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CANADA - BENEFITS

FLEX 2002 Handbook

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This Handbook provides a summary of the Nortel Networks Limited (Nortel Networks) FLEX Benefit Program. It does not supersede the actual plan documents, which in the event of a conflict will always govern the details of benefits coverage in all cases. While the Company hopes to continue the benefit plans described in this Handbook, it reserves the right to change, amend, reduce or even terminate any of the plans described in this Handbook at any time without prior notice to, or consent by, employees.

Please read this Handbook carefully. It has been designed to help you understand your FLEX Benefit selections.

To TopIntroduction

When it comes to decisions that affect your health and financial security, you want to be the one to make them. After all, only you know what will best meet your needs each year.

Company benefit programs traditionally give employees very little choice about how their benefit

dollars are spent. One set of benefits is usually offered to all employees, no matter how different their needs may be.

At Nortel Networks, the FLEX Benefits Program (FLEX for short) gives employees choice by combining into one program core Company-paid benefits, FLEX Credits, Company-subsidized health benefits, and additional benefit options, which employees can choose to buy.

The cost-sharing strategy and the practice of having employees choose their optional coverages annually allow the Company to provide a wide variety of benefits at a sustainable cost. It recognizes that people will value some benefits more than others, depending on their lifestyles and family situations - and that what they value may change from year to year. It's also in line with what's being offered by our competitors.

As you review the benefits available under each type of optional coverage, take note of the hints. They will help you become more aware of issues relevant to specific benefits, knowledge that will help you to be a more informed consumer, allowing you to get the most value from FLEX.

As in most other benefit programs, the costs for FLEX are directly related to the amount of claims and administrative fees and taxes. As a group, we collectively enjoy benefits at costs far below the cost of buying those same benefits at individual insurance rates. By becoming aware of the issues and choosing benefits wisely, you and Nortel Networks can work together to manage costs and keep the benefit options affordable for all employees.

Please read this Handbook carefully. It has been designed to help you understand your benefit selections and to guide you through the enrollment and claims process. If you require further assistance regarding FLEX or the enrollment process, check out other related materials on Services@Work or call Employee Services at ESN 333-4636, 905-863-4636, or toll-free: 1-800-684-4636.

To TopSection 1: All About Your FLEX Benefits Program

To TopHow FLEX Works

What You Will Find Here

FLEX Features

- A core set of benefits automatically provided to all eligible employees and paid for by the Company. This is the coverage you'll receive if you don't enroll.

- A choice among three options of medical coverage and three options of dental/vision/hearing care coverage - Basic, Comprehensive and Plus. The Company automatically funds each

employee to the middle option of coverage - Comprehensive for you and your spouse or for you and your children. Read on to learn about how to enroll in the health options you want, and the rebates you get if you don't need the Company-funded level of coverage.

- A menu of optional coverage and FLEX Credits to use to buy these benefits. If you want more options than your FLEX Credits will cover, you can buy these from your taxable pay.
- A Health Care Reimbursement Account that allows you to pay for a wide range of health care expenses with before-tax dollars* (if you have unused FLEX Credits).

  Hint *(exceptions apply for Quebec residents).

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What's Available And Who Pays

- **The Company pays the full cost of some benefits (you cannot opt out). This is what's referred to as your "core coverage":**
  - Company paid premiums for provincial health plans, where applicable,
  - Employee life insurance equal to your FLEX Earnings (a term used throughout FLEX that generally equates to your base salary).
  - Short-term disability (STD) coverage equal to 100% of your pre-disability FLEX Earnings for 13 weeks, then 70% of your pre-disability FLEX Earnings for an additional 13 weeks,
  - Long-term disability (LTD) coverage equal to 50% of your pre-disability FLEX Earnings after you have been disabled for 26 consecutive weeks, and
  - Employee Assistance Program (EAP) that offers up to 10.5 hours of individual or family counseling as well as information services.

  The Company provides you with several heavily subsidized medical and dental/vision/hearing care options. You select the level of coverage you need. The Company automatically funds each employee to the middle level of coverage - Comprehensive, for you and your spouse or you and your children - which is why you'll see a $0 cost for these options on the FLEX online enrollment tool or Personalized Enrollment Worksheet. If you don't have a spouse or children, or don't need this level of coverage, you can opt for a lower level of coverage and receive a rebate in the form of FLEX Credits to spend on other options.

  You can select coverage for:

  - You only,
  - You and your children and/or your spouse's children,

- You and your spouse, or
- You and your family (spouse and children, and/or spouse's children).

Or you can select to opt out of medical coverage if you (or, for Quebec residents, you and your family) have coverage elsewhere. If you opt out of medical coverage, you have to complete the "Medical Coverage Waiver Form" (Quebec / Other Provinces). You can also opt out of dental/vision/hearing care coverage if that isn't important to you. Because dental, vision, and hearing care are bundled together as a package, it's all or nothing - you can't select dental coverage alone, vision coverage alone, or hearing care coverage alone.

When you see negative numbers (shown with a minus sign) on the FLEX online enrollment tool or your Personalized Enrollment Worksheet, these are the rebates you get if you select that option. If you need more coverage than the Company funds, you can purchase it out of your allocation of Company-funded FLEX Credits, or with after-tax payroll deductions if you run out of FLEX Credits. Go to Taxing Decisions.

The way Nortel Networks medical and dental/vision/hearing care plans are structured, you may pay a portion of the cost. How much will depend on which option you select. On average, Nortel Networks employees pay 10% of the cost of health benefits. In addition, you may pay some deductibles or copayments depending on the option you select.

- **The Company provides you with FLEX Credits to use toward the purchase of optional coverage.** For 2002, each Canadian employee gets the equivalent of 0.39% of FLEX Earnings, over and above any rebates you may get from your health care selections. You can use FLEX Credits to purchase any of the following optional benefits:

  - Optional short-term disability (STD) coverage that increases your benefit to 90% of your pre-disability FLEX Earnings for weeks 14 through 26 of your disability,

  - Optional long-term disability (LTD) coverage that increases your benefit to 70% of your pre-disability FLEX Earnings when you have been disabled for 26 consecutive weeks, and

  - Optional accidental death and dismemberment (AD&D) insurance for yourself only or you and your family.

  Or you can use FLEX Credits to purchase medical and dental/vision/hearing care coverage above the company-funded level. If you run out of FLEX Credits, you can purchase any of these benefits with after-tax dollars through payroll deductions. Go to Taxing Decisions.

- **You have the option of contributing any unused FLEX Credits to a Health Care Reimbursement Account (HCRA), instead of taking them in taxable pay and paying the full federal and provincial income tax on this amount.** You can then use these before-tax dollars (except in Quebec) to pay for eligible expenses that are not covered by your provincial health insurance plan or Nortel Networks health care plans, such as plan deductibles, over-the-counter drugs, or guide dogs. Any FLEX Credits remaining in the account at the end of the year will be forfeited, so in your planning you must consider how many such expenses you expect to

have.

- **You have the option of buying the following benefits with after-tax dollars through payroll deductions:**
    - Additional life insurance for yourself, and
    - Dependent life insurance for your spouse and/or children.

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Eligible Employees

Current employees of Nortel Networks Limited, Nortel Networks Technology Limited, and related companies may enroll under the FLEX Benefits Program in Canada.

The benefits described in this Handbook are available to all Nortel Networks permanent employees who are regularly scheduled to work 18 hours or more a week. You must be covered by a provincial health plan to be eligible.

If you're eligible as an employee, your dependents may also be eligible.

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Eligible Dependents

Your eligible "dependents" include:

- **Your Spouse** — the person to whom you're legally married, or an unmarried partner of either gender, and who meet all the following criteria:
    - Is not related to you by blood, which would prohibit legal marriage,
    - Is age 18 or older,
    - Shares responsibility for your living expenses and general welfare,
    - Has been living with you for at least 12 consecutive months in a conjugal relationship, and
    - Is covered under a provincial health insurance plan.

- **Your Children** — who meet one of the following criteria:
    - Your natural children,

- Children legally adopted by you or placed with you for adoption,
- Your stepchildren,
- Your legal foster children,
- Your responsibility as a legal guardian, or
- Children of your spouse.

Children must be unmarried, financially dependent on you for support, covered under the provincial health plan and either:

- Under 21 years of age,
- Under 25* years of age if in full-time attendance at an accredited school, college or university or
- Physically or mentally handicapped, regardless of age (as long as the disability began before they turned 21, or before 25* if they were full-time students at the time).

You must provide proof of your dependent child's disability within 31 days of his or her 21st birthday (if not a full-time student) or 25th* birthday (if a full-time student), whichever applies.

Hint

Note: For Quebec residents, Bill 33 requires that eligible dependent children be covered for prescription drugs listed with the Régie de l'assurance-maladie du Québec (RAMQ), until they reach age 26 if they are a student at an accredited school, college or university.

For information on how to enrol your dependents please refer to "How to Enroll".

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If You and Your Spouse Both Work at Nortel Networks

If you and your spouse both work at Nortel Networks, please refer to:

1. "If You and Your Spouse Both Work at Nortel Networks"
2. "Optional Employee Life Insurance Coverage"
3. "Co-ordination of Benefits"

Special Notes on Eligibility
For life insurance, if both you and your spouse work for Nortel Networks, you can enroll as an employee *or* as a dependent, but not both. In addition, only one of you can enroll your eligible children as dependents. Under the medical care and dental/vision/hearing care plans, if you and your spouse work at Nortel Networks, you both may be enrolled as employees or one of you may be enrolled as an employee with the other enrolled as a dependent.

If your children are eligible for the Nortel Networks FLEX Benefits Program, they must enroll as employees. They are not eligible for coverage as your dependents.

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To TopWhen Coverage Begins

Core coverage begins on your date of hire with the company.

Optional coverage begins on your date of hire with the Company, provided you enroll within 31 days from your date of hire. Go to "If You're Hired On or After January 1, 2002".

If you don't complete the online enrollment or return your Personalized Enrollment Worksheet within 31 days of your date of hire, you'll automatically default to core coverage. You'll waive your right to enroll in optional coverage until the next annual enrollment period or until you experience a Status Change . For more information, go to "What To Do If You Have a Status Change During the Year". Please note, you'll also default to Basic medical coverage for you only (you and your family in Quebec). Any FLEX Credits available to you as a result of receiving default coverage will automatically be allocated to your taxable pay.

Regardless of when you enroll, any life insurance coverage requiring evidence of insurability will be effective on the date your request is approved by Clarica.

If you're on short-term disability on January 1, 2002, regardless of your annual enrollment selections, your 2001 short-term disability, long-term disability, and your and your dependent's optional life and AD&D insurance selections will remain in effect until you return to work for 60 consecutive days

To TopThings to Consider When You Enroll

Your Enrollment Itinerary for 2002 Annual Enrollment

For enrollment instructions, please see "Your Enrollment Itinerary for 2002 Annual Enrollment" in Section 3 of this Handbook.

About short-term disability (STD) coverage

What expenses would you and your family have to pay if you couldn't work for more than 13 weeks? What other sources of income does your family have? Do you have STD coverage available from any other source? Your answers can help you determine how much STD coverage you need.

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About long-term disability (LTD) coverage

What expenses would you and your family have to pay if you couldn't work for more than 26 consecutive weeks? Do you have other sources of disability coverage? If so, remember that your benefits from the LTD Plan will be offset by any benefits you receive from another source.

Your answer can help you determine how much coverage you need.

To continue receiving LTD benefits after you have been disabled for 18 months following the initial date of disability, you must be unable to perform the duties of any occupation (not just your own) for which you're reasonably qualified (or could become qualified) through education, training, or experience.

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About accidental death and dismemberment (AD&D) insurance

What expenses would your family have to pay if you died suddenly or suffered a serious disabling injury? How would your finances be affected if this happened to one of your eligible dependents? Your answers can help you determine the need for AD&D coverage and the amount.

AD&D coverage is not the same as:

- **Life insurance**. AD&D pays a benefit only if your death is accidental. If you have selected AD&D coverage and you die as the result of an accident, AD&D benefits will be paid to your beneficiary in addition to your life insurance.
- **Disability coverage**. If an accidental injury keeps you from working, the AD&D plan pays a one-time benefit only. Short- and long-term disability plans replace part or all of your income for an extended period

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About Medical and Dental/Vision/Hearing Care Coverage

Do you expect your medical and/or dental/vision/hearing care expenses in 2002 to decrease, increase, or stay the same as this year? You may want to refer to the Benefit Statement you received from Clarica to review what was reimbursed for medical and dental/vision/hearing care coverage for you and your eligible dependents in the past.

Do you plan to participate in the Health Care Reimbursement Account (HCRA)? If so, you can use it to pay your deductibles, copayments, your portion of eligible expenses in excess of the plan's reimbursement level, and many other predictable out-of-pocket expenses. You may also want to see if your spouse's plan covers some of these expenses.

How does the medical and/or dental/vision hearing care coverage available through FLEX compare with other plans available to you from other sources, such as your spouse's plan (if any)? Determine which plan best meets your needs. If you're also covered under another plan (such as your spouse's plan), a portion of your eligible expenses not reimbursed under the Nortel Networks plan could be reimbursed under your spouse's plan.

If your medical and dental/vision/hearing care expenses are minimal and predictable, you may want to pay for them through the Health Care Reimbursement Account (HCRA) rather than enroll in one of the medical and/or dental/vision/hearing care options.

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About Health Care Reimbursement Account (HCRA)

You can use a tax-effective HCRA to reimburse yourself for expenses that are listed as "eligible" under the Income Tax Act. Visit the Canada Customs and Revenue Agency Web site at http://www.ccra-adrc.gc.ca/ or request a copy of publication IT-519R2, *Medical Expense and Disability*, for a complete list. Make sure you're considering only eligible expenses in your estimates.

Ask yourself, will your out-of-pocket eligible expenses be higher or lower than in 2001, with the medical and/or dental/vision/hearing care coverage you select for 2002? Will your spouse's plan pay any of these expenses? Will you have sufficient amount of expenses to use up the amount of FLEX Credits allocated to the account? Your answers can help you determine whether an HCRA works for you.

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About Life Insurance

What expenses would your family have to pay if you died? What other sources of income (such as savings or retirement plans) does your family have? Your answers can help you determine how much coverage you need.

Hint

Please note: Nortel Networks does not require proof of your non-smoking status, but if you're discovered to be a smoker and are paying non-smoker rates, you or your beneficiary could be denied benefits. You're eligible for the non-smoker rate if you have not smoked or used a tobacco product for 12 continuous months. The same applies to your spouse.

