# Nortel Networks Inc.
# Short-Term Disability Plan

# Summary Plan Description
# 2012

# IN THIS SUMMARY PLAN DESCRIPTION

# ABOUT THIS SUMMARY PLAN DESCRIPTION

This is the Summary Plan Description (SPD) that describes the Nortel Networks Short-Term Disability Plan that is in effect for the 2012 Calendar Year. It is designed to provide you with a comprehensive resource providing detailed information about your short-term disability 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 – SHORT-TERM DISABILITY PLAN BENEFITS** describes the provisions of the Short-Term Disability Plan that determine your benefits.
- **SECTION TWO – ADMINISTRATIVE INFORMATION** includes administrative details about the Short-Term Disability Plan, such as how to file Claims and appeal denied Claims, where to get more information, your ERISA rights and how the Company may amend the plan.
- **SECTION THREE – GLOSSARY** contains brief descriptions of terms used in this SPD.

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

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

# SECTION ONE – SHORT-TERM DISABILITY PLAN BENEFITS

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

## Introduction to Short-Term Disability Plan Benefits

The Short-Term Disability Plan is part of the Nortel Networks FLEX Program, referred to as FLEX or FLEX Program in this document. 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. Under the Short-Term Disability Plan, you are provided short-term disability coverage as part of your Core FLEX Benefits.

Your short term disability benefits are designed to continue a portion of your income if you are unable to work due to Illness or Injury and meet specific definitions of "Disabled" under the plan. The Company administers the Short-Term Disability Plan. Long-Term Disability (LTD) benefits are described in detail in the LTD Plan Summary Plan Description (for STD leaves that began before 1/1/11 and eventually commence to LTD) or the MetLife Long Term Disability Certificate of Insurance (for leaves that commence on or after 1/1/11), as applicable, .

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 Short-Term Disability Plan consist of:

- this SPD, as well as
- subsequent information that is provided to you about 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.

## Information Used In Claim Determinations

The Company as Claims Administrator of the Short Term Disability Plan for claims commencing on or after January 1, 2011 retains the exclusive authority to interpret and administer the provisions of the Short-Term Disability Plan, including discretionary authority to:

- construe and interpret the terms of the Short-Term Disability Plan,
- determine the validity of charges submitted under the Short-Term Disability Plan, and
- make final, binding determinations concerning the availability of benefits under the Short –Term Disability Plan.

In addition to the standards described in this SPD, when Nortel makes a claims decision they also rely on standard texts and Nortel policies concerning medical conditions, disabling conditions, and physical and mental requirements for the performance of different occupations.

In connection with the determination of your Claim, you may request, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your Claim--including any written standards that were relevant other than this SPD. For this purpose, a document, record, or other information is treated as "relevant" to your Claim if it:

(1) was relied upon in making the determination on your Claim;

(2) was submitted, considered, or generated in the course of making the determination on your Claim, regardless of whether such document, record, or other information was relied upon in making the determination;

(3) demonstrates compliance with the administrative processes and safeguards required in making the determination on your Claim; or

(4) constitutes a statement of policy or guidance with respect to the Short-Term Disability Plan, regardless of whether such statement was relied upon in making the determination on your Claim.

To request a document, record, or other information described above in determination of your Claim, send a written request to Nortel at the following address:

HR
c/o Nortel Networks
PO Box 13010
Research Triangle Park, NC 27709-3010

# PLAN HIGHLIGHTS

| **STD Benefit** |
| --- |
| 100% of your pre-disability FLEX Earnings for up to 6 weeks, then 66 2/3%* of your pre-disability FLEX Earnings up through the next 20 weeks |

*****Or statutory minimum (if greater)

STD and LTD benefits are mutually exclusive and the determination of whether each option pays benefits is independent of the decision made under the other. However, you must receive benefits for the maximum period of 26 weeks under the STD Plan to be eligible for benefits under the LTD Plan. Under no circumstances will STD and LTD benefits be paid concurrently.

# WHO IS ELIGIBLE

You are eligible to participate in the Short-Term Disability Plan if you are a regular Employee working 20 or more hours per week.
If you are a non-payrolled worker or independent contractor, you are not eligible for the Short-Term Disability Plan.

