Nortel Networks Inc.
Medical 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 Medical Plan that are in effect for the 2012 Calendar Year. It is designed to provide you with a comprehensive resource providing detailed information about your medical 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 – MEDICAL PLAN BENEFITS** describes the provisions of the Medical Plan that determine your benefits.
- **SECTION TWO – ADMINISTRATIVE INFORMATION** includes administrative details about this plan, such as how to file Claims and appeal denied Claims, where to get more information, your ERISA rights, HIPAA Privacy Notice and how the Company may amend the plan.
- **SECTION THREE – GLOSSARY** contains brief descriptions of terms used in this document.
- **APPENDIX** includes supplemental information referenced in this document.

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.

AN IMPORTANT NOTE ABOUT THIS SPD

This Medical Plan SPD provides general information about the Managed Care and Out-of-Area Comprehensive Medical Plan options. In addition, please note that the Managed Care options may contain slightly different features depending on your Network Manager, e.g., Connecticut General Life Insurance Company (CIGNA)or Anthem Blue Cross Blue Shield (Anthem). Significant effort was undertaken in this SPD to document the variations that currently exist. However, new variations sometimes arise, for instance, when a new technology or treatment is developed. When there is a new variation, the Claims Administrator's documented internal protocol will be used to determine your coverage. As such differences are identified in the future, they will be documented in the plan's SPD as soon as possible.

SECTION ONE – MEDICAL PLAN BENEFITS

This section describes the provisions of the Medical Plan, including who is eligible, how participation is elected, what benefits are paid, and when participation ends.

INTRODUCTION TO MEDICAL PLAN BENEFITS

The Medical 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 Program benefits to create your own customized benefits package. The Medical Plan is an "Optional" benefit under the FLEX Program. There are no Core FLEX Benefits for Medical coverage – participation in the plan is voluntary.

The Company offers medical coverage to help protect you and your family from the high cost of medical treatment or hospitalization. Under FLEX, you can choose from a variety of medical options. During the annual FLEX enrollment, you are provided with a personalized enrollment worksheet or an online enrollment worksheet that shows your options.

The Medical Plan options available to you depend on whether you live in a Network Area or a Non-Network Area. If you live in a specified Service Area where Networks exist, you may enroll in one of the following "Network Area" options:

- No Coverage
- Preferred Provider Organization (PPO) (where available)

If there are no Networks in your area, then you may enroll in one of the following "Non-Network Area" options:

- No Coverage
- Out-of-Area Comprehensive

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

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

Such information includes the resources listed below.

Claims Administrator Information Used In Claim Determinations

The following is a list of the resources relied upon in Claims determination by the Claims Administrators for the Medical Plan, including:

- Connecticut General Life Insurance Company (CIGNA)
- Medco Health (Medco)
- OptumHealth Behavioral Solutions
- Anthem Blue Cross Blue Shield (Anthem)

You can obtain information on the criteria the Claims Administrator relies upon in determination of your Claim as described below.

CIGNA and Anthem

- CIGNA Standard Operating Procedures
- Anthem Medical Policy Guidelines

Used to determine whether your Claim meets the following standards that apply under this plan: Common Medical Standards; Educational, Experimental or Investigational; and Medically Necessary services, supplies and treatments.

- CIGNA Clinical Resource Tools
- Anthem Clinical Resources

Used to determine whether your Claim meets the following standards that apply under this plan: Common Medical Standards; Educational, Experimental or Investigational; and Medically Necessary services, supplies and treatments.

- Milliman & Roberts' Guidelines

Used to determine whether your Claim meets the following standards that apply under this plan: Common Medical Standards; Educational, Experimental or Investigational; and Medically Necessary services, supplies and treatments. Provides independent medical guidelines.

- Ingenix's Prevailing Healthcare Charges System

Used to determine whether your Claim meets the following standards that apply under this plan: Reasonable and Customary Charges.

To request the documents listed above that CIGNA relies upon in determination of your Claim, send a written request to CIGNA at the Claim office address on your Medical Plan ID Card or call CIGNA at 1-800-257-2702.

To request the documents listed above that Anthem relies upon in determination of your Claim, send a written request to Anthem at the following address:

P.O. Box 9907
Columbus, GA 31908
Phone: **1-877-5NORTEL**

Medco

- Medco Plan ESM Plan Design Document is used for retail Claims to determine:
  - Covered Expenses,
  - treatments that require prior authorization, and
  - exclusions, and limits, including dispensing limits

- Medco Plan ESN Plan Design Document is used for home delivery Claims to determine:
  - Covered Expenses,
  - quantity per Copayment requirements,
  - treatments that require prior authorization, and
  - exclusions, and limits, including dispensing limits

See "Appendix A" of this SPD for the above Medco documents.

- Medco clinical information is used when prescription medications require prior authorization. Medco refers to its clinical information in evaluating whether your prescription medication is covered under the plan.

To request the clinical information document that Medco relies upon in determination of your Claim, call Medco Member Services at 1-800-711-3460.

OptumHealth Behavioral Solutions

- Level of Care Guidelines, including:
  OptumHealth Behavioral Solutions Level of Care Guidelines - Introduction
  a. Mental Health Guidelines: Introduction
     MH Level Of Care Criteria: Crisis Assessment
     MH Level Of Care Criteria: 23-Hour Observation
     MH Level Of Care Criteria: Acute Inpatient
     MH Level Of Care Criteria: Subacute Inpatient
     MH Level Of Care Criteria: Residential Treatment
     MH Level Of Care Criteria: Partial Hospital/Day Treatment
     MH Level Of Care Criteria: Intensive Outpatient
     MH Level Of Care Criteria: Home Health
     MH Level Of Care Criteria: Outpatient
     MH Level Of Care Criteria: Outpatient Termination Guidelines
     Mental Health Continued Stay Criteria
  b. Substance Abuse Guidelines: Introduction
     SA Level Of Care Criteria: Crisis Assessment Services
     SA Level Of Care Criteria: 23-Hour Observation
     SA Level Of Care Criteria: Inpatient Detoxification
     SA Level Of Care Criteria: Inpatient Rehabilitation
     SA Level Of Care Criteria: Residential Rehabilitation
     SA Level Of Care Criteria: Chemical Dependence Halfway House
     SA Level Of Care Criteria: Partial Hospital/Day Treatment
     SA Level Of Care Criteria: Intensive Outpatient Program
     SA Level Of Care Criteria: Outpatient
     SA Level Of Care Criteria: Outpatient Discharge Guidelines
     Substance Abuse Continued Stay Criteria
  c. Mental Health LOC Guidelines Summary
  d. Substance Abuse LOC Guidelines Summary
  e. Dual Diagnosis LOC Guidelines Summary

You may access the OptumHealth Behavioral Solutions Level of Care Guidelines at the following OptumHealth website at www.ubhonline.com:

- Ingenix's Prevailing Healthcare Charges System (used to determine whether your Claim meets the plan's standard for: Reasonable and Customary Charges)

PLAN HIGHLIGHTS

Network Area Medical Options

Description	Preferred Provider Organization (PPO) 80/60 Option		Preferred Provider Organization (PPO) 90/70 Option	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible				
Annual Individual	$400	$600	$300	$500
Annual Family	$1200	$1,800	$750	$1500
Hospital Inpatient Stay Copayment	$350	$500	$350	$500
Outpatient Surgery Copayment	$250	$500	$250	$500
Reimbursement				
Hospital	80% [3,4,5]	60% [2,3,4,5]	90% [3,4,5]	70% [2,3,4,5]
Primary Care/Specialist Visit Copay	$25/$30	60% [2,3]	$25/$30	70% [2,3]
Out-of-Pocket Maximum[6] (Plus Deductible/Copayment)				
Individual	$3,500	$7,500	$3,500	$7,500
Family	$7,000	$15,000	$7,000	$15,000
Lifetime Medical Maximum	Unlimited	Unlimited	Unlimited	Unlimited

Non-Network Area Medical Option

	Out-of-Area Comprehensive Option
Deductible	
Annual Individual	$300
Annual Family	$900
Hospital Inpatient Stay Copayment	$300
Reimbursement	
Hospital	80% [2,3,4,5]
Office Visits	80% [2,3]
Out-of-Pocket Maximum[6] (Plus Deductible/Copayment)	
Individual	$2,000
Family	$4,000
Lifetime Medical Maximum	Unlimited

1 Precertification required.

2 Coverage is limited to Reasonable and Customary Charges.

3 Subject to annual Deductible.

4 If precertified.

5 Less Deductible per Hospital confinement.

6 Out-of-pocket maximum does not include Deductibles, Copayments, and any amounts you pay above Reasonable and Customary Charges as well as any expenses you incur under the Prescription Drug benefit..

WHO IS ELIGIBLE

You

You are eligible for the Medical 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 Medical Plan unless specified in the collective bargaining agreement. If you are a non-payrolled worker or independent contractor you are not eligible for the Medical Plan.

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

Your Dependents

If you are eligible for and enrolled in the Medical Plan, you may enroll your eligible Dependents. Eligible Dependents include:

- your spouse, including your common-law spouse (as determined under applicable state law) or Domestic Partner (if qualified under FLEX Program and Medical Plan rules),
- your Child(ren) and/or Domestic Partner's Child(ren) under age 26 without access to employer coverage. "Children" include:
  - your natural or legally adopted Children or Children placed with you for adoption; and
  - your step-Children, legally authorized foster Children, and any child for whom you are legal guardian, if these Children depend on you for support and maintenance and live with you in a regular, parent-child relationship for at least six months of the Calendar Year.
- your eligible, physically or mentally disabled Child(ren) and/or Domestic Partner's Child(ren) age 26 or over who are Wholly Dependent on you, incapable of self-sustaining employment, and unable to engage in the normal activities of a person of the same age, sex and ability by reason of mental or physical handicap and became disabled and Dependent before age 26. You must provide a notice of the disability to HR within 31 days of your child turning age 26 for that child to be considered an eligible Dependent.

Your spouse/domestic partner or child will not be considered a dependent under any plan while on active duty in the armed forces of any country. In addition, except for dependent life insurance, your spouse/domestic partner or child will not be considered a dependent under any plan if he or she is covered as an employee.

Qualified Medical Child Support Order

Your Children will be eligible for the Medical Plan if you are required to cover them as a result of a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order or judgment from a court that directs the Plan Administrator to cover a child for benefits under the health care plans. Coverage under the plan will be provided in

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

Your Domestic Partner and His or Her Child(ren)

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

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

About Domestic Partners

To be eligible for Domestic Partner coverage under the Medical Plan, you and your Domestic Partner must satisfy the following guidelines:

1. For the 12-month period before you sign the Affidavit of Domestic Partnership, you and your Domestic Partner must have:
   --lived in the same residence
   --shared financial obligations (including basic living expenses)
   --been each other's sole and exclusive partner
   --publicly represented yourselves as Domestic Partners
   --intended to continue this relationship in this manner indefinitely
2. Neither you, nor your Domestic Partner, may be married to anyone else.
3. You may not be related to your Domestic Partner by blood or marriage to a degree that would prohibit a legal marriage in the state where you live.
4. You and your Domestic Partner must be at least 18 years old.
5. You and your Domestic Partner must be mentally competent to consent to a contract.

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

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

Enrolling Your Domestic Partner

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

--Domestic Partnership Agreement

--Registration of Domestic Partnership with local government where you live

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

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

--Durable power of attorney for property or health care

--Evidence of joint ownership of a motor vehicle

--Evidence of joint checking, savings or credit accounts

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

Changes in Circumstances

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

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

- Your Domestic Partner's coverage will end at the end of the month when your partnership terminates.
- You will not be eligible to file or be designated a Domestic Partner on another Affidavit of Domestic Partnership for another 12 months after your last Domestic Partnership ended. This 12-month limitation also applies to your Domestic Partner if he/she also works for the Company.
- The Company or its agent(s) will not be responsible for notifying your Domestic Partner of the filing of the Statement of Termination of Domestic Partnership.
- If you do not file a request to terminate coverage within 31 days, you will continue to pay premiums for their coverage until the start of the next Plan Year, even though your Domestic Partner and his/her Child(ren) are ineligible for coverage.

Special Eligibility Rules

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

If both you and your spouse (or Domestic Partner) are eligible to participate in the Medical Plan, then special rules apply for enrolling in the plan. You may enroll as an Employee or as a Dependent, but not both. Only one of you may enroll your eligible Children as Dependents. In addition, both you and your spouse (or enrolled Domestic Partner) must select the same Medical Plan option in order for your combined expenses to apply to the family Deductible or family Out-of-Pocket Maximum.

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

Your child (or Domestic Partner's child) will not be considered an eligible Dependent if your Child is covered under this plan as an Employee.

If Your Eligible Dependent is in the Armed Forces

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

If You Have a Split Family

If you have eligible Dependents who permanently live apart from you (e.g., as a result of a divorce) and you want to enroll them in the plan, you must enroll them in the Medical Plan option you choose for yourself. If you are enrolled in a Managed Care option, they may receive In-Network Benefits if your Network Manager offers a Network where your Children live, and the Company contracts with the Network in that area. Otherwise, they will receive Out-of-Network Benefits. If this situation applies to you, please contact HR to arrange for your Dependent to have In-Network Benefits where they live. For this provision to apply, the following eligible Dependents must meet certain criteria:

- your step-Children, legally authorized foster Children, and any child for whom you are legal guardian must depend on you for support and maintenance and must live with you in a regular, parent-child relationship for at least six months of the Calendar Year.

For additional details on eligible Dependents, please refer to page 10.

If Your Dependent Lives Elsewhere

If you have eligible Dependents who are out of your Service Area, you must enroll them in the Medical Plan option you choose for yourself. If your Claims Administrator offers a Network where they live, they may receive in-network medical care there. Otherwise, they will receive Out-of-Network Benefits for medical care, except for Emergency treatment. If this situation applies to you, please contact HR for further information.

Who is Not Eligible

Please note that only the individuals described in the sections above as being “eligible Dependents” may be enrolled in the Plan. That means that anyone who does not meet that description, including the following individuals, are NOT eligible for coverage under the Nortel FLEX Program:
*Your ex-spouse following your divorce,
*Your unmarried partner with no recognized relationship under the plan,
*Your eligible married children’s spouse or children,
*Your children less then 26 with access to their employer’s medical coverage,
*Children of a parent who lives with you but has no legal relationship with you and does not qualify as a Domestic Partner,
*Your children who are not residing with you in a parent/child relationship,
*Your over-age dependents (not disabled),
*Your stepchildren following your divorce from the natural parent,
*Your grandchildren or other extended family dependents if you have no legal guardianship.

HOW TO ENROLL

You may choose to enroll for Medical Plan benefits:

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

To enroll, you must complete the enrollment process and pay the applicable Employee contributions. The Medical 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) that are made available at the time of enrollment. 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 Medical Plan upon your hire or during the Annual Enrollment Period, contact HR at: 1-800-676-4636. You may not enroll in the Medical Plan or change your coverage by contacting any of the Claims Administrators that process benefit Claims under the Plan; you must contact HR to obtain information about enrollment and report a Status Change.

Medical Plan Options under FLEX

The Medical Plan options available to you depend on whether you live in a Network Area or a Non-Network Area. Your Personalized Enrollment Worksheet or your online enrollment worksheet will show your available options based on your home ZIP code. If you have any questions about Network Areas, call HR at 1-800-676-4636.

If you live in a Network Area, you may select from the following options for Medical Plan benefits under the FLEX Program:

- No Coverage
- Preferred Provider Organization (PPO) (where available)
    - 90/70 PPO or

- 80/60 PPO

If you live in a Non-Network Area, you may enroll in one of the following options:

- No Coverage,
- Out-of-Area Comprehensive

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

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

Spousal Access Fee

*If you elect to cover your spouse/domestic partner under a Nortel Medical Plan option and your spouse/domestic partner has access to employer-provided medical coverage elsewhere, you will be required to pay an additional $50.00 each biweekly pay period in addition to the plan premium. The access fee will be taken out of your pre-tax pay unless you are covering a domestic partner, in which case it will be taken out of your after-tax pay. Even if your spouse or domestic partner chooses not to enroll in the employer-provided medical plan, he or she still has it available and therefore, the access fee will still apply.

*If your spouse/domestic partner doesn't have access to employer-provided medical coverage, you will not have to pay the additional access fee unless you fail to attest – on your Personalized Enrollment Worksheet, or while enrolling in the Medical Plan in Employee Self Service – that your spouse/domestic partner doesn't have access to employer-provided medical coverage. If you do not, the access fee will be withheld from your pay. You must complete this attestation EACH YEAR during annual enrollment or the access fee will be withheld throughout the following Plan Year for which the enrollment is made (unless you experience a qualified Status Change (see "Changing Your Selections" section below) that permits an appropriate change during the year).