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- Tax Rules
- Quebec Employees

Overview

One of the great features about FLEX is the additional buying power you can achieve through making selections that are tax effective. By making selections using tax-effective choices, you can stretch your benefits to give you much more value.

FLEX has been structured to be as tax effective as possible. Company-provided FLEX Credits are allocated first to those benefits which can be bought with before-tax dollars. If there are FLEX Credits left over after the cost for these selections has been calculated, you can further the tax-effective advantage by putting these into your HCRA. This way you can pay for expenses not covered under medical or dental/vision/hearing care coverage. Remember, you must have sufficient off-setting expenses throughout the year so you can use up the FLEX Credits allocated to the account. Only Company contributions (FLEX Credits) can be allocated to an HCRA.

Since only after-tax dollars can be used to buy optional life insurance, any FLEX Credits you wish to apply to this coverage will be treated as taxable pay.

Hint This section and all references to tax implications in this Handbook and other enrollment materials are offered as information based on current tax legislation. You may want to consult a tax advisor regarding the tax implications of your decisions.

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Tax Rules

The table below summarizes the current tax implications to consider when buying your optional coverage:

Coverage	Tax status of FLEX Credits used to buy coverage	Tax status of benefits paid
Short-Term Disability (STD) Coverage	Company-provided FLEX Credits used to buy optional STD coverage are not taxable to you.	Benefits are taxed as regular earned income.
Long-Term Disability (LTD) Coverage	Company-provided FLEX Credits used to buy optional LTD coverage are not taxable to you.	Benefits are taxed as regular earned income.

Accidental Death & Dismemberment (AD&D) Coverage	Company-provided FLEX Credits you used to buy optional AD&D coverage are not taxable to you, except in Quebec where they are taxed at the provincial level.	Benefits paid to you or your eligible dependents from the AD&D plan are not taxable.
Medical Coverage	Any FLEX Credits you use to pay for medical coverage are not taxable to you.	Benefits are not taxable, except in Quebec, where you're taxed at the provincial level on the average amount of claims paid, including expenses and provincial premium and sales tax, less any required payroll deductions.
Dental/Vision/Hearing Care Coverage	Any FLEX Credits you use to pay for dental/vision/hearing care coverage are not taxable to you.	Benefits are not taxable, except in Quebec, where you're taxed at the provincial level on the average amount of claims paid, including expenses and provincial premium and sales tax, less any required payroll deductions.
Health Care Reimbursement Account (HCRA)	Any FLEX Credits allocated to the HCRA are not taxable to you.	Benefits are not taxable, except in Quebec where you're taxed at the provincial level on amounts received, plus expenses and provincial premium and sales tax.
Optional Life Insurance	You can't directly use Company-provided FLEX Credits to buy this benefit. If you want to use FLEX Credits to assist you in buying life insurance, the FLEX Credits will be first converted to your pay and taxed as regular income. What is left can help offset your after-tax payroll deductions for this coverage.	Benefits paid from the life insurance coverage are not taxable to the beneficiary.
Dependent Life Insurance	You can't directly use Company-provided FLEX	Benefits paid from the dependent life insurance

	Credits to buy this benefit. If you want to use FLEX Credits to assist you in buying life insurance, the FLEX Credits will be first converted to your pay and taxed as regular income. What is left can help offset your after-tax payroll deductions for this coverage.	coverage are not taxable to you, the beneficiary.

Any health care expenses not reimbursed through medical or dental/vision/hearing care coverage or the HCRA may be eligible for medical expense income tax credits when you file your income tax return.

Hint

This section and all references to tax implications in this Handbook and other enrollment materials are offered as information based on current tax legislation. You may want to consult a tax advisor regarding the tax implications of your decisions.

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Quebec Employees

In Quebec, provincial tax is payable on Company-paid medical and dental/vision/hearing care benefits. Under FLEX, you'll be taxed at the provincial level on the average amount of claims paid on the plan options and coverage level you select. This includes the plan administrator's (Clarica's) administrative costs (expenses) and provincial premium and sales tax, less any payroll deductions that were required to buy these coverage levels.

For example, if you decide that you and your family don't need the full Comprehensive or Plus coverage because you expect to have only a few or no medical expenses in a plan year, you may select the Basic medical option. As a result you would have a lower taxable benefit than someone else who chooses Comprehensive or Plus options.

Remember, Bill 33 requires that you and your family must have drug coverage under your spouse's plan to decline optional medical coverage under your own plan.

The FLEX online enrollment tool illustrates the estimated per-pay taxable benefit (prior to any payroll deductions) for each medical and dental/vision/hearing care option and dependent coverage level.

You will also pay provincial income tax on Company-paid FLEX Credits used to buy optional AD&D coverage.

If you decide to allocate Company-provided FLEX Credits to an HCRA, the amount you claim for reimbursement under that account, plus expenses and provincial premium and sales tax, will be

deemed as a taxable benefit for provincial income tax purposes.

Hint This section and all references to tax implications in this Handbook and other enrollment materials are offered as information based on current tax legislation. You may want to consult a tax advisor regarding the tax implications of your decisions.

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To TopDisability Benefits

To TopCheck Out Your Core and Optional Short-Term Disability (STD) Coverage

What You Will Find Here

In Brief

The short-term disability plan replaces a portion of your income if you are totally disabled due to an illness or injury.

Nortel Networks pays the full cost of your core STD coverage. When you're absent from work for five consecutive days (or the equivalent of your standard work week) due to a non work-related injury or illness, and you provide supporting medical documentation, you qualify for STD benefits. The core STD coverage provides:

- 100% of your pre-disability FLEX Earnings for up to 13 weeks from your first day of absence, then
- 70% of your pre-disability FLEX Earnings for up to 13 additional weeks.

After 26 consecutive weeks, you may become eligible for long-term disability coverage.

If you want to increase your STD coverage, you can select optional STD coverage. This coverage provides:

- 100% of your pre-disability FLEX Earnings, for up to 13 weeks from your first day of absence, then
- 90% of your pre-disability FLEX Earnings, for up to 13 additional weeks.

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Defining Disability

To receive STD benefits, you must be totally disabled as a result of a medical impairment due to injury or illness, which prevents you from performing, in any setting, the essential duties of the occupation in which you participated just prior to the onset of disability.

Hint Note: Compensable work-related injuries are covered under applicable workers' compensation legislation.

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Your Payments

Once you qualify and are approved for STD, your STD payments start on the first working day of absence due to illness or injury. You receive 100% of your pre-disability FLEX Earnings for 13 weeks and then 70% (90% for optional STD coverage) is applied to your pre-disability FLEX Earnings to calculate your benefit amount for the additional 13 weeks of coverage. For eligible part-time employees, core and optional STD benefits are paid according to your actual salary at the time of disability.

Benefit payments stop if any one of the following occurs:

- You cease to be totally disabled.
- You fail to submit the necessary and required medical proof when requested, to the Health Center to substantiate continued disability.
- You fail to undergo an independent medical exam if requested by the Health Center.
- You fail to participate in a rehabilitation program approved by your attending physician and the Health Center.
- You engage in any occupation which normally involves remuneration or profit.
- You have received 26 weeks of core or optional STD coverage (whichever is applicable).
- It is the end of the month in which you attain age 65.
- You die.

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Other Income Sources May Reduce Your STD Payments

STD benefits are coordinated with any government disability benefits so that your income from all sources doesn't exceed 100% of your pre-disability FLEX Earnings for the first 13 weeks and either 70% (STD core coverage) or 90% (STD optional coverage) of your pre-disability FLEX Earnings for the remaining 13 weeks. Determination of income from all sources doesn't include any benefits paid on behalf of dependent children, any increases in government benefits after payments start or any individual disability policies.

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Rehabilitation/Modified Work and Your STD Payments

One of the primary objectives of any STD plan is to assist you in getting back on your feet as quickly as possible. Your STD plan includes this very important feature because it has been demonstrated consistently that rehabilitative and modified work programs make a difference in the rate of recovery.

Rehabilitation (rehab) is any program that has a purpose of returning you to remunerative employment that would provide an income equal to or greater than the disability benefit you were receiving when your disability began. Any rehab program must be approved by your attending physician and the Nortel Networks Health Center. Rehab programs can include: assessment, counseling, medical or psychological treatment, or a vocational retraining or education program.

Modified work allows for a change or modification to your job requirement. The modification may be working reduced hours or performing only some of your regular duties. Availability of modified work is determined by the Company. Your participation in any modified work program must be approved by your attending physician and the Nortel Networks Health Center.

Hint Note: Rehabilitation earnings don't offset any STD payments you receive. However, you can never earn more than 100% of your pre-disability earnings when STD payments and rehabilitation income are combined.

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Recurring Disability

Successive periods of absence for the same disability are added together in calculating your core or optional STD coverage. However, if you have successfully completed the relapse period (60 consecutive days of returning to work) between absences for the same disability, you're again eligible for the full period of coverage. An unrelated disability isn't subject to the relapse period.

If you have a recurrence of your disability due to the same or related causes within 60 consecutive

days of returning to work (relapse period), it will be considered a continuation of the previous period of disability. You'll be required to submit medical documentation confirming your disability.

If you become disabled for a different cause, or you return to work for longer than 60 consecutive days and become disabled for any cause, you'll be required to submit a new application for short-term disability benefits.

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To TopCheck Out Your Core and Optional Long-Term Disability (LTD) Coverage

In Brief

Nortel Networks pays the full cost of your core LTD coverage. If you're still disabled (according to the LTD coverage definitions) after 26 consecutive weeks, LTD coverage begins paying benefits. Core LTD coverage provides 50% of your pre-disability FLEX Earnings.

If you want to enhance your LTD coverage, you can select the optional LTD coverage. Optional LTD coverage provides 70% of your pre-disability FLEX Earnings. Note that the benefit amount will be reduced by any benefit you receive from certain other sources.

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Defining Disability

To qualify for LTD benefits, you must have qualified for benefit payments under core or optional STD. After receiving STD payments for 26 weeks (i.e., six months) - your qualifying period under LTD - you may receive LTD benefits. During the qualifying period and the 12 months immediately following it, you must be totally disabled - which means a medical illness or injury which prevents you from performing in any setting, the essential duties of the occupation in which you participated just before the disability started.

After the 18-month period, "totally disabled" means you're unable, because of the medical illness or

injury, to perform, in any setting, the essential duties of any occupation (not just your own) for which you're reasonably qualified (or could become qualified) through education, training or experience.

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Your Payments

Your LTD payments start at the end of your qualifying period (expiration of 26 weeks under STD), provided you're totally disabled and a claim is received within three months of the end of the qualifying period. The monthly disability benefit is calculated by applying the benefit formula (50% for core LTD coverage and 70% for optional LTD coverage) to your FLEX Earnings in force on the date you became totally disabled.

For example, if your monthly FLEX Earnings are $5,000 and you don't select the optional LTD coverage, your core LTD coverage payment would be $2,500 (50% x $5,000). If you select the LTD optional coverage, your payment would be $3,500 (70% x $5,000).

Benefit payments stop if any one of the following occurs:

- You cease to be totally disabled.
- You fail to submit medical proof to Clarica of continued disability when requested.
- You fail to undergo an independent medical exam if requested by Clarica.
- You fail to participate in a rehabilitation program approved by your attending physician and Clarica.
- You engage in any occupation that normally involves remuneration or profit.
- You retire or go on a special leave of absence prior to retiring, whichever occurs first.
- It is the end of the month in which you attain age 65.
- You die.

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Other Income Sources May Reduce Your LTD Payments

Your monthly core and optional LTD coverage payments will be reduced by payments you receive from:

- Canada/Quebec Pension Plan (C/QPP), excluding benefits for dependent children,
- Workers' compensation, and
- Disability income from other sources.

Hint Note: Core and optional LTD coverage are coordinated with any government and other disability benefits so that your income from all sources doesn't exceed 50% (core LTD

coverage) and 70% (optional LTD coverage) of your pre-disability FLEX Earnings. This doesn't mean you'll receive a lower benefit in total. You'll just receive payments from more than one source.

Any increase in government disability benefits after payments start doesn't affect the payment received under core or optional LTD coverage.

Benefits from other sources of income means benefits resulting from your disability, which you qualify to receive or would be eligible to receive if you made an application. These sources include but are not limited to:

- Another group insurance plan (including association group plans),
- An automobile insurance policy, and/or
- Any government plan providing income, excluding benefits for dependent children.

Other sources of income don't include:

- An individual disability income policy,
- A disability attachment to an individual life policy,
- Acts or plans for or on behalf of children,
- An increase in C/QPP benefits after you have begun receiving benefits and/or
- Benefits from military service.

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Rehabilitation/Modified Work and Your LTD Payments

One of the primary objectives of any disability plan is to assist you in getting back on your feet as quickly as possible. Your LTD plan includes this very important feature because it has been demonstrated consistently that rehabilitative and modified work programs make a difference in the rate of recovery.

Your LTD benefit payments will be reduced by 50% of any rehabilitation and modified work earnings.

Rehabilitation (rehab) is any program that has a purpose of returning you to remunerative employment that would provide an income equal to or greater than the disability benefit you were receiving when your disability began. Any rehab program must be approved by your attending physician and Clarica. Rehab programs can include: assessment, counseling, medical or psychological treatment, or a vocational retraining or education program.

Modified work allows for a change or modification to your job requirement. The modification may be working reduced hours or performing only some of your regular duties. Availability of modified work is determined by the Company. Your participation in any modified work program must be approved by your attending physician and Clarica.

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Maximum Benefit from All Sources While on Rehabilitation/Modified Work

Your total disability income from all sources can't exceed 85% of your pre-disability FLEX Earnings.

Example: Optional LTD Benefit Payments while on Rehab/Modified Work

(Based on $7,143 monthly gross pre-disability FLEX Earnings)

Monthly optional LTD coverage	$5,000
(optional coverage = 70% of $7,143)	
Less CPP disability benefit	$600
Less rehab earnings($3,500 @ 50%)	$1,750
LTD amount(after integration with other income)	**$2,650**

Calculation of 85% Maximum — All Other Income Sources

Gross Pre-Disability Monthly FLEX Earnings	$7,143
85%	**$6,072**

Disability Benefit Plus Other Income Sources

LTD amount (after integration with other income)	$2,650
CPP payment	$600
Rehab earnings	$3,500
Individual policy	N/A
Total from all sources	**$6,750**

Difference between 85% pre-disability earnings and income from all sources:

($6,750 – $6,072) =	**$ 678**

LTD Monthly Payment

($2,650 – $678) =	**$1,972**

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Cost-of-Living Adjustment (COLA)

One important feature of your optional LTD coverage is the application of a cost-of-living adjustment to protect your plan against the effects of inflation. Beginning after two years of receiving LTD benefit payments, each January the full amount of your disability payment will be increased by the lesser of 60% of the Consumer Price Index or 6%. This COLA feature does not apply if you are covered under the core LTD option only.

