2013

Nortel Networks

Annual Enrollment Guide

ABOUT NORTEL NETWORKS MEDICAL PLAN

It's important to remember that Nortel's medical plan is self-insured. This means that, after discounts are applied, Nortel Networks – not an insurance company – pays employees' claims. Third party administrators (CIGNA and Anthem) only provide administrative services such as managing networks and processing claims.

This guide is a brief summary of some important items but may not include everything you will need to make informed choices or access benefits. For more complete information about the terms and conditions of these plans please refer to the summary plan descriptions (SPD) on Nortel's health and group benefits website at http://www.nortel-us.com/current/benefits/ under "Explore Plans/Services". If you don't have internet access, you can call HR Shared Services at 1-800-676-4636 to have the SPDs sent to you.

This enrollment guide provides only a summary of the Nortel Networks plans. The actual plan documents govern the details of benefits coverage in all cases. Nortel reserves the right to change, amend, and reduce or terminate this plan, at any time, without prior notice to, or consent by, employees, retirees or surviving beneficiaries, in accordance with the terms of the plans and subject to applicable law. Receipt of this guide does not guarantee eligibility or benefit coverage.

2013 ANNUAL ENROLLMENT OVERVEW

2013 Annual Enrollment

To get the most out of Nortel's benefits and our online resources, you need to take action. It's up to you to evaluate your options and choose the benefits that make the best sense for you and your family. The external http://www.nortel-us.com/current/benefits/ site contains resources and tools to help you understand your benefits choices and make the right decisions and get answers 24/7.

A few reminders:

- If you do not enroll, most of your 2012 selections will be the default for 2013. Please note one exception:

  If you elect to cover a spouse/domestic partner under the medical plan, you will automatically be charged the $50 per-pay-period **spousal/domestic partner access fee** in 2013, unless you certify or recertify before November 18, that your enrolled spouse/domestic partner doesn't have access to other employer-provided medical coverage. Per plan rules, you must recertify before each new plan year. The spousal/domestic partner certification can be found on the "select dependents" screen within the medical benefit plan option in the on-line tool or the enrollment form mailed to employees without intranet access.

- Because of the current situation at Nortel, the choices you've made in previous years may no longer be best for you. http://www.nortel-us.com/current/benefits/ contains information to help you choose the right plans.

What's Changing

Changes to the benefit Plans for 2013 are summarized below:

- The CIGNA Well Aware Disease Management Program is being phased out as of December 31, 2012. Please note that participants will not receive any additional coaching calls under this program after December 31, 2012.

ELIGIBILITY

Who Is Eligible

You're eligible for benefits if you're a Nortel full-time or part-time employee regularly scheduled to work 20 hours or more per week. Your dependents are eligible for benefits under many benefits options:

- Your spouse, including your common-law spouse (under state law) or Domestic Partner (qualified under plan rules),
- Your Child(ren) and/or Domestic Partner's Child(ren) under age 26 who do not have access to employer provided coverage. "Children" include:
    - Your natural or legally adopted (or placed for adoption) Children, 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 Child(ren) and/or Domestic Partner's Child(ren) under age 26, and
    - Your eligible, unmarried, physically or mentally disabled Child(ren) and/or Domestic Partner's Child(ren) over age 25 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 Shared Services within 31 days of your child turning age 26 for that child to be considered an eligible Dependent.

Update Dependent Information!

Even if you chose to waive Medical Plan and Dental/ Vision/Hearing Care Plan coverage, it's important that all your dependents are listed accurately. You may have spousal group term life insurance and/or Accidental Death and Dismemberment (AD&D) Insurance for which this information would be required. Also, your dependents must be listed accurately so they can have easy access to the Employee Assistance Program (EAP).

Note: You must elect the applicable coverage for each dependent listed in order for your dependents to receive coverage.

Important Reminder!

If your spouse/domestic partner is currently covered under your Nortel medical plan, you will automatically be charged the spousal/domestic partner access fee of $50 each pay period in 2013 unless you recertify during this annual enrollment that your spouse/domestic partner does not have access to employer-provided medical coverage elsewhere in order to have this fee waived.

Your spouse/domestic partner or child may 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 may not be considered a dependent under any plan if he or she is covered as an employee.

Who Is Not Eligible

Please note that the following individuals are **not** eligible for coverage under the Nortel Benefits Program:

- Divorced spouses,

- Unmarried partners with no recognized relationship under the plan,
- Children of live-in parents with no legal relationship,
- Children not residing with the participant in a parent/child relationship,
- Over-age dependents (not disabled),
- Stepchildren following divorce of the natural parent, and/or
- Grandchildren or other extended family dependents with no legal guardianship.

If your circumstances have changed or you have elected the wrong level of coverage, please contact HR Shared Services to correct your dependents. Purposely insuring dependents who are ineligible is fraudulent and could result in disciplinary action.

ENROLLMENT DATES

Know What You Need to Do—and When

Your annual enrollment period is from November 9 thru November 21, 2012. Mark these important dates on your calendar!

Date	What It Means to You
Friday, November 9	**Enrollment begins.** It's time to make the best benefits decision for you! If you haven't already, review this enrollment overview guide and use the http://www.nortel-us.com/current/benefits/ site to learn about the 2013 benefits changes, evaluate your choices and see which benefits best fit your personal situation. Then use the mail or fax instructions and enroll!
Wednesday, November 21	**Enrollment ends.** You must enroll by this date. If you don't enroll by this date, you (and any covered dependents) will be assigned your current coverage as "default coverage." This means that your current coverage elections, along with any applicable plan changes, will continue at 2013 costs. If your spouse/domestic partner is enrolled in medical benefits under the Nortel plan, the Spousal Access Fee will automatically be applied if you default your coverage elections. A confirmation statement will be mailed to employees.
Sunday, Tuesday 1, 2013	**Your 2013 benefits choices take effect.** You can only change your benefits during the plan year if you experience a qualified status change. For information on qualified status changes go to http://www.nortel-us.com/current/benefits/ and click on "Explore Plans/Services".

If you'll be away during the enrollment period, you must contact HR Shared Services before the end of the enrollment period to make alternate arrangements for your enrollment.

If You Don't Enroll

If you don't enroll by November 21, you and any covered dependents will be assigned default coverage. This means that you'll automatically be enrolled in your current coverage at your current coverage level (that is, with the same covered dependents—unless a dependent is no longer eligible), but at 2013 prices.

This default coverage may not meet your and your family's needs for 2013. So it's important that you enroll during the annual enrollment period and choose the benefits that are right for you and your family.

If you have any Benefits Credits remaining after you are assigned default coverage, they will be paid to you as taxable pay.

Important Reminder! If your spouse/domestic partner is currently covered under your Nortel medical plan, you will automatically be charged the spousal/domestic partner access fee of $50 each pay period in 2013 unless

you recertify during this annual enrollment period that your spouse/domestic partner does not have access to employer-provided medical coverage elsewhere.

HOW TO ENROLL

How to Enroll

Fill out and mail your completed enrollment worksheet in the enclosed reply envelope you were provided, postmarked by November 21. You can also fax the completed worksheet to HR Shared Services at **(919) 905-9301** by November 21. Be sure to include a phone number where you can be reached if an HR Shared Services representative needs to contact you. Don't forget to keep a copy of your completed worksheet for your records. Also, if you faxed your completed worksheet, keep a copy of the fax receipt confirmation for your records.

Important Notice

A confirmation statement will be mailed to the homes of employees not actively at work. A confirmation statement will be emailed to those employees that are actively at work. Review your confirmation statement to make sure that it shows the coverage you chose. If you see a mistake, contact HR Shared Services immediately. Remember, you cannot make benefits changes in 2013 unless you experience a qualified status change. Keep your confirmation statement for future reference. If you don't receive a confirmation statement by December 11, contact HR Shared Services toll-free at 1-800-676-4636**.**

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CHOOSE THE RIGHT PLANS TOOLS

Enrollment Checklist

Step #1: Consider Your Needs

- **Review your health claims history for 2012.** To get the most out of your benefits, it's important to understand how you and your family currently use your health care coverage—and whether this coverage still meets your needs. You can view your 2012 claims history on your health plan administrator's (CIGNA, Anthem) Web site, or you can call your health plan administrator and ask them to mail you your 2012 claim statement. For your health plan administrator's web site and contact information go to http://www.nortel-us.com/current/benefits/ and click on Explore Plans/Services.
- **Talk with your family.** Your family situation, health status and financial needs may have changed since last year. Here are a few things to consider:
    - Do you want to enroll in your spouse/domestic partner's health plan?
    - What are the provisions for joining your spouse's/domestic partner's health plan during the year if you no longer work for Nortel?
    - Have you considered covering your spouse/domestic partner under his or her employer's coverage, if available? You may still choose Nortel health coverage for him or her, but you'll be charged the $50 spousal/domestic partner access fee each pay period in 2013.
    - Do you want to remove a dependent or cover a new one?
    - Have your health care needs or a family member's health care needs changed? For example, have you developed a chronic condition like asthma or diabetes? Do you anticipate needing surgery or any other medical procedures in 2013?
    - Are any of your children now old enough to need dental or vision care?
    - Do you want to make changes to your current disability, life insurance, or accidental death and dismemberment (AD&D) insurance coverage?

Does your current coverage still meet your needs? Or should you consider different coverage? Your answers to these questions can help you make the best benefits decisions for 2013—and start building a healthier future for you and your family.

Step #2: Evaluate Your Choices

- Learn about the benefits changes for 2013.
- Understand your costs**.** Review your 2013 costs for benefits coverage on your enrollment worksheet.

Step #3: Take Action!

- Earn health incentives for 2013**.** By completing the Healthy Lifestyles Health assessment and participating in the Healthy Lifestyles Program, you can earn points that you can exchange for prizes. Go to the Healthy Lifestyles Web site **https://www.findahealthieryou.com/** to learn more.
- Review your dependent information on file. Even if you waive coverage under the medical and/or dental/vision/hearing care options, it's important that your dependent information be accurate and up to date. This information is required for any spousal group term life insurance and/or AD&D insurance you may have, as well as for your family to access the Employee Assistance Program (EAP).
- Complete Spousal Certification for 2013 **-** If you are covering a spouse under the Nortel medical plan for 2013, you must certify whether your spouse has access to other employer-sponsored coverage. If you do not take this action, the spousal access fee of $50 per pay period will automatically be charged for the plan year.
- Enroll by the deadline! Choose the benefits that make sense for you and your family. Then, make your enrollment choices from November 9 through November 21, 2012. Be sure to take action so you can get what you want out of Nortel's benefits!

