisfactory proof of your Illness to the Claims Administrator before any benefits can be paid.

DEPENDENT TERM LIFE INSURANCE

If your spouse or Domestic Partner or Child dies while covered under the plan, you will receive a benefit.

Optional Spousal or Domestic Partner Term Life Insurance Amount

Optional spousal or Domestic Partner term life insurance coverage is available in the following amounts:

- No coverage
- $10,000
- $25,000
- $50,000 (requires EOI)
- $75,000 (requires EOI)
- $100,000 (requires EOI)

Optional Child Term Life Insurance Amount

Optional Child term life insurance coverage is available in the following amounts:

- No coverage
- $5,000*
- $10,000*
- $15,000*

In no event will the amount of insurance for each of your Children exceed 50% of your amount of insurance under core and optional Employee term life insurance coverage.

If you have optional Child term life insurance coverage for your Children and you gain a new eligible Dependent, the new Dependent will automatically be covered. Your newborn Child, age 14 days but less than six months, will automatically be covered in the amount of $1,000. You should contact HR with the name of the new Dependent as soon as possible.

*Per Child coverage (age six months, but less than 19 years; 25 years if a full-time student). Note: The amount will be the same for each Child.

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Optional Accidental Death & Dismemberment (AD&D) insurance coverage provides a benefit in the event of an Accident-related death or Bodily Injury, as described below.

Optional Employee AD&D Insurance Amount

Optional Employee AD&D insurance coverage is available in the following amounts:

- No coverage
- 1 X FLEX Earnings
- 2 X FLEX Earnings
- 3 X FLEX Earnings
- 4 X FLEX Earnings
- 5 X FLEX Earnings

Your coverage amount is rounded up to the next higher $1,000, up to a maximum of $1,000,000 (or five times FLEX Earnings, if less). The coverage amount you choose for yourself will affect the amount of coverage you can purchase for your eligible Dependents.

NOTE: FLEX participants who were receiving benefits under the Long-term Disability Plan on January 1, 2000, and who were covered by core AD&D benefits equal to one times FLEX Earnings at that time, continue to be covered by core AD&D benefits equal to one times FLEX Earnings, until the earlier of:

a. Return to Active Work status, or
b. Termination as a participant under the Life and AD&D Insurance Plan.

Optional Dependent AD&D Insurance Amount

Optional Dependent AD&D insurance coverage is available in the following amounts:

- No coverage
- Dependent coverage

NOTE: The loss may occur on or off the job while you are insured. However, the loss must occur within 90 days of the Accident to be eligible for optional AD&D insurance benefits. Optional AD&D insurance benefits are payable regardless of other insurance.

The amount of AD&D insurance on each of your Dependents is a percentage of your amount of optional Employee AD&D insurance. It is based on the persons who are your Dependents at the time the Claim is incurred. The percentage that applies is shown below.

Persons who are your Dependents:	Amount of Insurance on each Dependent, as a percentage of your Employee AD&D Insurance:
Your spouse or Domestic Partner only	60% on your spouse/Domestic Partner
Your Child (ren only)	20% on each Child
Your spouse or Domestic Partner and Child(ren)	50% on your spouse or Domestic Partner and 15% on each Child

Additional amount payable for a person's loss of life as a result of an Accident in a four wheel vehicle while using a seat belt: An amount equal to the lesser of:
1. 10% of the amount of insurance on the person; and
2. $10,000.

Additional amount payable for a person's loss of life as a result of an Accident in a four wheel vehicle equipped with a supplemental restraint system: An amount equal to the lesser of:
1. 10% of the amount of insurance on the person; and
2. $10,000.

To Whom Payable: The benefits are payable to you with these exceptions:
Benefits for any of your Losses that are unpaid at your death or become payable on account of your death will be paid to your Beneficiary or Beneficiaries.