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Recurring Disability

If you have a recurrence of your disability due to the same or related causes within 60 consecutive days of returning to work, it will be considered a continuation of the previous period of disability. You'll be required to submit medical documentation confirming your disability.

If you become disabled for a different cause, or you return to work for longer than 60 consecutive days and become disabled for any cause, you'll be required to begin the disability process again and apply for short-term disability benefits.

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To TopExclusions to Disability Benefits

No benefit is payable for:

- Intentionally self-inflicted injuries or illness, whether you're sane or insane.
- Committing or attempting to commit a criminal offence.
- Insurrection, strike, riot, civil disorder or war, if you are actually participating.
- Military service in any country.

You're not considered totally disabled unless under the active, continuous and medically appropriate care of a physician and are following the treatment prescribed by the physician for that disability.

You're not considered totally disabled due to the use of drugs or alcohol unless you are being actively supervised by and receiving continuous treatment for that disability from a rehabilitation center or an

institution designated for that treatment.

To TopOptional Accidental Death & Dismemberment (AD&D) Insurance Plan

To TopCheck Out Your Optional AD&D Coverage

What You Will Find Here

Optional Employee AD&D Coverage

AD&D coverage is available in multiples of your FLEX Earnings. You can buy coverage for yourself equal to:

- 1 X FLEX Earnings,
- 2 X FLEX Earnings,
- 3 X FLEX Earnings,
- 4 X FLEX Earnings, or
- 5 X FLEX Earnings.

Your coverage amount will be rounded up to the next higher $1,000, up to a maximum of $1,500,000. The coverage amount you select for yourself will affect the amount of coverage you can buy for your eligible dependents.

Under this plan, if you die as the result of an accident, your beneficiary receives the benefit amount you chose. In addition, you receive a portion of your full benefit if you lose a limb or your sight due to an accidental injury.

The amount of benefit is based on the loss suffered as detailed in the Schedule of Losses below:

Loss Suffered	Benefit Amount
Loss of Life	100%
Hemiplegia	200%
Paraplegia	200%
Quadriplegia	200%
Loss of Both Hands, Both Feet or Sight of Both Eyes	100%

Loss of One Hand and One Foot	100%
Loss of One Hand and Sight of One Eye	100%
Loss of One Foot and Sight of One Eye	100%
Loss of Speech and Hearing	100%
Loss of Use of Both Hands or Both Feet	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand, One Foot or Sight of One Eye	67%
Loss of Use of One Hand or One Foot	67%
Loss of Speech or Hearing	50%
Loss of Hearing in One Ear	50%
Loss of Thumb and Index Finger of One Hand	33%
Loss of Four Fingers of One Hand	33%
Loss of All Toes of One Foot	25%

If you suffer more than one of the losses listed above as a result of one accident, the plan will pay the amount of benefit for only one loss. The amount will be the highest payable of the losses you have suffered.

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Optional AD&D Coverage for Your Eligible Dependents

You can also buy AD&D coverage for your family, including your spouse and your eligible dependent children. The coverage amount you select for yourself will affect the amount of coverage you can buy for your eligible dependents.

Family coverage provides the following:

For this eligible dependent	AD&D coverage in this amount

Your spouse only	60% of your AD&D coverage amount
Your child (or children) only	For each child, 20% of your AD&D coverage amount
Your spouse and your child (or children)	Spouse: 50% of your AD&D coverage amount Each child: 15% of your AD&D amount

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Employee and Eligible Dependent Optional AD&D Coverage Rates

In 2002, the Optional Employee AD&D coverage rate is $0.02 per $1,000 of coverage per month. The family coverage rate is $.032 per $1,000 of coverage per month.

Hint

Note: Your family coverage will depend on your family status at the time the benefit is needed. For example, suppose you select Optional AD&D coverage of $100,000; you and your spouse don't have additional dependents. Your spouse will have AD&D coverage of $60,000 ($100,000 x 60%). Your cost is $3.20 per month (0.032 x $100). Subsequently, a child is born. Your coverage remains at $100,000. Your spouse's coverage reduces to $50,000 ($100,000 x 50%) and your child is insured for $15,000 ($100,000 x 15%). Your premium remains at $3.20.

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To TopExclusions to AD&D Coverage

No benefit is payable for a loss directly or indirectly due to:

- Suicide, while sane or insane,
- Self-inflicted injuries, while sane or insane,
- Disease,
- Civil disorder (including acts of terrorism) or war, whether or not war was declared,
- Full-time service in the armed forces of any country,
- Injuries sustained by you as a result of driving a vehicle if, when the injuries were sustained, your blood contained in excess of 80 milligrams of alcohol per 100 milliliters of blood, or
- Injuries received while riding in or on or boarding or alighting from an aircraft if, when the injuries were received:
  - You were operating, learning to operate or serving as a member of a crew of any aircraft, or
  - The aircraft was used for crop dusting, crop spraying, seeding, sky-writing, racing, testing, exploration or any other purpose except transportation.

To TopMedical Benefits

To TopCheck Out Your Core Medical Coverage

Before you make your FLEX selections, it's important to understand the core coverage provided by the Company at no cost to you. You should be aware of this core coverage in case you wish to select optional coverage in these areas.

Provincial Hospital/Health Insurance

What You Will Find Here

This insurance varies by province, but generally covers standard hospital ward accommodation, physicians' and specialists' services and diagnostic procedures. Specific information about covered expenses can be obtained from your local provincial health insurance office. In Alberta and British Columbia, where individual premiums are required, the Company pays the full cost for you and your eligible family members. In Newfoundland, Quebec, Ontario and Saskatchewan, the Company supports the cost of the plans through a payroll tax. (In all other provinces, the plans are supported by general tax revenues.)

Hint

Note for Alberta and British Columbia Residents:
In order for Nortel Networks to pay the individual provincial premium on your behalf, you must complete a commencement form. If Nortel Networks is not currently paying this premium and you wish to have this premium paid on your behalf, please contact Employee Services to request a copy of the commencement form. The form must be returned to Employee Services for processing.

With FLEX, you can select from among three medical options to supplement your provincial plan.

For further information about your provincial plan, you can call the office in your province directly at the following numbers:

Province	Provincial Plan	Contact Numbers
British Columbia	Medical Services Plan of British Columbia	205-952-3456
Alberta	Alberta Health Insurance Plan	780-427-1432
Saskatchewan	Saskatchewan Medical Care Insurance Branch	1-800-392-1207
Manitoba	Manitoba Health Insurance Services Plan	1-800-392-1207
Ontario	Ontario Health Insurance Plan	416-314-7444
Quebec	Quebec Health Insurance Plan	1-800-561-9749
New Brunswick	Medicare New Brunswick	506-453-2536
Nova Scotia	Nova Scotia Medical Services Insurance Plan	1-800-565-3611
Newfoundland	Newfoundland Medical Care Plan	709-758-1500

Prince Edward Island	Prince Edward Island Hospital & Health Services Plan	902-368-4900

Employee Assistance Plan (EAP)

This program offers up to 10.5 hours of individual or family counseling as well as information services to you or a family member. Sessions covered may be for therapeutic counseling, lifestyle counseling, or health promotion services.

To TopCheck Out Your Optional Medical Coverage

Optional Medical Coverage Table

The following chart outlines the optional medical coverage for reasonable and customary expenses only:

Benefit	Basic	Comprehensive	Plus
Percentage paid for covered services	80%	90%	100%
Prescription drugs • **Generic drugs** • **Brand-name drugs**	• Covered under all three options • Covered under all three options, only if there is no generic equivalent on the market or substitution isn't permitted by the physician		

Annual deductible • **Individual** • **Family**	None None	$25 $50	None None
Per-prescription copayment	$5	None	None
Dispensing fee maximum per prescribed drug	$7	$7	$7
Out-of-pocket maximum (once you've paid this maximum per year, the balance of prescription drug expenses will be paid at 100%)	$750 per person*	$750 per person*	None
Hospital coverage • **Acute and convalescent care**	None	Semi-private room rate, up to $150 per day for acute and convalescent care, and 90 days per disability for convalescent care	Semi-private room rate for acute and convalescent care, and up to 90 days per disability for convalescent care
Ambulance	Ground transportation and emergency air ambulance		
Professional services	Maximums per individual per year		
• **Chiropractor** • **Osteopath** • **Chiropodist** • **Speech therapy**† • **Naturopath** • **Massage therapy**† • **Podiatrist** • **Acupuncture**†	One combined maximum of $300 for these professionals	• $300 • $300 • $300 • $300 • $300 • $300 • $300 • $300	• $500 • $500 • $500 • $500 • $500 • $500 • $500 • $500

Psychologist	$350	$750	$1,000
Physiotherapy†	$350	$750	$1,000
Private-duty nursing † • **Maximum per calendar year**	$10,000	$12,500	$15,000
Out-of-province (within Canada) emergency medical expenses and travel assistance while travelling for personal reasons included * **	21 days maximum	31 days maximum	90 days maximum
Overall maximum per person	$1,000,000 lifetime*		

Hint For Quebec residents, please note that all plan options covering eligible prescription drugs are designed to meet the current requirements of Bill 33.

Hint **Chiropractic expenses covered only after provincial health insurance plan maximums have been reached, except for the Plus Option where coverage begins at the first visit where permitted by law.

Hint ***On any given trip within Canada, you're covered only for the time period specified for each option - that is, the Basic Option pays benefits if an emergency occurs during your first 21 days out of province (within Canada); the first 31 days for Comprehensive; the first 90 days for Plus.

Hint † Requires a referral from a physician.

Claims must be submitted within 18 months of the service date to be eligible for payment.

If you (and your eligible dependents if you're a Quebec resident) have medical coverage from some other source (such as your spouse's employer), you can waive medical care coverage. However, you need to complete a Medical Coverage Waiver form (Quebec / Other Provinces) and return it to Employee Services by the date indicated on the form. If you don't complete this waiver, you'll automatically be covered under the Basic medical care coverage for you only (you and your eligible dependents if you're a Quebec resident).

For medical care coverage, you can select a different option and coverage level than the one you

select for dental/vision/hearing care coverage.

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Eligible Expenses

To be eligible, the expenses must be medically necessary for the treatment of disease or injury and prescribed by a physician, unless otherwise specified. Your optional medical coverage provides coverage for the following expenses as indicated in "Optional Medical Coverage Table."

Eligible expenses are paid at reasonable and customary levels for the expenses listed in the following sections.

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Semi-Private Hospital Accommodation
(available for Comprehensive and Plus medical options only)

Comprehensive Option

The Comprehensive Option covers $150 per day for the difference between your provincial plan's standard ward room rate and the semi-private accommodation room rate during acute care treatment or while in a convalescent hospital. For convalescent care, coverage is limited to 90 days maximum per disability.

Plus Option

The Plus Option covers the difference between your provincial plan's standard ward room rate and the semi-private accommodation room rate during acute care treatment or while in a convalescent hospital. For convalescent care, coverage is limited to 90 days maximum per disability.

Hint If you submit an eligible claim for private hospital accommodation, you'll be paid up to the semi-private room rate. There is no coverage for the difference between the semi-private room rate and the private room rate.

A "hospital" is a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24-hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer or arthritis and for convalescing persons when approved by the plan administrator, Clarica. This doesn't include nursing homes, homes for the aged, rest homes or other places providing similar care.

HINT

Did you know that your provincial plan covers semi-private room accommodation under certain circumstances? If you're in an intensive care unit (ICU), the coronary unit, labour/delivery or case room, the provincial plan covers the cost of this accommodation. If semi-private accommodation is deemed medically necessary and stipulated by a physician or midwife, then a semi-private room is covered under the provincial plan. Make sure you only claim hospital expenses under FLEX that are not covered under the provincial plan.

In addition, hospitals may charge for semi-private accommodation that is not considered an appropriate charge and not covered under FLEX. Make sure you review your bill thoroughly and note that charges for semi-private accommodation should be based on a room that contains only two beds, regardless of whether both beds are in active use.

Your plan won't cover:

- Days where you requested ward accommodation or didn't authorize semi-private or private accommodation but were placed in semi-private or private rooms anyway,
- Days where semi-private or private accommodation is charged for an infant who is in the same room with the mother, or
- Days where a semi-private or private room is being held for you, regardless of where you are during those days (e.g., at home, in ICU).

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Ambulance Services
(For All Optional Coverage)

- Licensed ground ambulance service, to the nearest hospital equipped to provide the required treatment when your physical condition prevents the use of another means of transportation.

- Emergency air ambulance to the nearest hospital equipped to provide the required treatment when your or your eligible dependents' physical condition prevents the use of another means of transportation.

- If the patient requires the services of a registered nurse during the flight, the services and return airfare for a registered nurse are also covered.

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Prescription Drugs

Drugs and medicines approved in Canada and bearing a Drug Identification Number (DIN)

Generic Drugs

legally require a prescription from a physician or dentist and are subject to the following conditions for each medical option.

"Generic drugs" (unless the physician or dentist has indicated on the prescription that no substitution is allowed or if no generic equivalent exists) refers to drugs that legally require a prescription. This includes: life-sustaining drugs, as noted below; injectible drugs; compound prescriptions, regardless of their active ingredient; and needles, syringes and chemical diagnostic aids for the treatment of diabetes. Deductible, dispensing fee cap and reimbursement level apply as noted in " Optional Medical Coverage Table".

"Life-sustaining drugs" refers to drugs that may not legally require a prescription and are identified in the Compendium of Pharmaceuticals and Specialties under the following headings: anti-anginal agents; antiparkinsonism agents; bronchodilators; antihyperlipidemic agents; hyperthyroidism therapy; parasympathomimetic agents; tuberculosis therapy; anticholinergic preparations; anti-arrhythmic agents; insulin preparations; oral fibrinolytic agents; potassium replacement therapy; and topical enzymatic debriding agents.