BENEFITS OVERVIEW

How Benefits Work at Nortel

You automatically receive coverage for core benefits which are fully paid by Nortel. You cannot opt out of core coverage. In addition, you can choose to enroll for optional benefits that provide higher levels of coverage than your core benefits. In most cases, you'll share the cost of these optional benefits with Nortel.

Core Benefits	**Optional Benefits**
Nortel automatically provides you with these benefits at no cost to you	**You can enroll in these benefits and either share the cost with Nortel or pay for them on your own.**
• Employee life insurance equal to one times your Benefits Earnings, up to $1 million. • Short-term disability (STD) coverage equal to 100% of your pre-disability Benefits Earnings for 6 weeks, then 66-2/3% of your pre-disability Benefits Earnings for an additional 20 weeks. • Long-term disability (LTD) coverage equal to 50% of your pre-	• Medical coverage. • Dental/vision/hearing care coverage-this is bundled coverage; if you enroll, you'll receive coverage for all three. • Additional employee and dependent life insurance.

disability Benefits Earnings up to a maximum monthly benefit of $5000 after you've been on STD for 26 weeks. (Applies only to employees actively at work on 1/1/2011 who may be eligible.)

- The Employee Assistance Program (EAP), which provides free and confidential short-term counseling and work-life services.
- Employee and dependent accidental death and dismemberment (AD&D) insurance.

Paying for Benefits

Nortel pays the full cost of your core benefits and subsidizes the cost of your medical and dental/vision/hearing care benefits. In addition, Nortel provides you with Benefits Credits that you can use toward the purchase of optional medical benefits .See your enrollment worksheet for your 2013 benefits prices.

- If your benefits choices cost more than your Benefits Credits: You'll pay the difference either with before-tax or after-tax dollars through payroll deductions, depending on the benefit.
- If your benefits choices cost less than your Benefits Credits: You will receive them as additional taxable pay throughout the year.

Medical Benefits and the Employee Assistance Program (EAP)

Your Nortel medical option covers many health care expenses, including hospitalization, physicians' and specialists' services, and diagnostic tests and procedures.

Nortel offers the following medical options:

- If you live in a network area:
  - No coverage
  - The 80/60 Preferred Provider organization (PPO) option, offered through Anthem or CIGNA HealthCare
  - The 90/70 PPO option, offered through Anthem or CIGNA HealthCare.
- If you live in a non-network area:
  - No coverage
  - The Out-of-Area Comprehensive option, offered through CIGNA HealthCare

The PPO and Comprehensive options cover the same services; however, the level of medical coverage and your out-of-pocket costs for medical care may vary depending on the option.

Under the PPO and Comprehensive options, prescription drug benefits are provided through Medco Health Solutions, and mental health and substance abuse treatment benefits are provided through OptumHealth Behavioral Solutions.

When you enroll, you can choose from four coverage levels:

- You only
- You and your spouse/domestic partner
- You and your children and/or your domestic partner's children
- You and your family (spouse/domestic partner, your children, and/or your domestic partner's children)

You can choose different coverage levels for your medical option and your dental/vision/hearing care option. For example, you can choose medical coverage for you and your family and dental/vision/hearing care coverage for just you and your spouse.

Important Note: Don't Let the Spousal/Domestic Partner Access Fee Catch You by Surprise

Remember, you'll be charged the $50 spousal/domestic partner access fee each pay period in 2013 if you choose to cover your spouse/domestic partner under your Nortel medical plan and he or she has medical coverage available though his or her employer. If your covered spouse/domestic partner doesn't have access to employer-provided medical coverage elsewhere, you won't have to pay the access fee if you recertify to this fact during this fall's Annual Enrollment.

Just like last year, you will have to recertify that your spouse/domestic partner does not have access to other employer-provided medical coverage each year when you enroll or continue to enroll him or her for Nortel medical coverage. Otherwise, you'll automatically be charged the $50 spousal/domestic partner access fee each pay period in 2013 unless you experience a qualified status change. Go to http://www.nortel-us.com/current/benefits/ and click on "Explore Plans/Services" to view the Affidavit of Status Change under Forms.

Planning to Retire in 2013?

If you plan to retire in 2013, you must be actively enrolled in a Nortel Medical Plan immediately before retirement to be eligible for the Nortel Retiree Medical Plan when you retire. For other retiree medical plan eligibility requirements, see the Nortel Networks Retiree Medical Plan Summary Plan Description (SPD), which can be found at http://www.nortel-us.com/current/benefits/ under "Explore Plans and Services". For additional questions or to initiate enrollment in the Nortel Retiree Medical Plan, please call HR Shared Services toll-free at 1-800-676-4636**.**

Remember the EAP

In addition, you and your eligible dependents automatically are eligible for the Employee Assistance Program (EAP), which is provided by OptumHealth Behavioral Solutions. You don't have to enroll, and the EAP is available at no cost. The EAP provides confidential, expert counseling; referrals for child/elder care, legal/financial assistance, education, and other work-life services; and information on a range of work-life issues that may affect your health and well-being.

Consider This—Health Benefits

- As you compare how you used your 2012 health benefits with your current and anticipated needs, look at what you paid in out-of-pocket costs vs. what you paid for coverage out of your pay check.
    - If you paid for a high level of coverage but didn't incur a lot of out-of-pocket costs, you may want to think about buying a lower level of coverage for 2013.
    - On the other hand, if you elected a lower level of medical coverage for 2012 and ended up paying more out of pocket, you may want to elect a higher level of coverage for 2013.
- Is other health coverage available to you? If your spouse/domestic partner works, check out any health benefits coverage offered by your spouse/domestic partner's employer to see if you, your spouse/domestic partner, and/or your children should enroll in your spouse/domestic partner's coverage rather than Nortel's.

Look to Your Health Plan for Additional Support

Anthem and CIGNA both offer programs to help you and your family manage your health. These confidential, voluntary health management programs are available to you (if you're under age 65) and your eligible dependents at no cost. Offerings include:

- Toll-free numbers where you can talk with a registered nurse 24/7 and access pre-recorded health information.
    - Anthem: 1-877-5NORTEL (566-7835)
    - CIGNA: 1-800-257-2702
- Web sites where you can find health information, use online health tools, send an e-mail to a nurse, link to other health Web sites, and more. You'll need to register to take advantage of all the sites have to offer.

- Anthem: www.anthem.com
- CIGNA: www.cigna.com

Dental, Vision, and Hearing Care Benefits

Nortel offers two dental/vision/hearing care options that cover a range of services:

- Comprehensive
- Plus

You can choose any option you wish, regardless of which medical option you choose. Dental, vision and hearing care are bundled together, so if you enroll for coverage, you'll receive coverage for all three as a package. Keep in mind that there is only one vision plan—the Select option—so your vision coverage is the same whether you choose the Comprehensive or Plus dental/vision/hearing care option.

When you enroll, you can choose from four coverage levels:

- You only
- You and your spouse/domestic partner
- You and your children and/or your domestic partner's children
- You and your family (spouse/domestic partner, your children, and/or your domestic partner's children)

Remember, you can choose different coverage levels for your medical option and your dental/ vision/hearing care option. For example, you can choose medical coverage for you and your family and dental/vision/hearing care coverage for only you and your spouse.

Dental and hearing care benefits are provided through CIGNA HealthCare. Vision care benefits are provided through EyeMed Vision Care.

Short-Term Disability (STD)

STD benefits are intended to replace a portion of your income if you're totally disabled for five consecutive days (or the equivalent of your standard workweek) due to an approved, documented illness or injury. STD benefits are payable for up to 26 weeks of absence.

Long-Term Disability (LTD)

Employees whose leaves began in 2010 or before will continue on the previous LTD self-insured plan until the benefit ends or the plan is terminated. Please refer to the STD and LTD SPD at http://www.nortel-us.com/current/benefits/ under "Explore Plans and Services" for additional information about when the benefit may end or the plan terminated.

Effective 1/1/2011, employees actively at work in 2013 who begin an STD in 2013 and are unable to return to work after exhausting 180 days of STD may be eligible for a fully-insured LTD plan administered by MetLife. Nortel provides this LTD coverage at no cost to you. If eligible, you will receive coverage equal to 50% of your pre-disability benefit earnings up to a maximum monthly benefit of $5000.

Life Insurance

Life insurance helps protect your family's finances in the event of your death. In addition to receiving Nortel-paid core life insurance coverage, you can supplement your coverage as follows:

Optional Employee Life Insurance
Choose from additional available coverage options of one to five times your annual Benefits Earnings, rounded up to

the next $1,000 increment, up to a maximum of $3 million optional life insurance. Evidence of insurability (EOI) application and approval are required for coverage levels of four and five times your Benefits Earnings. The EOI application is also required if you want to increase the amount of your current optional employee life insurance during annual enrollment.

Optional Spousal/Domestic Partner Life Insurance
Choose optional coverage equal to $10,000, $25,000, $50,000, $75,000, or $100,000. EOI is required for any increases in spousal/domestic partner life insurance if the coverage amount will be over $25,000.

Optional Children's Life Insurance
Choose optional coverage of $5,000, $10,000, or $15,000 for each eligible dependent child. EOI is not required for this coverage.

You'll pay for optional life insurance coverage with after-tax payroll deductions. Coverage for both core and optional life insurance coverage is provided through Prudential.

Important Reminder

Optional life insurance rates for you are based on gender, current age and "smoker status." You're eligible for the non-smoker rate if you haven't smoked or used a tobacco product for 12 continuous months. Nortel doesn't require proof of your non-smoking status, but if you are found to be a smoker and are paying non-smoker rates, your beneficiary may be denied payment of life insurance benefits.