WHEN COVERAGE BEGINS

If you select Medical Plan FLEX Benefits, your coverage will begin as follows:

If you enroll and pay the required contribution …	**Your coverage will be effective on …**
As a new Employee within 31 days after your Hire Date	The day HR receives your selections.
Within 31 days of a Status Change event	The date the Status Change event occurs. (Refer to the "Changing Your Selections" on pages 18-19 for more details.)
During the Annual Enrollment Period	The first day of the next Plan Year, normally January 1

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

During the New Hire Enrollment Period

You and your eligible Dependents will automatically be enrolled for Company-paid medical coverage up to the day you make your Medical Plan benefits selections or for up to the first 31 days of your employment, whichever occurs first.

As a new Employee, you and your eligible Dependents are automatically covered for up to the first 31 days of employment under the following option –

- if you live in a Network Area:
  - the 80/60 PPO option that is offered in your Service Area and based on your home zip code.
- if you live in a Non-Network Area:
  - the CIGNA Out-of-Area Comprehensive option.

You have 31 days from your Hire Date to enroll in the Medical Plan. If you enroll within 31 days of your Hire Date, your medical coverage will be effective on the date HR receives your selections.

After the first 31 calendar days following your date of hire (or eligibility date), you will be defaulted to the above coverage for you only if you do not actively enroll in the Medical Plan before then. Your Dependents will be covered for EAP benefits only and WILL HAVE NO COVERAGE under the Medical Plan if you do not actively enroll during your first 31 calendar days of employment.

Your Medical Plan new hire default coverage (for you only, as explained above) will be the following option –

- if you live in a Network Area:
  - the 80/60 PPO option that is offered in your Service Area and based on your home zip code.
- if you live in a Non-Network Area:
  - the CIGNA Out-of-Area Comprehensive option.

If You Do Not Enroll

If you do not enroll under any of the above circumstances for medical coverage, you will have to wait until the next Annual Enrollment Period (or the date you experience a Status Change) to make a Medical Plan selection that changes your coverage out of the default option described in the section above.

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 Medical Plan options, for the next Plan Year. Before the Annual Enrollment Period begins, you will receive materials to help you make your decisions, as well as instructions on how to enroll. The FLEX selections you make during the Annual Enrollment Period will go into effect on the first day of the following Plan Year and remain in effect through the end of the Plan Year unless you make a new selection due to a Status Change.

If You Do Not Enroll

If you do not enroll during the Annual Enrollment Period, the option and coverage level in which you were enrolled during the prior year will continue through the next year (unless such options or coverage levels are eliminated) except for your Health and Dependent Day Care Reimbursement Account elections and the Spousal Access Fee attestation. You must enroll EACH YEAR to participate in the reimbursement accounts and certify your spouse/domestic partner does not have access to employer-provided medical coverage.

If your spouse/domestic partner is currently covered under a Nortel Medical Plan Option as your dependent you must enroll for FLEX each year and attest on your Personalized Enrollment Worksheet or while enrolling in the Medical Plan in Employee Self-Service that your spouse/domestic partner doesn't have access to employer-provided medical coverage or you will automatically be charged the spousal/domestic partner Access Fee each pay period throughout the next Plan Year (unless you experience a qualified Status Change (see "Changing Your Selections" section below) that permits an appropriate enrollment change during the year).

Special Enrollment Period

If you or your Dependents declined coverage under this Medical Plan because you or they have medical coverage elsewhere and one of the following events occurs, you have 31 days from the date of the event to enroll yourself and/or your Dependents in this Medical Plan.

- You and/or your Dependent(s) lose eligibility under the other health coverage for reasons including legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment, or termination for cause).
- The employer contributions to the other coverage have stopped.
- The other coverage was COBRA and the maximum COBRA coverage period ends.

As an Employee, you may enroll your new spouse within 31 days of your marriage and a new child within 31 days of his/her birth, adoption or placement for adoption. In addition, if you are not enrolled in the plan as an Employee, you must enroll in the plan before you enroll any of these Dependents. And, if your spouse or qualified Domestic Partner is not enrolled in the plan, you may enroll him/her in the plan when you enroll a child due to birth, adoption or placement for adoption provided you add the Dependent within 31 days of the Status Change. Coverage can be retroactive to the date of marriage, birth, adoption, or placement for adoption within the 31 day window.

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, regardless of the reason for your absence.

Note that this provision will not apply in instances in which doing so would violate Federal law. The enrollment or change in coverage for an eligible Dependent will become effective without regard to whether he or she is confined for medical treatment on the Effective Date. Your eligible Newborn child will be covered automatically for the first 31 days immediately following birth including hospitalization. You must actively select coverage for new Dependents and specifically enroll them in your Medical Plan option. No one, including Newborns, will automatically be enrolled in the Medical Plan, even if you're already enrolled for family coverage.

Special Dependent Coverage Rules for Newborn and Adopted Children

The following rules apply with respect to a child born to you or that you adopt when you:

- are covered under the plan, and
- are not covered for that child under the following rules.

You will become covered for that child from the moment of the child's birth, adoption or placement for adoption. Any Dependent child born while you are covered for Employee coverage will be covered automatically from birth for a period of thirty-one (31) days. Such coverage on a Newborn child will be continued beyond that thirty-one (31) day period only if you select coverage for the child no later than thirty-one (31) days after the child's birth.

You must notify HR of the birth, adoption or placement for adoption of your child and complete the enrollment process to add the child to your coverage within thirty-one (31) days of the birth, adoption or placement for adoption in order to have continuous coverage for that child beyond the first thirty-one (31) days of life or adoption or placement for adoption. Neither submission of paperwork after the thirty-one (31) day deadline nor any evidence of good health will continue coverage for the child continuously beyond that period if you do not elect coverage for the child within thirty-one (31) days of the child's birth, adoption or placement for adoption. No one, including Newborns or newly adopted Children, will automatically be enrolled in the Medical Plan beyond the first 31 days, even if you are already enrolled for family coverage.

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

- At the next Annual Enrollment Period for the Plan Year following that Annual Enrollment Period,
- As of the date that your enrollment is complete following your next Status Change that permits it, or
- As of the date that your enrollment is complete if all of the following criteria is met within 12 months after the birth, adoption or placement for adoption and in the same Calendar Year in which the 31-day Enrollment Period following the birth, adoption or placement for adoption ended:
    1. You notify HR of the birth, adoption or placement for adoption of your child
    2. You complete the enrollment process to add the child to your coverage and pay the required contribution.

Once a Child is enrolled, the Medical Plan benefits for the child will end as described in "When Coverage Ends" .

Changing Your Selections

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

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

- Marriage,
- Domestic Partner relationship becoming qualified for eligibility, and verified by HR
- Divorce, annulment, or legal separation,
- Rescinded divorce,
- Birth, adoption, placement for adoption or change in legal custody of a Dependent child,
- Death of a spouse, enrolled Domestic Partner or Dependent child,
- Change in your employment status affecting benefit eligibility (such as from or to part-time or full-time),

- Change in your spouse's or enrolled Domestic Partner's employment status affecting benefits eligibility (such as from or to part-time or full-time),
- Beginning or end of your spouse's or enrolled Domestic Partner's employment,
- Loss of spouse's or Domestic Partner's medical coverage,
- You, your spouse or enrolled Domestic Partner becomes eligible for Medicare or Medicaid,
- Loss of other group health plan coverage (for the Employee who declined coverage due to having other coverage but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause),
- Loss of employer contribution toward other group health plan coverage (for the Employee who declined coverage due to having other coverage),
- Covered child's loss of Dependent status (i.e., reaches age 26 or gains access to employer coverage),
- Dependent child becomes eligible (i.e., loss of employer coverage),
- Loss of other group health plan coverage when the other coverage was COBRA and the maximum COBRA coverage period ends,
- Benefits plan year of a spouse’s or Domestic Partner’s benefit plan differing from the Company Plan Year (e.g., your spouse’s or Domestic Partner’s benefits are effective on July 1 and yours are effective on January 1),

If you make changes to your benefit selections due to a Status Change, the change must be consistent with the Status Change. For example, if you experience the birth of a Dependent child, you may add coverage for your child under your Medical and Dental/Vision/Hearing Care Plans, select Optional Dependent Life Insurance for your child, increase your Optional Employee Life Insurance and/or change your contribution to your Health Care and or Dependent Day Care Reimbursement Accounts.

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. 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 your Medical Plan option, for example from the 80/60 PPO to the 90/70 PPO, until the next Annual Enrollment Period. However, you may change your Dependent coverage level (e.g., Employee and spouse, Employee and child) for the Medical Plan. Your Dependent coverage level change will be effective on the date HR receives all documents (i.e., via fax or mail, or via online affidavit). This type of change must be completed within 12 months of the date the Status Change occurred *and* within the Calendar Year in which the 31-day Enrollment Period following the Status Change ended. No other changes to Optional FLEX Program Benefits are permitted outside the 31-day Enrollment Period.

Coverage for Dependents who become ineligible (for example, Children who reach age 26) will be terminated back to the date of the Status Change event that made them ineligible when the Company discovers that they are no longer eligible—even if you do not report the Status Change. In addition, you will be required to repay any benefits paid for such former Dependents after they became ineligible under Medical Plan rules and could be subject to

further discipline by the Company and legal action as appropriate to any misrepresentation or fraud that may have been committed to obtain the benefits for which they were not eligible.

WHAT COVERAGE COSTS

You and the Company share the cost of Medical Plan coverage. The cost of coverage is determined by the Company each year. The Company reserves the right to change the cost of coverage as necessary. Each of the Medical Plan options has a different price, based on the level of coverage under the Plan. If you select the Medical Plan, your Employee contributions are deducted from your paycheck each pay period on a Before-Tax basis or you may be able to use FLEX Credits to pay some of the cost. The Company makes available FLEX Credits which may be used to pay for Medical Plan 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 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) that is made available at the time of an enrollment. The amount of FLEX Credits may also be changed by the Company.

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

When you pay for benefits Before-Tax, it means that the cost of coverage is deducted from your pay before Federal taxes are taken out (as well as most state and local taxes, except in New Jersey and Pennsylvania). Since your taxable income is effectively lowered, you pay less in taxes. You do not pay FICA (Social Security) tax on these benefits, so your Social Security benefits may be reduced slightly in the future. These Before-Tax Contributions will not affect the amount of your other benefits (like life insurance), which are calculated based on your FLEX Earnings.

If you elect to cover your spouse/domestic partner under a Nortel Medical Plan option and he/she has access to employer provided medical coverage elsewhere or you fail to certify during enrollment and or annual enrollment EACH YEAR your spouse/domestic partner does not have employer-provided medical coverage elsewhere, you will be required to pay $50 each pay period in addition to the plan premium. The Access Fee will be taken out of your pre-tax pay unless you are covering a domestic partner that does not qualify as a tax dependent under Internal Revenue Code (IRC) Section 152, in which case it will be taken out of your after-tax pay. Even if your spouse or domestic partner chooses not to enroll in employer-provided medical coverage, he or she still has it available to him/her and therefore, the Access Fee will apply.

WHEN CONTRIBUTIONS BEGIN

Contributions for Medical Plan FLEX benefits begin with the first full pay cycle following the Effective Date.

MAINTENANCE OF BENEFITS PROVISION

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

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

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

The Maintenance of Benefits provision reduces the advantages of double coverage, so you should decide whether you wish to be covered by the Company Medical Plan or by your spouse's (or Domestic Partner's) employer's Medical Plan.

Here is how the Maintenance of Benefits provision works:

The plan that pays benefits first is "primary." The plan that pays benefits next is "secondary." When the Company's Medical Plan is secondary, it will pay its normal benefits, reduced by any benefits paid by the primary plan. This means that you will not receive any benefits from the Medical Plan if the primary plan pays benefits that are equal to or greater than the benefits this plan would normally pay.

Determination of which plan is primary is as follows:

- Coverage as an Employee is considered primary over coverage as a Dependent.
- When a Dependent child is covered under two or more plans, the plan of the parent whose birthday comes earlier in the year (regardless of age) will be the primary plan unless the Dependent child's parents are separated or divorced. Then the following applies:
  1. The plan of the parent with custody pays first.
  2. The stepparent's plan pays next.
  3. The parent without custody pays next.
  4. Regardless of which parent has custody, whenever a court order specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
  5. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

- Coverage as an active Employee or that Employee's Dependent is determined before coverage as a laid-off or retired Employee. If the other plan does not have this rule and if, as a result, the programs do not agree on the order of benefits, this rule is ignored.
- When none of the above circumstances applies, the coverage you have had for the longest time pays first.

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

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

MEDICAL BENEFITS

THE PLAN PAYS BENEFITS FOR ELIGIBLE CHARGES INCURRED FOR MEDICAL SERVICES. THE FOLLOWING IS A SUMMARY OF THESE BENEFITS.

HOSPITAL PRECERTIFICATION

You must precertify Hospital and Skilled Nursing Facility admissions and certain other services if you:

- are enrolled in the Out-of-Area Comprehensive option
- receive care under the 90/70 or 80/60 PPO option (for both In-Network Benefits and Out-of-Network Benefits)

Precertification is a program designed to help save you and the Company time and money, and to ensure a high level of medical care. It helps you make informed decisions about proposed treatment, and encourages Physicians to provide care in the most appropriate setting for your situation. Your Doctor still directs your treatment, and you make the final decision about the treatment you receive.

Note: Refer to the Summary of Health Benefits on page 65 for the Out-of-Area Comprehensive, 90/70 or 80/60 PPO option for detail on services requiring precertification.

How Precertification Works

If you or a covered Dependent is scheduled for a Hospital admission or other service requiring precertification, you must have the services authorized ahead of time for full benefits to be paid. You or your Doctor begins the review and authorization process by calling the phone number on your Medical Plan ID Card.

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

If the service is not certified even after further review and contact with your Doctor, you will be notified of the reasons why and given the opportunity to appeal the decision. Please refer to **"SECTION TWO - ADMINISTRATIVE INFORMATION**" for further details on the appeal process.

In an Emergency

If you are hospitalized as a result of an Emergency situation, you, your Doctor or your covered Dependent must call the Hospital Precertification number within 48 hours following your admission for maximum benefits to be paid.

For Pregnancy

In accordance with the Federal law, Newborn's and Mother's Health Protection Act (NMHPA), the plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a normal (vaginal) delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or Newborn's attending provider from discharging the mother or Newborn earlier, as long as the attending provider has consulted with the mother. The plan may not require that an attending provider obtain authorization to prescribe a length of stay that does not exceed these periods (48 or 96 hours). The plan, however, does require that an attending provider obtain authorization to prescribe a length of stay exceeding the 48 or 96 hour limit.

If You Do Not Complete the Precertification Process

If you do not complete the Hospital Precertification process before your admission to the Hospital or Skilled Nursing Facility, after an Emergency admission or other service requiring precertification, benefits will be reduced by 20% if the confinement or service is determined to be Medically Necessary. If you decide upon hospitalization, Skilled Nursing Facility admission or other service after a Precertification denial, you will be required to pay 100% of the charges.

If you stay in the Hospital or Skilled Nursing Facility longer than the approved length of stay, you will be responsible for 100% of the charges for the excess days.

HOSPITAL AUDIT REWARD PROGRAM (HARP)

All Medical Plan coverage options participate in the Hospital Audit Reward Program. By reviewing your Hospital bills for accuracy, you could be eligible for a cash reward if you find an error in billing. A billing error is defined as a bill that includes services not provided to you. It does not include mathematical errors or typing errors.

Each time your efforts lead to a corrected Hospital billing and the error would have resulted in a Medical Plan overpayment, you will receive 50% of the benefit overpayment that would have been made. There is a minimum reward of $10 (i.e. a $20 bill error) and a $500 maximum reward (i.e. a $1,000 billing error) if you can determine an error was made.

If you find an error on a Hospital bill, obtain a HARP Transmittal Form from HR. You will need to contact your Provider or Hospital to receive a corrected bill and send the HARP Transmittal Form, the incorrect and corrected bills to HR who will review and forward to the correct Claims Administrator. If approved, the HARP award will be processed by Nortel Payroll and included in your paycheck. If the Claims Administrator denies the HARP award, you will be sent a letter of denial.

COVERED EXPENSES

In general, the following medical expenses (in this "Covered Expenses" section) are covered under all Medical Plan options. Variations between Managed Care options are noted.