Regardless of the option you choose (Basic, Comprehensive or Plus), you and your eligible dependents are covered for two types of drugs:

- **Tier 1 drugs:** These are medically necessary, life-sustaining drugs that bear a DIN, are sold only through prescription, and relate to illness or injury. Generally, there are no maximums connected to these classes of drugs, other than a lifetime maximum for overall medical care coverage, including prescription drugs. In Quebec, drugs listed under Quebec's basic drug formulary are not subject to the lifetime maximum.

All optional medical coverage provides a generic drug plan. You may ask why you should support a generic-only plan, even in the higher priced Comprehensive and Plus options. Consider what is in it for you:

- Generic drugs generally offer high quality and equal effectiveness to more expensive brand-name medications.
- Generic drugs keep claims costs low and/or stable. This protects the future viability and financial sustainability of optional medical coverage.
- Generic drugs provide value for your dollar.

In today's environment of government cost shifting and cutbacks, it is a challenge to keep drug plans at an affordable cost. If your physician advises on the prescription that no generic substitutions are allowed or no generic equivalent exists, then your option will pay at the brand-name costs, subject to the required copayment, reimbursement level, deductible and dispensing fee caps.

Maximum Dispensing Fees

The amount the plan pays for dispensing fees is capped at $7.00, but there are many pharmacies that charge dispensing fees lower than $7.00. Ask what the dispensing fee is before you fill your prescription. These fees can vary significantly from pharmacy to pharmacy.

If you take a maintenance drug (a prescription on an ongoing basis), you may want to ask your doctor for a larger maintenance supply of up to three months. A three-month supply will save on dispensing fee charges.

- **Tier 2 drugs:** These are certain therapeutic drugs that bear a DIN, are sold only through prescription, and don't relate to illness or injury. Generally, they are considered medically necessary in improving the quality of life. Below is a list of the classes of Tier 2 drugs that are covered and the annual or lifetime maximums. Please note that pre-authorization is required for certain classes of drugs to demonstrate that they are medically necessary.

Tier 2 drugs	Maximum amounts payable
○ Fertility drugs	○ $3,000 lifetime maximum
○ Oral contraceptives	○ $300 per calendar year/13 cycles per year
○ Drugs for erectile dysfunction (ED)	○ $1,200 per calendar year (pre-authorization required)
○ Smoking-cessation drugs	○ $500 maximum
○ Anti-obesity drugs	○ $1,000 per calendar year (pre-authorization required)
○ Preventive vaccines	○ $500 per calendar year

The company, at its sole discretion, may add or delete drugs from this list.

Over-the-counter drugs, experimental drugs and drugs that are cosmetic in nature are not covered under any of the medical plan options.

Examples of Pre-Authorization. Viagra was given full approval by Health Canada in March of 1999 and will be covered on a medically necessary basis only. Viagra and all drugs that are used to treat erectile dysfunction (ED) are subject to the following plan parameters:

- The calendar-year maximum is $1,200 per individual.
- Pre-authorization by Clarica is required to assess medical necessity. Medical necessity will be determined if one or more predisposing risk factors exist, like diabetes or hypertension, and if the ED condition has been present for at least six months. A pre-authorization form must be completed by your physician and forwarded to Clarica. Clarica will assess to determine medical necessity.

If approved, future claims for this classification of drug can be obtained by using your pay direct drug card. Your drug card won't provide authorization to the pharmacist to process claims for ED prior to your obtaining approval from Clarica. To submit a claim for ED-related drugs, go to "How To Submit a Claim".

Xenical was approved by Health Canada in June of 1999 and will be covered on a medically necessary basis only. Xenical and all other anti-obesity drugs are subject to the following plan parameters:

- The calendar-year maximum is $1,000 per individual.
- A pre-authorization form must be completed by your physician and forwarded to Clarica. Clarica will assess for medical necessity and advise whether the request was approved or declined.

If approved, future claims for this classification of drug can be obtained by using your pay direct drug

card. Your drug card won't provide authorization to the pharmacist to process claims for anti-obesity drugs prior to obtaining approval from Clarica. To submit a claim for anti-obesity drugs, please see "How To Submit A Claim".

Hint

Special note for Quebec employees: Effective January 1, 1997, drug coverage under all medical plan options complies with Bill 33 legislation. Your coverage under all medical plan options includes all drugs listed under Quebec's basic drug formulary as established by the Régie de l'assurance du Québec (RAMQ). This formulary is reviewed by the RAMQ on a regular basis and is subject to change - elimination or addition of drugs - as new drugs and drug products are introduced.

Out-of-Pocket Maximum
(For Basic and Comprehensive Medical Options Only).

The out-of-pocket maximum is intended to protect you and your eligible dependents in the event that you incur significant drug expenses in a given year. The most you'll pay out of your own pocket for reasonable and customary eligible prescription drug expenses in a year per eligible dependent is $750. Once you reach this maximum, the plan pays 100% of further reasonable and customary eligible prescription drug expenses for the rest of the calendar year. The maximum includes your per-prescription copayment and the 20% that you pay for covered expenses (Basic Option) or the 10% you pay for covered expenses (Comprehensive Option), up to certain maximums for Tier 2 drugs. If you're a Quebec resident, you and your covered dependent children have a combined $750 out-of-pocket maximum as stipulated by legislation.

HINT

Pay Direct Drug Card

No matter which optional medical coverage you select, you have added convenience with your pay direct drug card (provided by BCE Emergis). When you use your pay direct drug card at any participating pharmacy, the pharmacist is automatically paid for eligible drug products, up to the reimbursement level and dispensing fee maximum. You'll have to pay your portion of each drug claim, your deductible (if applicable), and any dispensing fee that exceeds the dispensing fee cap. You also pay for ineligible drug products and the difference between the generic and brand-name if you choose to buy the brand-name drug.

Hint

If your physician indicates on the prescription that no substitutions are allowed, or, if no generic equivalent exists, the cost of the brand-name drug will be covered.

Your drug card also offers an important health feature. Whenever you use your pay direct drug card, the BCE Emergis Health System will perform a number of edits that will allow the pharmacist to perform a Drug Utilization Review (DUR). DUR links the database showing all your purchases with the pay direct drug card, even those at other pharmacy chains. DUR will advise the pharmacist of situations that could cause you harm. Examples include:

- Side effects from a drug that interacts with another you recently purchased,

- Refills sooner than appropriate,
- Possible duplications,
- Dosages beyond the maximum therapy limits, or
- Inappropriate medication for your age or gender.

Generally, these edits won't cause your claim to be declined, but simply provide you the opportunity to discuss any warnings with your physician.

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Private Duty Nursing

This includes the services provided in your home that can only be rendered by a Registered Nurse, Registered Nursing Assistant, Certified Nursing Assistant or Licensed Practical Nurse who isn't a relative and who doesn't ordinarily reside in your home.

Through our plan administrator, Clarica, we've arranged pre-assessment services for all your private-duty nursing claims. Now you can obtain immediate assistance on what the medical plan covers, what the provincial plan covers and what your spouse's plan covers - so you can receive the most from all available plans.

All private-duty nursing claims require a physician's recommendation and will be required to go through the pre-assessment process before any claims are paid.

Hint Due to the high cost associated with private-duty nursing care and the pre-assessment requirements, it is highly recommended that you obtain pre-approval by Clarica of any expenses to ensure they are covered under the plan provisions prior to incurring any out-of-pocket expenses.

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Professional Services

This includes the services of a licensed chiropractor, chiropodist, massage therapist, naturopath, osteopath, podiatrist, speech therapist, or provincially regulated acupuncturist. In 2001, only Alberta and Quebec have provincially regulated acupuncturists. This may be extended to other provinces in the future. The annual maximum applies to each specialty, except where combined maximums are indicated. Provisions for reimbursement of covered expenses are subject to provincial legislation in each province. The following outlines the conditions for each plan option.

Basic Option

The Basic Option covers one combined maximum of $300 for all these professional services, per

person annually. You may submit claims for expenses after you have claimed the yearly maximum benefit under your provincial plan. FLEX will only reimburse you for services rendered after your provincial plan's yearly maximum has been reached. For example, if the provincial plan reimburses chiropractic care at $10 per visit up to a yearly maximum of $150, and a visit actually costs $15, you're responsible for paying the additional $5 until the $150 provincial maximum is reached. Once the yearly provincial maximum is reached, FLEX coverage begins for future visits.

Comprehensive Option

The Comprehensive Option covers a maximum of $300 per person annually for each practitioner. FLEX will only reimburse you for services rendered after your provincial plan's yearly maximum has been reached.

Plus Option

The Plus Option covers a maximum of $500 per person annually for each practitioner. For chiropractic services only, you may submit claims for chiropractic services immediately, regardless of your provincial plan's maximum annual benefit (see hint below). For all other eligible professional services, you may submit claims for expenses after you have claimed the maximum yearly benefit under your provincial plan. FLEX will only reimburse you for services rendered after your provincial plan's yearly maximum has been reached.

Hint

Note: For employees working in Alberta, any professional services will be reimbursed only after any coverage provided by Alberta Provincial Health Care has been exhausted. Legislation in Alberta prohibits providing payment for services before the provincial plan's maximum is satisfied. As a result of this legislation, you can submit for expenses only after you have claimed the maximum yearly benefit under your Alberta Provincial Health Care Plan. This would apply to all optional medical coverage.

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Psychologist Services

The services of a licensed, certified or registered psychologist are covered when medically necessary. Original receipts are required with all claim submissions.

Basic Option

The Basic Option covers an annual maximum of $350 per person.

Comprehensive Option

The Comprehensive Option covers an annual maximum of $750 per person.

Plus Option

The Plus Option covers an annual maximum of $1,000 per person.

HINT

EAP — Your Employee Assistance Program

Did you know you may access psychologist services under the professional services coverage as stated above as well as under your EAP plan? The EAP plan is provided by the company at no cost to you.

Simply call **1-800-263-1401** to arrange for an appointment. Family Guidance (FGI), our EAP provider, will arrange for an appointment with a counselor who lives nearest to your home or office. Ask Employee Services for a brochure to receive more information about EAP. The EAP provider will maintain your confidentiality.

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Physiotherapist Services

The services of a licensed, certified or registered physiotherapist are covered when medically necessary and recommended by a physician. In addition to the annual maximum under each medical coverage option, we also have a catastrophic provision.

The catastrophic provision provides for the payment of additional expenses in excess of the annual maximum for conditions which require extensive ongoing physiotherapy. The adjudication of any requests for payment under the catastrophic provision will be based on written documentation provided by your physician and based on approval by the plan administrator (Clarica). Any approved additional expenses will be reimbursed at 80%.

Basic Option

The Basic Option covers an annual maximum of $350 per person.

Comprehensive Option

The Comprehensive Option covers an annual maximum of $750 per person.

Plus Option

The Plus Option covers an annual maximum of $1,000 per person.

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Miscellaneous Supplies and Durable Medical Equipment

Available under all medical coverage options, this includes rental or, if deemed appropriate, the purchase or repair of a wheelchair, walker, hospital bed or other durable medical equipment required for therapeutic use in the home.

Hint If a dependent child is born with a lifetime disability or condition and will require wheelchairs throughout his/her life, due to normal growth, the purchase of more than one wheelchair per lifetime is covered.

Miscellaneous supplies and durable medical equipment include:

- Electric wheelchairs are covered at the reimbursement level of each medical plan option (80%/90% or 100%) to a lifetime maximum of $20,000, per person,
- Trusses, braces, crutches, fiberglass or plaster casts, artificial limbs or eyes and other prosthetic appliances and surgical dressings (must be medically necessary and not sports-related),
- Orthopedic shoes or orthopedic modification to shoes and orthotics when required for the correction of a deformity of the bones and muscles, provided they are not solely for athletic use, are covered up to a maximum of $400 per individual per calendar year ($200 maximum per foot per individual per calendar year),
- Diagnostic laboratory and X-ray examinations, blood transfusions and oxygen, including equipment for administration,
- Medically necessary supplies for the treatment of cystic fibrosis, diabetes, parkinsonism, severe cases of permanent psoriasis, and supplies required by paraplegics and quadriplegics or as the result of a colostomy,
- Mastectomy bras (maximum two bras or $85 per calendar year),
- Wigs and hairpieces - $150 per person per year (lifetime maximum of $1,500) if required as a result of chemotherapy or if required as a result of total hair loss from alopecia totalis,
- Trachea tubes,
- Eye patches required for treatment of lack of lachrymation,
- Food replacements when other food can't be consumed because of surgery to the digestive tract (limited to charges in excess of those considered reasonable and customary for a normal diet), and
- PSA tests for prostate cancer.

HINT

Before making a claim for any device or durable medical equipment, make sure you check out the coverage under your provincial plan first. Although provinces vary on the scope of coverage, most offer an Assistive Devices Program. No eligible device or durable medical equipment expense will be reimbursed under FLEX until the provincial plan has reimbursed for services covered under their plan first.

Take note of the reasonable and customary provision. The plan will only pay for medically necessary expenses. Make sure you ask questions to determine what is the best choice to provide effective care. If you're unsure about coverage, call Clarica and inquire about the reasonable and customary cost before you make a purchase.

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Dental Surgery Due to an Accident

Charges for dental services required as a direct result of accidental injuries to natural teeth are covered when such treatment is rendered and completed within six months of the accident. This excludes services required for a fracture or injury that results from a condition that existed before the accident. No prescription is required.

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Out-of-Province (within Canada) Emergency Medical Expenses and Travel Assistance Benefit

All optional medical coverage includes an out-of-province (within Canada) emergency medical and travel assistance benefit for personal travel. This benefit provides 24-hour assistance for medical emergencies while you and eligible dependents are traveling for pleasure outside of your province of residence but within Canada.

Your travel assistance benefit includes the following services related to a medical emergency:

- Emergency hospitalization required in Canada, but outside your province of residence up to the ward accommodation rate,
- Emergency treatment by a physician or surgeon, or referral treatment in Canada when services are not available in your province of residence and are recommended in writing by the attending physician and approved by your home province,
- Ambulance, and
- Certain transportation expenses for your family.

You're encouraged to take advantage of this service in the event of a medical emergency while traveling for personal reasons outside your province of residence but within Canada. The toll-free telephone number for the 24-hour help line is 1-800-810-0183.

Payment won't be made for treatment of an illness or injury that occurs outside of the covered travel period; 21 days for the Basic medical plan option; 31 days for the Comprehensive option and 90 days for Plus option.

Hint

Important Notice - Under this emergency medical travel assistance benefit, up-front payment to the hospital and coordination of payment under your provincial health plan will be arranged if you call the 24-hour help line. Failure to do so will mean you have to pay for the expense as soon as it is incurred and submit the claim to your provincial plan before submitting it to Clarica.