# HOW TO ENROLL

You are automatically enrolled in the portion of the Short-Term Disability Plan that provides the Core STD Benefits as described under "Plan Highlights" above.

# WHEN COVERAGE BEGINS

Core Short-Term Plan coverage is automatically effective on your date of hire as a new Employee. Refer to "Plan Highlights" on page 6 for more information about this coverage.

# WHEN COVERAGE ENDS

Your core STD Plan coverage will end on the earliest of:

- the date your employment ends, or
- the date you stop qualifying for coverage, or
- the date the STD Plan or the part of the plan providing the coverage ends, or

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

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

# WHAT COVERAGE COSTS

Core STD coverage is provided at no cost to you. The Company reserves the right to change your cost of coverage as necessary.

# FLEX EARNINGS

FLEX Earnings are the basis on which your STD benefits are calculated. For example, under Core STD, the benefit is 100% of your pre-disability FLEX Earnings for six weeks and then 66 2/3% of your pre-disability FLEX earnings up through the next 20 weeks. FLEX Earnings generally equal your base salary. However, if you are eligible for sales incentives, your FLEX Earnings include your target incentives, as defined each year by the Company (excluding bonuses). Your FLEX Earnings are determined on the following dates:

| If you are enrolling: | Your FLEX Earnings are your base salary as of: |
|---|---|
| For 2012 annual enrollment | January 1, 2012 |
| As a new hire | Your Hire Date |
| Part-time to full-time or vice versa | Effective Date of employment Status Change |

FLEX Earnings do not include:

- overtime pay,
- shift differentials,
- relocation payments or
- bonuses.

If your FLEX Earnings and FLEX Credits change during the Calendar Year (except due to an employment Status Change - e.g., full-time to part-time), related FLEX Payroll Deductions and Credits will not change during the year since these deductions are based on your FLEX Earnings as of the administrative preparation period just prior to the Annual Enrollment Period of the preceding year. If your FLEX Earnings *increase* during the year, pay-related benefits (e.g., disability, term life insurance, etc.) will be based on your FLEX Earnings at the time of your disability. However, if your FLEX Earnings *decrease* during the year (except due to an employment Status Change - e.g., full-time to part-time), pay-related benefits will be based on your FLEX Earnings as of the administrative preparation period just prior to the Annual Enrollment Period of the preceding year.

# SHORT-TERM DISABILITY BENEFITS

## STD Benefit Amount

Before STD benefits can begin, you must be Ill or Injured for five consecutive days. These five days constitute the "waiting period." If you are subsequently approved for STD, the five-day waiting period is treated as week one of your STD benefit period. The STD plan pays a weekly benefit of 100% of your pre-disability FLEX Earnings for up through six weeks of your disability. After the first six weeks of disability, the core STD Plan pays 66 2/3% of your pre-disability FLEX Earnings for up through the next 20 weeks. Core STD benefits are reduced by federal and state income tax, as well as other income you may receive, as described under the "Reduction of STD Benefits Due to Other Income" section on page 11.

## STD Benefits for Part-Time Employees

If you are a part-time Employee and work 20 hours or more per week, the number of hours you are regularly scheduled to work will be used to determine the amount of your disability benefit.

If you work less than 20 hours a week:

- Your medical leave of absence will be unpaid, unless otherwise required by applicable state law.
- You are eligible for a medical leave of absence only if you have been Actively at Work for at least 1,250 hours during the 12 months immediately prior to the beginning of the period of disability.

You may request a personal leave of absence if you are not eligible for a medical leave of absence but you are medically unable to work.

## Extension of Benefits Due to Part-Time Employment

If your Physician and the Company approve your return to work (for any company) on a part-time basis during the first six weeks that you are receiving STD benefits, you will receive all of your earned wages for the period that you work plus a reduced STD benefit for the period you receive disability benefits.

Because your return to work on a part-time basis will decrease the amount of STD benefits you receive, the resulting savings will be used to extend the number of weeks that you are eligible to receive benefits at 100% of your pre-disability FLEX Earnings.

# Definition of "Disability" for STD Plan Purposes

You are entitled to benefits from the STD Plan only if you are considered "Totally Disabled". You are considered Totally Disabled only when the Claims Administrator determines that you are unable to perform the essential functions of your job and this finding is supported by documentation from your Physician. This means that you cannot perform the work you were normally performing at the time of your disability, with or without reasonable accommodations, due to the limitations resulting from your Illness or Injury. In addition, you must be under the regular care of a Physician at all times during the period when you claim to be Totally Disabled to receive a benefit from the STD Plan.