Consider This—Life Insurance Benefits

- Do you have dependents who rely on your income? If so, how much will they need to meet future expenses if you were to die?
- Do you have other long-term debts that need to be paid?
- Do you have any personal life insurance policies outside of Nortel? If you have a mortgage, do you have mortgage insurance?
- Do you have other significant assets or sources of income that your dependents can count on if you were to die?
- How's your health? If you want to increase your life insurance coverage, you'll need to provide EOI, and your increased coverage won't take effect until the date Prudential approves your application.

Optional AD&D Insurance

Optional accidental death and dismemberment (AD&D) insurance provides coverage in the event of accidental death or loss of a limb, sight, hearing or speech. AD&D insurance is provided through Prudential.

You can choose to enroll in optional AD&D insurance coverage, as follows:

- Optional AD&D Insurance (employee only). Choose optional coverage for yourself of one to five times your annual Benefits Earnings, rounded up to the next $1,000 increment, up to a maximum of $1 million or 5X Benefits Earnings, if less.
- Optional AD&D Insurance (employee and family). Choose optional coverage for yourself of one to five times your annual Benefits Earnings, rounded up to the next $1,000 increment, up to a maximum of $1 million or 5X Benefits Earnings, if less. The amount that will be paid if one or more of your family members were to die is as follows:
    - If you have a spouse/domestic partner only: 60% of your optional AD&D coverage amount.
    - If you have a spouse/domestic partner and dependent children: 50% of your optional AD&D coverage amount for your spouse/domestic partner and 15% of your optional AD&D coverage amount for each child.

- If you have dependent children only: 20% of your optional AD&D coverage amount for each child.

You pay the entire cost of any optional AD&D insurance you choose to purchase; Nortel doesn't contribute to the cost. You'll pay for optional AD&D insurance coverage with Benefits Credits and/or after-tax payroll deductions.

MEDICAL

Overview

It's important that you review and familiarize yourself with the Medical Plan options available to you and your family. While the Company is committed to providing you with tools and education to help you make informed choices, it's ultimately your health care and your responsibility to make the best decisions during enrollment and throughout the year.

If you elect to cover your spouse/domestic partner under a Nortel Medical Plan option and he or she has access to employer-provided medical coverage elsewhere, you will be required to pay an additional $50 each pay period in addition to the plan premiums unless you experience a qualified status change. Go to http://www.nortel-us.com/current/benefits/ and click on "Explore Plans/Services" to view the Affidavit of Status Change under Forms. You'll need to certify each year on your Personalized Enrollment Worksheet that your spouse/domestic partner doesn't have access to employer-provided medical coverage elsewhere when you enroll to avoid the additional $50 each pay period.

You can recommend that your provider be added to the Anthem or CIGNA network by completing a provider nomination form, which can be requested by calling HR Shared Services toll-free at 1-800-676-4636 and sending it to the address located at the bottom of the nomination form.

*Note**:** Nortel cannot guarantee that nominated providers will choose to participate in either the Anthem or CIGNA networks. As a Nortel employee, you have an out-of-network provision.*

If you live in a network area, your options include:

80/60 Preferred Provider Organization (PPO) Option—A managed care option available to those who live in a network area. It generally pays benefits at 80% of covered charges when you see providers within the preferred provider network after the calendar-year deductible is met. If you go to a provider who is not a member of the network, the 80/60 PPO option generally pays 60% of covered charges after the calendar-year deductible (medical) is met. Under this option, you're not required to have a primary care physician (PCP) coordinate your care, and there are no claim forms for you to fill out (unless you receive services from an out-of-network provider).

This may be a good option for you if you want lower biweekly employee contributions, but are prepared to pay higher out-of-pocket costs. With this option, you'll pay a $25 primary care physician (PCP) or $30 (specialist) copayment ($0 copayment for preventive care) for in-network office visits without having to first meet a calendar-year deductible. For other in-network and out-of-network benefits, you'll first have to meet a calendar-year deductible before the plan begins paying benefits.

For complete details on this option, refer to the Medical Plan Summary Plan Description (SPD), which can be found at http://www.nortel-us.com/current/benefits/ under "Explore Plans/Services" or by calling HR Shared Services toll-free at 1-800-676-4636**.**

90/70 Preferred Provider Organization (PPO) Option—The 90/70 PPO option is a type of managed care option available to those who live in a network area. It generally pays benefits at 90% of covered charges when you see providers within the preferred provider network after the calendar-year deductible is met. If you seek care from a provider who is not a member of the network, the 90/70 PPO option generally pays 70% of covered charges after the calendar-year deductible is met. Under this option, you're not required to have a PCP coordinate your care, and there are no claim forms for you to fill out (unless you receive services from an out-of-network provider).

This option provides a high level of coverage with lower out-of-pocket costs when you receive care. It may be a good choice if you expect to use a lot of medical care and are willing to make higher biweekly employee contributions in exchange for lower out-of-pocket costs when care is received.

For complete details on this option, refer to the Medical Plan Summary Plan Description (SPD), which can be found at http://www.nortel-us.com/current/benefits/ under "Explore Plans/Services "or by calling HR Shared Services toll-free at 1-800-676-4636**.**

How to Find Network Providers

To find a provider that participates in your network, you can check the provider directory on the plan administrator's Web site or call them directly. For plan administrator contact and website information, go to http://www.nortel-us.com/current/benefits/ under Explore Plans/Services.

Your Personalized Enrollment Worksheet will show all Medical Plan options available in your area.

If you live in non-network area:

Out-of-Area Comprehensive Option, offered through CIGNA—Available to those who live in a non-network area. There are no in-network or out-of-network benefit levels for the comprehensive option. Generally, this option pays 80% after the calendar-year deductible for most covered expenses, including doctor's office visits. However, you'll receive 100% coverage for preventive care, such as routine physicals.

For complete details on this option, refer to the Medical Plan Summary Plan Description (SPD), which can be found at http://www.nortel-us.com/current/benefits/ under Explore Plans/Services or by calling HR Shared Services toll-free at 1-800-676-4636**.**

If you elect no coverage

You also can decide not to participate in a Nortel Medical Plan option. **However, if you are planning to retire in 2013, you must be actively enrolled in a Nortel Medical Plan immediately before retirement to be eligible for the Nortel Retiree Medical Plan.** For other retiree medical plan eligibility requirements, see the Nortel Networks Retiree Medical Plan Summary Plan Description (SPD), which can be found at http://www.nortel-us.com/current/benefits/ under Choose the Right Plans (at the bottom of the page) or by calling HR Shared Services toll-free at 1-800-676-4636.

For more information about these plans, review the Summary of Health Benefits below.

Your Costs

Here's a look at your bi-weekly before-tax contributions for the Medical Plan network area options.

2013Medical Plan Costs—Network Area Options		
	80/60 PPO Option	**90/70 PPO Option**
You Only	25.66	41.88
You + Children	55.44	93.78
You + Spouse	76.17	121.13
You + Family	114.28	186.86

***Note**: In addition to the costs above, you will pay an additional $50 per pay period to cover your spouse/domestic partner if he or she has access to employer-provided medical coverage elsewhere. Misrepresenting your spouse's/domestic partner's access to employer-provided medical coverage is a serious offense and could result in the termination of your health care benefit and disciplinary action.*

Here's a look at your biweekly before-tax contributions for the Medical Plan non-network area options.

2013 Medical Plan Costs – Non-Network Area Option	
	Out-of-Area Comprehensive Option
You Only	37.69
You + Children	84.40
You + Spouse	109.01
You + Family	168.17

***Note:** In addition to the costs above, you will pay an additional $50 per pay period to cover your spouse/domestic partner if he or she has access to employer-provided medical coverage elsewhere. Misrepresenting your spouse's/domestic partner's access to employer-provided medical coverage is a serious offense and could result in the termination of your health care benefit and disciplinary action.*

PRESCRIPTION DRUG

When you enroll in a PPO or Out-of-Area Comprehensive Medical Plan option, your prescription drug benefits are provided through the Medco Health network. This means you'll receive the highest level of benefits if you use Medco's home-delivery pharmacy service or a retail pharmacy that participates in the Medco Health network.

How It Works

Your prescription drug benefits are provided by Medco Health. Express Scripts and Medco Health Solutions, Inc. have come together as one company to manage your prescription benefit. Medco is now a part of the Express Scripts family of pharmacies.

How Prescriptions Are Filled

If you fill your prescriptions through:

- A participating retail pharmacy, you will receive in-network benefits.
- The home-delivery pharmacy service, you will receive cost savings on your maintenance medications.
- An out-of-network retail pharmacy, you will be responsible for the full cost of the drug at the time of purchase (and a lower level of benefits) and you will need to submit a claim to Medco Health for reimbursement.

For a list of participating network retail pharmacies, contact Medco Health at 1-800-711-3460 or visit www.medcohealth.com/.

Coverage

You can choose from among three types of medication when it comes to your prescription drug needs:

- Generic drugs
- Preferred brand-name drugs
- Non-preferred brand-name drugs

You'll pay the least amount for generic and the preferred brand-name drugs included on the Medco Health Formulary—so it's important to take a copy of the formulary with you to the doctor. Talk to him or her to see if a less-costly equivalent drug is available for your needs. To obtain a copy of the formulary, visit www.medcohealth.com/, or contact Medco Health at 1-800-711-3460.

Pay-the-Difference Feature

If you choose a brand-name drug that has a generic equivalent available, you will pay the applicable brand-name coinsurance amount, PLUS, the dollar difference between the cost of the generic and the brand-name drug. This rule applies even if your prescribing doctor indicates your prescription should be "Dispense as Written." To avoid paying more for a drug that has a generic equivalent, it is important that you always ask if a generic is available and appropriate for your needs when getting a prescription from your doctor.

Note: The amount of the difference between the brand-name drug and generic alternative does not count toward satisfying the out-of-pocket maximum for drugs filled through the home-delivery pharmacy service.

Retail Refill Allowance (RRA) for Maintenance Medications

You're permitted three fills (the original plus two refills) at a retail pharmacy at the retail coinsurance amount for long-term or maintenance medications. For additional refills of the same medication at an in-network retail pharmacy, you'll have to pay 60% of the cost of that medication.