To be an eligible medical expense, the service must be Medically Necessary and adhere to Common Medical Standards. In some cases, coverage is limited to Reasonable and Customary Charges or other limits and maximums. The Claims Administrator determines whether a service meets the plan's Medically Necessary criteria and Common Medical Standards. The Claims Administrator also determines what Reasonable and Customary Charges are under the plan. The information developed and used by the Claims Administrator in their determinations of Medically Necessary criteria and, Common Medical Standards are contained in the resources listed under "Claims Administrator Information Used in Claim Determinations" on pages 6, 7 and 8. You can obtain information on the criteria the Claims Administrator relies upon in determination of your Claim as explained within the list.

Certain services and supplies require Precertification, or preauthorization by the Claims Administrator in advance of receiving the services and supplies for full benefits to be paid. Services for which you must receive Precertification or preauthorization are noted in this section. This section also shows the details on benefit levels and limits for Covered Expenses. Expenses specifically excluded from coverage are shown in the "What is not Covered" section.

Employee Assistance Program

Nortel offers an Employee Assistance Program (EAP) benefit through OptumHealth Behavioral Solutions. The EAP benefit is available to you and your eligible Dependents twenty-four (24) hours/seven (7) days a week. This program can help you or your family with resources and expertise on a wide variety of subjects to assist with the demands of everyday life, as well as major events. You and your eligible Dependents automatically receive access to the Employee Assistance Program (EAP) --- at no cost to you. You do not have to enroll in a Medical Plan option to have this benefit. Benefits can be accessed by calling 1-800-842-2991 or via www.liveandworkwell.com (access code: 800-842-2991, include the hyphens), OptumHealth Behavioral Solutions' web site. All services are confidential and in accordance with federal and state laws.

The EAP offers the following benefits:

- Assessment, consultation and problem solving
- Risk screening and crisis intervention
- Advocacy to help you address your situation
- Referral to a licensed network practitioner for up to eight counseling sessions at no charge per member and/or eligible Dependent per Calendar Year (based on clinical necessity)
- Referral to community resources
- Adult and elder care resource information
- Child and family care resource information
- Educational materials specific to issue and Educational resource info
- Legal consultation from a licensed attorney
- Mediation services
- Financial counseling from a credentialed financial professional
- Online work/life information

In order to receive EAP counseling benefits, you must contact OptumHealth Behavioral Solutions and pre-certify sessions. When you call OptumHealth Behavioral Solutions, you will speak with a mental health professional who will refer you to a licensed practitioner within the OptumHealth Behavioral Solutions network. If assistance outside EAP counseling is needed, you may be referred for additional services as follows:

- OptumHealth Behavioral Solutions EAP Worklife services or appropriate community resources and/or
- If you are a PPO or Out-of-Area Comprehensive option participant, you may be referred for mental health or substance abuse treatment with benefits administered by OptumHealth Behavioral Solutions (as described in the following section).

When you receive care through the OptumHealth Behavioral Solutions network, you have no Claims to file. The OptumHealth Behavioral Solutions practitioner will handle the paperwork for you. If you have questions about your EAP benefit, you may contact OptumHealth Behavioral Solutions at 1-800-842-2991.

Mental Health and Substance Abuse Treatment Benefits

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

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

Nortel Networks managed mental health and substance abuse treatment benefit provides assistance in addressing such problems as depression, and drug or alcohol abuse. Mental health services include outpatient individual, family, group, child, or adolescent therapy; medication management; evening and weekend programs; day treatment programs; and hospitalization. Substance abuse services include sober living programs, halfway homes, structured outpatient programs, partial day treatment, and residential treatment for substance abuse rehabilitation, as well as acute Inpatient care.

Certified Care

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

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

See the "Summary of Mental Health and Substance Abuse Treatment Benefits" on page 27 for further details on In-Network and Out-of-Network Benefit amounts.

Uncertified Care

Expenses incurred for mental health and substance abuse treatment services that are not certified by OptumHealth Behavioral Solutions prior to receiving the services are subject to penalties and reductions in benefits. This includes in-patient and intermediate care. The services will be reviewed to determine if they were Medically Necessary. The review will be completed following receipt of the Claim by OptumHealth Behavioral Solutions. If determined to be Medically Necessary by OptumHealth Behavioral Solutions, the services will be covered at the Out-of-Network

Benefit level. Coverage is limited to Reasonable and Customary Charges. The standards OptumHealth Behavioral Solutions follows in making these determinations are contained in the documents listed under "Claims Administrator Information Used In Claim Determinations" on pages 6, 7 and 8. Information on how to obtain copies is also described there.

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

Additionally, if Inpatient treatment or other intensive levels of care are not pre-certified by OptumHealth Behavioral Solutions, a 20% non-notification penalty will be applied. This non-notification penalty does not count toward the Medical Plan's overall Out-of-Pocket Maximum.

Summary of Managed Mental Health and Substance Abuse Treatment Benefits

This information outlines the mental health and substance abuse treatment benefits available if you enroll in a PPO or Out-of-Area Comprehensive Option under the Medical Plan.

Description	**Coverage**	
	In-Network	**Out-of-Network**
Calendar Year Deductible	None	$200/person[1,7, 10]
Separate Deductible for Hospital Admission	None	$150/per admission[2,3,7]
Inpatient Services[1, 3, 5] (Precertification Required)		
Mental Health	100%[1, 3, 5,]	70% of eligible charges after a $200 Calendar Year Deductible and a $150 Hospital Deductible [1, 2,3,4,5,7,8,9]
Substance Abuse	100%[1,3, 5,]	70% of eligible charges after a $200 Calendar Year Deductible and a $150 Hospital Deductible[1,2,3,4,5, 7,8,9]
Intermediate Care	100%[1, 3, 4,5]	80% of eligible charges after $200 Calendar Year Deductible and a $150 Hospital Deductible [1, 2,3,4,5,7,8,9]
Outpatient Services		
Individual Treatment:	Visits 1-17: $20 Copayment (Does not include EAP visits)	70% of Reasonable and Customary Charges, after $200 Calendar Year Deductible [7 8,]
	Visits over 17: $25 Copayment	
Group Treatment:	Visits 1-17: $10 Copayment	70% of Reasonable and Customary Charges, after $200 Calendar Year Deductible [7, 8,]
	Visits over 17: $20 Copayment	
In-Home Mental Health Care	100% [, 11]	70% of eligible charges after $200 calendar year deductible are met up to 100 visits per calendar year[8, 11]

Description	Coverage	
	In-Network	**Out-of-Network**
Drug Testing as an Adjunct to Substance Abuse Treatment	100%	No benefit
Description		
Medication Management	$5 Copayment for up to 30-minute visit, no limit	70% of Reasonable and Customary Charges, after $200 Calendar Year Deductible for up to 30-minute visit, no limit. [7, 8]
Calendar Year Out-of-Pocket Maximum (excluding Deductible and Copayments)[10]	$3,500/person $7,000/family	$7,500/person $15,000/family
Lifetime Maximum	Unlimited	Unlimited

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NOTES

[1] Inpatient and Intermediate Care are subject to Precertification. If there is a combined medical/mental health or medical/substance abuse treatment admission, only the Hospital Inpatient Deductible for the primary diagnosis applies.

[2] The $150 per admission Hospital Deductible for Out-of-Network admissions applies after the annual $200 Deductible is met.

[3] If Hospital or Intermediate Care is not precertified, there is a non-notification penalty of 20%. There is a 48-hour grace period for Emergencies. The non-notification penalty does not count toward the out-of-pocket maximum; there is a non-notification penalty of 20%. 100% denial for no authorization

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

[5] Subject to care manager approval.

[6] Outpatient care is reviewed after visit 10 and every 10 visits thereafter.

[7] The $200 per person annual Deductible is subtracted from a Claim before any benefit is paid and is separate from the Hospital Inpatient Deductible. Covered expenses you pay toward the In Network Out-of Pocket maximum do not count toward the out-of-network annual deductible. The annual out-of-network mental health and substance abuse treatment deductible and out of pocket maximum cross accumulates with the medical deductible and out of pocket maximum.

[8] Coverage is limited to Reasonable and Customary Charges.

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

[10] Deductibles and Out of pocket maximum do not cross accumulate between in and out of network care. Out-of-pocket maximum does not include Deductibles, Copayments, and any amounts you pay above Reasonable and Customary Charges, as well as any expenses you incur under the Prescription Drug benefit.

[11] In-Network Benefits count towards Out-of-Network Benefit maximum

Prescription Drug Benefits

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

This Prescription Drug benefits program covers all eligible prescriptions filled on an outpatient basis. Drugs dispensed in a Hospital, other Inpatient settings or physician's offices are covered as Hospital or Physician expenses under the Medical Plan option in which you enrolled unless they are Specialty Drugs and managed by Accredo (see "Specialty Drug Channel Management" below).

Prescription Drug Formulary

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

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

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

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

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

Member Pay-the-Difference Feature

The Pay-the-Difference feature is designed to provide higher coverage for lower-cost alternatives to Brand-Name Drugs. Whenever you buy a Brand-Name Drug that has a lower-cost generic equivalent, whether through a retail pharmacy or through the Home Delivery Service, you'll pay the applicable Brand-Name Coinsurance plus the difference between the cost of the generic equivalent and the cost of the Brand-Name Drug. This includes anytime that your Doctor indicates that the prescription should be "Dispensed As Written".

Retail Pharmacy Benefits

In-Network Benefits

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

Generic Drugs:
20% Coinsurance for up to a 30-day supply
Maximum: $25 for up to a 30-day supply
Minimum: $7 or the cost of the drug, whichever is less for up to a 30-day supply

Preferred Brand-Name Drugs:
20% Coinsurance for up to a 30-day supply
Maximum: $50 for up to a 30-day supply
Minimum: $15 or the cost of the drug, whichever is less for up to a 30-day supply

Non-preferred Brand-Name Drugs:
30% Coinsurance for up to a 30-day supply
Maximum: $65 for up to a 30-day supply
Minimum: $30 or the cost of the drug, whichever is less for up to a 30-day supply

Unless your Physician specifies a Brand-Name Drug, your prescription will be filled with a Generic Drug, where available. If you choose to purchase the Brand-Name Drug when a Generic Drug is available or if your Doctor indicates the prescription should be "Dispensed As Written", you will be responsible for the Brand-Name Drug Coinsurance plus the difference between the cost of the Generic and the Brand-Name Drug as described in the "Member Pay-the-Difference Feature" on page 29.

See "What Is Not Covered Under Prescription Drug Benefits" on page 33 for charges not covered under the Prescription Drug benefits.

Out-of-Network Benefits

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

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

Retail Refill Allowance for Maintenance Medications

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

Alternatively, if you use the Home Delivery Pharmacy Service, your costs will be based on the Home Delivery Pharmacy Service Coinsurance. You'll pay only one Coinsurance for up to a 90-day supply of medication.

Specialty Drug Channel Management

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

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

When You are Traveling

If you need a prescription filled when you are away from home, contact Medco Health's customer service department at 1-800-711-3460 to obtain the name and location of the nearest participating pharmacy. The same benefits are available to you at any Medco Health participating pharmacy.

If You Do Not Live Near a Network Pharmacy

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

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

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

Emergencies

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

Home Delivery Pharmacy Service

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

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

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

For Up to a 90-day Supply

- 20% Coinsurance ($15 minimum (or the cost of the drug whichever is less), $50 maximum, for Generic Drug
- 20% Coinsurance ($45 minimum (or the cost of the drug whichever is less), $100 maximum for Preferred Brand-Name Drug
- 30% Coinsurance ($90 minimum (or the cost of the drug whichever is less) , $130 maximum for Non-preferred Brand-Name Drug

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

You must complete the Medco Health Home Delivery Pharmacy Service Order form found on www.nortel-us.com/ or www.medco.com enclose the prescription written by your Physician (your Physician should write the prescription for a 90-day supply) and send it to Medco Health along with your Coinsurance for each order. You will receive the prescription along with a new order form by return mail.

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

Note: Any out-of-pocket expenses for Prescription Drug benefits administered through Medco Health (Out-of-Network Prescription Drug expenses, In-Network Prescription Drug Coinsurance or Copayments) do not apply toward your Medical Plan Out-of-Pocket Maximum.

Home Delivery Out-of-Pocket Maximum

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

Note: The amount of the difference between the Brand Name drug and generic alternative you pay as a result of the "Member Pay-the-Difference Feature" does not count toward the satisfaction of the out-of-pocket maximum.

Maximum Benefit

There is no lifetime limit or Lifetime Maximum on the Prescription Drug program benefit.

Covered Prescription Drugs

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

- an eligible Prescription Drug for which a written prescription is required
- oral and injectable insulin dispensed only upon the written prescription of a Physician
- a compound medication of which at least one ingredient is a federal legend drug
- any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a Physician or other lawful Provider

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

What Is Not Covered Under Prescription Drug Benefits

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

- charges that would not have been made if the person were not covered by these benefits
- charges that you are not legally required to pay
- drugs not approved by the Federal Drug Administration (FDA) for treatment
- expenses incurred to the extent that payment is unlawful where the person lives when the expenses are incurred
- Experimental drugs or drugs labeled "Caution — limited by federal law to investigational use"
- immunization agents, biological sera, blood or blood plasma
- medication which is taken or administered, in whole or part, at the place where it is dispensed or while a person is a patient in an institution which operates, or allows to be operated, on its premises a facility for dispensing pharmaceuticals
- non-federal legend drugs, other than insulin
- prescriptions filled in excess of the number specified by the Physician
- prescriptions dispensed more than one year from the date of the Physician's order
- prescriptions dispensed prior to consumption of 75% of existing prescription when taken as directed
- prescriptions for more than a 90-day supply at any one time
- prescriptions that can be reimbursed under any Workers' Compensation law or government program, other than Medicaid
- Rogaine or Propecia for hair growth or Renova for cosmetic use
- Retin-A/Avita/Tazorac for participants over age 35 without preauthorization
- therapeutic devices and supplies, except for disposable hypodermic syringes and needles for the administration of insulin and glucose test strips.

When processing your prescription benefit Claims, Medco refers to the resources listed under "Claims Administrator Information Used In Claim Determination" – see pages 6, 7 and 8. Prescription medications that require prior authorization and information on how you can obtain the clinical information Medco relies upon in determination of your Claim is also described there. Additional Medco information that is used in prescription benefit Claims determinations is included in Appendix A of this SPD.

Health Management Program

Health management services are provided by your Claims Administrator, CIGNA or Anthem BlueCross BlueShield (Anthem). These confidential programs are offered to Nortel employees and retirees less than 65 and their eligible dependents at no cost. They include:

- **Nurse lines** that provide toll-free access to registered nurses 24-hours a day, 7 days a week, for questions about conditions, symptoms, medications, or other health information.

  Anthem: 1877-5NORTEL (566-7835)
  CIGNA: 1-800-257-2702

- **Web sites** for :

  - Health related information,
  - Health tools, such as health risk assessment, weight and exercise logs, carbohydrate calculator and blood sugar tracker,
  - E-mail a nurse feature (Anthem only),
  - Links to other useful web sites, and more.

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

  Anthem: www.anthem.com
  CIGNA: www.myCIGNA.com

- **Pre-recorded health information** via toll-free phone lines.

  Anthem: 1-877-5NORTEL (566-7835)
  CIGNA: 1-800-257-2702

- **Chronic disease management assistance** for:

  - Understanding your condition and how to manage symptoms,
  - Understanding and following your doctor's treatment plan,
  - Understanding medications, side effects, contraindications, etc.,
  - Becoming a good health care consumer,
  - Navigating the health care system,
  - Providing your doctor with updates (requires your consent) and national treatment guidelines on your condition.

  Anthem: 1-877-5NORTEL (566-7835)
  CIGNA: 1-877-888-3091

Note: Employees and Dependents with chronic health conditions (e.g. diabetes, asthma, heart disease) can choose to participate in a confidential program to help improve their health by enrolling in the Health Management Program sponsored by their Claims Administrator.

Preventive Care Benefits

Network Area Options

Preferred Provider Organization (PPO) Options In-Network Coverage

When you choose coverage in the 90/70 or 80/60 PPO option and use an In-Network Provider, Preventive Care expenses are covered at 100% for you and your eligible Dependents.
In-Network Preventive Care services are based on American Medical Association (AMA) schedules for recommended periodic health examinations for Children and adults. Specific benefits may vary depending on your Network. However, some of the preventive services that are eligible under the plan include:

Well-child care for Children

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

Adults

- annual flu shot for adults, or as prescribed by Physician for high risk patients (e.g., immunosuppressed chronic disease)
- annual Pap smear for women
- immunizations for tetanus-diphtheria every 10 years
- laboratory and diagnostic procedures for individuals at high risk for particular health problems
- mammograms (according to AMA recommendations)
- physical exam (according to AMA recommendations)
- sigmoidoscopy (according to AMA recommendations)
- vision and hearing tests for adults

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

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

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

When you use an Out-of-Network Provider well-baby care expenses up to age six, including immunizations, are also generally covered at 70% (90/70 PPO) or 60% (80/60 PPO). Note that both PPO options' out-of-network Preventive Care benefits are limited to Reasonable and Customary Charges.