A "Physician" means a licensed practitioner of the healing arts acting within the scope of his or her license. When a Total Disability is caused by any condition other than a medically determinable physical impairment, a "Physician" means a legally qualified Physician who specializes in the practice of psychiatric medicine or has, by reason of training or experience, a specialized competency in the field of psychiatric medicine sufficient to give the necessary evaluation and treatment of mental Illness.

The proof that your Physician submits must be written proof of objective clinical documentation (i.e., lab tests, x-rays, medical reports, etc.) of your Total Disability. The Claims Administrator will approve or deny your Claim for STD benefits at its discretion. Independent Medical Evaluations (IMEs) (either additional physical examinations and medical testing or file reviews of existing medical records) may also be required, at the Company's expense, in order to arrive at this final determination. Your benefit will be denied if you do not provide such objective proof of your Claim within the required time.

Disabilities due to an Illness or Injury that, as determined by the Claims Administrator, are primarily based on self-reported symptoms, have a limited pay period during your lifetime. "Self-reported symptoms" means the manifestations of your condition you share with your Doctor which are not verifiable using tests, procedures, and clinical examinations normally accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to, headache, pain, fatigue, stiffness and soreness, ringing in the ears, dizziness, numbness, and loss of energy. The pay period limitations are at the discretion of the

Claims Administrator. If objective medical and clinical evidence is not submitted or changes in the treatment plan or more aggressive treatment is not commenced within a reasonable period, the benefit will be terminated.

# Reasonable Accommodations

Reasonable accommodations may be made for the limitations resulting from your Illness or Injury which would allow you to return to active work. If a reasonable accommodation has been identified, but you choose not to accept the accommodation, your STD benefit may be discontinued. If the Company is unable to accommodate limitations resulting from your Illness or Injury, your benefit will not be affected. Reasonable accommodations may include, but are not limited to:

- General accommodations — the removal of structural, communication, or other barriers, and
- Job-related accommodations, such as:
    - Part-time or modified work schedules,
    - Home-based work,
    - Reassignment to vacant positions,
    - Acquisition or modification of tools, equipment, and/or furniture, and
    - Modifications to business travel schedules.

# When Benefits Begin and End

Administratively, STD Plan benefits will begin on the sixth consecutive working day of your disability. At the onset of your disability, if you are a full-time employee working part-time (due to your disability)and on partial disability the remainder of the time, STD benefits will not begin until your absence satisfies the equivalent of five full-time work days, e.g., 10 part-time work days. If you begin to receive STD benefits, the five-day waiting period will count toward your total period of disability.
If you begin to receive STD benefits, the five-day waiting period will count toward your total period of disability benefit payments.

STD benefits end when:

- Your eligibility ends,
- You are no longer Totally Disabled,
- Your employment with the Company ends,
- the STD Plan ends, or
- You have received 26 weeks of STD benefits.

## If You Are Disabled Again

You must be an active Employee at the time an Illness or Injury occurs to qualify for STD benefits. Therefore, once a period of Total Disability has ended (by your recovery, a finding by the Claims Administrator that benefits are no longer payable to you, or by payment of the maximum STD benefit), you will have no STD coverage until you return to Active Work status.

If, after you return to Active Work, you become Totally Disabled again, your new period of Total Disability will be considered a continuation of your first disability if:

- It has the same cause as the first disability, or a related cause, *and*
- You were Actively at Work less than 30 consecutive days since you were Totally Disabled, *or*
- You have not returned for one full day of full-time Active Work between the two disability periods.