If you are not living, benefits for your Dependent's losses are payable to your spouse or Domestic Partner if your spouse or Domestic Partner is living. If neither you nor your spouse or Domestic Partner is living, then:
1. benefits for your spouse's or Domestic Partner's losses will be paid to your spouse's or Domestic Partner's estate;
2. benefits for your Child's losses will be paid to your Child who suffered the loss. If that Child is not living, the benefits will be paid to that Child's estate.

Additional Benefits

An additional benefit may be payable for a loss for which a benefit is payable under the other terms of this coverage or would be payable except for the **limitation per Accident** of those terms. Any such benefit is payable in addition to any other benefit payable under this coverage. Any additional conditions that apply to an additional benefit are shown below. An additional benefit is payable only if those conditions are met.

1. **Additional benefit for loss of life as a result of an Accident in a four wheel vehicle while using a seat belt:**
   This additional benefit for the person's loss of life is payable only if this test is met.
   The person sustains an accidental Bodily Injury resulting in the loss while:
   a. the person is a driver or passenger in a four wheel vehicle; and
   b. the person is wearing a Seat Belt in the manner prescribed by the vehicle's manufacturer; and
   c. the actual use of a Seat Belt at the time of the Bodily Injury is verified in an official report of the accident, or is certified in writing by the investigating official(s).
   Four wheel vehicle means a vehicle that is:
   a. duly licensed for passenger use;
   b. designated primarily for use on public streets and highways; and
   c. in the list below:
      (i) a private passenger automobile;
      (ii) a station wagon;
      (iii) a van, jeep or truck-type vehicle which has a manufacturer's rated load capacity of 2,000 pounds or less; or

(iv) a self-propelled motor home.

Seat Belt means an unaltered lap restraint or lap and shoulder restraint. It includes a government approved child restraint device when used in accordance to the manufacturer's directions.

Losses not covered under this additional benefit: A loss is not covered under this additional benefit if it results from driving or riding in any four wheel vehicle used in a race or a speed or endurance test, or for acrobatic or stunt driving.

2. **Additional benefit for loss of life as a result of an Accident in a four wheel vehicle equipped with a supplemental restraint system:**

This additional benefit for the person's loss of life is payable only if this test is met.

The person sustains an accidental Bodily Injury resulting in the loss while:

a. the person is a driver or passenger in a four wheel vehicle equipped with a factory-installed supplemental restraint system; and
b. the person is in a seat designed to be protected by an air bag; and
c. the person is wearing a seat belt in the manner prescribed by the vehicle's manufacturer; and
d. the actual use of a seat belt at the time of the Bodily Injury is verified in an official report of the accident, or is certified in writing by the investigating official(s).

Four wheel vehicle means a vehicle that is:

a. duly licensed for passenger use;
b. designated primarily for use on public streets and highways; and
c. in the list below:
   (i) a private passenger automobile;
   (ii) a station wagon;
   (iii) a van, jeep or truck-type vehicle which has a manufacturer's rated load capacity of 2,000 pounds or less; or
   (iv) a self-propelled motor home.

Seat belt means an unaltered lap restraint or lap and shoulder restraint.

Supplemental restraint system means an air bag system intended to add protection to the head and chest areas.

Losses not covered under this additional benefit: A loss is not covered under this additional benefit if it results from driving or riding in any four wheel vehicle used in a race or a speed or endurance test, or for acrobatic or stunt driving.

Benefits Payable

If you elect optional Employee AD&D insurance and/or Dependent AD&D insurance coverage and you or your eligible covered Dependents die or experience loss as the result of an Accident, you or your Beneficiary will receive a benefit through the AD&D insurance coverage.

Loss means the person's:

1. loss of life;
2. total and permanent loss of sight;
3. loss of hand or foot by severance at or above the wrist or ankle;
4. total and permanent loss of speech;
5. total and permanent loss of hearing in both ears;
6. loss of thumb and index finger of the same hand by severance at or above the metacarpophalangeal joint; or
7. loss due to Quadriplegia, Paraplegia, or Hemiplegia.