To avoid paying the increased price, you'll be required to get additional refills of that same prescription through the home-delivery pharmacy service. How does this work? After the second time you fill a long-term or maintenance drug through the retail pharmacy, you'll receive a letter from Medco Health reminding you of this provision and explaining how to switch that prescription to the home-delivery pharmacy service.

*Example: How Home Delivery Can Save You Money:**

Let's assume you need a six-month (180-day) supply of Nexium® Caps (20 mg).

	In-Network Retail Pharmacy	**Home Delivery Pharmacy Service**
Month 1	$40.00 for first 30-day prescription	$100.00 for a 90-day supply
Month 2	$40.00 for first refill	N/A
Months 3	$40.00 for second refill	N/A
Months 4 – 6	$118.00 (60% of $196.67 for 3 months) for additional refills	$100.00 for a 90-day supply
Total	**$474.00 for a 180-day supply**	**$200.00 for a 180-day supply**

***All drug prices in this example are current as of October 11, 2012.*

Note: With the home-delivery pharmacy service, you'll pay for a 90-day supply even if your prescription is written for up to a 30-day supply. This means if you fill a prescription that is written for a 30-day supply through the home-delivery pharmacy service, you'll pay the applicable home delivery pharmacy service 90-day supply coinsurance amount. In the case of a new prescription, however, Medco Health will allow a 30-day supply, at a 30-day coinsurance amount, on a first-time trial basis only.

Getting Started with Home Delivery

First, talk with your physician about your desire to save money by using the home delivery pharmacy service for your maintenance medication. Then, ask him/her to fill out the "Prescription Fax Form" which can be found on Medco Web site at www.medcohealth.com/ or by calling 1-888-EASYRX1 (number for physicians only). The form includes instructions on how to fill out and fax it. Please note that only your physician can fax the completed form. However, your physician may prefer to have you mail in your prescription. You can access the online form at www.medcohealth.com/ or you can call Medco at 1-800-711-3460 and ask to have a form mailed to you. Instructions on how to download and print the form are included on the Medco site. Just complete the form and mail it with your prescription to the address provided.

Once Medco receives your prescription, your order will be processed within three to five days**.** It may take up to two weeks until you receive your new order, so have your doctor write a 30-day prescription to have filled at your local pharmacy in addition to the 90-day prescription for home delivery. All prescriptions will be delivered to you with free standard shipping, unless you request express shipping. Keep in mind, for a new prescription it makes sense to use your local retail pharmacy until your doctor is comfortable that the new drug will work for you.

For more information about Prescription Drug coverage go to the Summary of Health Benefits section.

EAP

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.

Provided through the OptumHealth Behavioral Solutions, the EAP is designed to enrich and support you in both your personal and your working life. Here are some of the benefits the EAP offers:

- Confidential information and counseling service.
- Resources and expertise to help you or your family on a wide variety of subjects to assist with the demands of everyday life as well as major events.
- Support for a wide range of concerns including stress, depression, relationship issues, family concerns, and alcohol or drug problems.
- 24/7 Phone access.
- Up to eight in-person visits per calendar-year with a counselor or therapist per eligible family member (and other services).

Some outpatient services (e.g., psychiatrist visits, psychological testing, chronic conditions, medication management) are covered under your managed Mental Health and Substance Abuse Program benefit, not through the EAP. Contact OptumHealth Behavioral Solutions directly for proper authorization.

If you would like more information on EAP counseling or other EAP services, call 1-800-842-2991 or visit the Web site online at www.liveandworkwell.com/ and enter access code: 800-842-2991 (include the hyphens).

MENTAL HEALTH AND SUBSTANCE ABUSE

When you enroll in a PPO or Out-of-Area Comprehensive option, you'll have access to mental health and substance abuse treatment benefits administered through OptumHealth Behavioral Solutions (formerly known as UBH). These benefits cover any outpatient counseling you or your eligible dependents may need beyond the first eight visits covered by the EAP.

The Summary of Health Benefits – Mental Health & Substance Abuse Treatment summarizes the behavioral health benefits available under all the Nortel Networks Medical Plan options.

To receive the maximum level of benefits, you should call OptumHealth first before you go for care, and follow the recommended course of treatment using the OptumHealth network mental health professional to whom you're referred.

If you receive care from a provider or facility that is not part of the OptumHealth Behavioral Solutions network, your benefit level will be lower than the network level. These reduced benefits are defined as out-of-network benefits. If you fail to call OptumHealth Behavioral Solutions to precertify your care, you may be charged a penalty and your benefits may be reduced. In some cases, if you fail to precertify your care, no benefits will be paid. Please refer to Summary of Health Benefits for a description of your network and out-of-network benefits, as well as specific precertification requirements for out-of-network outpatient services.

Benefits will be denied if your care is considered not to be a covered service.

For more information about Mental Health and Substance Abuse coverage, review the Summary of Health Benefits below.

DENTAL, VISION AND HEARING CARE PLAN

Overview

To receive coverage for the Dental/Vision/Hearing Care Plan, you must actively enroll, as this is an optional benefit. When enrolled in the plan, your coverage is bundled together as a package (i.e., if you only need dental coverage, you'll still automatically receive benefits for vision and hearing care as part of the package).
If you do not enroll for 2013, your coverage will default to the same coverage you had in 2012.
You can choose from the following two coverage options:

- Comprehensive option
- Plus option

Keep in mind that there is only one vision plan—the Select option—so your vision coverage is the same whether you choose the Comprehensive or Plus dental/vision/hearing care option.

Your Costs

Here's a look at your biweekly before-tax contributions for the dental/vision/hearing care plan options for 2013:

2013 Dental/Vision/Hearing Care Plan Costs		
	Comprehensive Option	**Plus Option**
You Only	$5.43	$10.93
You + Children	$10.98	$22.01
You + Spouse	$11.11	$22.16
You + Family	$16.69	$33.25

For more information about Dental, Vision and Hearing Care coverage, review the Summary of Health Benefits at http://www.nortel-us.com/current/benefits/ under "Choose the Right Plans".

HEALTH MANAGEMENT PROGRAM

Nortel offers you a health management program that provides you with access to programs, events and tools. Our goal is to help you achieve optimal health and well-being, more effectively manage your health care costs, and achieve work-life balance.

Nortel offers you health management services through your health plan administrator (CIGNA or Anthem). Both are nationally recognized leaders in health improvement, and will offer Nortel employees and retirees less than age 65 voluntary confidential health management programs designed to assist you and your eligible dependents in managing your health. These programs are offered to you and your eligible dependents at no cost. They include:

- Nurse lines that provide toll-free access to registered nurses 24/7 for questions about conditions, symptoms, medications or other health information.
  Anthem: (877) 5NORTEL (566-7835)
  CIGNA: 1-800-257-2702
- Web sites for:
  - Health-related information.
  - Health tools, such as a health risk assessment, weight and exercise logs, a carbohydrate calculator and a blood sugar tracker
  - Email 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;
    – Your doctor's treatment plan; and
    – 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

How Do I Enroll?

Enrollment is not required. 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 contacting CIGNA or Anthem at one of the disease management numbers provided above. Participants with chronic health conditions may also receive an invitation by telephone directly from their Medical Plan administrator to participate in these voluntary programs.

SHORT-TERM DISABILITY (STD)

STD plan benefits are designed to continue all or part of your income if you're unable to work due to an approved injury or illness. STD plan benefits are available for up to 26 weeks. STD leaves commencing 1/1/11 are funded and administered by Nortel. Any STD benefit you receive will be taxable. For complete STD plan details and qualification

requirements, refer to the STD Plan Summary Plan Description (SPD) at http://www.nortel-us.com/current/benefits/ under “Explore Plans/Services” or by calling HR Shared Services toll-free at 1-800-676-4636.

The Company provides you with core STD Plan coverage-at no cost to you-as follows:

If you're disabled for...	You receive coverage equal to...
First 6 weeks	100% of your pre-disability Benefits Earnings
Weeks 7 through 26	66-2/3% of your pre-disability Benefits Earnings

LONG-TERM DISABILITY (LTD)

Effective 1/1/2011, employees actively at work in 2013 who begin STD in 2013 and are unable to return to work after exhausting 180 days of STD may be eligible for an insured LTD plan benefit administered by MetLife. Nortel provides this LTD Plan coverage at no cost to you. If eligible, you’ll receive coverage equal to 50% of your pre-disability Benefits Earnings up to a maximum monthly benefit of $5,000. Please note there is no optional buy-up option under this policy.

If you did not return to work after 26 weeks of disability that commenced in 2010 or before, you may be eligible for the self-insured Nortel LTD plan benefits. This means your disability benefit would be funded by Nortel. That is, the benefits are paid from the general assets of Nortel. The self insured LTD Plan is administered by The Prudential Insurance Company of America. Those on LTD prior to 1/1/11 who continue to be eligible for disability benefits will remain on the Nortel self-insured plan until this self insured plan is terminated or they recover from their disability or reach retirement age (whichever occurs first).

Any LTD benefit you receive will be taxable. For complete LTD plan details and qualification requirements, refer to the LTD Plan Summary Plan Description (SPD) or the MetLife Long Term Disability Certificate of Insurance, as applicable, which can be found at http://www.nortel-us.com/current/benefits/ under “Explore Plans/Services” or by calling HR Shared Services toll-free at 1-800-676-4636**.**

LIFE INSURANCE AND ACCIDENT AND DISMEMBERMENT (AD&D) INSURANCE

Life Insurance and AD&D Insurance Available for Domestic Partners

You may purchase Dependent Life Insurance and AD&D Insurance for your domestic partner and domestic partner’s children.

Employee Group Term Life Insurance

The Company provides you with core employee group term life insurance benefits—at no cost—to help cover your family’s financial needs if something were to happen to you. This insurance is underwritten by The Prudential Insurance Company of America and provides coverage equal to one times your Benefits Earnings up to $1 million.

You also have the choice to select:

- Optional employee group term life insurance
- Optional dependent group term life insurance
- Optional AD&D insurance.

Beneficiary information is required. You must designate a beneficiary for your life insurance. If you have not yet designated a beneficiary or want to change your beneficiary, contact HR Shared Services toll-free at 1-800-676-4636 to request a beneficiary form.