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

Here are some examples of how this provision works:

- You have received STD benefits for 10 weeks, and you return to Active Work for one week before the same Illness requires you to stay at home again. In this case, STD benefits continue under the previous Claim for the rest of the 26-week period (if you are determined to be Totally Disabled under the STD plan provisions).
- You have received STD benefits for 10 weeks, and you return to Active Work for 30 consecutive days. Then, the same Illness requires you to stay at home again. In this case, you will have to file a new Claim and are eligible for STD benefits for a new 26-week period (if you are determined to be Totally Disabled under the STD plan provisions).
- You have received STD benefits for 10 weeks, and you return to Active Work for one day. Then, a different Illness requires you to stay at home again. In this case, you will have to file a new Claim and are eligible for STD benefits for a new 26-week period (if you are determined to be Totally Disabled under the STD plan provisions).
- You have received STD benefits for 10 weeks and are released to return to work. You do not return to work and a different (or the same) Illness or Accident prevents you from working. In this case, you are not eligible for STD benefits under a new or previous claim as you did not return to Active Work (i.e., you must be an active Employee at the time an Illness or Injury occurs to qualify for STD benefits).

If you return to Active Work from STD the same day you would have become eligible for LTD and become Totally Disabled within three consecutive months of your STD return to work date due to the same or related cause, you may be eligible to commence LTD benefits.

# Reduction of STD Benefits Due to Other Income

STD benefits will be reduced by any other income payable to you or your Dependents as a result of your disability or retirement, so that the sum of your STD benefits and any other income will not exceed the

maximum benefit level for which you are eligible. The plan also takes into account other income for which you are eligible but which you may not have yet received.

For the purposes of this plan, "other income" includes:

- Income received from any employer or from any occupation for compensation or profit, including self-employment,
- Workers' Compensation benefits (excluding payments of legal fees incurred in the Claim process),
- Disability, retirement, or unemployment benefits provided under any group insurance or pension plan or any other arrangement of coverage for individuals in a group (whether on an insured or uninsured basis), and
- Any other disability, retirement, or unemployment benefits required or provided for under any law of any government, including, but not limited to:
    - Unemployment compensation benefits,
    - No-fault wage replacement benefits,
    - Statutory disability benefits, and
    - Social Security benefits (if a family offset is applicable, the family offset will be applied against your STD benefit – regardless of whether or not a Dependent lives with you and is or is not considered a Dependent for tax purposes) and
    - the Canada Pension Plan, and the Quebec Pension Plan, including Dependents' benefits, but not counting any increase in benefits after STD benefit payments have started under this plan,

For example, if your weekly STD benefit is $200, and you are also receiving $100 a week from Workers' Compensation, then your STD benefits will be reduced to $100 a week so that your total income equals $200 a week.

For the purposes of this plan, other income will be treated as follows:

- Any periodic payments will be allocated to weekly periods,
- Any single lump-sum payment, including any periodic payments that you or your Dependents have elected to receive in a single lump sum will be allocated to weekly periods. However, any single lump-sum payment under Workers' Compensation laws will be fully offset in its entirety against any benefits otherwise payable by this plan, or
- Any periodic or single lump-sum payments received as a retroactive award may be allocated retroactively.

It is your responsibility to complete any required applications, such as for Social Security benefits, as well as undertake any necessary processes for appeal if initially denied.

If the Claims Administrator finds that the actual amount of Social Security and other income that you receive is different from the amount used to determine your STD benefits, the following rules apply:

- If STD benefits have been underpaid, this plan will be required to make a lump-sum payment to bring the total payments to the amount that should have been paid.
- **If STD benefits have been overpaid, you will be required to make a lump-sum reimbursement payment to the plan. Failure to comply with this requirement of the plan will be considered grounds for immediate termination of your STD claim, your other Nortel**

**benefit programs, and your employment. It may also result in any and all further action legally available to Nortel, including but not limited to reporting this unpaid debt to credit reporting agencies, pursuing collection through collection agencies and taking legal action to recover the amount due to the plan.**

# Applying for Social Security Benefits

If you anticipate that your Illness or Injury will be long term or will result in a permanent disability, you must apply for Social Security Disability benefits in a timely and diligent manner.