Non-Network Area Option

Out-of-Area Comprehensive Option Coverage

If you are enrolled in the Out-of-Area Comprehensive option, you and your eligible Dependents age six and over will generally be covered at 100% for a Preventive Care physical exam,

Well-baby care expenses up to age six, including immunizations, are also generally covered at 100%
Note that the Out-of-Area Comprehensive option's Preventive Care benefits are limited to Reasonable & Customary Charges.

Other Covered Expenses

The following expenses are also covered under the Medical Plan options. Remember: To be an eligible medical expense, the service must be Medically Necessary and adhere to Common Medical Standards. In some cases, coverage is limited to Reasonable and Customary Charges or other limits and maximums. The Claims Administrator determines whether a service meets the plan's Medically Necessary criteria and Common Medical Standards under the plan. The Claims Administrator also determines what Reasonable and Customary Charges are under the plan.

Certain services and supplies require Precertification or preauthorization by the Claims Administrator in advance of receiving the services and supplies for full benefits to be paid. Services for which you must receive Precertification or preauthorization are noted in this section. Expenses specifically excluded from coverage are shown in the "What is Not Covered" section.

Assistant Surgeon

Services rendered by an assistant surgeon are covered based on Medical Necessity. Benefits are limited based upon the amount of the primary surgeon's eligible services for the surgery. An assistant surgeon must be a physician. Surgical assistant's services are not covered

Ambulance Service

Local service to a Hospital in connection with care for an Emergency or if otherwise Medically Necessary. Such service also covers your transfer from one Hospital to another if Medically Necessary. Air ambulance is covered subject to Medical Necessity.

Chiropractic Benefits

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

For CIGNA Managed Care options:

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

Dental Coverage

Dental coverage is provided under the Medical Plan for treatment due to accidental Injury to sound, natural teeth. (Sound, natural teeth are defined as natural teeth that are free of active clinical decay or in good repair, have at least 50% bony support, and are functional in use.) This treatment must be provided within twelve months of the Accident. Coverage includes charges for Doctor's services, X-ray exams and services necessary to restore or replace injured teeth. When you receive preauthorization from the Claims Administrator, Dental Coverage under the Medical Plan is also provided for:

- a charge made for removal of a Non-odontogenic tumor.
- other Medically Necessary services to treat:
  - Temporomandibular Joint Disorder (TMJ) (see page 47)
  - Jaw abnormalities (see Orthognathic Surgery, page 44)
  - Correction of Congenital anomaly in Children that was present at birth.

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

Additional dental exclusion information can be referenced in "What is Not Covered" on page 48. See the Dental/Vision/Hearing Care Plan Summary Plan Description on www.nortel-us.com/ for information about other dental coverage available under FLEX Benefits.

Durable Medical Equipment

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

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

In addition to meeting criteria for Medical Necessity, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the patient's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.
The equipment must meet the following criteria:

- It can stand repeated use;

• It is manufactured solely to serve a medical purpose;

• It is not merely for comfort or convenience;

• It is normally not useful to a person not ill or Injured;

• It is ordered by a Physician;

• The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item;

• It is related to the patient's physical disorder.

The following items related to Durable Medical Equipment or patient convenience are specifically **excluded:**

- Air conditioners, humidifiers, dehumidifiers, or purifiers;
- Arch supports and corrective shoes;
- Heating pads, hot water bottles, home enema equipment, or rubber gloves;
- Sterile water;
- Deluxe equipment, such as motor-driven chairs or beds, when standard equipment is adequate;
- Rental or purchase of equipment if you are in a facility which provides such equipment;
- Electric stair chairs or elevator chairs;
- Physical fitness, exercise, or ultraviolet/tanning equipment;
- Residential structural modification to facilitate the use of equipment;
- Other items of equipment which do not meet the listed criteria.

If you are enrolled in a Managed Care option, the Network Manager determines whether the equipment will be rented or purchased for coverage under the plan. If you are enrolled in the Out-of-Area Comprehensive Option, the plan will cover either rental or purchase of the equipment.

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

For Managed Care options, to receive In-Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor the Network Manager identifies. If you're enrolled in the Out-of-Area Comprehensive Option, contact your Claims Administrator for recommendations for suppliers in your area with whom the Claims Administrator has discount arrangements.

Predetermination Review:

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

Emergency Care

An Emergency is a sudden and serious situation that happens unexpectedly and requires immediate medical attention. Examples include an apparent heart attack, severe bleeding, sudden loss of consciousness, severe or multiple injuries, convulsions, apparent poisoning. Contact Member Services if there is any question of whether a condition is considered an Emergency.

The plan covers Emergency care, including, but not limited to:

- Ambulance transportation to the nearest Emergency facility and transfers to other facilities in order to receive appropriate services
- Hospital Emergency room care — within 48 hours of an accidental Injury or the onset of a sudden or serious Illness

Important Note: If the Emergency room is used for a condition that is not a medical Emergency, benefits may be reduced (and in some cases no benefits paid).

Home Health Care

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

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

For all CIGNA options, including the Managed Care and Out-of-Area Comprehensive Option:

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

For Anthem options:

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

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

- part-time or intermittent home nursing care given or supervised by a registered nurse
- part-time or intermittent Home Health Care Agency aide service, mainly for care of the person
- physical, occupational or respiratory therapy by a qualified therapist
- nutritional counseling furnished or supervised by a registered dietitian
- medical supplies, lab services, drugs and medicines prescribed by a Physician.

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

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

- the services are furnished by the Home Health Care Agency for that care and treatment in the patient's home and charged for by the Home Health Care Agency.

Hospice Care Program

The Medical Plan covers Hospice care services provided to a covered person who has been certified by his/her treating Physician to be "Terminally Ill". Terminally Ill means a life expectancy of six months or less, as certified by the patient's treating Physician, who recommends admittance to a Hospice care facility. The plan also covers Hospice care expenses incurred for bereavement counseling services provided to the Terminally Ill patient's family unit after that person's death.

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

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

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

The plan covers Hospice care services provided to a covered person diagnosed with a Terminal Illness.

The plan also covers Hospice care expenses incurred for counseling services provided to the Terminally Ill patient's family unit after that person's death.

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

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

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

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

Covered charges include:

- counseling services provided by members of the Hospice team

- Hospice Room and Board while an Inpatient in a Hospice facility and
- necessary medical and surgical supplies.

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

For CIGNA options: There is a benefit maximum of 3 bereavement counseling sessions per family, per occurrence, for in-network and out-of-network care combined. The following charges related to Hospice care are excluded under CIGNA options:

- Twenty-four hour nursing care, including homemaker and/or Home Health Care Agency aide services provided during periods of crisis, but care during these periods must be predominantly nursing care.
- Homemaker services, which may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the care plan.

For Anthem options: There is no specific benefit maximum for bereavement counseling sessions. Charges for counseling services furnished to the patient's family unit (i.e., the Employee and eligible Dependents and/or Domestic Partner), after the death of the Terminally Ill participant are outside of the scope of Anthem's services but may be eligible for coverage under the mental health and substance abuse treatment benefits.

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

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

Infertility

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

Inpatient Hospital Services

The plan covers services and supplies furnished by a Hospital during a Hospital stay, including:

- Ambulance use for local travel
- Anesthetics and their administration
- chemotherapy or radiation therapy
- diagnostic laboratory and X-ray services
- drugs and medications
- operating and recovery room charges
- Hemodialysis

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

These services will be covered if your Hospital admission is precertified. Please refer to "Hospital Precertification" on page 22 for further information on Hospital Precertification.

Inpatient Physician and Surgeon Services

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

Maternity and Newborn Coverage

Maternity:

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

Newborn Care:

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

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

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

Medical Supplies

Covered medical supplies include:

- allergy sera and biological sera
- Anesthetics and their administration
- blood and blood transfusions by or for the patient (if blood is not replaced)
- drugs and medication prescribed by a Doctor, or dispensed and administered in a Doctor's office
- hypodermic needles and syringes other than for insulin
- injectables, other than prescribed insulin given or authorized by a Physician
- other fluids to be injected into the circulatory system
- oxygen

Organ Transplant

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

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

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

All Medical Plan options offer you and your eligible Dependents access to the finest Hospitals in the country for approved organ transplant procedures, as well as coronary bypass grafts, angioplasties and other procedures. These services are provided through CIGNA's LIFESOURCE Organ Transplant Network® and Anthem's Blue Distinction Center of Excellence. Your Medical Plan enrollment directs which of these programs you may use.

The LIFESOURCE Organ Transplant Network® and Blue Distinction Center of Excellence are nationally recognized for their delivery of highly specialized procedures and for the state-of-the-art care they provide to their patients. However, you do not have to use the LIFESOURCE Organ Transplant Network® or the Blue Distinction Center of Excellence to receive benefits for these procedures or therapies.

What is Covered under the Organ Transplant Program

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

If you do not complete the preauthorization process before you receive services, benefits will be reduced by 20% if the service is determined to be Medically Necessary. This 20% benefit reduction does not count toward the Medical Plan's overall Out-of-Pocket Maximum. If you decide to receive the services after a preauthorization denial by the Claims Administrator, no benefits will be paid under the plan.

Companion Travel Program

Under the Companion Travel Program, you can choose a person to accompany you to the LIFESOURCE Organ Transplant Network® or Blue Distinction Center of Excellence for an approved organ transplant and to remain there for all or a portion of your stay. The Companion Travel Program pays benefits for some of the charges incurred by the person accompanying you.

Maximum Travel and Lodging Benefit

For CIGNA options: There is a $10,000 Lifetime Maximum benefit per procedure.

For Anthem options: There is a Lifetime Maximum benefit of $10,000 for all procedures. Transplants with multiple organs transplanted are considered one procedure.

For more information on the LIFESOURCE Organ Transplant Network,® Blue Distinction Center of Excellence and participating institutions, contact your Network Manager's Member Services. Refer to **"SECTION TWO - ADMINISTRATIVE INFORMATION"** for a list of Member Services' addresses and phone numbers.

Orthognathic Surgery

Coverage is provided for expenses for maxillofacial Surgery to correct growth defects, jaw disproportions or malocclusions ONLY when services are:

- to correct a Congenital anomaly in Children that was present at birth or
- Medically Necessary. To qualify as Medically Necessary the condition must meet the criteria established by the American Association of Oral and Maxillofacial Surgeons (AAOMS).
- Under the 90/70 or 80/60 PPO option (for both In-Network Benefits and Out-of-Network Benefits), you must obtain precertification before receiving orthognathic surgery to be eligible for benefits.

Orthoptic (Visual) Therapy

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

Outpatient Physician Services

Coverage for outpatient physician services includes:

- anesthesiologists
- surgeons

Outpatient Services

The following outpatient treatments are covered under the plan:

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

Outpatient Short-Term Rehabilitation

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

- cardiac rehabilitation
- chiropractic therapy (CIGNA options only)
- pulmonary therapy
- treatment by a physical or occupational therapist

- speech therapy:

  – to develop or improve speech after Surgery to correct a defect that occurred at birth and which impaired or would have impaired the ability to speak.

  – to restore speech after a loss or impairment of a demonstrated previous ability to speak caused by an Injury or Illness. This loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.

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

Chiropractic therapy (paid under these Outpatient Short-Term Rehabilitation Benefits under CIGNA plans only), speech, occupational, and physical therapy services are limited based on the options you select. Refer to the Benefits web site at www.nortel-us.com/- "Choose the Right Plans" – "2012 Summary of Health Benefits" for coverage/limitations by plan option. For Managed Care options, both In-Network Benefits and Out-of-Network Benefits for therapy services will count toward the benefit maximum.

Physician Services

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

Private Duty Professional Nursing

Private duty professional nursing services by a registered nurse are covered under the plan, as long as:
- intensive nursing care by such a nurse is required to medically treat an acute Illness or Injury, and
- the patient is not in either a Hospital, or any other health care institution that provides nursing care

Reconstructive Surgery Following Mastectomy

The plan covers breast reconstruction following a mastectomy necessitated by cancer. The following services are also covered under the plan, as required under Federal Law (The Women's Health and Cancer Rights Act of 1998), in the same manner and at the same level as those for other Covered Expenses:

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

Skilled Nursing Facility

The Medical Plan options cover Skilled Nursing Facility services and supplies that are furnished for recovery from either an Illness or Injury that caused a prior Hospital stay or from a related Illness or Injury, up to 60 days per Calendar Year. For the Managed Care options, both In-Network Benefits and Out-of-Network Benefits for Skilled Nursing Facility services and supplies will count toward the benefit maximum.

For all Medical plan options:

- You must Precertify Skilled Nursing Facility admissions to be eligible for Skilled Nursing Facility benefits. Refer to "Hospital Precertification" on page 22 for details about how Hospital Precertification works.
- If you do not complete the Precertification process before your admission to the Skilled Nursing Facility, benefits will be reduced by 20% if the confinement is determined to be Medically Necessary. This 20% benefit reduction does not count toward the Medical Plan's overall Out-of-Pocket Maximum.
- If you decide upon a Skilled Nursing Facility stay after a Precertification denial by the Claims Administrator, no benefits will be paid under the plan. And if you stay in the Skilled Nursing Facility longer than the Claims Administrator's approved length of stay, no benefits will be paid under the plan for the excess days.

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

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

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

- the person's Physician recommends the Skilled Nursing Facility stay
- the person is under continuous care of his or her Physician
- the person's Physician certifies that the person needs 24-hour-a-day nursing care and
- the stay must be other than in connection with care for a mental disorder. Mental disorders include, but are not limited to, senile deterioration, drug addiction, alcoholism, chronic brain syndrome and mental retardation.

If a confinement is in a distinct part of an institution which meets both the definition of a Hospital and of a Skilled Nursing Facility, then the benefits, if any, payable for that confinement will be determined on the basis of the benefits payable for the Skilled Nursing Facility confinement rather than those for a Hospital confinement.

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

Note: Benefits for a confinement in a distinct part of an institution which meets both the definition of a Hospital and a Skilled Nursing Facility will be determined on the basis of benefits payable for a confinement in a Skilled Nursing Facility.

Specialty Physician Services

Coverage for specialty Physician services includes:

- allergy testing and treatment

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

Surgical Services

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

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

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

If two or more surgical procedures are performed in one session, the maximum benefit will be:

- 100% of the charges for the major procedure, plus
- 50% of the charges for the other procedure as if both surgical procedures had been performed separately.

Temporomandibular Joint Disorder

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

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

For the Managed Care Options, In-Network Benefits are provided as described below:

- Under the 90/70 or 80/60 PPO option (for both In-Network Benefits and Out-of-Network Benefits), you must obtain precertification before receiving TMJ services to be eligible for benefits.

Urgent Care Center Services

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

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

Note: PPO Options do not have urgent care copays.

WHAT IS NOT COVERED

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

Biofeedback
Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing is not covered by Anthem but may be covered by CIGNA with precertification. .

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

Chiropractor
Charges by a chiropractor for:

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

Common Medical Standards
Charges for services that do not meet Common Medical Standards.

Confinement
Expenses for:

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

Convenience Items
Charges for personal comfort items and services.

Cosmetic Surgery
Charges for Cosmetic Surgery, except when necessary:

- because of an accidental Injury
- because of infection or other diseases, such as Surgery to reconstruct a breast after a mastectomy
- to treat a condition, including a birth defect, which impairs the function of a part of the body of a Dependent child (e.g., cleft palate).

Custodial Care
Expenses for Custodial Care.

Dental
Expenses for:

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

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

Experimental
Investigational, Experimental or Educational charges.

Eye Care
The following charges related to treatment of the eye:

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

Foot Condition
A charge for Doctor's services for:

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

Hair
Hair transplants, hair pieces or wigs (except when necessitated by disease or Accidental Injury), wig maintenance, or prescriptions or medications related to hair growth.

Hearing Care
Charges for:

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

Homemaker
Charges for services of a homemaker.