The Travel Well benefit (not covered under FLEX), covers Nortel Networks employees for out-of-country medical emergencies and travel assistance while on Company business and personal travel.

For more information, please contact Travel Well at ESN 333-2710 or 206-622-9581 or http://travelwell.ca.nortel.com/.

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Maximum Lifetime Benefits

Levels apply as noted in "Optional Medical Coverage Table".

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Exclusions to Medical Coverage

No benefit is payable for:

- Contraceptives, other than oral,
- Food and food supplements, including dietary supplements,
- Vitamins, minerals, protein supplements and therapeutic nutrients except those which can only be purchased with a written prescription of a physician or dentist,
- Cosmetic or hygienic products,
- Products, which are deemed by the plan administrator to be household remedies,
- Experimental drugs,
- Expenses for services and products, rendered or prescribed by a person who is ordinarily a resident in the claimant's home or who is related to the claimant by blood or marriage,
- Expenses for which benefits are payable under a Workers' Compensation Act or a similar statute,
- Expenses incurred for self-inflicted injuries,
- Expenses incurred due to civil disorder or war, whether or not war was declared,
- Expenses for which benefits are payable under a government plan,
- Expenses for benefits which are legally prohibited by the government for coverage,
- Out-of-province expenses for elective (non-emergency) medical treatment or surgery,
- Expenses for the services of a homemaker,
- Expenses which are purchases solely for athletic use,
- Dental expenses, except those specifically provided under the policy for treatment of accidental injuries to natural teeth,
- Utilization fees which are imposed by the provincial health care plan for the use of a service,
- Expenses incurred out-of-province for the regular treatment of an injury or disease which existed prior to the employee's or dependent's departure from his province of residence,
- Expenses incurred outside the employee's province of residence if provincial health coverage is not in force,
- Expenses for over-the-counter drugs, or
- Expenses for the treatment of Temporomandibular Joint Syndrome (TMJ).

To TopDental/Vision/Hearing Care Benefits

What You Will Find Here

To TopCheck Out your Optional Dental/Vision/Hearing Care Coverage

Eligible Expenses

Your optional dental/vision/hearing care coverage covers eligible expenses at the reimbursement levels indicated in the "Optional Dental/Vision/Hearing Care Coverage Table" shown below.

The following chart outlines the optional dental/vision/hearing care coverage for reasonable and customary expenses only:

Benefit	Basic	Comprehensive	Plus
Dental Care Coverage			
Deductible	None	None	None
Coverage for preventive services (such as exams, cleanings and fluoride treatments)	100%	100%	100%
Coverage for restorative services (such as fillings)	80%	90%	100%
Coverage for oral surgery	80%	80%	100%
Coverage for endodontics (treatment of roots) and periodontics (treatment of gums)	80%	80%	100%
Coverage for major services (such as crowns, dentures, bridges)	N/A	50%	50%
Coverage for orthodontia (treatment to correct tooth or bite alignment)	N/A	50%	50%
Annual benefit maximum per person per year	$1,000	$2,000	$2,500
Lifetime maximum per person for orthodontia	N/A	$2,000	$3,000
Dental Fee Guide (general practitioners)	Current	Current	Current

Vision Care Coverage			
Coverage for eligible expenses	N/A	90%	100%
Maximum benefit per calendar year for each dependent child under age 19 and every 2 calendar years for each adult	N/A	$200	$300
Hearing Care Coverage			
Coverage for eligible expenses	80%	90%	100%
Maximum benefit per person every two years	$500	$750	$1,000

Dental reimbursements are based on the fee guide for general practitioners. Claims must be submitted within 18 months of the service date to be eligible for payment.

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Dental Care Services

Covered Dental Services

Preventive (basic) services include:

- Routine oral examinations, cleaning of teeth (routine scaling) and fluoride applications once every six months. Routine scaling limited to 1 unit every six months (1 unit =15 minutes of treatment time).
- Complete oral examinations, including scaling, polishing and complete X-rays, once every 60 months.
- X-rays, including bite-wing X-rays once every 12 months, full-mouth X-rays once every 60 months and diagnostic X-rays as required for dental surgery.
- Oral hygiene instruction once per lifetime.

Periodontic services include:

- Removal of teeth, including surgical extraction of impacted teeth,
- Fillings, including amalgam, silicate, acrylic and composite fillings,
- General anesthesia required for dental surgery,
- Space maintainers for missing primary teeth and certain habit-breaking appliances,
- Pit and fissure sealants for dependent children under age 19, and

- Adjustment, repair, relining and rebasing of an existing fixed bridge, removable partial or complete denture.

Periodontic services include:

- Diagnosis and treatment of disease of the gums, tissues and bones supporting the teeth, including surgical removal of cysts and neoplasms in these areas, and
- Additional scaling (deep scaling) limited to 8 units per calendar year (1 unit = 15 minutes of treatment time).

Hint Note: 10 units overall scaling maximum per calendar year (2 units routine scaling and 8 units additional scaling).

Endodontic services include:

- Diagnosis and treatment of root canals and pulp, including root canal therapy.

Major restorative services include:

- Dental inlays, onlays and crowns, including gold and porcelain veneer restorations, where other material is not suitable, provided there is cuspid or incisal damage. This means that the dental X-rays must show visible damage on the top or side of tooth.

- Creation of a fixed bridge or removable partial or complete denture.
- Replacement of a fixed bridge that is at least five years old and replacement of dentures that are at least three years old.

Orthodontic services include:

- Treatment and supplies required to correct improper bite (excluding treatment for Temporomandibular Joint Syndrome).
- Treatment for eligible employees and eligible dependents

Detailed listing of Dental services covered:

Diagnostic/Preventive (basic) services include:

- Routine oral examination and diagnosis:
    - Complete oral exams (once every 60 months), recall oral exams (once every 6 months); special oral examinations; treatment planning; minor emergency treatment; consultation; house call, institutional call and office visit;
- Test and Laboratory Examinations:
    - Biopsy of oral tissue; pulp vitality tests
- Radiographs:
    - Periapical (one complete series every 60 months); occlusal; bitewing (once every 12

months); extra oral; sialography; radiopaque dyes to demonstrate lesions; temporomandibular films; panoramic (once every 36 months); interpretation of radiographs received from another source; tomography

- Preventive Services:
    - Polishing (once every 6 months); preventive scaling (if done in conjunction with recall type services (once every 6 months); preventive recall package including a combination of recall examination, dental prophylaxis, oral hygiene instruction and/or topical application of fluoride (once every 6 months); topical application of fluoride phosphate (once every 6 months); oral hygiene instruction (once per lifetime); pit and fissure sealants (for persons under the age of 19); interproximal discing of teeth; recontouring of teeth; caries control
- Appliances to control oral habits
- Space maintainers
- Anesthesia in conjunction with oral surgery:
    - General anesthesia; deep sedation; conscious sedation
- In office laboratory procedures

Restorative

- Plastic Fillings:
    - Amalgam; acrylic or composite resin; transitional restoration of fractured anterior; steel crown-primary teeth
- Surgical Incision
    - Miscellaneous surgical services
- Surgical Services
    - Uncomplicated removals; surgical removals, transplantation and repositioning
- Anesthesia in conjunction with oral surgery
    - General anesthesia; deep sedation; conscious sedation
- Repairs and Adjustments
    - Porcelain repairs; recementing crown; denture repairs (only); repairs to bridges; denture relining and rebasing;
- In office laboratory procedures

Endodontics

- Endodontics
    - Pulpotomy; root canal therapy; periapical services; gingival plasty; curettage; alveolectomy, banding of tooth; canal and/or pulp enlargement; intentional removal, apical; filing and reimplantation; emergency procedures
- Anesthesia in conjunction with oral surgery
    - General anesthesia; deep sedation; conscious sedation
- In office laboratory procedures

Periodontics

- Periodontics (excluding periodontic appliances)
    - Non-surgical services; surgical services; post-surgical treatment; occlusal equilibration (not exceeding 8 time units in a calendar year); scaling and root planing (not exceeding 10 time units in a calendar year under Parts 1 and 4)
- Surgical Services; surgical excision
- Anesthesia in conjunction with oral surgery
    - General anesthesia; deep sedation; conscious sedation
- In office laboratory procedures

Major Restorative

- Dentures
    - Complete dentures and partial dentures
    - Addition and adjustments
        - Adjustments to dentures
- Bridges
    - Examinations
        - Oral examination; diagnostic casts
    - Fixed Bridgework
        - Bridge pontics; retainers; other prosthetic services
    - Anesthesia in conjunction with oral surgery
        - General anesthesia; deep sedation; conscious sedation
    - In office laboratory procedures
- Crowns
    - Examinations
        - Oral examinations; diagnostic casts
    - Crowns*, inlays and onlays (including gold and porcelain veneer where other material is not suitable). *Crowns are covered when placed on a tooth that is functionally impaired by incisal angle or cuspal damage. Proof of the damage must be evident on an x-ray submitted with the claim.
        - Gold foil restoration; metal inlay restorations; composite inlay restorations; porcelain inlay restoration; porcelain/ceramic inlay restorations; crowns; other restorative services; hemisection
    - Surgical services
        - Fractures; frenectomy, miscellaneous surgical services
    - Anethesia in conjunction with oral surgery
        - General anesthesia; deep sedation; conscious sedation
    - In office laboratory procedures
    - Antibiotic drug injections (when prescribed by a dentist)

Orthodontics

- Observation, adjustment
    - Oral examination; cephalometric radiograph; hand and wrist radiograph; oral surgical procedure for orthodontic purposes; surgical exposures of erupted tooth, with orthodontic treatment; observation, adjustment; repairs, alterations; active applicances for tooth guidance of uncomplicated tooth movement; retention appliances
- Comprehensive treatment
- Anesthesia in conjunction with oral surgery
    - General anesthesia, deep sedation; conscious sedation
- In office laboratory procedures

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Payment of Dental Services

The Dental Fee Guide

The Canadian Dental Association sets procedure codes that are used for identification of the individual treatments performed by all dentists. If a province doesn't use the Canadian Dental Association procedure codes, the codes listed in that province's fee guide for the same procedure would apply. The fee guide lists the procedure code charges established for **general practitioners** by each provincial dental association.

Some dentists charge more than the current fee guide. If you think this is the case, ask your dentist why the charges are more than the fee recommended by the provincial dental association.

The Alberta Dental Association has not published a fee guide since 1997. However, in 2002, based on industry benchmarking results, the inflation factors used for 2001 will be updated for 2002. For the latest information, please read the "2001 Insurance Industry Inflation Factor Applicable to the 2000 Reasonable and Customary Reimbursement Amounts for Employees in Alberta" on Services@Work.

No Assigning of Payments to Your Dentist

Beginning in 2002, you'll no longer be able to assign your reimbursement for dental claims directly to your dentist. Instead, you pay the dental fees and then claim reimbursement from Clarica yourself. There will be a short waiting period between paying the amount and being reimbursed - even a shorter waiting period if you apply for electronic funds transfer with Clarica and request your reimbursement directly to your bank account. Recent studies have indicated that charges from dentists for services that aren't assigned are lower than charges for the same services that are assigned.

Pre-Treatment Plans for Major Work

Don't get caught having to pay for expensive dental work you thought was covered. For any services

that will cost you in excess of $200, ask the dentist to prepare a pre-treatment plan and send it in to Clarica for assessment. Find out before the services are rendered what your dental/vision/hearing care coverage option will pay.

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Limitations

Where a choice of dental services exists, payment is limited to the least costly professionally acceptable alternative. If you receive more costly treatment, you'll be required to pay the additional costs. This is known as the "alternate benefit provision." For example, the plan will cover dental implants, providing partial reimbursement up to the level the plan would have reimbursed for an alternate service, such as a bridge.

Replacement of an existing denture is an eligible expense if the replacement is required to replace an existing denture which was installed at least three years before the replacement. The replacement will be limited to a maximum eligible expense of the value and quality of the original denture.

Replacement of an existing bridgework, crown, onlay or inlay is an eligible expense only if the original work was installed at least five years previously. Payment is limited to the maximum eligible expense of the value and quality of the original bridgework, crown, inlay or overlay.

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Exclusions to Dental Coverage

No benefit is payable for:

- Expenses for cosmetic services,
- Bonded amalgams,
- Expenses incurred for the treatment of malocclusion or for orthodontic treatment, except under the orthodontic benefit,
- Expenses for replacement of space maintainers, dentures orthodontic appliances or periodontal appliances which have been lost, stolen or mislaid,
- Expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
- Expenses for prosthetic devices which are ordered while you or your dependent are covered under this plan, but are installed after termination of this benefit, or
- Expenses for permanent splinting.

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To TopVision Care Services

Vision care services are provided under the Comprehensive and Plus Options. No vision care services are provided for employees who select the Basic Option. The reimbursement levels and maximums for all services combined and frequency limitations are in accordance with each plan option as indicated in "Optional Dental/Vision/Hearing Care Coverage Table".

Eyeglasses and Contact Lenses

Coverage is available for expenses incurred for the purchase and repair of eyeglasses, prescription sunglasses and contact lenses necessary for the correction of vision when prescribed by an optometrist or an ophthalmologist.

Eye Examination

An eye examination by an ophthalmologist or optometrist to the extent not covered by your provincial plan is covered.

Laser Eye Surgery

We've added coverage for this procedure as an eligible expense according to the reimbursement level and annual maximums for the applicable plan option - Comprehensive or Plus - you select. Note that the plan maximums per person every two calendar years will still apply, and won't cover the full cost of the surgery. However, if you have directed any unused FLEX Credits to an HCRA, you can still claim the unpaid portion of the surgery through that account or you may be able to claim it as a medical expense on your income tax form.

Hint

Note: Some provinces have changed coverage for eye exams to once every two years. Your optional dental/vision/hearing care coverage will cover eye exams once per calendar year, but not in the year coverage is available under the provincial plan. Check with your optometrist to determine the last date you had an eye exam.

HINT

Did you know that we have a preferred provider relationship with Preferred Vision Services (PVS)? You can buy quality eyewear at savings of up to 20%. These savings are available on all frames, prescription lenses and lens add-ons at registered PVS locations. (See "Appendix I: Contact Directory" for their telephone number)

To TopHearing Care Services

Hearing Aids

The purchase and repair of hearing aids are covered, excluding batteries, to the maximum eligible

expense as outlined in "Optional Dental/Vision/Hearing Care Coverage Table".