Quadriplegia means the complete and irreversible paralysis of both upper and both lower limbs.
Paraplegia means the complete and irreversible paralysis of both lower limbs.
Hemiplegia means the complete and irreversible paralysis of the upper and lower limbs on one side of the body.

The amount of benefits payable depends on the nature of your loss, as shown below:

For Loss of or by Reason of…	The Following Percent of the Participant's Amount of Insurance is Paid ...

Life	100
Both hands, both feet, sight of both eyes, one hand and one foot, one hand and sight of one eye or one foot and sight of one eye	100
Speech and Hearing	100
Quadriplegia	100
Paraplegia	75
One hand, one foot or sight of one eye	50
Speech	50
Hearing	50
Hemiplegia	50
Thumb and Index Finger of the Same Hand	25

Limitation Per Accident:
The total payment for all losses due to any one Accident will not be more than the full amount of insurance.

Loss of sight means total, irrecoverable loss of sight. Loss of hand or foot means loss by severance at or above the wrist or ankle.

Benefits for accidental loss are payable only if all of these conditions are met:
(1) The person sustains an accidental Bodily Injury while covered under the plan.
(2) The loss results directly from that Bodily Injury and from no other cause.
(3) The person suffers the loss within 90 days after the Accident. But, if the loss is due to Quadriplegia, Paraplegia, or Hemiplegia, the person suffers the loss within 365 days after the Accident.

Not all such losses are covered. See "Exclusions" below.

Exclusions

AD&D insurance benefits are not payable from the plan if your or your eligible covered Dependent's death or Bodily Injury results from:

1. Suicide or attempted suicide, while sane or insane
2. Intentionally self-inflicted injuries, or any attempt to inflict such injuries
3 Sickness, whether the loss results directly or indirectly from the Sickness
4. Medical or surgical treatment of Sickness, whether the loss results directly or indirectly from the treatment
5. War or any act of war, declared or undeclared, including resistance to armed aggression
6. Any infection. But, this does not include:
    a. a pyogenic infection resulting from an accidental cut or wound; or
    b. a bacterial infection resulting from accidental ingestion of a contaminated substance.
7. An Accident that occurs while the person is serving on full-time Active Duty for more than 30 days in any armed forces. But this does not include Reserve or National Guard Active Duty for training.
8. Travel or flight in any vehicle used for aerial navigation. This includes getting in, out, on or off any such vehicle. This (8) applies only if:
    a. the person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
    b. the person is performing as a pilot or a crew member of any aircraft.
    c. the person is riding as a passenger in an aircraft leased or operated by the Company.
9. Commission of or attempt to commit a felony.
10. Being legally intoxicated or under the influence of any narcotic unless prescribed by a Doctor and taken as prescribed.

11. Participation in these hazardous sports: scuba diving; bungee jumping; skydiving; parachuting; hang gliding; or ballooning.

WHEN COVERAGE ENDS

For You

Your core Employee term life insurance, optional Employee term life insurance, optional AD&D insurance coverage will end on the earliest of:

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

Note: If you retire directly from Nortel Networks Inc. (NNI) and you are eligible for NNI's Retiree Medical, Life and Long-Term Care Plan, your Employee term life insurance, optional term life insurance and optional AD&D insurance coverage will end on the last day of the month in which your employment ends.

For coverage purposes, your employment will end when you are no longer Actively at Work as an eligible full-time or part-time Employee. However, the Company may consider you as still Actively at Work during certain types of approved leaves of absence from work.

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.

NOTE: If your Employee term life insurance coverage ends, your Dependents' coverage will also end.