Hospital
Any charges:

- for Hospital care and services rendered after the patient has been discharged from the Hospital

- for Hospital care and services when a registered bed patient is absent from the Hospital
- for care and services during a Hospital Inpatient Stay if the covered person's condition does not require:
  - constant direction and supervision by a Physician
  - constant availability of nursing personnel
  - immediate availability of diagnostic therapeutic facilities and equipment found only in a Hospital setting
- for private Hospital room, unless Medically Necessary or unless the Hospital has no Semi-Private room
- at a federal Hospital or any other Hospital operated by a government unit, except for charges you are legally required to pay, or charges covered under any government law or plan, except a federal/state plan (e.g., Medicaid) or law or plan where benefits are in excess of this plan.

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

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

Obesity
Charges for treatment of obesity unless Medically Necessary.

Observation or Diagnostic Study
Charges incurred for:

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

Other Charges

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

Outpatient Short-Term Rehabilitation
Outpatient rehabilitation services, chiropractic services and any other type of service or supply for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Sexual Function
Expenses for:

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

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

TMJ
Expenses for treatment of Temporomandibular Joint Dysfunction (TMJ), unless Medically Necessary and as described under the "Other Covered Expenses" section.

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

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

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

HOW THE NETWORK AREA MANAGED CARE OPTIONS WORK

The Managed Care options represent a managed medical approach within networks. A Network is a group of Physicians, Hospitals and other health care Providers in a community. Physicians must meet strict eligibility standards before they can be admitted to the Network. Some of the considerations are:

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

The Network Manager screens and contracts with the Providers, and continues to monitor them on an ongoing basis. The Network Managers are CIGNA and Anthem. **Your *home* zip code will determine which Network is available in your area.**

Although the Medical Plan options are intended to be the same regardless of the Network in which you enroll, there may be some differences.

Provider Directory

The Provider Directory lists Primary Care Physicians (PCPs), specialists, hospitals, other facilities and other types of practitioners. You can obtain a copy of the Provider Directory from the Claim Administrator's internet site or by calling their Member/Customer Services. See the "Contact Information for Claims Filing" chart in **"SECTION TWO – ADMINISTRATIVE INFORMATION."**

Directions to Claim Administrators' web sites and other contact information can be found on the Benefits web site at www.nortel-us.com/ in the "Explore Plans and Services" section.

Network Medical Plan Names

CIGNA refers to Medical option names differently than Nortel Networks, so in order to avoid confusion:

If the CIGNA materials say:	The Nortel Networks option is:
Open Access Plus Network	PPO

The Managed Care options represent a managed medical approach within networks. A Network is a group of Physicians, Hospitals and other health care Providers in a community. Physicians must meet strict eligibility standards before they can be admitted to the Network. **Note:** The Physicians participating in the Network may differ by Managed Care Option.

Plan Benefits

The 90/70 and 80/60 PPO options pay the maximum level of benefits when you use In-Network Providers. "In-Network" for these options means that you are receiving care from a Doctor, laboratory, Hospital, etc., that is participating in the Network. You may use Out-of-Network Providers, but benefits are reduced, except in a life-threatening Emergency.

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

In-Network Benefits

Below is an overview of In-Network Benefits. See the Benefits web site at www.nortel-us.com/- "Choose the Right Plans" section for further information on In-Network Benefit levels for each Medical option:

With the 90/70 or 80/60 PPO option, you will pay a Copayment, a flat dollar amount, for certain Physician and other professional services received from In-Network Providers (without having to first meet the Calendar Year deductible). Then under the 90/70 PPO for all other services you must first satisfy a $300/person and a $750/family Calendar Year Deductible before In-Network Benefits begin. . Under the 80/60 PPO, you must first satisfy a $400/person and a $1200/family Deductible before In-Network Benefit payments begin.

When the Deductibles for all family members combined reach the family Deductible, the Deductible will be considered satisfied for all family members that Calendar Year. However, in reaching the family Deductible, no one person can contribute more than one individual Deductible.

There is a separate $350 hospital Inpatient stay Copayment for each In-Network Hospital admission under the 90/70 PPO and a separate $350 Hospital Inpatient Stay Copayment for each In-Network Hospital admission under the 80/60 PPO. For most in-network services, the plan pays 90% of covered charges (90/70 PPO) or 80% of covered charges (80/60 PPO) you pay the rest. When the amount of Covered Expenses you pay reaches the Out-of-Pocket Maximum ($3,500/person and $7,000/family under the 90/70 PPO and the 80/60 PPO) in a Calendar Year (not

including the Deductible, Copayments or amounts exceeding Reasonable and Customary Charges), the plan pays 100% of the covered charges for the rest of the Calendar Year.

Note that a Hospital Inpatient Stay Copayment applies to the mother and each Newborn for each Hospital admission.

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

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

It is the Medical Plan's intention, under certain circumstances, to provide benefits above the Managed Care option's In-Network Benefit limit for the following benefits:

- Skilled Nursing Facility
- Outpatient Short-Term Rehabilitation.

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

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

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

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

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

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

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

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

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

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

Remember, most of your FLEX selections remain in effect the entire Calendar Year and may not be changed. However, you can make certain changes in your FLEX Benefit choices during the 31-day period after you experience a Status Change. See "Changing your Selections" on page 18 for more details.

Out-of-Network Benefits

Below is an overview of Out-of-Network benefits. See the Benefits web site at www.nortel-us.com/ - "Choose the Right Plans" section for further information on Out-of-Network Benefit levels for each Managed Care option.

Under the 90/70 or 80/60 PPO option, you may use Out-of-Network Providers any time you need health care, but benefits are reduced. Under the 90/70 PPO, you must first satisfy a $500/person and a $1500/family Deductible before Out-of-Network Benefit payments begin. Under the 80/60 PPO, you must first satisfy a $600/person and a $1,800/family Deductible before Out-of-Network Benefit payments begin. When the Deductibles for all family members combined reach the family Deductible, the Deductible will be considered satisfied for all family members that Calendar Year. However, in reaching the family Deductible, no one person can contribute more than their individual Deductible. There is a separate $500 Hospital Inpatient Stay Copayment for each Out-of-Network Hospital admission under the 90/70 PPO option and a separate $500 Hospital Inpatient Stay Copayment for each Out-of-Network Hospital admission under the 80/60 PPO option.

You may use Out-of-Network Providers any time you need health care, but benefits are reduced. You will have to pay an annual Deductible for most Covered Expenses before benefit payments begin. Then the plan pays a percentage of the cost, and you pay the rest. When the amount of Covered Expenses you pay out of your own pocket reaches the "Out-of-Pocket Maximum" in a Calendar Year (not including certain expenses like the Deductible, any Copayments and any charges in excess of the Reasonable and Customary Charges), the plan pays 100% of the covered charges for the rest of that Calendar Year. The Out-of-Network Out-of-Pocket Maximum for each option is shown in the "Summary of Health Benefits" on the Benefits web site at www.nortel-us.com/ - "Choose the Right Plans".

When you use Out-of-Network Providers, you will have to file a Claim to be reimbursed for plan benefits. Refer to "**SECTION TWO – ADMINISTRATIVE INFORMATION**," under "Filing Claims" for information about how and where to file Claims.

Note that a Hospital Inpatient Stay Copayment applies to the mother and each Newborn for each Hospital admission.

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

A Note About the Out-of-Pocket Maximum

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

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

- charges for mental health and substance abuse treatment [no caps]
- charges in excess of Reasonable and Customary Charges
- charges above plan maximums
- charges applied to the Deductibles
- eligible charges under the plan’s Prescription Drug benefits
- Copayments

Emergencies

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

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

Remember, Emergency rooms should only be used for Emergencies.

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

If you are a PPO option participant, you receive Out-of-Network Benefits when you see Out-of-Network Providers and In-Network Benefits when you see In-Network Providers. In-Network benefits may be available in emergencies as described in the preceding section.

Your Medical ID Card

Your Medical ID Card includes your Copayment amount for easy reference when you need care. You will need to show your card when you go to In-Network Providers for care so your Physician will know how much your Copayment is. In addition, there is information and important telephone numbers printed on the card which you may

need for Emergencies and Precertification. Be sure to keep your Medical ID Card with you at all times to ensure you receive In-Network Benefits.

Member Services

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

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

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

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

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

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

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

Managed Care Options* Summary of Health Benefits - Preferred Provider Organization (PPO) Options

Description	Coverage			
	Preferred Provider Organization (PPO) 80/60 option		Preferred Provider Organization (PPO) 90/70 option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible[9] (Individual/Family)	$400/$1200	$600/$1,800	$300/$750	$500/$1500
Hospital Inpatient Stay Copayment (Precertification required)	$350	$500	$350	$500
Outpatient Surgery Copayment	$250	$500	$250	$500
Calendar Year Out-of-Pocket Maximum [9] (Individual/Family)	$3,500/$7,000 (plus Deductibles/ Copayments)	$7,500/$15,000 (plus Deductibles/ Copayments)	$3,500/$7,000 (plus Deductibles/ Copayments)	$7,500/$15,000 (plus Deductibles/ Copayments)
Lifetime Maximum (per person)	Unlimited	Unlimited	Unlimited	Unlimited
Inpatient Hospital Services (Precertification required) Semi-Private Room & Board Operating & Recovery Room Lab & X-Ray Drugs, Medications Hemodialysis Radiation & Chemotherapy Rehab Services Intensive Care Preadmission Testing Well-Newborn Care Other Eligible Hospital Charges	80% Coinsurance[6] (after Hospital admission deductible)	60% Coinsurance [1,2,5,6] (after Hospital admission deductible)	90% Coinsurance[6] (after Hospital admission deductible)	70% Coinsurance [1,2,5,6] (after Hospital admission deductible)
Inpatient Physician Services (Precertification required)	80% Coinsurance[6]	60% Coinsurance [2,5,6]	90% Coinsurance[6]	70% Coinsurance [2,5,6]

* The PPO Medical Plan options are offered by both CIGNA HealthCare (CIGNA) and Anthem Therefore, your Personalized Enrollment Worksheet will show which Network is available in your area.

Description	Coverage			
	Preferred Provider Organization (PPO) 80/60 option		**Preferred Provider Organization (PPO) 90/70 option**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient Surgeon's Services (Precertification required)	80% Coinsurance[6]	60% Coinsurance [2,5,6]	90% Coinsurance[6]	70% Coinsurance [2,5,6]
Physical Exam Adult and Children (age 6 and up)	100% Coinsurance	60% Coinsurance[2,6]	100% Coinsurance	70% Coinsurance[2,6]
Physician Services Preventive Care Well-Child Care Routine Immunizations & Injections Vision & Hearing Screening (as part of PCP exam) Annual OB/GYN Exam Sigmoidoscopy	100% Coinsurance	60% Coinsurance[2,6]	100% Coinsurance	70% Coinsurance[2,6]
Physician Services Medical Care	$25Copayment per visit; 100% Coinsurance	60% Coinsurance [2,6]	$25 Copayment per visit; 100% Coinsurance	70% Coinsurance [2,6]
Specialty Physician Services Office Visits Referral Physician Services Second Surgical Opinion Pre- & Post-Natal Exam (Copayment on first visit only) Allergy Testing & Treatment (In-Network allergy injections when billed independently without an office visit are not subject to the Copayment).	$30 Copayment per visit; 100% Coinsurance	60% Coinsurance [2,6]	$30 Copayment per visit; 100% Coinsurance	70% Coinsurance [2,6]
Outpatient Surgical Charges Operating & Recovery Room Presurgical testing	80% Coinsurance[5,6] after each outpatient surgery copayment	60% Coinsurance after each outpatient surgery copayment	90% Coinsurance[5,6] after each outpatient surgery copayment	70%Coinsurance after each outpatient surgery copayment
Outpatient Treatments Hemodialysis Radiation & Chemotherapy	80% Coinsurance[5,6]	60% Coinsurance [2,5,6]	90% Coinsurance[5,6]	70% Coinsurance [2,5,6]
Outpatient Services (includes anesthesiologist, pathology interpretations, etc.)	80% Coinsurance[5,6]	60% Coinsurance [2,5,6]	90% Coinsurance[5,6]	70% Coinsurance [2,5,6]
Outpatient Surgeon's Services	80% Coinsurance[5,6]	60% Coinsurance[2,5,6]	90% Coinsurance[5,6]	70% Coinsurance [2,5,6]

Description	Coverage			
	Preferred Provider Organization (PPO) 80/60 option		Preferred Provider Organization (PPO) 90/70 option	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Outpatient X-Ray & Lab (Certain outpatient radiology services require precertification	80% Coinsurance[6] (must use network labs)	60% Coinsurance [2,5,6]	90% Coinsurance[6]; (must use network labs)	70% Coinsurance [2,5,6]
Emergency Care Primary Care/Specialist Office	$25/$30Copayment per visit; 80% Coinsurance	60% Coinsurance [2,6]	$25/$30 Copayment per visit; 90% Coinsurance	70% Coinsurance [2,6]
Emergency Care Hospital Emergency Room Accident or Illness	$100 Copayment per visit[3] (waived if admitted); 80% Coinsurance	60% Coinsurance [2,3,6]	$100 Copayment per visit[3] (waived if admitted); 90% Coinsurance	70% Coinsurance [2,3,6]
Emergency Care Ambulance	80% Coinsurance[6]	60% Coinsurance [2,6]	90% Coinsurance[6]	70% Coinsurance [2,6]
Other Professional Services				
CIGNA Outpatient short term rehabilitation: physical, speech (pre-certification required), cognitive and occupational therapy, up to 90 Visits per condition per calendar Year; includes Chiropractic Services	**$ 30 Copayment**	60% Coinsurance	**$30 Copayment**	70% Coinsurance
ANTHEM Outpatient Short-term rehabilitation: physical, speech, and occupational therapy, up to 30 visits per therapy per Calendar year	**$30 Copayment**	60% Coinsurance	**$30 Copayment**	70% Coinsurance
ANTHEM Chiropractic Services	**$30 Copayment**	60% Coinsurance	**$30 Copayment**	70% Coinsurance
Private Duty Professional Nursing	80% Coinsurance[6,7]	60% Coinsurance (Up to $10,000 per patient per Calendar Year[2,6,7])	90% Coinsurance[6,7]	70% Coinsurance (Up to $10,000 per patient per Calendar Year[2,6,7])
Assisted Reproduction, up to $5,000 Lifetime Maximum per person	80%[4,6] Coinsurance	60%[2,4,6] Coinsurance	90% [4,6] Coinsurance	70%[2,4,6] Coinsurance

Description	Coverage			
	Preferred Provider Organization (PPO) 80/60 option		Preferred Provider Organization (PPO) 90/70 option	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Infertility Diagnosis & treatment	80%[6] Coinsurance	60%[2,6] Coinsurance	90%[6] Coinsurance	70%[2,6] Coinsurance
Home Health Care For CIGNA options: • One Home Health Aide equals two hours of service For Anthem options: • One Home Health Aide visit equals four hours of service	80% Coinsurance[6,7]	60% Coinsurance (limited to 100 visits per Calendar Year[2,6,7])	90% Coinsurance[6,7]	70% Coinsurance (limited to 100 visits per Calendar visit Year[2,6,7])
Hospice	80% Coinsurance[6]	60% Coinsurance[2,6]	90% Coinsurance[6]	70% Coinsurance[2,6]
Skilled Nursing Facility (Precertification required) (up to 60 days per Calendar Year)	80% Coinsurance[1,4,6]	60% Coinsurance[1,2,4,6] (Semi-Private room)	90% Coinsurance[1,4,6]	70% Coinsurance[1,2,4,6] (Semi-Private room)
Durable Medical Equipment	80% Coinsurance[6,7]	60% Coinsurance[2,6,7]	90%	70% Coinsurance[2,6,7]
Chiropractic Services (For CIGNA options: **Coverage for all chiropractic services is determined under Outpatient Short-Term Rehabilitation** benefits (rather than under the Chiropractic Benefits) and is subject to the Outpatient Short-Term Rehabilitation benefit limitations.)	$30 Copayment;	60% Coinsurance (limited to 24 visits per Calendar Year)[2,6]	$30 Copayment;	70% Coinsurance (limited to 24 visits per Calendar Year)[2,6]
Dental Emergency Surgery	For accidental Injury to sound, natural teeth	For accidental Injury to sound, natural teeth	For accidental Injury to sound, natural teeth	For accidental Injury to sound, natural teeth
Precertification	Provider initiated[8]	Employee initiated[5]	Provider initiated[8]	Employee initiated[5]
Preexisting Condition Limitations	None	None	None	None

Prescription Drugs - Retail

	In-Network	**Out-of-Network**
Generic:	20% Coinsurance for up to a 30-day supply Maximum per prescription: $25 for up to a 30-day supply Minimum per prescription: $7 for up to a 30-day supply	60% Coinsurance

Preferred Brand-Name:	20% Coinsurance for up to a 30-day supply Maximum per prescription: $50 for up to a 30-day supply Minimum per prescription: $15 for up to a 30-day supply	60% Coinsurance
Non-preferred Brand-Name:	30% Coinsurance for up to a 30-day supply Maximum per prescription: $65 for up to a 30-day supply Minimum per prescription: $30 for up to a 30-day supply	60% Coinsurance

Note: If a Brand-Name Drug is filled when a Generic Drug is available, you'll pay the Brand-Name Drug Coinsurance plus the difference in cost between the Generic Drug and the Brand-Name Drug – even if your Doctor requests the Brand-Name Drug.