To TopHealth Care Reimbursement Account (HCRA)

To TopCheck Out Your Health Care Reimbursement Account

The Health Care Reimbursement Account (HCRA) can help you save on taxes. With the account, you set aside money on a before-tax basis to reimburse yourself for eligible health care expenses. If you're a Quebec resident, you'll be taxed at the provincial level.

Once you have selected your optional coverage under FLEX, you may find that you have some FLEX Credits left over. For example, you may have decided not to select any optional medical or dental/vision /hearing care coverage because you have more than enough coverage under your spouse's plan. You can allocate unused FLEX Credits to an HCRA and use them to cover health-related expenses not covered by your spouse's plan.

What You Will Find Here

You may allocate unused FLEX Credits to the HCRA, or take them as taxable pay, but not a combination of both. The minimum contribution is $1 per pay period. During the annual enrollment period or when you make a Status Change, if you don't advise where to direct any unused FLEX Credits and are not currently enrolled in the HCRA, they will automatically be allocated as taxable pay.

To TopUnique Features of an HCRA

- You can use your FLEX Credits on a before-tax basis which increases the purchasing power of these FLEX Credits (to a lesser degree in Québec). Go to "Taxing Decisions" for details.
- You can claim any health-related expenses that would be tax-deductible and listed in the *Income Tax Act* (Canada) and its Regulations and Interpretation Bulletins. This is a much broader list of expenses than those covered under the Basic, Comprehensive or Plus options under FLEX.
- You can file a claim against your total annual allocation at any time - even though technically, the allocation to your HCRA is on a per-pay period basis.
- You can claim eligible expenses for yourself, your spouse or any dependents for whom you're financially responsible, as defined by the *Income Tax Act*. This could include your dependent parents or other dependents.
- You can claim your deductible and any amounts you must pay after the Company-paid reimbursement level under FLEX.

Make sure you have coordinated benefits with your spouse's plan first (if applicable) before you use up any FLEX Credits under your HCRA .

How Does the Before-Tax Feature Help Me?

Assume you have unused FLEX Credits of $150. If you select to receive these FLEX Credits as extra pay, they will be taxed. If you're in the 30% tax bracket, you'll receive about $105 of the original $150. The other $45 will go to government tax.

If you deposit the same $150 in a HCRA instead, you can use the full untaxed amount to pay for any out-of-pocket health-related expenses. The result is wiser use of your FLEX Credits. You make your FLEX Credits go further through improved tax effectiveness.

Hint Note: In Quebec, amounts reimbursed from your HCRA are subject to provincial income tax.

Private Health Services Plan — Use It or Lose It!

The Canada Customs and Revenue Agency (CCRA) will allow FLEX Credits to be treated on a before-tax basis only if this benefit is deemed as a private health services plan. To qualify for this distinction, there must be an element of risk associated with the provisions of the plan. The risk is associated with the use of your FLEX Credits and/or medical expenses. CCRA allows a plan to either carry forward FLEX Credits or carry forward expenses. The Nortel Networks plan operates on a carry-forward expense basis.

Once you set up an account for the year, you can't make changes in your FLEX Credit allocation amount until the next annual enrollment period. The only exception is when you have a Status Change.

You have until March 31, 2003, to submit claims for eligible expenses incurred between January 1, 2002, and December 31, 2002, for reimbursement from your year 2002 HCRA allocation. You'll forfeit any FLEX Credits allotted for 2002 that remain in the HCRA after March 31, 2003.

CCRA doesn't permit cash-out of unused amounts and doesn't permit you to contribute your own money toward an HCRA.

If you have an HCRA and you record a Status Change such that you'll be selecting HCRA again, you have 31 days to use up the balance in the HCRA based on your previous selection.

To Top**Carry Forward Eligible Expenses For One Year**

If you have more eligible expenses in 2002 than FLEX Credits allocated to your account, you may carry forward into the next year expenses for which you weren't reimbursed. You may be reimbursed for these 2002 expenses from FLEX Credits you allocate to your 2003 HCRA. You can budget ahead and know what dollar amount is required to be allocated in 2003 to cover unpaid health expenses from 2002.

An example of carry-forward expenses for one year:

Year 2002

Over-the-counter (OTC) drug expenses:	$150

minus	
FLEX Credit allocation:	$125
equals	
Unreimbursed expenses:	$25
Year 2003	
Unreimbursed expenses from year 2002:	$25
Plus	
Known OTC drug expenses:	$100
Equals	
Potential FLEX Credit allocation:	$125

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Some Eligible and Ineligible Expenses

You can use the HCRA to reimburse yourself for expenses that are listed as "eligible" under the Income Tax Act. Eligible expenses include such things as deductibles and copayments. The Canada Customs and Revenue Agency (CCRA) doesn't allow reimbursement for some types of expenses, for example, health club memberships, humidifiers and hot tubs. (Visit the CCRA Web site at http://www.ccra-adrc.gc.ca/ or request a copy of publication IT-519R2, Medical Expense and Disability, for a complete list.)

You should know that if you get reimbursed through the HCRA for health care expenses, you can't claim medical expense income tax credits for these same expenses when you file your federal income tax return.

Outside Quebec: If you have expenses that could be paid through the HCRA, it may be more tax effective to direct unused FLEX Credits to the HCRA than it is to take the unused FLEX Credits as taxable pay. You may want to consult a tax advisor before making your decision.

In Quebec: Current Quebec tax legislation considers claims reimbursed through an HCRA as taxable income at the provincial level. However, the HCRA is still a valuable component of your benefits package, because you pay no federal tax on it.

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Life Insurance

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Check Out Your Core Life Insurance Coverage

Core Life Insurance for You

What You Will Find Here

Your life insurance helps protect your family's finances if you die.

Nortel Networks provides core employee life insurance at no cost to you. Core coverage provides your beneficiary with a benefit amount equal to your FLEX Earnings if you die while you're covered.

If you're an active employee on January 1 following your 65th birthday, your core coverage will be reduced by 50%. Upon retirement you may receive retiree life insurance coverage based on the plan you are participating in under the Capital Accumulation and Retirement Program.

There is an option to convert your policy to an individual policy within 31 days of your termination date.

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Check Out Your Optional Life Insurance Coverage

Optional Employee Life Insurance Coverage

If you think you need more life insurance than the core coverage provides, you can buy additional coverage. Optional life insurance is available in multiples of your FLEX Earnings. You can buy additional coverage equal to:

- 1 X FLEX Earnings,
- 2 X FLEX Earnings,
- 3 X FLEX Earnings,
- 4 X FLEX Earnings (requires evidence of insurability), or
- 5 X FLEX Earnings (requires evidence of insurability).

Optional life insurance ends at retirement or when you reach your 65th birthday, whichever comes first. There is an option to convert your policy to an individual policy within 31 days of your last date of employment or your retirement date. The maximum benefit for core plus optional coverage is $3,000,000.

The cost will be based on your gender, your age on December 31 of the plan year, whether or not you smoke, and the amount of coverage you select.

Optional Dependent Life Insurance Coverage — Spouse

- No coverage
- $10,000
- $25,000
- $50,000
- $250,000
- $300,000
- $350,000
- $400,000

- $100,000
- $150,000
- $200,000
- $450,000
- $500,000

Optional Dependent Life Insurance Coverage — Children

- No coverage
- $5,000
- $10,000
- $15,000
- $20,000
- $25,000

For life insurance: If both you and your spouse work for Nortel Networks, you can enroll as an employee or as a dependent, but not both as an employee and a dependent. In addition, only one of you can enroll your eligible children as dependents.

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Determining Your Benefit Amount

Your core life coverage is one times your FLEX Earnings, rounded to the next higher $1,000. To determine your optional employee life insurance coverage amount, first multiply your FLEX Earnings by the option level you have selected. If the result is not an even multiple of $1,000, then round it up to the next higher $1,000. Here's an example, using FLEX Earnings of $21,300:

Multiple	Benefit	Amount
One times FLEX Earnings =	$21,300	$22,000
Two times FLEX Earnings =	$42,600	$43,000
Three times FLEX Earnings =	$63,900	$64,000
Four times FLEX Earnings =	$85,200	$86,000
Five times FLEX Earnings =	$106,500	$107,000

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Optional Life Insurance Coverage Rates

Optional Life Insurance Coverage Rates for You and Your Spouse

Optional employee life insurance coverage rates are as follows:

	Smoker				Non-Smoker			
Employee/Spouse's age on Dec 31, 2002	Male Monthly	Male Bi-Weekly	Female Monthly	Female Bi-Weekly	Male Monthly	Male Bi-Weekly	Female Monthly	Female Bi-Weekly
Under 25	$ 0.060	$ 0.028	$ 0.034	$ 0.016	$ 0.034	$ 0.016	$ 0.026	$ 0.012
25-29	$ 0.060	$ 0.028	$ 0.034	$ 0.016	$ 0.034	$ 0.016	$ 0.026	$ 0.012
30-34	$ 0.068	$ 0.031	$ 0.034	$ 0.016	$ 0.034	$ 0.016	$ 0.026	$ 0.012
35-39	$ 0.077	$ 0.036	$ 0.060	$ 0.028	$ 0.034	$ 0.016	$ 0.034	$ 0.016
40-44	$ 0.119	$ 0.055	$ 0.085	$ 0.039	$ 0.068	$ 0.031	$ 0.051	$ 0.024
45-49	$ 0.221	$ 0.102	$ 0.128	$ 0.059	$ 0.119	$ 0.055	$ 0.085	$ 0.039
50-54	$ 0.357	$ 0.165	$ 0.204	$ 0.094	$ 0.213	$ 0.098	$ 0.128	$ 0.059
55-59	$ 0.578	$ 0.267	$ 0.323	$ 0.149	$ 0.340	$ 0.157	$ 0.221	$ 0.102
60-65	$ 0.833	$ 0.384	$ 0.442	$ 0.204	$ 0.493	$ 0.228	$ 0.315	$ 0.145

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Determining Your Cost for Employee or Spouse Life Insurance Coverage

Optional life insurance coverage rates for you and your spouse are based on gender, age on December 31 of the plan year and life insurance "smoker status". You and/or your spouse are eligible for the life insurance "non-smoker" rate if you haven't smoked or used a tobacco product in the previous 12 consecutive months.

If you are discovered to be a smoker and are paying non-smoker rates, you or your beneficiary could be denied benefits. Notify Employee Services immediately if you change from non-smoker to smoker status anytime during the year.

The FLEX online enrollment tool will show you what it will cost for you and your spouse to buy optional life insurance.

If you don't have online access, you can calculate the cost by using the table.

Here's an example. Ellen's spouse is a 37-year-old, non-smoking male. She wants to buy $100,000 of life insurance coverage in his name. Ellen is paid bi-weekly.

$0.016 (from the table) x $\frac{\$100{,}000}{1{,}000}$ = $1.60 every two weeks

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Optional Dependent Life Insurance Coverage Rates for Your Children

Your cost to cover all your eligible children is $0.475 per $5,000 of coverage.

Here's an example. If you choose $25,000 of coverage, your cost is:

$0.475 x $\frac{\$25{,}000}{\$5{,}000}$ = $2.38 per month

$2.38 x $\frac{12}{26}$ = $1.10 per pay (based on 26 pay periods)

Return to "Optional Life Insurance Coverage Rates" Table of Contents
Return to Main Table of Contents

To TopEvidence of Insurability

When you are first eligible to buy optional life insurance, or when you increase the amount of coverage you already have, Clarica may ask you for information about your health before approving your request. This is called providing evidence of insurability. To submit evidence of insurability, you complete a short medical questionnaire. The forms you use are called the Statement of Health for Member and the Statement of Health for Dependent Spouse/Children Form. It's important that you complete the form entirely and accurately, and return it to Clarica within 31 days from your event date.

Both you and your spouse may be required to provide evidence of insurability, depending on the amount of coverage requested. You won't be required to provide evidence of insurability for optional dependent life insurance coverage for your children

Clarica may decide it needs further information before approving your request. If so, you and/or your spouse may be asked to submit additional medical information or have a physical examination. If they request this, you have 60 days from the date of notification to do so. If you don't submit additional medical information within 60 days, your application will be closed. The new levels of **optional employee life insurance** and **optional dependent life insurance** won't become effective until medical evidence has been accepted and your application has been approved.

During the assessment process, you and/or your spouse will be insured at your current coverage amounts until you are approved for the amounts requested. If you and your spouse are not approved for the new amounts, your current coverage will remain in effect. Any increase in coverage amount

begins on the date of approval.

At annual enrollment:
You'll be required to submit evidence of insurability if you want to increase the amount of your **optional employee life insurance** coverage.

You'll be required to submit evidence of insurability for your spouse if you're selecting **optional dependent life insurance** coverage if you did not select this coverage within 31 days from the date you were first eligible to do so, or you're increasing your spouse's current coverage to more than $50,000.

The forms will be sent to you along with your Confirmation Statement. You must return completed forms to Clarica within 31 days of the start of the plan year: that is, by January 31.

If you are a new hire:
You will be required to provide evidence of insurability if your core life insurance coverage will be more than $600,000.

You will be required to provide evidence of insurability for **optional employee life insurance** if you choose an amount that is four or five times FLEX Earnings, or if the total amount is $1 million or greater. However, you do not have to provide evidence of insurability for **optional employee life insurance** of one, two or three times FLEX Earnings (as long as the amount is under $1 million) and you submit your selection within 31 days of your hire date.

If you're selecting **optional dependent life insurance** for your spouse, you'll not be required to submit evidence of insurability if the amount selected is $50,000 or lower, as long as you make your selection within 31 days of your hire date.

You must submit the form to Clarica within 31 days from your date of hire.

If you have a Status Change
You will be required to provide evidence of insurability for **optional employee life insurance**:

- If you want to increase your amount by more than one increment of FLEX Earnings, and/or
- If you are requesting an amount that is four or five times FLEX Earnings, or the total amount is $1 million or higher.

Also, your spouse will have to provide evidence of insurability if you want to increase optional dependent life insurance coverage to an amount that is more than $50,000.

You must submit the form to Clarica within 31 days from the date of your status change.

To Top
Naming Your Beneficiary

Your core and optional employee life insurance coverage is payable to one or more designated beneficiaries. Unless you indicate otherwise, the Company will assume that you intend the same beneficiary or beneficiaries to be designated for your core and optional life, AD&D and Business

Travel Accident insurance. The beneficiary(ies) you currently have on file will remain in effect until you file a Beneficiary Designation Form. If you're enrolling for the first time or if you wish to change your beneficiary designations, you can obtain the beneficiary forms from Services@Work.