For Your Dependents

Your optional Dependent term life insurance coverage will end on the earliest of:

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

Your optional Dependent AD&D insurance coverage will end on the earliest of:

- the date your optional Employee AD&D insurance coverage ends, or
- the date the covered Dependent stops qualifying for coverage, or
- the date the part of the plan providing the coverage ends, or
- the date you fail to pay any required premium contribution,

Conversion Privilege

The conversion privilege gives you the option to convert all or part of your term life insurance coverage (including optional Dependent term life insurance) under the plan to an individual policy if your coverage ends. You will not have to provide Evidence Of Insurability for this coverage.

To convert coverage, you must submit an application and pay the first premium within 31 days after your coverage ends or within 15 days after you receive written notice of the conversion privilege, whichever is later. However, under no circumstances may you convert your coverage to an individual policy if you do not apply for individual coverage and pay the first premium within 92 days after your coverage ends. If you would like to convert your term life insurance to an individual policy, you should contact HR who will provide you with a conversion letter indicating the amount and type of coverage that you can convert. You may then take the conversion letter to your local Prudential agent to convert your coverage.

To convert your term life insurance coverage, you must submit an application and pay the first premium within 31 days after your coverage ends or within 15 days after you receive written notice of the conversion privilege …

You cannot convert more than the amount of your coverage at the time coverage ends.

If all insurance under the policy is canceled for your class of Employees, and you have been covered for at least five years, you may convert the lesser of:

- the amount of your coverage in excess of the amount of term life insurance for which you are or become eligible during the 31-day conversion period, or
- $2,000

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

Death Benefit During An Employee Term Life Insurance Or Dependent Term Life Insurance Conversion Period

A death benefit is payable under this section if you or a Dependent dies:

(1) within 31 days after ceasing to be covered under the plan; and
(2) while entitled to a conversion of the Employee term life insurance or Dependent term life insurance coverage to an individual contract.

The amount of the benefit is equal to the amount of Employee term life insurance or Dependent term life insurance under this coverage.

For information about term life insurance conversion, contact the Claims Administrator, Prudential Group Insurance toll free at 1-877-889-2070.

You may not convert optional AD&D Insurance.

OTHER IMPORTANT INFORMATION

Limits on Assignments

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

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

For more information on limits of assignments or how to assign benefits as a gift, contact your legal or tax advisor or the Claims Administrator (as defined in "**SECTION TWO – ADMINISTRATIVE INFORMATION**").

Total Disability

If you become Totally Disabled, you should contact HR as soon as possible to determine what can be done to continue your Life and AD&D Insurance Plan coverage. The Company will pay the cost of optional Employee term life insurance if you furnish proof of your Total Disability between 9 and 12 months after your Total Disability began, and thereafter as requested.

If you die during the first 12 months of Total Disability, your insurance will be paid even if you had not furnished proof of the disability or premiums had not been continued.

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: 510

Funding Method: Insured with contributions held in trust

Contribution Source: the Companies that sponsor the Plan and participating Employees contribute to the cost of coverage of the optional life insurance coverages and the AD&D insurance. The companies that sponsor the Plan pay the full cost of core Life Insurance Plan 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 at 1-800-676-4636.

The address for Nortel Networks Inc. is:	Nortel Networks Inc. 4001 East Chapel Hill-Nelson Highway P. O. Box 13010 Research Triangle Park, NC. 27709-3010
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 optional employee and dependent term life insurance benefits and AD&D insurance benefits under the Plan):

Retirement Services Group

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

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, 2012, 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. 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 or whether eligibility for plan participation is available under the written terms of the plan.

The claims fiduciaries for each type of Claim under the Life and AD&D Insurance Plan are noted in the list below.