Prescription Drugs - Home Delivery

	In-Network	**Out-of-Network**
Generic:	20% Coinsurance for up to a 90-day supply ($15 minimum, $50 maximum)	Not applicable
Preferred Brand-Name:	20% Coinsurance for up to a 90-day supply ($45 minimum, $100 maximum)	Not applicable
Non-preferred Brand-Name:	30% Coinsurance for up to a 90-day supply ($90 minimum, $130 maximum	Not applicable

Note: If a Brand-Name Drug is filled when a Generic Drug is available, you'll pay the Brand-Name Drug Coinsurance plus the difference in cost between the Generic Drug and the Brand-Name Drug – even if your Doctor requests the Brand-Name Drug.

NOTES

[1] Subject to Hospital Precertification.

[2] Subject to Reasonable & Customary Charges.

[3] **NOTE CONCERNING EMERGENCY ROOM:** In-Network Benefits are available for Emergency Room charges for medical Emergencies only. If the Emergency Room is used for a condition that is not a medical Emergency, Out-of-Network Benefits apply. A medical Emergency is generally defined as an Illness or Injury of such

a nature that failure to get immediate medical care could put a person's life in danger or cause serious harm to bodily functions. Some examples of a medical Emergency are: apparent heart attack, severe bleeding, sudden loss of consciousness, severe or multiple injuries, convulsions, apparent poisoning.

[4] In-Network Benefits count toward the Out-of-Network Benefit maximum, and vice versa.

[5] Whenever a covered person faces confinement in a Hospital or needs non-Emergency Surgery, follow the directions for Hospital Precertification of these services as described on your Medical ID Card. Eligible charges for hospitalization may be reduced for days not precertified and eligible charges for elective Surgery may also be reduced.

[6] Subject to annual Deductible.

[7]In-Network Benefits count toward the Out-of-Network Benefit maximum.

[8]The Employee is responsible for ensuring that the admitting Doctor completes the Precertification process.

[9]Deductibles and Out of pocket maximum do not cross accumulate between in and out of network care.

HOW THE OUT-OF-AREA COMPREHENSIVE OPTION WORKS

If you live outside of an area served by the PPO Networks, you may choose the Out-of-Area Comprehensive option.

Annual Deductible

Before benefit payments begin, you will pay an annual Deductible. When the Deductibles for all family members combined reaches the family Deductible, the Deductible will be considered satisfied for all family members that Calendar Year. However, in reaching the family Deductible, no one person can contribute more than their individual Deductible.

Reimbursement Level

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

Out-of-Pocket Maximum

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

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

- charges for mental health and substance abuse treatment
- charges in excess of the Reasonable and Customary Charge
- charges above plan maximum amounts

- charges applied to the Deductible
- eligible charges under the plan's Prescription Drug program
- Copayments.

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

Common Accident Exception

When two or more covered persons in a family are injured in the same Accident, Covered Expenses for those Injuries will be combined to meet one Deductible for all such covered persons for that Calendar Year. This exception applies only to determine benefits for those Injuries.

Hospital Precertification

You must call Intracorp at 1-800-257-2702 to get Hospital Precertification for all Hospital Inpatient Stays and Skilled Nursing Facility admissions.

Filing Medical Claims

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

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

Out-of-Area Comprehensive Option
Summary of Health Benefits

Description	Coverage
Calendar Year Deductible (Individual/Family)	$300/$900
Hospital Inpatient stay Copayment (Precertification required)	$300
Calendar Year Out-of-Pocket Maximum (Individual/Family)	$2,000/$4,000 (plus Deductible)
Lifetime Maximum (per person)	Unlimited
Inpatient Hospital Services Semi-Private Room & Board Operating & Recovery Room Lab & X-Ray Drugs, Medications Hemodialysis Radiation & Chemotherapy Rehab Services Intensive Care Preadmission Testing Well-Newborn Care Other Eligible Hospital Charges	80% Coinsurance [1,2,3,4] (after Hospital admission deductible)
Inpatient Physician Services (Precertification required)	80% Coinsurance [2,3,4]
Inpatient Surgeon's Services (Precertification required)	80% Coinsurance [2,3,4]
Preventive Care Well-baby Care (up to age 6) Adult and Child physical exam (age 6 and up) Routine Immunizations & Injections Annual OB/GYN Exam (includes routine mammogram)	100% Coinsurance; [2] no Deductible
Physician Services Adult & Child Medical Care	80% Coinsurance [2,4]

Description	Coverage
Specialty Physician Services Office Visits Second Surgical Opinion Pre- & Post-Natal Exam Allergy Testing & Treatment	80% Coinsurance [2,4]
Outpatient Surgical Charges Operating & Recovery Room Presurgical Testing	80% Coinsurance [2, 3, 4]
Outpatient Treatments Hemodialysis Radiation & Chemotherapy	80% Coinsurance [2,3,4]
Outpatient Services (includes anesthesiologist, pathology interpretations, etc.)	80% Coinsurance [2,3,4]
Outpatient Surgeon's Services	80% Coinsurance [2,3,4]
Outpatient X-Ray & Lab	80% Coinsurance [2,4]
Emergency Care Doctor's Office	80% Coinsurance [2,4]
Emergency Care Hospital Emergency Room Accident or Illness	80% Coinsurance [2,4]
Emergency Care Ambulance	80% Coinsurance [2,4]
Outpatient Short-Term Rehabilitation	80% Coinsurance [2,4] **90 visits per condition per year maximum**
Private Duty Professional Nursing	80% Coinsurance (up to $10,000 per Calendar Year per patient [2,4])
Home Health Care	80% Coinsurance[2,4] (up to 100 visits per Calendar Year)
Assisted Reproduction, up to $5,000 Lifetime Maximum per person	80% Coinsurance[2,4]
Infertility Diagnosis & treatment	80% Coinsurance[2,4]

Description	Coverage
Skilled Nursing Facility	80% Coinsurance [1,2,4] (Semi-Private room, limited to 60 days per Calendar Year)
Hospice	80% Coinsurance[2,4]
Durable Medical Equipment	80% Coinsurance [2,4]
Chiropractic Services	See "Outpatient Short-Term Rehabilitation" above
Precertification	Employee initiated[3]
Preexisting Condition Limitations	None

Prescription Drugs - Retail

	In-Network	Out-of-Network
Generic:	20% Coinsurance for up to a 30-day supply Maximum per prescription: $25 for up to a 30-day supply Minimum per prescription: $7 for up to a 30-day supply	60%
Preferred Brand-Name:	20% Coinsurance for up to a 30-day supply Maximum per prescription: $50 for up to a 30-day supply Minimum per prescription: $15 for up to a 30-day supply	60% Coinsurance
Non-preferred Brand-Name:	30% Coinsurance for up to a 30-day supply Maximum per prescription: $65 for up to a 30-day supply Minimum per prescription: $30 for up to a 30-day supply	60% Coinsurance

Note: If a Brand-Name Drug is filled when a Generic Drug is available, you'll pay the Brand-Name Drug Coinsurance plus the difference in cost between the Generic Drug and the Brand-Name Drug – even if your Doctor requests the Brand-Name Drug.

Prescription Drugs - Home Delivery

	In-Network	**Out-of-Network**
Generic:	20% Coinsurance for up to a 90-day supply ($15 minimum, $50 maximum)	Not applicable
Preferred Brand-Name:	20% Coinsurance for up to a 90-day supply ($45 minimum, $100 maximum)	Not applicable
Non-preferred Brand-Name:	30% Coinsurance for up to a 90-day supply ($90 minimum, $130 maximum)	Not applicable

Note: If a Brand-Name Drug is filled when a Generic Drug is available, you'll pay the Brand-Name Drug Coinsurance plus the difference in cost between the Generic Drug and the Brand-Name Drug – even if your Doctor requests the Brand-Name Drug.

NOTES

[1] Subject to Hospital Precertification.

[2] Subject to Reasonable & Customary Charges.

[3] Whenever a covered person faces confinement in a Hospital or needs non-Emergency Surgery, follow the directions for Hospital Precertification of these services described on your identification card. Eligible charges for hospitalization may be reduced for days not precertified, and eligible charges for elective Surgery may also be reduced.

[4] Subject to annual Deductible.

WHEN COVERAGE ENDS

For You

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

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

For Your Dependents

Medical coverage for your eligible Dependents will end on the last day of the month in which one of the following occurs:

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

Continuing Coverage

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

Extension of Health Care Protection

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

Your coverage under the plan may be extended if you are totally disabled (as defined in the Disability Summary Plan Description) from a Sickness or Injury and are under a Doctor's care.

The extension covers all Sicknesses or Injuries. Coverage will be extended for the time you remain disabled (as defined in the Nortel Networks Disability Plan Summary Plan Description) from a Sickness or Injury and are under a Doctor's care.

In the event of your death, if you are enrolled with Dependent coverage, such coverage will be extended for a maximum of ninety (90) days from your date of death.

The following applies to Hospice Care Program coverage:

If you are totally disabled (as defined in the Nortel Networks Disability Plan Summary Plan Description) and under a Doctor's care, Hospice Care coverage during that total disability will be extended up to three (3) months if coverage terminated because:

- the plan was terminated, or

- the Hospice Care Program within the plan was terminated for all Employees of the Company or for a group of Employees of which the person is a member. If such coverage terminates for any other reason, Hospice Care Program coverage during that total disability will be extended for up to twelve (12) months.

This provision also applies to Hospice Care Program coverage for your Dependent. Your Dependent will be considered Totally Disabled if, because of an Injury or Sickness:

- Your Dependent is unable to engage in the normal activities of a person of the same age, sex and ability; or
- In the case of a Dependent who normally works for wage or profit, he is not performing such work.

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

COBRA

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

SECTION TWO - ADMINISTRATIVE INFORMATION

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

IDENTIFYING INFORMATION

Plan Type under ERISA: Welfare Plan

Plan Number: 506

Funding Method: Self-funded with Employee and employer contributions held in the VEBA.
Contribution Source: the Companies that sponsor the Plan and participating Employees contribute to the cost of coverage

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

The address for Nortel Networks Inc. is: Nortel Networks Inc.
4001 E. Chapel Hill Nelson Hwy.
Research Triangle Park, NC. 27709

Agent for Service of Legal Process:	The Corporation Trust Company Corporation Trust Center 1209 Orange Street Wilmington, DE 19801

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

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

Bank of America
Institutional Retirement
213 South LaSalle Street
Chicago, IL 60697

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. The ultimate decision about your eligibility for benefits under the plan is made by the named ERISA "Claims fiduciary" who has responsibility for the determination of your Claim. See the corresponding SPD of the year in which the Claim was incurred for information on appeal procedures for Claims. Each of the Claims fiduciaries has been delegated the exclusive authority by the Plan Administrator to interpret and administer the provisions of the Plan that apply to the Claim under review, including discretionary authority to:

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

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

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

Claims Administrator	Address	Phone Number

<u>1. Medical Benefits</u>

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

CIGNA

Claims Administrator	Address	Phone Number
All Locations Options: PPO, and Out-of-Area Comprehensive	PO Box 5200 Scranton, PA. 18505-5200* OR	1-800-257-2702
	P. O. Box 182223 Chattanooga, TN. 27422-7233*	1-800-257-2702

* Refer to the back of your ID card as the P.O. Boxes are split geographically.

Anthem PPO	P.O. Box 99077 Columbus, GA 31908	1-877-5NORTEL

Providers should follow the instructions for filing claims listed on the back of your member ID card.

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

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

Claims Administrator	Address	Phone Number
OptumHealth Behavioral Solutions	P O Box 30755 Salt Lake City, UT 84130-0755	1-800-842-2991

3. Prescription Drug Benefits

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

Claims Administrator	Address	Phone Number
Medco Health	PO Box 2187 Lee's Summit, MO 64063-2187	1-800-711-3460

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

Employee Benefits Committee

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

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

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

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

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

COBRA

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

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

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

Filing Claims

This section outlines the procedures and applicable time limits for filing Claims and filing appeals of denied Claims and other benefit determinations under the Medical Plan. These procedures are intended to comply with the requirements of ERISA and will be interpreted in accordance with ERISA requirements.

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

In order to properly process your request, please refer to the "Contact Information for Claims Filing" chart on pages 70-72 for a complete list of all Claims Administrators, their respective addresses and phone numbers. Claim forms are available on the Benefits website at www.nortel-us.com/ "Explore Plans/Services" – "Forms" and from HR. The Claim must describe the occurrence, character and extent of the service.

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

Please note that determinations made by the Claims Administrator or Employee Benefits Committee (EBC) relate solely to whether or not benefits are available under the plan for the proposed treatment or procedure or whether

eligibility for plan participation is available under the written terms of the plan. The determination as to whether a health service will be provided to you is between you and your Physician or other health care Provider.

Payment of Plan Claims

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

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

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

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

The rights and benefits of you (Medical Plan members) and your eligible Dependents under this plan are not subject to the Claims of your creditors and cannot be voluntarily or involuntarily assigned, sold or transferred to anyone else. Employees and their eligible Dependents are the only "participants" and "beneficiaries" of this plan, as defined under the provisions of the Employee Retirement Income Security Act of 1974. The plan will not reimburse third parties who have purchased or been assigned benefits by Physicians or other Providers.

Claim Determinations

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

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

Timeframe for Claim Determinations

Urgent Care Claims that Require Immediate Action

Urgent care Claims are those Claims where:

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

In these situations:

- The Claims Administrator will notify you of the initial benefit determination in writing or electronically within 72-hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation.

- If you filed an urgent Claim improperly, or did not supply enough information for the Claim Administrator to make a decision, here is the process for urgent Claim determinations:
  1. The Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent Claim was received.
  2. If additional information is needed to process the Claim, the Claims Administrator will notify you of the information needed within 24 hours after the Claim was received.
  3. You will then have 48 hours to provide the specified additional information to the Claims Administrator.
  4. The Claims Administrator will notify you of a determination no later than 48 hours after:
     - The Claims Administrator's receipt of the requested information; or
     - The end of the 48 hour period within which you were to provide the additional information to the Claims Administrator, if the information is not received within that time.
       - If you don't provide the specified additional information within the 48 hour period to the Claims Administrator, your Claim may be denied.

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

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

Pre-Service Claims

Pre-service Claims are those Claims where the terms of the Medical plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical non-urgent care. This decision can be a determination of whether or not benefits will be paid at all, or the level of benefits that will be received. If your Claim was a pre-service Claim and was submitted properly with all needed information, the Claims Administrator will notify you of the Claim decision within 15 days of receipt of the Claim.

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

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

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

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

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

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

Concurrent Care Claims

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

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

- The Claims Administrator will notify you of a determination on your request for benefits for the extended treatment within 24 hours, provided the Claims Administrator receives your request at least 24 hours prior to the end of the treatment for which benefits were previously approved.
    - If your request for benefits for the extended treatment is not made at least 24 hours prior to the end of the treatment for which benefits were previously approved, the request will be treated as an urgent care Claim and decided according to the timeframes described above.

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

Post-Service Claims

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

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

1. An extension is necessary, due to matters beyond the control of the plan and
2. The Claims Administrator notifies you before the initial 30-day period expires of the reasons why an extension is required and a date by which you can expect a decision.

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

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

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

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

Appealing a Denied Claim

If You Receive an Adverse Benefit Determination

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

1. The specific reason(s) for the adverse benefit determination.

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

Procedures for Appealing an Adverse Benefit Determination

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

- The patient's name and the identification number from the ID card (if applicable).
- The date(s) of medical service(s).
- The Provider's name.
- The reason you believe the Claim should be paid.
- Any documentation or other written information to support your request for Claim payment.

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

You have the right to:

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

training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the initial adverse benefit determination nor the subordinate of any such individual.

6. The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the decision.

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

Urgent Claim Appeals That Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims fiduciary to request the appeal as soon as possible.
- The Claims fiduciary will provide you with a written or electronic determination as soon as possible, but no longer than 72 hours following receipt by the Claims fiduciary of your request for review of the determination taking into account the seriousness of your condition.