**While your application for Social Security or other sources of disability income is pending, the plan may estimate your income from these sources and use that amount to determine your benefit under this plan. Before your Social Security benefits or other sources of disability income begin, you may choose to sign a Reimbursement Agreement to reimburse the plan for the amount of the excess payment that you receive as an STD benefit. If you sign this agreement, your Social Security benefit or other income will not be taken into consideration for your STD benefit while your applications, and any subsequent appeals, are pending. However, you will have to pay that amount back immediately when your Social Security benefit begins. You must make a lump-sum reimbursement payment to the Plan equal to the amount of the offset for the Social Security benefit that was not taken while the Social Security (or other disability income) benefit award was pending. Contact the Claims Administrator immediately upon your receipt of notification that your Social Security (or other) benefit has been awarded. The Claims Administrator will calculate the amount of the overpayment that you must repay to the Plan. Failure to comply with this requirement of the plan will be considered grounds for immediate termination of your STD claim, your other Nortel benefit programs, and your employment. It may also result in any and all further action legally available to Nortel, including but not limited to reporting this unpaid debt to credit reporting agencies, pursuing collection through collection agencies and taking legal action to recover the amount due to the plan**

If your claim for Social Security disability benefits is denied, you must appeal at the Reconsideration level. If benefits are denied again, you must appeal at the Administrative Law Judge level.

If you do not give the STD plan written proof that your application for other disability benefits has been denied, the plan may estimate your weekly Social Security benefits and other income, and use that amount to determine your benefit under this plan.

# Exclusions

STD benefits will not be paid for any disability resulting from:

- Intentionally self-inflicted injuries, including a disability or an Injury that results from the use of hallucinogenic or narcotic drugs, except when legally prescribed by a Physician and taken in accordance with the Physician's direction,
- Your participation in the commission of an assault or felony, or
- War or any act of war (declared or undeclared), insurrection, or rebellion, or your participation in a riot or civil commotion

# OCCUPATIONAL DISABILITY BENEFITS

Disability benefits may be payable to you for an occupational disability. Occupational disabilities are those caused by:

- An Injury arising out of, or in the course of, any employment for wage or profit, or
- A disease covered with respect to such employment by any Workers' Compensation law, occupational disease law, or similar legislation.

This benefit is provided on the same terms as the benefit for a non-occupational disability. (See Reduction of STD Benefits Due to Other Income on page 11.) STD benefits are provided as a supplement to your Worker's Compensation pay. Total disability benefits paid will not exceed the applicable STD benefit amounts.

# OTHER IMPORTANT INFORMATION

## A Note about State Disability Laws

In certain locations, state-mandated disability plans supersede the Company's plans. As a result, applicable state disability law may alter the provisions described in this summary. States that have requirements for disability coverage include: California, Hawaii, New Jersey, New York and Rhode Island. Plan requirements vary by state.

New Jersey and California based employees are eligible for disability benefits under their respective state disability benefit programs. The Nortel Networks Inc. Short Term Disability Plan and policies will coordinate benefits with the state plans on a non-duplication basis. This means that New Jersey or California based employees applying for disability benefits are required to submit a claim for disability benefits to their respective state plans. The state plans will be the primary plan, with the Nortel Networks Inc. Short Term Disability Plan being secondary. In addition to following Nortel's Medical Leave of Absence Process and Family Care Leave Process, New Jersey and California based employees with a claim for disability benefits will need to file both with the state and with the Nortel Networks Inc. Short Term Disability Plan.

The New Jersey or California state plans will be responsible to cover the mandated benefits as the first or primary payor. In instances where the benefit is also approved by the Nortel Networks Inc. Short Term Disability Plan, employees will be eligible for an additional "top up" payment if the Nortel benefit amount exceeds the State's plan benefit amount.

While applications for the state disability income are pending, the Nortel Networks Inc. Short Term Disability Plan will estimate the income from the state disability plan and use that amount to determine any remaining benefit under the Nortel plan. Please be advised it will be your responsibility to provide documentation to Nortel of the determination of a different coverage amount or denial of benefits by the state plan in order to have the Nortel payments adjusted.

Additional information about the New Jersey and California state disability plans is available from HR or you may contact the states directly:

| | | |
|---|---|---|
| **California** Employee Development Department | California Employee Development Department (EDD) website<br><br>(http://www.edd.ca.gov/Disability/) | 1-800-480-3287 |
| **New Jersey** Division of Temporary Disability Insurance | State of New Jersey Department of Labor and Workforce Development website.<br><br>(http://lwd.dol.state.nj.us/labor/tdi/worker/state/sp_clt_menu.html) | 1-609- 292-7060. |

# Limits on Assignments

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

- Be responsible for determining the validity of a purported gift assignment, or
- Be held to know about an assignment unless it has received a copy of it.

For more information on limits of assignments or how to assign disability benefits as a gift, contact the Claims Administrator (as listed on page 30).