Claims Administrator	Address	Phone Number

Life and AD&D Insurance Plan – Initial Claims for Life and AD&D eligibility to participate/coverage level and initial Claims and all appeals for denied payment of Life and AD&D benefits Claims:

The Prudential Insurance Company of America
PO Box 8517
Philadelphia, PA 19176
1-800-524-0542

First level appeals of denied eligibility to participate/ coverage levels Claims:

HR
Nortel Networks
PO Box 13010
Research Triangle Park, NC 27709-3010
Direct: 919-905-9351
Toll Free 1-800-676-4636

Second/final level appeals of denied eligibility to participate/ coverage levels Claims:

Employee Benefits Committee
c/o Nortel Networks

Mailstop: 570 02 0C3
PO Box 13010
Research Triangle Park, N.C. 27709-3010

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 plan. These procedures are intended to comply with the requirements of ERISA and will be interpreted in accordance with ERISA requirements. These procedures are effective for Claims filed on or after January 1, 2012.

To make a formal Claim for benefits, you must file a written Claim with the Claims Administrator. However, HR will submit Claims on your behalf after their receipt of the required Claim information from you so you or your beneficiary should call HR first (1-800-676-4636) and as soon as possible to report a claim.

In order to properly process your request, please refer to the "Contact Information for Claims Filing" chart above for a complete list of all Claims Administrators, their respective addresses and phone numbers.

For AD&D Insurance Claims, proof must be furnished within 90 days after the date of loss. A Claim will not be considered valid unless the proof is furnished within this limit. However, it may not be reasonably possible to do so. In that case, the Claim will still be considered valid if the proof is furnished as soon as reasonably possible. The definition of reasonably possible is determined by the Claims Administrator.

When filing a Claim for benefits after a Bodily Injury, the Life and AD&D Insurance Plan may require you to undergo a physical examination at the Company's expense.

Initial Determination on Benefit Claims by Prudential as the Claims Administrator

Prudential will notify you of their Claim determination within 90 days of the receipt of your Claim (if your claim is one that they have the authority to decide per the chart above). This period may be extended by 90 days if such an extension is necessary due to special circumstances. A written notice of the extension, the reason for the extension and the date by which the Claims Administrator expects to decide your Claim, will be furnished to you within the initial 90-day period. However, if a period of time is extended due to your failure to submit information necessary to decide the Claim, the period for making the benefit determination by Prudential will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

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

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

If the written notification indicates that the Claim is denied due to a participation eligibility issue, you or your Beneficiary (depending on when the Claim is raised) will be directed to address any appeal to Nortel's HR as explained under the "Appeals of Adverse Determination Regarding Plan Participation Issues" section below. Otherwise, your Beneficiary will need to follow the procedure described in the section, "Appeals of Claims Denied by Prudential as the Claims Administrator", to file an appeal

Appeals of Claims Denied by Prudential as the Claims Administrator

If your Claim for benefits is denied by Prudential or if you do not receive a response to your Claim within the appropriate time frame (in which case the Claim for benefits is deemed to have been denied), you or your representative may appeal your denied Claim in writing to Prudential. Your appeal must be sent to Prudential within 180 days of your receipt of the written notice of denial or 180 days from the date such Claim is denied.

You have the right to:

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

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

The Prudential Appeals Review Unit will make a determination on your Claim appeal within 60 days of the receipt of your appeal request. This period may be extended by up to 60 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Prudential Appeals Review Unit expects to render a decision will be furnished to you within the initial 60-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

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

(a) the specific reason(s) for the adverse determination,
(b) references to the specific plan provisions on which the determination was based,
(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit Claim upon request,
(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
(f) a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

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

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

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

The Prudential Appeals Review Unit will make a determination on your second Claim appeal within 60 days of the receipt of your appeal request. This period may be extended by up to 60 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which the Appeals Review Unit expects to render a decision will be furnished to you within the initial 60-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

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

Plan Benefits Provided by
Prudential Insurance Company of America
Prudential Plaza
Newark, New Jersey 07102

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

Appeals of Adverse Determination Regarding Plan Participation Issues to HR (First Level Appeal)

a. First Level Appeal

The Company, through HR and the Employee Benefits Committee, retains the exclusive right to interpret and administer the participation provisions of the plan.