Pre-Service and Post-Service Claim Appeals

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

For appeals of **pre-service Claims** (as defined on page 74)

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

For appeals of **post-service Claims** (as defined on page 75)

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

Participation Appeals

For appeals regarding denial of your eligibility to participate in the plan, the enrollment of your Dependents in the plan, coverage option elections, the Effective Date of enrollment in the plan under all options or COBRA eligibility, the Company retains the exclusive right to interpret and administer the participation provisions of the Medical Plan. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to submit your first appeal.

- The first level appeal will be conducted and you will be notified by HR, the Claims Administrator, of the decision within 60 days from receipt of a request for appeal of a denied Claim.
- If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Employee Benefits Committee, the Claims fiduciary. Your second level appeal request must be submitted to the Claims fiduciary within 60 days from receipt of the first level appeal decision.
- See below for a description of procedures for the second level appeal conducted by the Employee Benefits Committee.

The Employee Benefits Committee (EBC) conducts the second level appeal for determining your eligibility to participate in the Medical Plan, the enrollment of your Dependents in the Medical Plan, coverage option elections or the Effective Date of enrollment in the plan under all options.

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

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

The EBC will notify you of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

Final Note on Medical Plan Claim Appeals

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or Federal court, but only after you have exhausted the plan's claims and appeals procedure as described on page 76.

YOUR RIGHTS UNDER COBRA

You, your Dependents and your Domestic Partner have the option to temporarily extend your health care coverages at full group rates, plus a 2% administration fee, in certain instances when coverage under certain FLEX Benefits (identified under "COBRA Participation" below) would otherwise end. This is called COBRA coverage. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. To be eligible for COBRA coverage continuation you must first be enrolled in the Medical Plan you wish to continue on the day before you become ineligible.

COBRA Participation

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

Continued coverage is normally available for a maximum of 18 or 36 months, depending upon the event outlined in the chart below. If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify Ceridian (COBRA Administrator – See page 72 for contact information) in writing in a timely fashion, you and your entire family may be entitled to receive an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have to start prior to the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage. The qualified Beneficiary must provide the written determination of disability from the Social Security Administration to Ceridian within 60 days of the latest of the date of the disability determination by the Social Security Administration, the date of the qualifying event or the benefit termination date; and prior to the end of the 18 month COBRA continuation period.

The continuation premium for the additional 11 months will be increased from 102% to 150% of the full group rate per person. The maximum continuation period if multiple events should occur that result in a loss of group health coverage is a total of 36 months. For example, if you terminate and then die while covered by the plan, your Dependent's coverage may continue for a maximum of 36 months from the original qualifying event date.

COBRA Continuation Period

CIRCUMSTANCES	MAXIMUM CONTINUATION PERIOD			
	You	**Spouse or Domestic Partner**	**Children or Domestic Partner's Children**	
You lose coverage because of work hours	18 months	18 months	18 months	reduced
You terminate for any reason gross misconduct)	18 months	18 months	18 months	(except
You are disabled as defined by Social Security) when you terminate lose coverage due to reduced work hours or you become disabled within 60 days of commencement COBRA coverage	29 months	29 months	29 months	or of
You die	N/A	36 months	36 months	
You and your spouse divorce	N/A	36 months	36 months	
You and your Domestic Partner terminate your relationship	N/A	36 months	36 months	

You become entitled to Medicare	N/A	36 months	36 months

CIRCUMSTANCES	MAXIMUM CONTINUATION PERIOD		
	You	**Spouse or Domestic Partner**	**Children or Domestic Partner's Children**
Your or your Domestic Partner's child no longer qualifies as a Dependent	N/A	N/A	36 months
Your spouse or Domestic Partner is disabled (as defined by Social Security) when you terminate or lose coverage due to reduced work hours or your spouse becomes disabled within 60 days of commencement of COBRA coverage	29 months	29 months	29 months
Your or your Domestic Partner's child is disabled (as defined by Social Security) when you terminate or lose coverage due to reduced work hours or becomes disabled within 60 days of commencement of COBRA coverage	29 months	29 months	29 months

Notification

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

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

You may contact HR as follows:

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

Election

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

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

If you elect COBRA continuation:

- Initially, you may keep the same level of coverage you had at the time of the event or choose a lower level of coverage (e.g., you only, you and your Children and/or Domestic Partner's Children, you and your spouse (or Domestic Partner) or you and your family, or each individual independently).
- Coverage will begin retroactively one day after the date that benefits were terminated as a result of the qualifying event.
- You may change coverage during the Annual Enrollment Period or if you experience a Status Change, as described in "Changing Your Selections" in **"SECTION ONE - MEDICAL PLAN BENEFITS**."
- You may enroll any newly eligible spouse or child under the usual plan rules.

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

Note: If you are eligible for Nortel Networks Retiree Medical Plan at the time you leave Nortel Networks as an active Employee, election of COBRA coverage waives your rights to enroll in the Nortel Networks Retiree Medical Plan.

Cost of Participation

COBRA participants must pay monthly premiums for their coverage:

- For medical coverage, premiums are based on the full group rate per covered person set at the beginning of the Plan Year, plus 2% to cover administrative costs.
- Regular monthly premiums are due to the COBRA Administrator (Ceridian) by the first of each month. Failure to submit monthly premium payments by invoice due date will result in termination of health benefits.
- If you are disabled under the Social Security definition, COBRA premiums for months 19–29 reflect the full group cost per person, plus 50%.

When COBRA Ends

COBRA coverage will end before the maximum continuation period if:

- a person who was covered under COBRA becomes covered under another group health plan, after the date of COBRA election, not offered by the Company (providing the plan does not have Preexisting Condition limitations affecting the covered person). COBRA coverage will end if the Preexisting Condition limitation does not apply, or will end as of the date when the limitation expires. You are entitled to receive credit equal to the period of your COBRA coverage against the new plan's Preexisting Condition limitation period, so long as the new coverage begins without a break in coverage of 63 days or longer.
- you or your eligible Dependents become entitled to Medicare after the date of COBRA election,. Covered Dependents who are not entitled to Medicare can continue coverage under COBRA until the maximum continuation period is reached. If you become entitled to Medicare within 18 months before the termination of your employment (or a reduction in your work hours) that entitles you to COBRA continuation coverage, your qualified Dependents will be eligible for COBRA coverage for up to 36 months from the date you became entitled to Medicare.
- you or your eligible Dependents have met Preexisting Condition exclusions under a new employer's plan.
- any required premium for continued coverage is not paid within 30 days after it is due. (Payments are due on the first day of each month.)
- the Company ceases to provide Medical Plan benefits to all Employees.

In order to protect your family's rights, you should keep HR and Ceridian informed of any changes in the addresses of family members. You should also keep a copy for your records, of any notices you send to either HR or Ceridian.

THIRD PARTY LIABILITY

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

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

If you make a claim for medical benefits before you receive payment from any third party or its insurer, or any other insurer, you are considered by the Plan to have agreed that any recovery you receive from any third party, its insurer, or any other insurer will be used to repay the Plan for its payments on your behalf. The Plan's right to recovery applies whether:

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

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

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

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

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

- Subrogation: The Plan is subrogated to (stands in the place of) all rights of recovery you or your covered Eligible Dependent have against any third party or insurer for all or any portion of the benefits provided or to be provided by the Plan.
- Restitution: In addition, if you or a covered Eligible Dependent receives any payment from any third party or insurer, the Plan has the right to obtain restitution from you, your attorney or any third party, for all amounts the Plan has paid and will pay, up to and including the full amount you receive.
- Constructive Trust: The Plan has a right to obtain a legal order that you, your attorney, or anyone acting on your behalf is considered to hold any amount you recover from any third party or insurer for medical benefits provided or to be provided under the Plan in a constructive trust for the benefit of the Plan.
- Lien Rights: Further, the Plan will automatically have an equitable lien to the extent of medical benefits paid by the Plan for which any other party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any insurance coverage, for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of medical benefits paid by the Plan including, but not limited to you or your representative or agent; any third party or insurer; and/or any other source possessing funds representing the amount of medical benefits paid by the Plan.
- Stay or Other Equitable Relief: The Plan has a right to obtain a stay of any legal proceedings brought by you or your covered Eligible Dependent against any third party and to enjoin you and your assignees from adjudicating the matter. It also may obtain a preliminary or permanent injunction, a declaration of rights, or specific performance against you, your attorney, or any assignee of either of them. Moreover, the Plan has the right to obtain any other appropriate equitable relief to redress any violation of the Plan or enforce the terms of the Plan. The Plan also has the right to obtain such judicial relief against you or any assignee as may be available under state law, including a claim for breach of contract.

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

Cooperation. You and your covered Eligible Dependents are prohibited from prejudicing the Plan's subrogation or recovery interest or prejudicing the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude any portion of the cost of any medical benefits provided by the Plan. The Plan has the right to conduct an investigation regarding

the injury, illness, or condition for which medical benefits were provided under the Plan to identify any third party or insurer responsible for the payment of all or any portion of those benefits. The Plan reserves the right to notify the third party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

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

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

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

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

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

YOUR RIGHTS UNDER ERISA

As a participant in the Company's Medical 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 Employee Benefits Security Administration (EBSA).

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may request a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a summary of this annual report.

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

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

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

Assistance With Your Questions

If you have questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA).

RIGHT TO CERTIFICATE OF HEALTH COVERAGE

When you leave the Company's employment for any reason, or terminate your coverage in the Medical Plan, the Company will provide you a written certificate confirming the period of your participation in this plan as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You will need the certificate if you become eligible to enroll in another health plan that excludes coverage for preexisting medical conditions. Your new plan will be required to give you credit for your period of coverage in this plan, against the Preexisting Condition exclusion period (which cannot be more than 12 months for individuals who enroll when first eligible or 18 months for late enrollees).

If you are enrolled in the Medical Plan for at least 12 months, do not have a break in coverage of 63 days or longer, and enroll in your new plan as soon as you are eligible, the new plan cannot exclude any Preexisting Condition that you have. If you have a break in coverage of at least 63 days, the new plan will not be required to give you credit for your period of coverage under this plan. The Company will also provide a certificate for any Dependent who ends coverage under this plan for any reason.

The Company will provide a certificate to former Employees and/or their Dependents automatically when:

- coverage terminates
- COBRA continuation, if elected, terminates
- a request is made within 24 months of the date plan coverage terminates.

HIPAA only provides proof of insurability. It does not offer a continuation of benefits. (Note: COBRA continuation coverage also counts as creditable coverage.)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) YOUR RIGHTS UNDER HIPAA

PRIVACY

The Nortel Networks Group Health Plan which includes this plan (to the extent that it covers Employees of NNI or other U.S. subsidiary that has adopted the Plan) the Nortel Networks Medical Plan was amended to include the

health information privacy requirements effective April 14, 2003 and security requirements effective April 20, 2005 specified in HIPAA. The following section describes the permitted use and disclosure of protected health information under HIPAA.

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

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

Nortel Networks will:

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

SPECIAL ENROLLMENT

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

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

HR
Nortel Networks
PO Box 13010
Research Triangle Park, N.C. 27709-3010
Toll-free: 1-800-676-4636
Direct: 919-905-9351

CERTIFICATE OF HEALTH COVERAGE

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

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

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

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

STATEMENT OF HIPAA PORTABILTY RIGHTS

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was

recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

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

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

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

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

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

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

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

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

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

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

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

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

FUTURE OF THE PLAN

Although the benefits currently available in the 2012 Plan Year are described in this summary for the Company's Medical Plan, the Company reserves the right to change or end the plan described in this summary at any time. Any plan changes will result from actions taken and approved by the Company. The Company may adopt such changes or terminate the plan at any time and for any reason.

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

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

Access Fee
If you elect to cover your spouse/domestic partner under a Nortel medical plan option and your spouse/domestic partner has access to employer-provided medical coverage elsewhere, you will be required to pay $50 per pay period in addition to the plan premium. The Access Fee will be taken out of your pre-tax pay unless you are covering a domestic partner that does not qualify as your tax dependent under Internal Revenue Code (IRC) Section 152, in which case it will be taken out of your after-tax pay. Even if your spouse or domestic partner chooses not to enroll in employer-provided coverage, he or she still has it available to them and therefore the Access Fee will still apply. If your spouse/domestic partner doesn't have access to employer-provided medical coverage elsewhere, you will not have to pay the Access Fee as long as you certify during enrollment and or annual enrollment each year your spouse/domestic partner does not have access to employer-provided coverage.

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.

Affidavit of Domestic Partnership
A Nortel form which Employees entering a Domestic Partnership are required to submit (usually a short form on-line in which Employee indicates that he/she understand the eligibility requirements and agree to them). Also available on www.nortel-us.com/ .

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 Medical Plan and have adopted the Medical Plan.

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.

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

form with OptumHealth Behavioral Solutions to apply for reimbursement of eligible expenses under the Program. The reimbursement level will depend on the type of care you receive.

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

Anesthesia
The administration of drugs used to reduce or diminish the sense of pain, temperature, touch, etc.

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

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

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

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

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

Children
Dependents who are:

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

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

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

Claims Administrator
The Company or third party administrators (as identified in this Summary Plan Description) that are responsible for processing and paying benefit Claims and other various administrative services.

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

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

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

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

Companion Travel Program
You can choose a person to accompany you to the LIFESOURCE Organ Transplant Network® or Blue Distinction Center of Excellence for an approved organ transplant and to remain there for all or a portion of your stay. The Companion Travel Program pays benefits for some of the charges incurred by the person accompanying you.

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

Congenital
A condition present at birth that is not hereditary.

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

Core FLEX 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 Plan coverage at 100% of your pre-disability base salary (called FLEX Earnings - see this glossary for more on what is and isn't included in this amount) for six weeks, then 66 2/3% of your pre-disability FLEX Earnings for up to 20 additional weeks,
- Long-Term Disability Plan coverage at 50% of your pre-disability FLEX Earnings after you have been disabled for 26 consecutive weeks,
- Employee Life Insurance Plan coverage 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.

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

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

Custodial Care
Care that provides a level of routine maintenance for the purpose of meeting personal needs. This care can

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

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

Dependent
Dependents include:

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

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

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

Doctor
A licensed practitioner of the healing arts acting within the scope of 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 Partners available on www.nortel-us.com/, or completing the affidavit online prior to the time of benefit selection. Contact HR for more information.

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

Educational
A service or supply that is being provided to promote development beyond any level of function previously demonstrated or for which the primary purpose is to provide the patient with any of the following training in the activities of daily living:

- instruction in scholastic skills such as reading and writing
- preparation for an occupation, or
- treatment for learning disabilities.

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

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

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

Enrollment Period
See “Annual Enrollment”. The FLEX Benefits may be selected during the Annual Enrollment period, a 31-day Enrollment Period when you first become eligible for benefits as a new Employee or after you experience a Status Change.

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

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

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

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

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 Medical Benefits.

FLEX Earnings
Your base salary. FLEX Earnings do not include other types of pay, including but not limited to, overtime, shift differentials, relocation payments or bonuses. If you are eligible for sales incentives, your FLEX Earnings include your base salary and target incentives, as defined each year by the Company (excluding bonuses). Part-time Employees' premium calculations under the FLEX Disability, Life and AD&D plans are based on a 25-hour work week if the Employee regularly works 20-34.5 hours per week, and on a 40-hour work week if the Employee regularly works more than 35 hours per week. Claim calculations on these benefits are based on the number of hours worked that a part-time Employee has averaged over the 12 weeks immediately preceding the event which caused a Claim for benefits to be filed. Effective June 1, 2006, if you are a part time Employee regularly scheduled to work 20 or more hours per week, your FLEX Earnings are based on the number of hours you are regularly scheduled to work.

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

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

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

Highest Benefit Level: If your care is certified by OptumHealth Behavioral Solutions and provided by a OptumHealth Behavioral Solutions Network Provider (In-Network Benefits), your benefits will, in most cases, be paid at 100%, less any applicable Copayments, with no Deductible. (See the “Summary of Managed Mental Health and Substance Treatment Abuse Benefits” at page 27 for further information.)

HIPAA – Health Insurance Portability and Accountability Act of 1996 – Federal legislation that describes access to health insurance when changing jobs by restricting certain preexisting condition limitations and guarantees availability and renewability of health insurance coverage for all employers regardless of Claims experience and business size. Also provides privacy and protection of personal medical information of individuals. See page 87, “Your Rights Under HIPAA” for more detail.

Hire Date
The date your employment with the Company begins.

Home Delivery Pharmacy Service
A mail order program administered by Medco Health Solutions, L.L.C. which is used for long-term or Maintenance Drugs, such as medication for high blood pressure or arthritis.