Imputed Income Tax

Federal regulations require you to pay imputed income tax on the value of Company-provided life insurance in excess of $50,000. To avoid this tax, you may select the lower $50,000 option if one times your Benefits Earnings is more than $50,000. To select this option, you must complete and return the Core Life Insurance Waiver. If you choose to "cap" your employee life insurance at $50,000, you're not eligible to purchase optional life insurance.

Note: Your cost is based on your age. Costs increase significantly as you reach the next "milestone" age bracket (i.e., 30, 35, 40, 45, 50, etc.).

Do You Need to Change Your "Smoker Status"?

To change your "smoker status," contact HR Shared Services anytime during the year. It's important to note that in order to change your "smoker status" from smoker to non-smoker, you must have been a non-smoker for at least 12 months.

Optional Employee Group Term Life Insurance

In addition to the core coverage provided by the Company, you may choose to purchase optional employee group term life insurance (payable with after-tax contributions). Like your core employee life insurance, this insurance is underwritten by The Prudential Insurance Company of America.

You may choose from the following coverage levels:

Core plus 1 x Benefits Earnings

Core plus 2 x Benefits Earnings

Core plus 3 x Benefits Earnings

Core plus 4 x Benefits Earnings

Core plus 5 x Benefits Earnings

This means, for example, if you select core plus one times Benefits Earnings, you're essentially receiving a total coverage of two times your Benefits Earnings.

The maximum amount of core employee group term life insurance that you carry can't exceed $1 million. Optional group term life insurance coverage cannot exceed $3 million.

You may also be required to provide evidence of insurability (EOI) when purchasing optional employee group term life insurance if you:

- Select four or five times your Benefits Earnings in optional employee group term life insurance coverage.
- Increase your optional life insurance during the annual enrollment period.

Calculate Optional Employee Group Term Life Insurance Costs

The following table lists the cost for every $1,000 of group term life insurance you can buy in 2013. Keep in mind that rates are subject to change as you reach the next "milestone" age bracket (i.e., 30, 35, 40, 45, 50, etc.) during the plan year and in future years.

Employee's Age on 12/31/12	Biweekly Cost Per $1,000 of Group Term Life Insurance	
	Non-smoker	Smoker

Under 25	$0.014	$0.016
25–29	$0.014	$0.016
30–34	$0.018	$0.021
35–39	$0.021	$0.024
40–44	$0.029	$0.031
45–49	$0.044	$0.047
50–54	$0.069	$0.072
55–59	$0.126	$0.135
60–64	$0.189	$0.208
65–69	$0.361	$0.396
70-74	$0.598	$0.648
75 or older	$0.645	$0.648

Optional Dependent Group Term Life Insurance

Dependent group term life insurance pays benefits to you in the event of the death of your spouse/domestic partner or dependent children. This insurance is underwritten by The Prudential Insurance Company of America.

You have the option to purchase this additional coverage—payable with after-tax contributions—during the Benefits 2013 annual enrollment period.

You can select coverage for your…	In the amount of…
Dependent Children	• $5,000 • $10,000 • $15,000
Spouse/Domestic Partner	• $10,000 • $25,000 • $50,000* • $75,000*

- $100,000*

** EOI required for amounts of $50,000 or more.*

If you select coverage for your dependent children or your domestic partner's dependent children, the coverage amount is the same for each covered child and the cost is the same regardless of the number of children you cover.

*If you select coverage for your spouse/domestic partner***,** the cost is based on your:

- Spouse's/domestic partner's age, and
- The amount of coverage you choose.

Calculate Optional Spousal/Domestic Partner Group Term Life Insurance Cost

The following table lists the cost for every $1,000 of group term life insurance you can buy in 2013. Keep in mind that rates are subject to change as your spouse/domestic partner reaches the next "milestone" age bracket (i.e., 30, 35, 40, 45, 50, etc.) during the plan year and in future years.

Spouse's/Domestic Partner's Age on 12/31/12	Biweekly Cost Per $1,000 of Group Term Life Insurance
Under 25	$0.014
25–29	$0.014
30–34	$0.018
35–39	$0.021
40–44	$0.029
45–49	$0.044
50–54	$0.069
55–59	$0.126
60–64	$0.189
65–69	$0.361
70 or older	$0.598

To calculate what your optional spousal/domestic partner group term life insurance will cost:

- From the table, find the biweekly cost for your spouse's/domestic partner's age.
- Multiply the amount of group term life insurance divided by 1,000 by the appropriate cost.

Here's an example. If you want to buy $75,000 of group term life insurance for your 37 year-old spouse/domestic partner, your cost would be calculated as follows:

$75,000 divided by 1,000 x $0.021 = $1.58 biweekly

You'll be required to provide EOI (satisfactory to Prudential) for your spouse/domestic partner if you select optional spousal/domestic partner group term life insurance coverage greater than $25,000 and you don't already have this level of coverage in effect.

Calculate Optional Child Group Term Life Insurance Rates

Biweekly Cost Per $1,000 of Group Term Life Insurance	
Dependent Child	$0.037

Optional AD&D Insurance

You can choose to purchase optional AD&D insurance, which provides protection for you and your dependents from accidental injuries resulting in death or the loss of limbs, hearing, speech or sight. This insurance is underwritten by The Prudential Insurance Company of America.

You will pay for this coverage with after-tax contributions. You can select single coverage for yourself only, or family coverage for yourself and your eligible dependents, as follows:

For You*	Spouse/Domestic Partner	For Children	Spouse/Domestic Partner and Children
1 x Benefits Earnings	■ 60% of your optional AD&D coverage amount	■ 20% of your optional AD&D coverage amount for each child	Spouse/domestic partner: ■ 50% of your optional AD&D coverage amount For each child: ■ 15% of your optional AD&D coverage amount
2 x Benefits Earnings			
3 x Benefits Earnings			
4 x Benefits Earnings			
5 x Benefits Earnings			

** The maximum amount of AD&D coverage you can carry for yourself is $1 million.*

Note: This AD&D policy does not provide coverage for sickness. It provides accident insurance only, and does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department.

Calculate Optional AD&D Insurance Rates

Biweekly Cost Per $1,000 of AD&D Insurance	
You Only	$0.005
Family	$0.009

SUMMARY OF HEALTH BENEFITS

Summary of Health Benefits - Network Area

The chart below outlines the main features of the Medical Plan options available to you if you live in a network area.

Network Area Medical Options				
Benefit Description	80/60 Preferred Provider Organization (PPO) Option		90/70 Preferred Provider Organization (PPO) Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar year deductible [10] • Individual • Family	• $400/person • $1,200/family	• $600/person • $1,800/family	• $300/person • $750/family	• $500/person • $1,500/family
Hospital inpatient stay copayment	$350[1]	$500[1]	$350[1]	$500[1]
Outpatient surgery copayment	$250[1]	$500[1]	$250[1]	$500[1]
Calendar year out-of-pocket maximum[8] [10] • Individual • Family	• $3,500/person • $7,000/family	• $7,500/person • $15,000/family	• $3,500/person • $7,000/family	• $7,500/person • $15,000/family
Lifetime maximum benefit/person	Unlimited	Unlimited	Unlimited	Unlimited
Physician Services				
Primary care physician office visits	$25 copayment	60%[3,4]	$25 copayment	70%[3,4]
Specialist office visits	$30 copayment	60%[3,4]	$30 copayment	70%[3,4]
Prenatal visits	$30 copayment	60%[3,4]	$30 copayment	70%[3,4]

Network Area Medical Options				
Benefit Description	80/60 Preferred Provider Organization (PPO) Option		90/70 Preferred Provider Organization (PPO) Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	(for first visit only; excludes X-ray and lab)		(for first visit only; excludes X-ray and lab)	
Inpatient surgeon's fees	80%[1,4]	60%[1,3,4]	90%[1,4]	70%[1,3,4]
Anesthetic services and ancillary services	80%[1,4]	60%[3,4]	90%[1,4]	70%[3,4]
Inpatient hospital services	80%[1,4]	60%[1,3,4]	90%[1,4]	70%[1,3,4]
Allergy injections	$30 copayment[9]	60%[3,4]	$30 copayment[9]	70%[3,4]
Other Professional Services				
CIGNA Outpatient short-term rehabilitation: physical, speech (pre-certification required), and occupational therapy, up to 90 visits per condition per calendar year; includes chiropractic services	$30 copayment[5,7]	60%[3,4,5,7]	$30 copayment[5,7]	70%[3,4,5,7]
Anthem Outpatient short-term rehabilitation: Physical therapy: (30 visits per calendar year) Speech therapy: (30 visits per calendar year) Occupational therapy: (30 visits per calendar year)	$30 copayment[5,7]	60%[3,4,5,7]	$30 copayment[5,7]	70%[3,4,5,7]
Anthem Chiropractic services	$30 copayment[7]	60%, up to 24 visits per calendar year[2,3,4,7]	$30 copayment[7]	70%, up to 24 visits per calendar year[2,3,4,7]
Private duty nursing	80%[2,4]	60% up to $10,000/person/ calendar year[2,3,4]	90%[2,4]	70% up to $10,000/person/ calendar year[2,3,4]