There are two kinds of beneficiary designations: Revocable and Irrevocable. **Revocable** means you can change whom you designate as a beneficiary at any time without authorization from your designated beneficiary. **Irrevocable** means you're giving authority to your designated beneficiary. You alone can't change your beneficiary designation: you must have agreement and signed consent from your designated beneficiary to make a change.

If you don't name a beneficiary for core and optional employee life insurance coverage, the proceeds will be paid to your estate. You should consider reviewing your named beneficiary(ies) during the annual enrollment period or when a Status Change occurs, such as the birth of a child or a change in spousal status.

You're automatically the beneficiary for any optional dependent life insurance coverage under FLEX.

Hint Note: In Québec, certain beneficiary designations may be automatically deemed to be irrevocable. If you require more details, check with Clarica to determine if an irrevocable status applies to your beneficiary designation.

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Your Conversion Option

If you leave the Company, you have the right to convert your current core and optional employee life insurance coverage to an individual policy without being required to submit evidence of insurability. The amount you can convert is subject to a maximum conversion amount of $200,000 for each of core life and optional life insurance coverage. You must apply and pay the first month's premium before the expiration of 31 days (the conversion period) from the date you leave the Company. If you die during the conversion period, your beneficiary will receive the benefit payable under your core and optional employee life insurance coverage (if applicable), even if you don't apply for an individual policy.

You may also convert your optional dependent life insurance coverage for your spouse to an individual policy without the need for evidence of insurability. The amount you can convert is subject to a maximum conversion amount of $200,000. Once again, the application and payment of the first month's premium must occur before the expiration of the 31-day conversion period. If your spouse dies during the conversion period, you'll receive the benefits payable under the optional dependent life insurance coverage for your spouse. There is no conversion option for your dependent life insurance coverage for your children.

HINT

Should you leave the Company, review your need to convert to an individual life insurance policy. If you have a medical condition that would preclude you from obtaining an individual policy later or from obtaining the same amount of group coverage with your new employer due to medical

requirements, you may want to take advantage of the conversion option. The cost of your new policy will be based on individual insurance rates in force at your current age. The type of individual policy available, its plan provisions and rates are determined by Clarica and have no relationship to the group contract that covers FLEX Benefits. Contact Clarica for further information regarding conversion.

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Exclusions to Life Insurance Coverage

No benefit is payable for a loss directly or indirectly due to suicide, while sane or insane, for optional employee and dependent life insurance coverage. This exclusion is applicable only if it occurs within the first two years of the effective date of any optional employee and dependent life insurance.

No benefit is payable for the loss of a dependent child if the death occurs within 24 hours of birth.

There are no exclusions relating to acts of war or terrorism for core life insurance coverage and for optional employee and dependent life insurance coverage. There are exclusions for AD&D coverage. Go to Exclusions for AD&D Coverage for more details.

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Life Insurance Benefit Checklist

Determining the life insurance coverage option you need to secure your family's financial future can be a complicated matter. Some people use four to six times annual earnings. But others argue that there is no set way to gauge accurately how much is really enough for you. Careful planning is the key.

By determining what your family's needs are now, or might be in the future, you can more accurately assess how much life insurance coverage you'll need to guarantee them a secure lifestyle. There are several factors you need to consider when determining how much coverage is enough for you and your loved ones:

- Monthly Income - Your family probably relies, in whole or in part, on your income to cover monthly expenses such as food, clothing and household expenses. This need is critical to a family's survival, and it's usually where the loss of income is felt the most.
- Present Life Insurance - You'll need to consider how much life insurance you currently have from all sources, both in and outside the Company.
- Shelter - It's probably important to you that your children remain in a familiar school with teachers and friends they know, if something happens to you. You may wish to provide enough funds to meet mortgage or rent payments for several years, or even to pay off the mortgage. Do you have mortgage insurance with your lender? If so, how do the coverage and costs compare?
- Emergencies - Your family may need funds to cover unexpected emergencies, such as accidents, home repairs and other unanticipated expenses that can upset a family's finances.
- Education - Providing for a child's college education is a concern of many parents. You may

want to provide funds to ensure that you'll still be able to finance your child's education if you're not around.

- Last Expenses - Your family will encounter funeral and possibly medical expenses upon your death, and may also have tax obligations and debts that need to be paid.

To TopSection 3: Using Flex - Enrolling, Submitting Claims And Managing Changes

To TopHow To Enroll During the Annual Enrollment Period

Once a year, during the annual enrollment period, you have the opportunity to look at the benefits offered and decide which plans meet your needs and the needs of your eligible dependents.

If you are a new hire enrolling for the first time, go to "How To Enroll If You're Hired On or After January 1, 2002". If you are experiencing a Status Change, go to "What To Do If You Have A Status Change During the Year".

To TopActions to Take

- Getting Ready To Enroll
- Your Enrollment Itinerary for 2002 Annual Enrollment
- Your Enrollment Options

Getting Ready To Enroll

As you think about your FLEX selections:

- Check the cost of coverage - use the FLEX online enrollment tool (or your Personalized Enrollment Worksheet if you do not have access to the Intranet) to determine your total cost.
- Check the cost or any rebates available for the medical options and for the dental/vision/hearing care options you have chosen.
- Compare the options carefully and check for additional information at Services@Work.

What You Will Find Here

- Before making your final selections, first review your spouse's coverage (if any) so you can make informed decisions about your optional coverage under FLEX.
- Determine the best options for you and your family.
- Decide if you want to allocate your unused FLEX Credits to an HCRA.

- Remember to choose a beneficiary for your life insurance. It's important to determine who will receive your insured amount if you die. Your family could encounter delays and legal problems if you haven't named a beneficiary.

Please note: Aside from annual enrollment, there are two other circumstances in which you can make benefit selections:

- When you are newly hired. Go to "How To Enroll If You're Hired On or After January 1, 2002".
- When you have a Status Change. Go to "What To Do If You Have A Status Change During the Year".

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Your Enrollment Itinerary for 2002 Annual Enrollment

- **Review the Confirmation Statement** sent to your home. This sets out your current FLEX selections and 2002 costs.
- **Review the *Decision Maker***. This online resource outlines what's new, helps you determine if you need to enroll and if yes - what you need to do for this year during annual enrollment.
- **Review this *Handbook***. It tells you what is provided automatically, and what choices you have. Each plan option listed in the FLEX online enrollment tool (or Personalized Enrollment Worksheet sent to you if you don't have access to the intranet) has a corresponding section in this Handbook.
- **Check the enrollment schedule**. This year, the annual enrollment period is **November 16 to November 30, 2001**. If you're going to be on vacation during this period, **contact Employee Services before you leave**.
- **Check the FLEX online enrollment tool for costs**, and to make your selections. You may want to look at the bottom-line cost to you of different combinations of options before you make your final selections.
- **Check the Benefit Statement that you received in the mail from Clarica**. This statement lists all the

Remember:

- The coverage you select during the annual enrollment period will be effective from January 1, 2002, through December 31, 2002, subject to eligibility. You can't make changes to your coverage during the year unless you have what's known as a Status Change such as marriage or the birth of a child.
- If you have a Status Change during the year, you must notify Employee Services, update your dependent information, and submit your completed benefit selections within 31 days of the event. Coverage is effective from the date of the event unless evidence of insurability is required for life insurance. Any life insurance coverage requiring evidence of insurability will be effective on the date of approval. If

benefits that you and your dependents have used in the most recent 12-month period available.

you submit the Status Change after 31 days, the enrollment selections won't become effective.

- **Enroll online**. If you plan to make changes to your FLEX selections, update your dependent information or change your or your spouse's smoker status.
- **If you don't have access to the intranet**, a separate package including a Personalized Enrollment Worksheet and print *Decision Maker* will be mailed to your home in time for the annual enrollment period. You'll need this package to get started. It includes instructions to help you update your dependents' information and complete your enrollment. If you don't receive it, contact Employee Services.
- **Record your confirmation number**. If you don't receive a confirmation number, your selections have not been recorded.
- **If you make changes to your FLEX selections, you'll receive a revised Confirmation Statement**. Watch the mail at home for it and review it to make sure you have the coverage you selected. If you have questions, please call Employee Services.
- **If you don't make changes to your FLEX selections**, the Confirmation Statement sent to you in the mail prior to the annual enrollment period, will serve as your confirmation for the 2002 plan year.
- **Keep your Confirmation Statement for future reference**.

Hint Please note: The FLEX annual enrollment period for 2002 is November 16 through 30, 2001. If you're going to be on vacation during this two-week period, contact Employee Services before you leave.

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Your Enrollment Options

Enrolling Online

You will need:

- **Your 7-digit Global ID number**,
- **Your NorPASS password**.

If you don't know your NorPASS password, or it has expired, call NT4-HELP (ESN 684-4357) or 1-800-684-4357or go to http://norpass.ca.nortel.com/ and follow the instructions for Password-

Related Services.

1. Launch Netscape 3.0 or greater or Internet Explorer 4.0 or greater and go to the FLEX online enrollment tool at https://eflex.us.nortel.com:49185/.

2. Enter your 7-digit Global ID and NorPASS password in the User Name and Password fields of the logon windows and follow the instructions.

3. Confirming dependents (if you're a newly hired employee, please go to step 4): To confirm your dependents' information, click on the Enrollment Form icon. This takes you to the Dependent Verification screen. Make sure your dependents' names date of birth, and genders are correct and complete. Click Dependent Verification Complete.

4. Adding new dependents: To add any eligible dependents, follow the instructions on the Dependent Verification screen.

5. Enrolling for 2002: On the Enrollment screen, follow the instructions. When you have completed your selections and are ready to submit them, click on the Enroll Me Now! button at the bottom of the Summary screen. This completes your enrollment. You won't be able to make any further changes during this annual enrollment period.

6. Once you have successfully enrolled, a confirmation number appears on your screen. Write this number down and keep it for your records. If you don't receive a confirmation number, you may not have enrolled successfully.

Enrolling On Paper

You will only receive a Personalized Enrollment Worksheet if you don't have access to the intranet.

- Go through the Personalized Enrollment Worksheet and make your selections for each plan option.

- Add up the costs of the items you have selected in Section A of the Personalized Enrollment Worksheet. (These are the options toward which Company-provided FLEX Credits can be applied on a before-tax basis: STD, LTD, AD&D (except Quebec), medical and dental/vision /hearing care coverage.) The negative numbers in this section represent FLEX Credit rebates ¾ so remember to **SUBTRACT** these amounts as you go if you've chosen an option that carries a rebate. Because of the rebates, the total you get for this section may be either a positive or a negative number.

- Enter the total from above on your Personalized Enrollment Worksheet beside the line called "Cost (+)/Rebate (-)." Make sure to include the positive or negative sign, whichever is applicable. Enter the sum of the "Cost/Rebate" line and the "FLEX Credits Per Pay" line beside the "Section A Total" line. Note that your FLEX Credits are shown as a negative number here.

- If the "Section A Total" is less than $0, then this amount represents your unused FLEX Credits that you can allocate to your tax-effective HCRA (minimum $1 per pay period) or take as

taxable pay. If the "Section A Total" is more than $0, then this amount represents your cost, which will be paid through payroll deductions.

- Go on to Section B. These are your optional employee and dependent life insurance coverage choices that can be bought only with after-tax dollars, through payroll deductions.

- **Mail your completed Personalized Enrollment Worksheet** in the enclosed reply envelope, or fax it to Employee Services at 905-863-8550 or ESN 333-8550 and include a phone number where you can be reached in the event that the Employee Services representative needs to contact you. Retain your Personalized Enrollment Worksheet, along with a copy of the fax receipt confirmation if you faxed your Personalized Enrollment Worksheet, for your records.

If you have a Status Change and you're enrolling a newly eligible dependent or making appropriate changes to your benefit selections, go to "What To Do If You Have A Status Change During The Year".

Return to "Actions to Take" Table of Contents
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To TopForms Required

If you want to make any of the changes listed below, you must complete the appropriate forms and return them as instructed on the form.

- If you're required to submit evidence of insurability for life insurance, you'll receive a Statement of Health for Member or Statement of Health for Dependent Spouse/Children form in the mail, along with your Confirmation Statement.

- If you need to name a beneficiary for your life insurance and AD&D insurance, complete and return a Beneficiary Designation Form.

  Hint Please note that the same beneficiary will apply to your Business Travel Accident Insurance, unless you make a different arrangement with Employee Services.

  Print out the form, which is available on Services@Work under FLEX Benefits.

- If you're waiving medical care coverage because you (you and your family in Quebec) have coverage elsewhere, you'll need a Medical Coverage Waiver form (Quebec / Other Provinces). Go to Services@Work to download and print the form. Complete and return it to Employee Services by the deadline stipulated on the form. This is not required if you submitted the form and waived coverage last year.

To TopYour Confirmation

Soon after you enroll, you'll receive a Confirmation Statement itemizing your selections and your per-pay period contribution. This statement also will show Nortel Networks average employees' cost

for the health care options and coverage level you select, as well as the Nortel Networks cost for core life insurance, STD and LTD coverage. If discrepancies appear on this Statement, please contact Employee Services immediately and be sure you have your confirmation number for reference.

Remember, if you do not enroll, you will not be sent another Confirmation Statement. The Confirmation statement sent to you in the mail at the start of the annual enrollment period will serve as your Confirmation Statement for the 2002 FLEX plan year.

If you have any questions about your coverage, call Employee Services at ESN 333-4636, 905-863-4636, or toll-free: 1-800-684-4636.

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What Happens If You Don't Enroll

If you don't make your FLEX Benefits selections for 2002, your default coverage will depend on whether or not you were enrolled in FLEX in 2001.

Your default coverage for this plan	If you were enrolled in FLEX for 2001	If you were NOT enrolled in FLEX for 2001
Medical Care (Note that if you default to Basic coverage, you'll receive the appropriate FLEX Credit rebate)	Your 2001 option and coverage level	Company paid provincial premiums (where applicable) and EAP
Dental/Vision/Hearing Care (Note that if you default to no coverage, you'll receive the appropriate FLEX Credit rebate)	Your 2001 option and coverage level	No coverage
Employee Life Insurance	Core coverage plus Your 2001 optional coverage amount	Core coverage only
Dependent Life Insurance Spouse Dependent children	 Your 2001 coverage level Your 2001 coverage level	 No coverage No coverage
AD&D	Your 2001 option and coverage level	No coverage
STD	Your 2001 option	Core coverage only
LTD	Your 2001 option	Core coverage only

Health Care Reimbursement Account	If you had unused FLEX Credits in 2001 and allocated them to the HCRA, and if the same selections for 2002 generate unused FLEX Credits, these Credits will be directed to your HCRA.(Minimum $1 per pay period)	HCRA - Any unused FLEX Credits will be directed to taxable pay

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Enrolling Your Dependents and Recording Information Online

There are three circumstances in which you would enroll eligible dependents for FLEX:

- At annual enrollment, and
- When you have a Status Change. Go to "What To Do If You Have A Status Change During the Year".
- When you are newly hired. Go to "How To Enroll If You're Hired On or After January 1, 2002".