Home Health Care Agency
An organization that meets at least one of the following three requirements:

1. It is established and operated in accordance with applicable licensing and other laws.
2. It is a Home Health Care Agency as defined in Medicare.

3. It administers a home health care plan and meets all of these requirements:
    - It has a full-time administrator.
    - It keeps written records of services and supplies furnished to the patient.
    - Either its staff includes at least one registered nurse (RN) or it has access to nursing care by a registered nurse.
    - Its Employees are bonded.
    - It maintains malpractice insurance.
    - It has the primary purpose of providing home health care.
    - It has a delivery system for bringing supportive services to the home.

Home Health Care Visit
A visit by a member of a Home Health Care team.

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

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

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

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

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

Hospital
An institution that meets either of these two tests:

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

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

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

Hospital Inpatient Stay
A Hospital stay for which a Room and Board charge is made by the Hospital.

Hospital Outpatient Stay
A Hospital stay for which no Room and Board charge is made by the Hospital.

Hospital Precertification
A process where the need for your Hospital admission, as well as your length of stay, is verified prior to admittance.

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

IHSP - International Health Service Plan
Medical Plan option provided to Nortel Employees and their families (if applicable) on international assignment.

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

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

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

In-Network Providers
See "Network Providers".

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

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

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

- Residential Rehabilitation: Acute overnight services that are typically provided in a freestanding Residential Treatment Center for the care of a Substance-Use Disorder. A residential rehabilitation program is appropriate when a member lacks the motivation or social support system to remain abstinent, but does not require the structure and the intensity of services provided in a hospital.

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

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

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

Lifetime Maximum
The total of all medical benefits paid during a participant's lifetime.

Maintenance Drug/Medications
Prescription Drugs that are taken on a long-term basis (for at least three months) to treat chronic conditions such as asthma, allergies, high blood pressure, and a dysfunctional thyroid.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Member Services
Customer service centers for Managed Care networks that can answer questions about Providers, send you a Provider Directory or identification card, and help you choose a Primary Care Physician.

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

Network Area
The geographic area in which Managed Care networks are available. If you live in the Network Area, based on your home ZIP code, you can enroll in one of the Network Area medical options offered to you.

Network Manager
The company responsible for managing the network, including evaluating and selecting Network Providers. Network Managers for the Company's Managed Care medical options are CIGNA HealthCare and Anthem.

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

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

Non-Network Area
Refers to the geographic areas that are not served by the Managed Care network options. If you live in the Non-Network Area, based on your home ZIP code, you can enroll in one of the Non-Network Area medical options offered to you.

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

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

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

Optional FLEX Benefits
Benefits you pay for with FLEX Credits, Before-Tax Contributions 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
- Dental/Vision/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:

- Additional group term life insurance for yourself,
- Dependent group term life insurance for your spouse and/or Children, and
- Optional AD&D insurance for your spouse and/or Children.

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

Oral Surgery
Oral Surgery performed within the mouth for treatment of a medical condition including surgical procedures for treatment of fractures, or dislocations of the jaw, tumors, lacerations within the mouth or Surgery involving the bone, as in reconstructive Surgery. These procedures are beyond the scope of basic tooth, gingiva and alveolar bone related problems and are considered covered medical expenses.

Out-of –Area Comprehensive
Medical option offered to Employees whose home zip codes do not give them access to the Managed Care Options.

Out-of-Network Benefits
The level of benefits you receive under a Managed Care Medical Plan option when you use a health care Provider who does not participate in a Network.

Out-of-Network Provider
Medical Plan providers who have not entered into an agreement to participate in a Network.

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

Pay-the-Difference
The Pay-the-Difference feature is designed to provide higher coverage for lower-cost alternatives to Brand-Name Drugs. Whenever you buy a Brand-Name Drug that has a lower-cost generic equivalent, whether through a retail pharmacy or through the Home Delivery Service, you'll pay the applicable Brand-Name Copayment/Coinsurance plus the difference between the cost of the generic equivalent and the cost of the Brand-Name Drug. This includes anytime that your Doctor indicates that the prescription should be "Dispensed As Written".

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

Personalized Enrollment Worksheet
An enrollment form provided by the company in either soft or hard copy which allows you to review your current benefits and make changes during the Annual Enrollment Period, within 31 days of your hire or when you are making a Status Change.

Physician
See "Doctor".

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

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

Precertification
Under some Managed Care medical options, you must get Precertification from your Network Manager for any medical treatment you receive. Under the Out-of-Area Comprehensive option, you may be required to get Precertification for Hospital admission or non-Emergency Surgery from your Claims Administrator. If you don't get the required Precertification, the Medical Plan will pay benefits at a lower level or might not pay benefits at all.

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

Preexisting Condition
Any condition for which you:

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

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

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

Pre-Operative Exam
Necessary medical x-rays and/or laboratory tests ordered by the attending Physician that are performed in the seven days prior to a scheduled hospitalization or Surgery.

Prescription Drug
For Prescription Drugs payable under the Medical Plan, this means only:
1. A medicinal substance that, by law, can be dispensed only by prescription,
2. A compound medication that includes a substance described in (1), or
3. Prescribed oral and injectable insulin and insulin syringes.

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

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

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

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

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

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

Reasonable and Customary Charge
A charge for a Covered Expense that is the normal charge made by a licensed practitioner for a similar service and does not exceed the normal charge made by most Providers in the geographic area where the service is provided.

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

Second Surgical Opinion
An opinion secured by a Physician who:
- is not in practice with or related to the Physician who gave the original recommendation for Surgery, and
- whose practice would normally include treatment of the condition for which Surgery was originally recommended.

The Second Surgical Opinion may not be rendered by the Physician selected to perform the Surgery.

Semi-Private
A class of accommodations in a Hospital or Skilled Nursing Facility in which at least two patient beds are available per room.

Service Area
The geographical area within which health care services are provided for covered persons by Providers in a certain network.

Short-Term Rehabilitation
Therapy that is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function) which has been lost or impaired due to an Injury, disease or Congenital defect.

Sickness
See "Illness".

Skilled Nursing Facility
An institution that meets all of these tests:

- it is legally operated.
- it mainly provides short-term nursing and rehabilitation services for persons recovering from Illness or Injury. The services are provided for a fee from its patients, and include both:
  - Room and Board, and
  - twenty-four hour a day skilled nursing service.
- it provides the services under the full-time supervision of a Doctor or registered nurse (RN).
- it keeps adequate medical records.
- if not supervised by a Doctor, it has the services of one available under a fixed agreement.

"Skilled Nursing Facility" does not include an institution or part of one that is used mainly as a place for rest or for the aged.

Specialist
A Physician whose practice is limited to a particular branch of medicine or Surgery other than general practice, internal medicine, pediatrics, or family practice.

Specialty Drug

Certain medications used to treat chronic and often complex conditions. These are typically high cost, legend drugs that require special handling and administration, temperature controlled shipping, and careful adherence to treatment protocols. See "Appendix A – Prescription Benefits" for a list of Specialty Drugs.

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.

Summary of Health Benefits
Table which outlines the various Medical Plan Options available and the differences between them

Surgery
Generally recognized and accepted Medically Necessary operative procedures for the treatment, diagnosis or evaluation of an Illness or Injury.

Temporomandibular Joint Dysfunction (TMJ)
A malfunction of the joint between the lower jawbone and the temporal bone.

Terminally Ill
The medical prognosis of a person with a chronic, progressive Illness that has been designated not curable by the covered person's attending Physician. Expected survival must be six months or less at the time of referral to a Hospice under the Medical Plan.

Termination Date
The last day you work for the Company.

Termination of Domestic Partnership Statement
A Nortel form which notifies the Company that a Domestic Partnership has dissolved.

Wholly Dependent
Complete dependency for the full care, support and maintenance of a physically or mentally disabled individual, including services necessary to maintain life, such as Room and Board, health and comfort of the Dependent.

Workers' Compensation
State regulations providing for partial salary replacement and medical care to Employees who suffer job-related illnesses or injuries

APPENDIX A – Prescription Benefits

Medco Information Used In Claim Determination

ESM - Retail Plan

Covered Drugs:

The following are covered benefits unless listed as an exclusion below

- ♦ Federal Legend Drugs
- ♦ State Restricted Drugs
- ♦ Compounded Medications of which at least one ingredient is a legend drug
- ♦ Insulin
- ♦ Needles and Syringes
- ♦ OTC Diabetic Supplies (except Blood Glucose Testing Monitors)
- ♦ Oral Contraceptives
- ♦ Legend Contraceptive devices and injections
- ♦ Retin-A/ Avita through age 35
- ♦ Yohimbine
- ♦ Anabolic Steroids

Managed Care Prior Authorization:

- ♦ Drugs to treat Impotency (i.e. Caverject, Edex, Muse) limited to a 6 day supply or 6 units, whichever is lesser per Claim
- ♦ IVR - Viagra limited to a 6 day supply or 6 tablets whichever is lesser per Claim
- ♦ IVR – Retin-A/ Avita age 36 and older

Exclusions:

The following are excluded from coverage unless specifically listed as a benefit under "Covered Drugs".

- ♦ Non-Federal Legend Drugs
- ♦ OTC Contraceptive jellies, creams, foams, or devices
- ♦ Contraceptive implants
- ♦ Gamma Globulin
- ♦ Ostomy Supplies
- ♦ Blood Glucose Testing Monitors
- ♦ Therapeutic devices or appliances
- ♦ Drugs whose sole purpose is to promote or stimulate hair growth (i.e. Rogaine®, Propecia®) or for cosmetic purposes only (i.e. Renova®).
- ♦ Allergy Sera
- ♦ Biologicals, Immunization agents or Vaccines
- ♦ Blood or blood plasma products
- ♦ Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- ♦ Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- ♦ Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

- ♦ Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- ♦ Charges for the administration or injection of any drug.

Dispensing Limits:

- ♦ The amount of drug which is to be dispensed per prescription or refill will be in quantities prescribed up to a 90 day supply.

ESN – Home Delivery (Mail-Order) Plan

Covered Drugs:

The following are covered benefits unless listed as an exclusion below

- ♦ Federal Legend Drugs
- ♦ State Restricted Drugs
- ♦ Compounded Medications of which at least one ingredient is a legend drug
- ♦ Insulin
- ♦ Needles and Syringes
- ♦ OTC Diabetic Supplies (except Blood Glucose Testing Monitors)
- ♦ Oral Contraceptives
- ♦ Legend Contraceptive devices and injections
- ♦ Retin-A/ Avita through age 35
- ♦ Anabolic Steroids

Quantity Per Copayment:

- ♦ Drugs to treat Impotency (except Viagra) for males age 18 and over limited to a 90 day supply or 18 units, whichever is lesser per Claim

Managed Care Prior Authorization:

- ♦ IVR - Viagra limited to a 90 day supply or 18 tablets whichever is lesser

Exclusions:

The following are excluded from coverage unless specifically listed as a benefit under "Covered Drugs".

- ♦ Non-Federal Legend Drugs
- ♦ OTC Contraceptive jellies, creams, foams, or devices
- ♦ Contraceptive implants
- ♦ Gamma Globulin
- ♦ Retin-A/ Avita age 36 and over
- ♦ Ostomy Supplies
- ♦ Blood Glucose Testing Monitors
- ♦ Therapeutic devices or appliances
- ♦ Drugs whose sole purpose is to promote or stimulate hair growth (i.e. Rogaine®, Propecia®) or for cosmetic purposes only (i.e. Renova®).
- ♦ Allergy Sera
- ♦ Biologicals, Immunization agents or Vaccines
- ♦ Blood or blood plasma products
- ♦ Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- ♦ Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- ♦ Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- ♦ Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.

- Charges for the administration or injection of any drug.

Dispensing Limits:

- The amount of drug which is to be dispensed per prescription or refill will be in quantities prescribed up to a 90 day supply.

Specialty Drugs

The following is a list of drugs classified by Medco as Specialty Drugs. Specialty drugs are available through Accredo Health Group, a subsidiary of Medco Health. Coverage for these medications and listed drugs may vary. To confirm plan coverage and to order, call toll-free **1-800-501-7260** between 8:00 a.m. and 8:00 p.m., Eastern Standard Time, Monday through Friday — or just have your doctor contact Medco at **1-800-987-4904**.

RARE DISEASE

Adagen® (pegademase bovine)
Advate® (antihemophilic factor [recombinant])
Aldurazyme® (laronidase)
Alphanate® (antihemophilic factor [human])
AlphaNine® ***SD*** (coagulation factor IX [human])
Aralast® (alpha[1]-proteinase inhibitor [human])
Bebulin® ***VH*** (factor IX complex)
BeneFIX® (coagulation factor IX [recombinant])
Carimune® *NF* (immune globulin intravenous [human])
Cerezyme® (imiglucerase)
Elaprase**TM** (idursulfase)
Fabrazyme® (agalsidase beta)
Feiba® ***VH*** (anti-inhibitor coagulant complex)
Flebogamma® (immune globulin intravenous [human])
Flolan® (epoprostenol sodium)
Gammagard® ***Liquid*** (immune globulin intravenous [human])
Gammagard® ***S/D*** (immune globulin intravenous [human])
Gamunex® (immune globulin intravenous [human])
Helixate® ***FS*** (antihemophilic factor [recombinant])
Hemofil®***M***(antihemophilic factor [human])
Humate-P® (antihemophilic factor/vonWillebrand factor complex [human])
Hyate:C® (antihemophilic factor [porcine])
Koate®***-DVI*** (antihemophilic factor [human])
Kogenate® ***FS*** (antihemophilic factor[recombinant])
Letairis**TM** (ambrisentan)
Monarc-M**TM** (antihemophilic factor [human])
Monoclate-P® (antihemophilic factor [human])
Mononine® (coagulation factor IX [human])
Myozyme® (alglucosidase alfa)
Naglazyme® (galsulfase)
NovoSeven® (coagulation factorVIIa [recombinant])
Octagam® (immune globulin intravenous [human])
Orfadin® (nitisinone)
Polygam® ***S/D*** (immune globulin intravenous [human])
Profilnine® ***SD*** (factor IX complex [human])
Proplex® ***T*** (factor IX complex)
Recombinate**TM** (antihemophilic factor [recombinant])
ReFacto® (antihemophilic factor [recombinant])
Remodulin® (treprostinil sodium)
Revatio® (sildenafil citrate)

***Soliris*TM** (eculizumab)
Stimate® (desmopressin acetate)
Tracleer® (bosentan)
Ventavis® (iloprost)

SELF-ADMINISTERABLE

Actimmune® (interferon gamma-1b)
Apokyn® (apomorphine hydrochloride)
Avonex® (interferon beta-1a)
Betaseron® (interferon beta-1b)
Bravelle® (urofollitropin)
Cetrotide® (cetrorelix acetate)
Chorex-10™ (chorionic gonadotropin)
Chorionic gonadotropin (generic)
Copaxone® (glatiramer acetate)
Enbrel® (etanercept)
Follistim AQ™ (follitropin beta)
Forteo® (teriparatide [rDNA origin])
Fuzeon® (enfuvirtide)
Ganirelix acetate (formerly *Antagon*™)
Genotropin® (somatropin [rDNA origin])
Gonal-f® (follitropin alfa)
Gonal-f® ***RFF*** (follitropin alfa)
Humatrope® (somatropin [rDNA origin])
Humira™ (adalimumab)
Increlex® (mecasermin [rDNA origin])
Infergen® (interferon alfacon-1)
Intron® ***A*** (interferon alfa-2b)
Kineret® (anakinra)
Luveris® (lutropin alfa)
Menopur® (menotropins)
Norditropin® (somatropin [rDNA origin])
Norditropin/NordiFlex® (somatropin [rDNA origin])
Novarel® (chorionic gonadotropin)
Nutropin® (somatropin [rDNA origin])
Nutropin AQ® (somatropin [rDNA origin])
Omnitrope™ (somatropin [rDNA origin])
Orfadin® (nitisinone)
Ovidrel® (choriogonadotropin alfa)
Pegasys® (peginterferon alfa-2a)
PEG-Intron® (peginterferon alfa-2b)
PEG-Intron® ***Redipen***® (peginterferon alfa-2b)
Pregnyl® (chorionic gonadotropin)
Profasi® ***HP*** (chorionic gonadotropin)
Pulmozyme® (dornase alfa)
Raptiva® (efalizumab)
Rebif® (interferon beta-1a)
Repronex® (menotropins)
Saizen® (somatropin [rDNA origin])
Sensipar® (cinacalcet hydrochloride)
Serostim® (somatropin [rDNA origin])
Tev-Tropin® (somatropin [rDNA origin])
Tobi® (tobramycin)
Zorbtive® (somatropin [rDNA origin])