For appeal of a claim denial regarding your eligibility to participate in the plan, your enrollment in the Plan, and the Effective Date of enrollment in the Plan, you should first appeal to HR within 180 days of the receipt of the written notice of denial or 180 days from the date such Claim is denied. Your appeal should be in writing and submitted to HR at the following address:

HR	Nortel Networks P.O. Box 13010 Research Triangle Park, NC 27709-3010	800-676-4636 919-905-9351

You have the right to:

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

The first level appeal will be conducted by HR and you will be notified of their decision within 60 days from receipt of a request for appeal of a denied Claim.

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

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

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

If you are not satisfied with the first level appeal decision, you have a second and final opportunity to have the decision reviewed. Refer to the following section for further details about your final administrative appeal right.

Appealing a Denied Claim for Plan Participation Issues Determined by HR to the Nortel Networks Employee Benefits Committee

(Second Level Appeal)

b. Second Level (Final) Appeal

If your first appeal regarding your eligibility to participate in the Plan, your enrollment in the Plan, or the Effective Date of enrollment in the Plan is denied by HR, you have a right to file a second level (final) appeal with the EBC. If you wish to appeal the denial of your first appeal, your second appeal should be in writing and submitted to the EBC at the following address:

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

Your second level (final) appeal request must be submitted to the EBC within 180 days from receipt of the first level appeal decision. The EBC has the final discretionary authority to construe and to interpret this plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits. The EBC's decisions on such matters are final and conclusive

You have the right to:

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

The EBC will make a decision on your appeal of a denial of your participation Claim under the plan no later than the date of the meeting of the Committee that immediately follows the plan's receipt of a request for review, unless the request for review is filed within thirty (30) days preceding the date of such meeting. (The Committee holds monthly meetings.) In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Committee following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Committee will provide you with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension.

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

The Committee will notify you of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made. The Employee Benefits Committee's notice of an adverse benefit determination regarding participation issues on appeal will contain all of the following information:

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

General Information about Life and AD&D Insurance Plan Participation Appeals

You and your plan may have other voluntary alternative options, such as mediation. One way to find out what may be available to you is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

HOW BENEFITS ARE PAID

Employee Term Life Insurance

Normally, your Beneficiary receives benefits in a lump sum payment. However, if you or your Beneficiary choose, alternate methods of payment, such as monthly installments, can be used. Installment payments are not available:

- for optional spousal or Domestic Partner life insurance or optional Child life insurance
- for the loss of life benefit under your AD&D insurance
- if your Employee term life insurance is less than $2,500

If you or your Beneficiary prefer benefits to be paid in installments, contact HR for more information.

Note: If your Beneficiary dies while receiving installment payments, the remaining installments will be paid in one sum to the executors or administrators of your Beneficiary's estate.

Immediate Advance Feature

Your Beneficiary can receive $5,000 of the total coverage amount within five days of notifying HR of your death. Generally, the benefit will be paid tax-free to your Beneficiary.

Dependent Term Life Insurance

If a covered family member dies, you will receive benefits in a lump sum payment. No alternate methods of payment are available.

Optional AD&D Insurance

Optional Employee AD&D Insurance

The plan will pay a lump sum benefit to your Beneficiary, depending on the coverage you select, if you die as the result of a covered Accident. If a covered accidental Bodily Injury results in a loss covered under the plan, the plan will pay a lump sum benefit directly to you.

Optional Dependent AD&D Insurance

If a covered family member dies as the result of a covered Accident or an accidental Bodily Injury results in a loss covered under the plan, you will receive benefits in a lump sum payment. No alternate methods of payment are available.

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.

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 Pension and Welfare Benefit Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, 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 Pension and Welfare Benefits Administration.

FUTURE OF THE PLAN

Although the benefits currently available (in the 2012 Plan Year) are described in this summary for the Company's Life and AD&D Insurance 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 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.

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

Bodily Injury
Injury to the body of a Covered Person.