# Errors in Payments

If the Claims Administrator determines that you have received an overpayment of benefits due to an error, you will be required to reimburse the Claims Administrator or have the overpayment deducted from subsequent benefit payments payable under the STD plan or any other Company welfare plan.

# SECTION TWO – ADMINISTRATIVE INFORMATION

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

## Identifying Information

Plan Type under ERISA: Welfare Plan

Plan Number: 509

Funding Method: Self-funded

Contribution Source: the Companies that sponsor the Plan pay the full cost of the core STD plan coverage

Companies that Sponsor the Plan: Nortel Networks Inc. (employer identification number 04-2486332) and certain other related companies sponsor this Plan for their eligible Employees. For a current list of sponsoring companies, please contact HR at 1-800-676-4636.

The address for Nortel Networks Inc. is:
Nortel Networks Inc.
4001 East Chapel Hill-Nelson Highway
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):
Retirement Services Group
Bank of America
213 South LaSalle Street
Chicago, IL 60697
312-828-2345

# CONTACT INFORMATION FOR CLAIMS FILING AND APPEAL REVIEW

The list 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 entities responsible for each type of Claim and Appeal of denied Claims under the Short-Term Disability Plan are noted in the list below:

**Initial Claims for STD eligibility to participate/coverage level and initial Claims and first level appeals for denied payment of STD benefits Claims :**

Nortel's Disability Representative
c/o Nortel Networks HR
Mailstop: 570 02 0C3
PO Box 13010
Research Triangle Park, NC 27709

**Second/final level appeals:**

Employee Benefits Committee (EBC)
c/o Nortel Networks
Mailstop: 570 02 0C3
PO Box 13010
Research Triangle Park, NC 27709

# FILING CLAIMS AND APPEALS

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

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

## Short-Term Disability Plan Benefit Claims and Appeals

### 1. Filing a Claim for payment of a benefit under the Short-Term Disability Plan:

The process for requesting a Short-Term Disability Plan benefit is as follows:

a. Contact Nortel HR at 1-800-676-4636 to initiate the process. A representative will conduct an interview to obtain all necessary information for your Short-Term Disability claim.

b. The Company's designated Disability Representative will send necessary forms to you for your physician to complete. With your signed consent, the Company's designated Disability Representative will review medical information from your treating physician(s). The Company's designated Disability Representative will review all documentation and notify you of the decision to approve or deny your request for Short-Term Disability Plan benefits. If the Company's designated

Disability Representative does not receive the completed medical forms within **15 calendar days of last day worked, your pay will be suspended.**

## 2. Decision Regarding an Initial Claim for Short-Term Disability Plan Benefits

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

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

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

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## 3. Appealing a Denied Short-Term Disability Plan Claim

**First Level Appeals**

Appeals regarding the STD Plan must be made in writing to Nortel's Designated Disability Representative. See the list above for contact information. Your appeal should include an explanation of the facts surrounding the request, and any documentation that will support the request.

Nortel's Designated Disability Representative will notify you of the appeal decision on your participation or coverage level issue under the Short-Term Disability Plan (as applicable) within 45 days of the receipt of your Claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your appeal, will be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which Nortel's Designated Disability Representative expects to decide on your appeal, will be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to render a decision, the period for making the benefit determination by Nortel's Designated Disability Representative will be stopped from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

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

a. the specific reason(s) for the denial,
b. references to the specific plan provisions on which the benefit determination was based,
c. a description of any additional material or information necessary for you to perfect a Claim and an explanation of why such information is necessary,
d. a description of your right to file a second/final appeal with the Employee Benefits Committee (as explained below), the appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following the conclusion of your appeals.

**Second/Final Level Appeal for Denied Claims to the Employee Benefits Committee (EBC)**

If a Short-Term Disability Plan first level appeal is denied by Nortel's Disability Representative, the Employee Benefits Committee reviews any additional appeal request that you file, i.e. they make the decision concerning your final appeal.

If your second/final level appeal is denied or if you do not receive a response to such appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may appeal in writing to the Employee Benefits Committee (EBC). See the list above for contact information. Your final appeal must be submitted within 180 days of your receipt of the written notice of denial or 180 days from the date such an appeal is denied. You may submit with your appeal any written comments, documents, records and any other information relating to your appeal. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your appeal free of charge.