Network Area Medical Options				
Benefit Description	80/60 Preferred Provider Organization (PPO) Option		90/70 Preferred Provider Organization (PPO) Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care				
Well-baby care (up to age 6)	$0 copayment	60%[3,4]	$0 copayment	70%[3,4]
Child physical exam (age 6+)	$0 copayment	60%[3,4]	$0 copayment	70% [3,4]
Adult physical exam	$0 copayment	60%[3,4]	$0 copayment	70%[3,4]
Routine OB/GYN exam (includes routine mammogram)	$0 copayment	60%[3,4]	$0 copayment	70%[3,4]
X-ray and laboratory – preventive screening	100%	60%[3,4]	100%	70%[3,4]
Hospital Services				
Inpatient treatment	80% after each hospital inpatient stay copayment[1,4]	60% after each hospital inpatient stay copayment[1,3,4]	90% after each hospital inpatient stay copayment[1,4]	70% after each hospital inpatient stay copayment[1,3,4]
Outpatient treatment	80%[1,4]	60%[1,3,4]	90%[1,4]	70%[1,3,4]
Outpatient surgery	80% after each outpatient surgery copayment[1,4]	60% after each outpatient surgery copayment[1,3,4]	90% after each outpatient surgery copayment[1,4]	70% after each outpatient surgery copayment[1,3,4]
Emergency room	80% after $100 copayment (waived if admitted)	60% after $100 copayment (waived if admitted)[3]	90% after $100 copayment (waived if admitted)	70% after $100 copayment (waived if admitted)[3]
Urgent care	80%[4]	60%[3,4]	90%[4]	70%[3,4]
Skilled nursing facility, up to 60 days/ calendar year	80%[1,4,5]	60%[1,3,4,5]	90%[1,4,5]	70%[1,3,4,5]
Hospice	80%[4]	60%[3,4]	90%[4]	70%[3,4]
Other Medical Services				
Assisted reproduction, up to $5,000 lifetime maximum per person	80%[4,6]	60%[3,4,6]	90%[4,6]	70%[3,4,6]
Infertility diagnosis and treatment	80%[4]	60%[3,4]	90%[4]	70%[3,4]
Home health care	80%[2,4]	60% up to 100 visits/calendar year[2,3,4]	90%[2,4]	70% up to 100 visits/calendar year[2,3,4]

Network Area Medical Options				
Benefit Description	80/60 Preferred Provider Organization (PPO) Option		90/70 Preferred Provider Organization (PPO) Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic X-ray and lab	80%[4] (must use network labs)	60%[3,4]	90%[4] (must use network labs)	70%[3,4]
Radiation and chemotherapy	80%[4]	60%[3,4]	90%[4]	70%[3,4]
Durable medical equipment	80%[2,4]	60% [2,3,4]	90%[2,4]	70% [2,3,4]

[1]Precertification required for all inpatient admissions and may be required for certain outpatient procedures.

[2]In-network benefits count toward out-of-network maximum benefit.

[3]Subject to reasonable and customary (R&C) limits.

[4]Subject to calendar year deductible.

[5]Benefits paid for both in-network and out-of-network care count toward the Medical Plan's calendar year benefit limit. Examples of a calendar year benefit limit include "60 days/calendar year" or "30 visits calendar year."

[6]The Medical Plan pays up to a $5,000 lifetime maximum/participant for assisted reproduction services (e.g., impregnation or fertilization). Benefits paid for both in-network and out-of-network care count toward the Medical Plan's lifetime benefit limit.

[7]When outpatient short-term rehabilitation services are received on an outpatient basis at a hospital facility, the Medical Plan's benefits are described under "Hospital Services - Outpatient Treatment."

[8]Charges in excess of the R&C limits, charges above plan maximum amounts, charges applied to the deductible, and any expenses you incur under the plan's prescription drug benefits do not count toward the calendar year out-of-pocket maximum.

[9]If not part of an office visit, no charge for the injection.

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

Summary of Health Benefits - Non-Network Area

The chart below outlines the main features of the CIGNA Out-of-Area Comprehensive option available to you if you live in a non-network area.

Non-Network Area Medical Option	
Benefit Description	**Out-of-Area Comprehensive Option**
Calendar year deductible • Individual • Family	 • $300/person • $900/family
Hospital inpatient stay copayment	$300[1]
Calendar year out-of-pocket maximum[5] • Individual • Family	 • $2,000/person • $4,000/family
Lifetime maximum benefit/person	Unlimited

Non-Network Area Medical Option	
Benefit Description	**Out-of-Area Comprehensive Option**
Physician Services	
Primary care physician office visits	80%[2,3]
Specialist office visits	80%[2,3]
Prenatal visits	80%[2,3]
Outpatient surgeon's fees	80%[2,3]
Inpatient surgeon's fees	80%[1,2,3]
Anesthetic services and ancillary services	80%[2,3]
Inpatient hospital services	80%[1,2,3]
Other Professional Services	
Outpatient short-term rehabilitation: physical, speech, and occupational therapy, up to 90 visits per condition per calendar year Also includes chiropractic services under this description	80%[2,3] 80%[2,3]
Private duty nursing	80% up to $10,000/person/calendar year[2,3]
Preventive Care	
Well-baby care (up to age 6)	100% with no deductible[2]
Child physical exam (age 6+)	100% with no deductible[2]
Adult physical exam	100% with no deductible[2]
Routine OB/GYN exam (includes routine mammogram)	100% with no deductible[2]
Hospital Services	
Inpatient treatment	80% after each hospital inpatient stay copayment[2,3]
Outpatient treatment	80%[1,2,3]
Emergency room	80%[2,3]
Skilled nursing facility, up to 60 days/calendar year	80%[1,2,3]
Hospice	80%[2,3]
Other Medical Services	
Assisted reproduction, up to $5,000 lifetime maximum per person	80%[2,3,4]
Infertility diagnosis and treatment	80%[2,3]
Home health care	80% up to 100 visits/calendar year[2,3]
Diagnostic X-ray and lab	80%[2,3]
Radiation and chemotherapy	80%[2,3]
Durable medical equipment	80% [2,3]

[1]Precertification required.

[2]Subject to reasonable and customary (R&C) limits.

[3]Subject to calendar year deductible.

[4]The Medical Plan pays up to a $5,000 lifetime maximum/participant for assisted reproduction services (e.g., impregnation or fertilization).

[5]Charges in excess of the R&C limits, charges above plan maximum amounts, charges applied to the

deductible, and any expenses you incur under the plan's prescription drug benefit do not count toward the calendar year out-of-pocket maximum.

Summary of Health Benefits - Prescription Drugs

The following chart outlines the prescription drug benefits available to you if you enroll in a PPO or Out-of-Area Comprehensive option. There are no changes in plan benefits for 2013.

Your Prescription Drug Benefit At-A-Glance[1]				
	Retail Pharmacy[2] (up to a 30-day supply)		Home Delivery Pharmacy Service (up to a 90-day supply)	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*
Out-of-Pocket Maximum	Not applicable	Not applicable	$3,000/year/per person[3]	Not applicable
Generic Drugs	20% coinsurance ($7 minimum, $25 maximum)[4,5]	60% coinsurance	20% coinsurance ($15 minimum, $50 maximum)[4,5]	Not applicable
Preferred Brand-Name Drugs	20% coinsurance ($15 minimum, $50 maximum)[4,5]	60% coinsurance	20% coinsurance ($45 minimum, $100 maximum)[4,5]	Not applicable
Non-Preferred Brand-Name Drugs	30% coinsurance ($30 minimum, $65 maximum)[4,5]	60% coinsurance	30% coinsurance ($90 minimum, $130 maximum)[4,5]	Not applicable

[1]If a brand-name drug is filled when a generic equivalent is available, you'll pay the brand-name drug employee coinsurance plus the difference in cost between the generic and brand-name drug.
[2]You're allowed one initial prescription plus two refills at the above coverage for maintenance medications filled at a retail pharmacy. For three or more refills, you'll pay 60% of the prescription cost.
[3]The amount of the difference between the brand-name drug and generic alternative does not count toward satisfying the out-of-pocket maximum.
[4]Coinsurance is a portion (percentage) of covered expenses. For example, if your coinsurance is 20% of the amount of covered expenses, you'll pay 20% of the cost and the plan will cover 80% of the cost.
[5]On occasion, the discounted cost of your prescription is less than the stated minimum coinsurance amount. In those instances, you will be charged the discounted cost of the drug.

Summary of Health Benefits - Mental Health & Substance Abuse Treatment

This chart 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.

Mental Health and Substance Abuse Treatment Benefits		
Feature	**In-Network**	**Out-of-Network**
Calendar year deductible	None	$200/person[2,6]
Calendar year out-of-pocket maximum[2,6]	• $3,500/person • $7,000/family	• $7,500/person • $15,000/family
Lifetime maximum benefit (all services combined)	Unlimited	Unlimited
Inpatient services		

Mental Health and Substance Abuse Treatment Benefits		
Feature	**In-Network**	**Out-of-Network**
(Precertification required) • Mental health • Substance abuse	• 100%[1] • 100% [1]	• 70% of eligible charges after $200 calendar year deductible and $150 deductible/hospital admission[1, 2,,3,] • 70% of eligible charges after $200 calendar year deductible and $150 deductible/hospital admission[1,2,3]
Intermediate care Mental health and substance abuse	100%[1,3]	80% of eligible charges after $200 calendar year deductible and $150 deductible/hospital admission[1,2,3,]
Outpatient services Individual Treatment	• Visits 1 - 17: $20 copayment (Does not include EAP visits) • Visits over 17: $25 copayment	70% after $200 calendar year deductible, [2,3]
Group Treatment	• Visits 1 - 17: $10 copayment (Does not include EAP visits) • Visits over 17: $20 copayment	70% after $200 calendar year deductible [2,3]
In-home mental health care	100%	70% of eligible charges after $200 calendar year deductible are met up to 100 visits per calendar year[3]
Drug testing as an adjunct to substance abuse treatment	100%	70% after $200 calendar year deductible [2,3]
Medication management[5]	$5 copayment for up to 30-minute visit; no limit	70% after $200 calendar year deductible for up to a 30-minute visit; unlimited visits [2,3]

[1] Precertification required for all inpatient admissions and intermediate care. 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. 100% denial for no authorization

[2]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.

[3]Subject to reasonable and customary (R&C) limits.

[4]Includes, but is not limited to, 24-hour intermediate care facilities (e.g., residential treatment, group homes, halfway houses, therapeutic foster care, partial hospital/day treatment, structured outpatient treatment programs). Intermediate care is subject to the same plan maximums that apply to inpatient care benefits.

[5] Medication management visits that exceed 30 minutes are considered under outpatient individual treatment sessions.

[6] Deductibles and Out of pocket maximum do not cross accumulate between in and out of network care. Behavioral Health Out-of- Pocket Maximum includes charges for medical, mental health and substance abuse treatment. Does not include charges in excess of the R&C limits, charges above plan maximum amounts, and charges applied to the deductible.