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

Child/Child (ren)
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,
- your Domestic Partner's Children

To be eligible for coverage, step children, legally authorized foster children, and children for whom you are the legal guardian 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 a specific plan.

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

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 662/3% of your pre-disability FLEX Earnings for up to 20 additional weeks,
- Long-Term Disability coverage at 50% of your pre-disability FLEX Earnings after you have been disabled for 26 consecutive weeks, up to a maximum coverage amount of $120,000.
- Employee term 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 Benefits by purchasing Optional FLEX Benefits with FLEX Credits provided by the Company and with Before-Tax and After-Tax Contributions.

Dependent
Dependents include:

- your spouse, including your common-law spouse as recognized by applicable state law,
- your unmarried Children under the age of 19,
- your unmarried Children between the ages 19 and 25 who are full-time students at an accredited school and are primarily supported by you, and
- your unmarried, physically or mentally disabled Children age 19 or over who are Wholly Dependent on you for support and maintenance and became disabled and Dependent before age 19 (or before age 25 while a full-time student). You must provide notice of the disability to HR within 31 days of your Child turning age 19 for that Child to be considered an eligible Dependent. If the Child is over age 19, the Child must have become incapacitated before age 19 *and* while covered under the plan to be considered an eligible Dependent.

Your spouse or child is not considered a Dependent under the plans while on Active Duty in the armed forces of any country. In addition, your child is not considered a Dependent under the plans if he or she is covered as an Employee. Your domestic partner and Children of your domestic partner are not eligible Dependents under the Life and AD&D Insurance plan.

Doctor
A licensed practitioner of the healing arts acting within the scope of the license.

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 Partnership 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". 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 you may use to purchase Optional FLEX 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.

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.
-

HR
Nortel's Human Resources. By contacting you can ask questions about any of the plans, request needed forms or change your employee information, such as your home address.

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

Imputed Income
According to the IRS, Imputed Income is the value of certain types of Company-paid benefits. It is added to the taxable earnings on your W-2 form at the end of the year. For purposes of the FLEX program, Imputed Income is:

- the value of your Company-paid life insurance greater than $50,000 or
- the value of Company-paid medical and dental/vision/hearing care coverage for your Domestic Partner and your Domestic Partner's Children.

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

Member Services
Customer service centers for Managed Care networks that can answer questions about providers and send you a Provider Directory.

Optional FLEX Benefits
Benefits you pay for with FLEX Credits or After-Tax Contributions. Optional FLEX Benefits supplement Company paid Core FLEX Benefits. You can apply FLEX Credits or make Before-Tax Contributions to the following options:

- Medical coverage for yourself or yourself and your enrolled Dependents (you have sufficient FLEX Credits to buy medical coverage for yourself only under the Preferred Provider Organization, or Out-of-Area Comprehensive option if you don't live within a Network Area, but you may waive medical coverage if you choose),
- Dental, Vision and Hearing Care coverage for yourself or yourself and your eligible Dependents,
- You can apply FLEX Credits or make After-Tax Contributions to the following options:
- Employee term life insurance for yourself,
- Dependent term life insurance for your spouse and/or Children, and
- Optional AD&D insurance for yourself, your spouse and/or Children.

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

Physician
See "Doctor".

Plan Administrator
Nortel Networks Inc. (NNI) acting by and through its Board of Directors, except where noted otherwise.

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.

Seriously Injured
A condition for which benefits are payable under AD&D Insurance coverage due to dismemberment or loss of sight as defined in this SPD.

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.

Termination Date
The last day you work for the Company.

Terminally Ill
The medical prognosis of a person with a chronic, progressive Illness that has been designated not curable by the covered person's attending Physician. Expected survival must be six months or less at the time of application for Accelerated Benefits under your Employee term life insurance benefits.

Total Disability, Totally Disabled - You are considered Totally Disabled if you cannot work because of Injury or Illness and you are under the regular care of a Physician.

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.