You have the right to:

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

The EBC will make a decision on your appeal of a denial of your participation/coverage level appeal under the plan no later 45 days of the receipt of your appeal request. This period may be extended by up to 90 days

if the EBC determines that special circumstances require an extension of time. 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.

The EBC's notice of an adverse benefit determination on your final appeal will contain all of the following information:

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

## Final Note on Short-Term Disability Plan Claim Appeals

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

# YOUR RIGHTS UNDER ERISA

As a participant in the Company's Employee benefit plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that, as a plan participant, you will be entitled to:

## Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office or your work location, during normal working hours, all plan documents governing the plan, including insurance contracts (if any), 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 (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may request a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a summary of this annual report.

## Prudent Actions by Plan Fiduciaries

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

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

## Enforce Your Rights

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

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

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).

# FUTURE OF THE PLAN

Although the benefits currently available (in the 2012 Plan Year) are described in this summary for the Company's Short-Term Disability Plan, the Company reserves the right to change or end the plans 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

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

If a different definition of any of the following words is provided in the section describing a particular benefit plan, that definition applies instead of the definition listed below.

**Accident/Accidental**
An unexpected event resulting in bodily Injury by an external trauma.

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

**Affiliates**
Subsidiaries of, or other companies related to, Nortel Networks Inc. (NNI), that have been authorized by the Board of Directors of NNI to provide coverage for their employees under the Company's Short-Term Disability Plan and have adopted those programs.

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

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

**Behavioral Illness**
A mental, psychoneurotic or personality disorder, or chemical dependency (alcohol and substance abuse).

**Calendar Year**
January 1 through December 31. This period is also known as the Plan Year.

**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 responsible for processing and paying benefit Claims and other various administrative services.

**Company** – Nortel Networks Inc.

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

- Short-Term Disability coverage at 100% of your pre-disability base salary (called FLEX Earnings - see this glossary for more on what is and isn't included in this amount) for six weeks, then 66 2/3% of your pre-disability FLEX Earnings for up to 20 additional weeks,
- Long-Term Disability coverage at 50% of your pre-disability FLEX Earnings up to a maximum monthly benefit of $5,000.00 after you have been disabled for 26 consecutive weeks,
- Employee Life Insurance equal to one times your FLEX Earnings,
- Employee Assistance Program provides free confidential counseling for up through the first 8 visits.

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

**Dependent**
For the purpose of Status Changes, Dependents include:

- your spouse, including your common-law spouse as recognized by applicable state law,
- your qualified Domestic Partner, (see definition of Domestic Partner),
- your unmarried Children and your Domestic Partner's unmarried Children under the age of 26, (see definition of Children) unless they are covered by an employer plan ,
- your unmarried Children and your Domestic Partner's unmarried Children of any age who have a mental or physical disability that began before age 26

For the purpose of a reduction in STD or LTD benefits due to other income (i.e., application of the family offset), a Dependent includes:

- any Dependent receiving Social Security Disability Benefits due to your disability regardless of whether or not that Dependent is living with you and is or is not considered a Dependent for tax purposes.

**Disability Representative**
Person vested with responsibility of monitoring and managing disability claims

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

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

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

**Enrollment Period**
See "Annual Enrollment." The FLEX Benefits may be selected during a 31-day enrollment period when you first become eligible for benefits as a new employee or after you experience a Status Change.

**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 Earnings**
Generally, your base salary. FLEX Earnings do not include other types of pay, including but not limited to, overtime, shift differentials, relocation payments or bonuses. However, 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. If you are a part-time employee and work 20 hours or more per week, the number of hours you are regularly scheduled to work each week will be the number of hours you will receive each week for your disability benefit.

**Gross Disability Payment**
Core Short-Term Disability: 66 2/3% of pre-disability FLEX Earnings before any deductions are taken

**Hire Date**
The date your employment with the Company begins.

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

**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.

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

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

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

**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.

**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.

**Sickness**
See "Illness."

**Termination Date**
The last day you work for the Company.

**Total Disability, Totally Disabled**
For the Short-Term Disability plan, the inability to perform the work you normally perform due to Illness or accidental Injury, as certified by a Physician.

**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 Benefits**
Benefits covered under Workers' Compensation law.