Summary of Health Benefits - Dental/Vision/Hearing Care

The chart below outlines the main features of the Dental/Vision/Hearing Care Plan Comprehensive and Plus options.

Dental/Vision/Hearing Care Plan Options		
Feature	**Comprehensive**	**Plus**
Dental Care Coverage (provided by CIGNA Healthcare)		
Note: Reasonable and customary (R&C) limits apply to all coverage amounts.		
Calendar year deductible • Individual • Family	 • $25/person • $75/family	 • $50/person • $150/family
Preventive services (e.g., x-rays, cleanings, fluoride treatments, sealants and space maintainers for children under 14 years)	100% of covered expenses (no deductible)	100% of covered expenses (no deductible)
Basic services (e.g., fillings, extractions, oral surgery, periodontal treatment, minor restorations)	80% of covered expenses	80% of covered expenses
Major services (e.g., crowns, onlays, dentures, bridges)	50% of covered expenses	60% of covered expenses
Orthodontics (treatment such as straightening of teeth)	50% of covered expenses	50% of covered expenses
Annual maximum dental benefit (excludes orthodontia, includes oral surgery)	$1,500/person	$2,000/person
Lifetime maximum orthodontics benefit	$1,500/person	$2,000/person
Vision Care Coverage (provided by EyeMed Vision Care)		
Copayment for vision care services	$10 copayment	$10 copayment
Routine exam, frames and lens benefits from an EyeMed provider[1]	Covered up to plan allowance after applicable copayments	Covered up to plan allowance after applicable copayments
Contact lens benefit from an EyeMed provider[2]	Up to $150/calendar year for elective contact lenses[3]; medically necessary contact lenses are covered in full[4]; contact lenses are in lieu of spectacle lenses. *Note:* Only one claim per year — please see footnotes.	
Services from an out-of-network provider: • Exam Spectacle lenses[5]: • Single • Bifocal • Trifocal • Lenticular • Contact lenses/elective (in lieu of spectacle lenses) • Contact lenses/necessary[3] (in lieu of spectacle lenses)	Reimbursed after copayment up to the following under Comprehensive and Plus options; the contact lens allowance is for CL materials only**:** • $50 • $40 • $60 • $80 • $125 • $105 • $210	

Dental/Vision/Hearing Care Plan Options		
Feature	**Comprehensive**	**Plus**
• Frames	• $45	
Laser Vision Correction Discount	When arranged with a participating provider, the discount is 15% off the retail price or 5% off any promotional offer.	
Plan pays benefits for: • Exams • Spectacle lenses[5] • Contact lenses[6] • Frames	Once every: • Calendar year • Calendar year • Calendar year • Two calendar years	Once every: • Calendar year • Calendar year • Calendar year • Two calendar years
Hearing Care Coverage (provided by CIGNA Healthcare)		
Eligible expenses (hearing aids and hearing exams)	80% of covered expenses	100% of covered expenses
Maximum benefit every two calendar years	$750	$1,000

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

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

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

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

[5]In-network, there are discounts for elective lens options. Out-of-network, expenses for elective lens options are your responsibility. Examples of elective lens options are tinting, polycarbonates, and progressives. If you have any questions, please contact EyeMed.

[6] In lieu of spectacle lenses

CONTACT INFORMATION

In addition to answering questions about coverage and claims, health plans offer valuable online information, tools and services that can help you get better results from the care you receive. These services are available to you and your dependents at no additional cost. You can also contact your plan by phone if you have a question about your benefits or if you can't find what you're looking for online.

For more complete information about the terms and conditions of these plans please refer to the summary plan descriptions (SPD) on Nortel's health and group benefits website at http://www.nortel-us.com/current/benefits/ under "Explore Plans/Services". If you don't have internet access, you can call HR Shared Services at 1-800-676-4636 to have the SPDs sent to you.

	Online	Telephone
Nortel		
HR Shared Services		**Direct:** 919-905-9351 **Toll-free:** 1-800-676-4636
Medical and Mental Health and Substance Abuse Treatment Benefits		
CIGNA Health Care PPO and Out-of-Area Comprehensive (**Note:** CIGNA refers to Nortel's PPO network as "Open Access Plus.")	www.cigna.com	**Toll-free:** 1-800-257-2702 **International Locations:** 1-800-441-2668
Anthem PPO (**Note:** Anthem refers to its PPO network as "PPO.")	www.anthem.com **Mobile Provider Finder:** www.anthem.com/mobile	**Toll-free:** 1-877-5NORTEL (1-877-566-7835)
Healthy Lifestyles		
Healthy Lifestyles	www.findahealthieryou.com	1-877-252-8410
Prescription Drug Benefits		
Medco Health	www.medco.com	**Toll-free (Participants only):** 1-800-711-3460 **Toll-free (First-time users only):** 1-877-782-7862
Dental Care Benefits		
CIGNA Health Care CIGNA Dental Core Network	www.cigna.com	**Toll-free:** 1-800-257-2702

(formerly CIGNA Dental PPO)

Vision Care Benefits		
EyeMed Vision Care	**Member site:** www.eyemedvisioncare.com **Non-member site:** www.enrollwitheyemed.com **For replacement contact lenses by mail:** www.eyemedcontacts.com	**Toll-free:** 1-866-680-1186 **Laser benefit:** 1-877-5LASER6
Hearing Care Benefits		
CIGNA HealthCare	www.cigna.com	**Toll-free:** 1-800-257-2702
Employee Assistance Program and Behavioral Health Benefits		
OptumHealth Behavioral Solutions	www.liveandworkwell.com **Access code:** 800-842-2991 (include the hyphens)	**Toll-free:** 1-800-842-2991
Short-Term Disability (STD) Benefits		
STD Claims		HR Shared Service at 1-800-676-4636 or 919-905-9351 (ESN 355)
Long-Term Disability (LTD) Benefits		
LTD Claims		**Claims prior to 1/1/2011** call Prudential at 1-800-842-1718. **Claims commencing on or after 1/1/2011** call Metlife at 1-800-638-2242
Life and Accidental Death and Dismemberment (AD&D) Insurance		
Prudential Group Life Claims Division		**Toll-free:** 1-800-524-0542
Other		
Ceridian		
Benefits Billing Service	www.ceridian.com	**Toll-free:** 1-800-995-9935
COBRAServe	www.ceridian.com	**Toll-free:** 1-800-877-7994
Internal Revenue Service (IRS)	www.irs.gov	**Toll-free:** 1-800-TAX-FORM (1-800-829-3676)

Notice of Creditable Prescription Drug Coverage

The following is creditable prescription drug coverage information for Medicare-eligible Nortel employees and their covered dependents.

Note: Individuals who are not currently eligible for Medicare and do not expect to become eligible before January 1, 2013 can disregard this notice.

Nortel is required to provide this notice to all Medicare-eligible plan participants. The purpose of the notice is to provide participants in all Nortel Networks Medical Plan options with a statement of assurance that the prescription drug coverage you have through Nortel is "Creditable Coverage." This means that on average, your Nortel coverage is at least as good as the Medicare prescription drug coverage. You can keep your current Nortel prescription drug coverage without change.

If you waive Medicare prescription drug coverage now, but decide in a subsequent year that you want to enroll in a Medicare prescription drug plan, this notice will serve as confirmation to Medicare that you have had Creditable Coverage in the interim. As a result, you will not have to pay a late penalty on your Medicare prescription drug plan's monthly premium if you decide to enroll during a subsequent annual enrollment window.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Nortel and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Nortel has determined that the prescription drug coverage offered by the Nortel Networks Medical Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.**

3. **Nortel Networks Inc. reserves the right to amend or discontinue its Nortel Networks Medical Plan and the coverage and benefits provided thereunder, including prescription drug coverage for the avoidance of doubt, at any time and for any reason.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan from October 15 through December 7. Beneficiaries leaving employer coverage may be eligible for a Special Enrollment period to sign up for a Medicare prescription drug plan.

Be aware if you decide to enroll in a Medicare prescription drug plan, you will not have prescription drug coverage with your Nortel Networks Medical Plan. Also, if you drop your Nortel Networks Medical coverage, you will not be able to re-enroll.

If you drop your Medical Plan coverage with Nortel and enroll in a Medicare prescription drug plan, you will not be able to get the Nortel Networks Medical Plan coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

In addition to prescription drugs, your current Nortel Networks Medical Plan coverage pays for other health expenses. If you enroll in a Medicare prescription drug plan and continue to participate in the Nortel Networks Medical Plan for medical coverage, the Nortel plan will not provide any additional drug coverage and your premiums will not be reduced. If a drug is not covered by the Medicare plan or is covered at a lower level, the Nortel Networks Medical Plan will not provide any additional prescription drug benefits.

You should also know that if you drop or lose your coverage with the Nortel Networks Medical Plan and don't enroll in Medicare prescription drug coverage after your Nortel coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If, after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage.

For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage.

For more information about this notice or your current prescription drug coverage…
contact HR Shared Services for further information at **1-800-676-4636**. **NOTE:** You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, and if coverage through Nortel changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage
More detailed information about Medicare plans that offer prescription drug coverage will be available in the "Medicare & You 2013" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program for personalized help (see your copy of the "Medicare & You 2013" handbook for their telephone number)
- Call **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit the SSA online at **www.socialsecurity.gov**, or call them at **1-800-772-1213** (TTY **1-800-325-0778**).

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Notice of Privacy Practices

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access To This Information. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the plans – whether received in writing, in an electronic medium, or as an oral communication. Protecting the confidentiality of your personal health information is an important priority for Nortel Networks Group Health Plan. Consequently, Nortel has adopted policies to safeguard the privacy of your health information and comply with HIPAA. This notice describes the HIPAA privacy practices of the following plans:

Nortel Networks Employee Assistance Program
Nortel Networks Medical Plan
Nortel Networks Dental/Vision/Hearing Care Plan
Nortel Networks Retiree Medical Plan
Nortel Networks Retiree Long-Term Care Benefits
Nortel Networks Health & Welfare Benefits Trust

The plans covered by this notice will share information with each other as necessary to carry out treatment, payment, or health care operations. The plans collectively constitute an organized health care arrangement under HIPAA and are referred to as the Group Health Plan in this notice. You may be covered by one or more of these plans. However, the provision of this notice to you does not establish your coverage or give you any right to coverage under any of these plans. Coverage is determined by the requirements of each of the plans.

The Group Health Plan's Duties With Respect to Health Information about You

The Group Health Plan is required by law to maintain the privacy of your protected health information and to provide you with this notice of the Group Health Plan's duties and privacy practices with respect to your protected health information. If you participate in an insured health plan option, you will receive a separate notice directly from the insurer. It's important to note that these rules apply to the Group Health Plan, not Nortel Networks as an employer – that's the way the HIPAA rules work. Different policies may apply to other Nortel Networks programs or to health information or data that Nortel Networks acquires about you from sources other than the Group Health Plan. Such information is not "protected health information" under HIPAA.

Examples of protected health information include: completed medical claim forms, claims appeals determinations, explanation of benefits, hospital bills, prescriptions & diagnoses.

This notice explains:

- How your protected health information may be used, and
- What rights you have regarding this information.

How the Group Health Plan May Use Your Health Information

The HIPAA privacy rules generally allow the use and disclosure of your protected health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

For treatment. So that you receive appropriate treatment and care, providers may use your protected health information to coordinate or manage your health care services. For example, your physician uses your information when he or she consults with a specialist regarding your condition.

For payment. To make sure that claims are paid accurately and you receive the correct benefits, the Group Health Plan may use and disclose your protected health information to determine plan eligibility and responsibility for coverage and benefits. For example, the Group Health Plan may use your information when conferring with other health plans to resolve a coordination of benefits issue. The Group Health Plan may also use your protected health information for claims and utilization management activities, including a review of all appeals of denied claims. That means that the Group Health Plan may send your information to individuals or entities who must review your information to make a decision about your appeal or to assist with the review of your appeal. Only the "minimum necessary," as defined under the HIPAA privacy rules, will be used or disclosed.

For health care operations. To ensure quality and efficient plan operations, the Group Health Plan may use your protected health information in several ways, including plan administration, wellness and risk assessment programs, quality assessment and improvement, customer service, and vendor review. Your information could be used, for example, to assist in the evaluation of a vendor who supports administration of the Group Health Plan. The Group Health Plan may also contact you with appointment reminders or to provide information about treatment alternatives or other health-related benefits and services available. The amount of protected health information used or disclosed will be limited to the "minimum necessary" for these purposes, as defined under the HIPAA privacy rules.

In no event will the Group Health Plan use or disclose your protected health information that is genetic information for underwriting purposes. In addition to rating and pricing a group insurance policy, this means the Group Health Plan may not use genetic information (including that requested or collected in a health risk assessment or wellness program) for setting deductibles or other cost sharing mechanisms, determining premiums or other contribution amounts, or applying preexisting condition exclusions.

How the Group Health Plan May Share Your Health Information with Nortel Networks Inc. (Plan Sponsor)

The Group Health Plan and any health insurance issuer may also disclose your protected health information without your written authorization to Nortel Networks (the plan sponsor) for Group Health Plan administration purposes. If you are covered under an insured health plan, the insurer also may disclose protected health information to Nortel Networks in connection with treatment, payment or health care operations. However, Nortel Networks will not use or disclose the protected health information provided by the Group Health Plan except as permitted or required by the plan documents and by law. Only employees of Nortel Networks who need access for plan administration functions will have access to such protected health information.

Other Permitted Uses and Disclosures of Your Health Information

Federal regulations allow the Group Health Plan to use and disclose your protected health information, without your authorization, for several additional purposes, in accordance with law:

- Public health
- Reporting and notification of abuse, neglect or domestic violence
- Oversight activities of a health oversight agency
- Judicial and administrative proceedings
- Law enforcement
- Research, as long as certain privacy-related standards are satisfied
- To a coroner or medical examiner
- To organ, eye or tissue donation programs
- To avert a serious threat to health or safety
- Specialized government functions (e.g., Military and veterans' activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations)
- Workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness
- Other purposes required by law, provided that the use or disclosure is limited to the relevant requirements of such law.

In Special Situations…
The Group Health Plan may disclose your protected health information to a family member, relative, close personal friend, or any other person whom you identify, when that information is directly relevant to the person's involvement with your care or payment related to your care.

The Group Health Plan may also use your protected health information to notify a family member, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, the Group Health Plan will act in your best interest regarding such disclosure and will disclose only information that is directly relevant to the person's involvement with your health care.

The Group Health Plan will make other uses and disclosures only after your written authorization. You may revoke your authorization in writing at any time as allowed under the HIPAA rules. However, you can't revoke your authorization if the Group Health Plan has taken action relying on it. In other words, you can't revoke your authorization with respect to disclosures the Group Health Plan has already made.

Your Rights Regarding Protected Health Information

You have the following rights with respect to your protected health information that is maintained by the Group Health Plan. These rights are subject to certain limitations, as described below.

Right to Inspect and Copy Your Health Information

You have the right to inspect and copy your protected health information that is maintained by the Group Health Plan. However, you do not have such a right to information that is compiled for civil, criminal or administrative proceedings. If the Group Health Plan doesn't maintain protected health information that you request but knows where it is maintained, you will be informed of where to direct your request.

The Group Health Plan may deny your rights to access, however, in certain circumstances. If your request is denied, you may request a review in some instances. The instances when you may request a review include: when a licensed health care professional has determined that the access may endanger the life or safety of you or someone else; when the information is about another person and a licensed health care professional has determined that access might endanger that other person; or when your personal representative requests the information and a licensed health care professional has determined that the access may endanger you or another person. Access may also be denied in some other circumstances that are not reviewable, including: when disclosure would likely breach a promise of confidentiality to the person who provided the information; when you consented to denial of access in order to participate in a clinical trial; or when the information was compiled in reasonable anticipation of, or for use in, a legal proceeding.

You may also file a complaint concerning the denial, as explained under "Complaints", below.

If you choose to exercise the right to inspect and copy, you must submit a written request to the Group Health Plan. Within 30 days of the receipt of your request (60 days if the protected health information is not accessible onsite), the Group Health Plan will provide you with:

- the access or copies you requested or a summary or explanation of the information requested, if desired;

- a written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or

- a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Group Health Plan expects to address your request.

The Group Health Plan reserves the right to charge for expenses (i.e. copying, postage, etc) incurred in providing you access to protected health information.

Right to Amend Your Health Information That Is Inaccurate or Incomplete

With certain exceptions, you have a right to ask the Group Health Plan to amend your protected health information. The Group Health Plan may deny your request for a number of reasons. For example, your request may be denied if the protected health information is accurate and complete, was not created by the Group Health Plan, or is not available for inspection (e.g., information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, you must submit a written request to the Group Health Plan, and include a statement to support the requested amendment. Within 60 days of receipt of your request, the Group Health Plan will:

- make the amendment as requested;
- provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- provide a written statement that the time period for reviewing your request will be extended (for no more than 30 more days) along with the reasons for the delay and the date by which the Group Health Plan expects to address your request.

Right to Receive An Accounting of Your Health Information

You have a right to receive an accounting of certain disclosures of your protected health information made by the Group Health Plan. You generally may receive an accounting of disclosures if the disclosure is required by law or in connection with public health activities.

HIPAA privacy rules do not provide for an individual's right to an accounting of several types of disclosures including, but not limited to disclosures made:

- for treatment, payment, or health care operations;
- where authorization was provided;
- to you about your own health information;
- incidental to other permitted or required disclosures;
- to family members or friends involved in your care (where disclosure is permitted without authorization)
- for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances;
- as part of a "limited data set" (health information that excludes certain identifying information); or
- before April 14, 2003 (the general date that the HIPAA privacy rules are effective).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you choose to exercise this right, you must submit a written request to the Group Health Plan. Within 60 days of the request, the Group Health Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Group Health Plan expects to address your request. You may make one request in any 12-month period at no cost to you. The Group Health Plan reserves the right to charge a fee for subsequent requests. If the Group Health Plan exercises its right to charge a fee you will be notified in advance and have the opportunity to change or revoke your request.

Right to Request Restrictions On Certain Uses and Disclosures of Your Health Information and the Group Health Plan's Right To Refuse

You may ask the Group Health Plan to restrict how it uses and discloses your protected health information for treatment, payment, or health care operations, except for those uses or disclosures required by law. You may also ask the Group Health Plan to restrict uses and disclosures of your protected health information to your family members, relatives, friends, or other persons you identify who are involved in your care or payment for your care. However, the Group Health Plan is not required to agree to these requests. And if the Group Health Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Group Health Plan (including an oral agreement), or unilaterally by the Group Health Plan

for protected health information created or received after you're notified that the Group Health Plan has removed the restrictions.

Right to Receive Notification of Breaches

If your unsecured protected health information is acquired, used or disclosed in a manner that is impermissible under the HIPAA privacy rules and that poses a significant risk of financial, reputational or other harm to you, the Group Health Plan must notify you within 60 days of discovery of such breach.

Right to Request Confidential Communications of Your Health Information

You may request to receive your protected health information by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For example, you may only want to have protected health information sent by mail or to an address other than your home.

For more information about exercising these rights, contact the office below.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who received this notice electronically may request a paper copy at any time.

Complaints

If you believe that your privacy rights have been violated, you may file a written complaint without fear of reprisal. Direct your complaint to the office listed below under "Contact Information" or to the Secretary of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201.

About this Notice

The Group Health Plan must abide by the terms of the privacy notice currently in effect. It reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information it maintains. If the Group Health Plan changes this notice, you will be provided a new notice electronically. If you do not have access to the Nortel Networks Intranet, the new notice will be sent to you by U.S. mail.

Contact Information

You may exercise the rights described in this notice by contacting the Nortel Networks office identified below, which will provide you with additional information. The contact is:

Nortel Networks Inc.
HR Shared Services
Dept. 7094, Mail Stop 570020C2
P.O. Box 13010
Research Triangle Park, North Carolina, 27709-3010
1-800-676-4636

WHCRA Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Nortel Networks Medical Plan.

If you would like more information on WHCRA benefits go to http://www.dol.gov/ebsa/publications/whcra.html.