If your children work at Nortel Networks and are eligible for the FLEX Benefits Program, they must enroll as employees. They are not eligible for coverage as your dependents.

You will be able to view information about your dependents from the FLEX online enrollment tool. Whether you're updating records on existing dependents or adding new dependents, you'll be able to submit the information online.

If you don't have intranet access, call Employee Services. If you wish your eligible dependents to be covered, you need to individually enroll each of them under the optional medical and dental/vision /hearing care coverage.

Only the eligible dependents you have on record with Clarica will be eligible for coverage. If a claim is made for a dependent who you haven't registered with Clarica, the claim will be declined (even if you have selected a coverage level under medical and/or dental/vision/hearing care that would qualify that dependent).

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If You and Your Spouse Both Work at Nortel Networks

Both you and your spouse will receive full FLEX Credits and may select separate optional coverage under FLEX. For example, you could select optional medical coverage that covers you and your family and decline optional dental/vision/hearing care coverage, leaving your spouse to select optional dental/vision/hearing care coverage with his/her FLEX Credits. Or, one of you could select family coverage under medical and optional dental/vision/hearing care coverage and the other could receive his/her FLEX Credits as additional taxable pay or allocate them to the Health Care Reimbursement Account to help cover out-of-pocket health expenses not covered under FLEX. Remember, if you wish to coordinate claims between yourself and your spouse, you must both select "employee plus spouse" or "family coverage".

To TopHow Salary Changes Affect FLEX

If your salary changes during the year, any payroll deductions, FLEX Credits or costs for optional coverage won't change. However, salary changes during the year do affect the benefits coverage amount under life insurance and disability benefits, which will be calculated and paid out based on your FLEX Earnings at the time of your disability or death. FLEX Earnings are generally your base salary from Nortel Networks. For the purposes of determining FLEX Credits and premiums for earnings-related benefits, the calculation for 2002, will be based on FLEX Earnings as at September 28, 2001. If you were hired after September 28, 2001 your FLEX Earnings will be based on your salary as of your hire date.

If you are a part-time employee, company-provided FLEX Credits will be the same formula as for full-time employees, but will be based on a 25-hour workweek. Your premium payments for optional life and disability coverage will be your FLEX Earnings based on a 25-hour workweek.

Optional life and disability claims are paid according to your actual salary at the time of death or disability.

To TopHow to Enroll If You're Hired on or After January 1, 2002

Most of the information in this *Handbook* applies to you as a newly hired employee. However, there are a few key differences:

- You have 31 days from your date of hire to enroll in FLEX. If you don't enroll within 31 days, you'll receive core coverage.
- When you enroll on or before your hire date or within 31 days of your hire date, any coverage you select will be effective on your date of hire, except for any life insurance coverage requiring evidence of insurability.
- Regardless of when you enroll, any life insurance coverage requiring evidence of insurability will be effective on the date of approval by Clarica.

Please ensure that you have all the required documentation and forms for the new hire enrollment process for FLEX, by referring to the checklist enclosed in your new hire package.

To TopWhat To Do If You Have A Status Change During The Year

You may change your benefit selections between annual enrollments periods if you experience a Status Change. It's your responsibility to notify Employee Services within 31 days of the status change.

A Status Change is a change in your personal situation that affects your benefit needs, and triggers a 31-day period during which you can change your FLEX options outside of the annual enrollment period. The list of Status Changes includes but is not limited to:

- Marriage, or completion of 12 months of continuous cohabitation with a domestic partner of

either gender,
- Divorce, legal separation or discontinuation of a domestic relationship,
- Birth, adoption or change in custody of a dependent child,
- Loss, commencement or change in your spouse's employment affecting benefits coverage,
- Your child's change in dependent status, and
- Death of a spouse or dependent child.

If you become disabled, this isn't considered a Status Change.

When you have a Status Change during the year, you may add (or remove) dependents and you may change your coverage appropriately.

Here's what to do:

- If you have a Status Change, you must advise Employee Services and complete the process within 31 days of the event occurring, if you want to change dependent information and/or make changes to your FLEX Benefits.

- Access the FLEX online enrollment tool to update your dependent information.
- Make any benefit changes consistent with the Status Change.
- Verify that your changes are accurate. If they are, accept the online affirmation to validate your Status Change.

If you follow these rules, changes become effective from the date of the event, except in the case of the adoption of a child. Coverage for an adopted child becomes effective on the date the child is a legal dependent. Also, any life insurance requiring evidence of insurability will be effective on the date approved by the insurance company.

The benefit change you make must be consistent with the Status Change. For example, if you have a baby, you may add coverage for the child under medical and dental/vision/hearing care and/or select optional dependent life insurance coverage.

To TopWhat Happens to Your Benefits If You Become Disabled, Inactive, Leave the Company, Retire or Die?

To TopWhen on Short-Term Disability

While you're on short-term disability, your FLEX Credits and applicable employee contributions through payroll deductions will continue.

Your Benefits:

STD and LTD: You'll receive core or optional STD and LTD coverage depending on the options you are covered under at the time you become disabled.

What You Will Find Here

AD&D: Your current optional employee and/or dependent AD&D insurance coverage will continue during your period of short-term disability.

- When You Retire
- Continuation of Benefits For Your Survivors If You Die

Medical and Dental/Vision/Hearing Care: Your current optional coverage will continue during your short-term disability. You'll retain the option and coverage level in effect at the time of your disability.

Life Insurance: Your current core life insurance coverage and your current optional employee and dependent life insurance coverage will continue during your period of short-term disability.

While on STD, you can't make changes to your current STD, LTD, AD&D and Life selections during annual enrollment or if you have a Status Change.

If you make a new STD selection at annual enrollment, but are on STD January 1 when the benefit year begins, you won't receive the STD, LTD, AD&D and Life coverage you selected until you return to work for 60 consecutive days (relapse period). You must notify Employee Services within 31 days of satisfying the relapse period if you wish to make a change.

If you make new medical and/or dental/vision/hearing care selections at annual enrollment and are on STD on January 1 when the benefit year begins, you will receive the new medical and dental/vision /hearing care options and dependent coverage level you selected.

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When on Long-Term Disability

While you're receiving LTD benefits, your contributions toward STD, LTD, AD&D insurance and Life insurance coverage will be waived. If you are in the plus medical option and/or plus dental/vision /hearing care option, and you choose to remain in the plus options while receiving LTD benefits, you will be required to continue your contributions to maintain this level of coverage. If you choose not to remain in the plus options, you will be covered under the comprehensive option and you won't be required to make any contributions.

Your Benefits

STD and LTD: You'll receive current core or optional STD and LTD coverage depending on the option you are covered under at the time of disability.

AD&D: Your current optional employee and/or dependent AD&D coverage will continue during your period on LTD.

Medical and Dental/Vision/Hearing Care: While you're on LTD you'll automatically receive comprehensive coverage for medical and dental/vision/hearing care. No payments will be required from you. You'll receive comprehensive coverage even if you were enrolled in the basic option or if you had waived coverage. If you're already in the plus option at the time of disability, you can continue with that selection but you'll have to continue your contributions to maintain this level of

coverage. If you're in the basic or comprehensive options when you go on LTD, you can't upgrade to the plus option. If you don't choose to remain in the plus option at the time of disability, you can't select plus coverage at a later date, while still receiving disability benefits.

Life Insurance: Your current optional employee and/or dependent life insurance coverage will continue during your period on LTD.

While on LTD, you won't be eligible to make any changes to any of your current coverage selections during annual enrollment or if you have a Status Change, until you return to work and satisfy your relapse period (60 consecutive days). You must notify Employee Services within 31 days of satisfying the relapse period if you wish to make a change.

If while on STD, you make new selections for medical and/or dental/vision/hearing care coverage at annual enrollment, but then go on LTD on January 1 when the benefit year begins, you won't receive the medical and/or dental/vision/hearing care selections until you return to work for 60 consecutive days. You must notify Employee Services within 31 days of satisfying the relapse period if you wish to make a change.

If you have a Status Change while on LTD, you can change your dependent coverage level by adding or deleting a dependent to your current medical and dental/vision/hearing care benefit.

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When on Maternity Leave

STD, LTD and Life coverage: Your current core and/or optional coverage will continue for the legislated portion of your leave of absence. Payroll deductions, where necessary, will be deducted from the top-up allowance. Once the top-up allowance has been exhausted, the deductions will accrue on payroll and will be deducted upon your return to work.

You'll also have the opportunity to enroll or change your applicable optional coverage within 31 days from the birth of your child. The coverage option you choose will remain in effect throughout the remainder of the legislated leave. If you choose to go on personal leave after the legislated leave is over, your core and/or optional coverage will end.

AD&D, Medical, and Dental/Vision/Hearing Care coverage: Your current optional coverage will continue for the legislated portion of your leave of absence. Payroll deductions, where necessary, will be deducted from the top-up allowance. Once the top-up allowance has been exhausted, the deductions will accrue on payroll and will be deducted upon your return to work.

You'll also have the opportunity to enroll or change your applicable optional coverage within 31 days from the birth of your child. The coverage option you choose will remain in effect throughout the remainder of the legislated leave. If you choose to go on personal leave after the legislated leave is over, your core and/or optional coverage will end.

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When on a Leave of Absence

When on a paid leave of absence other than STD or LTD. For more information on what happens

to your benefits while on STD or LTD - see above.

STD/LTD and Life coverage:
Unpaid leave of absence: Your current core or optional coverage will end the first of the month following 30 days from your leave date. Payroll deductions, where necessary, will accrue on payroll and be deducted upon your return to work.

Paid leave of absence: Your current core or optional coverage will continue during a paid leave of absence. Exceptions apply for certain Company initiated leaves.

AD&D, Medical, Dental/Vision/Hearing Care:
Unpaid leave of absence: Your current optional coverage will end the first of the month following 30 days from your leave date. Payroll deductions, where necessary, will accrue on payroll and be deducted upon your return to work.

Paid leave of absence: Your payroll deductions for current optional coverage will continue during a paid leave of absence.

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When You Leave Nortel Networks

STD/LTD: Eligibility for core or optional STD and LTD coverage ends on the last day of your employment.

AD&D: Your optional employee and/or dependent AD&D coverage ends on the last day or your employment or eligibility.

Medical and Dental/Vision/Hearing Care: Your optional coverage will stop at the end of the month following the last day of your employment or eligibility.

Life Insurance: Your employee and dependent optional life insurance coverage ends on the last date of your employment or eligibility.

To Top

When You Retire

STD/LTD: Your core or optional STD and LTD coverage ends on your retirement date.

AD&D: Your optional employee and dependent AD&D coverage ends on your retirement date.

Medical and Dental/Vision/Hearing Care: Your optional coverage ends and you may be covered for retiree healthcare based on the plan you are participating in at retirement, under the Capital Accumulation and Retirement Program (CARP).

Life Insurance: Your life insurance benefits in retirement (if any), will be based on the plan you will be participating in at retirement, under the Capital Accumulation and Retirement Program.

For further information on retiree coverage please refer to the CARP folder on Services@Work.

To TopContinuation of Benefits for Your Survivors If You Die

For Medical and Dental/Vision/Hearing Care: Optional coverage for medical and dental/vision /hearing care is available to survivors of deceased employees who were participating in either the Traditional Part I or Traditional Part II Capital Accumulation and Retirement Programs immediately prior to their death. The survivor must elect an immediate pension option and pay the required premiums to receive survivor benefits coverage. Those who are eligible for survivor benefits will receive the same coverage that the deceased employee would have been eligible for, had he/she proceeded to pension. Go to the CARP folder on Services@Work for details on your applicable healthcare coverage.

If you die, and at the time of death weren't participating in CARP --Traditional Part I or Traditional Part II, or your spouse doesn't choose an immediate pension option, your eligible dependents will continue to be covered for medical and dental/vision/hearing care benefits under FLEX for 12 months, as long as they remain eligible. There is no cost to your dependents.

To TopHow to Submit a Claim

To TopMaking a Claim

If you wish to claim eligible expenses incurred by yourself or a covered dependent under FLEX, you'll need to:

- Obtain a claim form with your personal information pre-entered (Medical Claim Form or Dental Plan Claim Form) from Customer Access on the Clarica Web site.
- Submit the completed claim form, along with original bills or receipts. You'll be required to indicate the Nortel Networks Benefit Plan Policy Number (#90002) and your certificate number (your Global ID) on the claim form.
- You can also use Customer Access on the Clarica Web site to make claims inquiries to find out the payment status of your medical, drug, dental/vision/hearing care or HCRA claims.

What You Will Find Here

To submit a claim for any drug required to treat erectile dysfunction (ED) or obesity, you'll need to:

- Obtain the appropriate claim form from Services@Work:
  - Erectile dysfunction - Authorization Application - Exception Drugs.
  - Obesity - Special Authorization Application for Drug Products for Treatment of Obesity.
- Complete the form. Please ensure both the employee section and physician section are completed and signed.
- Mail the completed form to Clarica using the address indicated on the form.

If you're coordinating your benefits with your spouse, please follow the additional procedures to submit a claim:

- Submit claims for your own expenses to your optional medical or dental/vision/hearing care plan first. If your plan doesn't reimburse 100% of your expenses, you may then submit the unpaid portion for consideration under the terms of your spouse's plan, if your spouse's plan has a COB provision.

- Submit claims for your spouse's expenses to your spouse's plan first. If your spouse's plan doesn't cover 100% of the submitted expenses, you may then submit the unpaid portion for consideration under the terms of your optional medical or dental/vision/hearing care plan.

- Submit claims for your dependent children's expenses to the plan of the parent whose birthday is earlier in the year. If that plan doesn't reimburse 100% of your eligible expenses, you may then submit the unpaid portion under the terms of the other plan.

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Health Care Reimbursement Account Claims

In order to submit a Health Care Reimbursement Account (HCRA) claim, please follow this procedure:

- You may submit claims under the HCRA. The minimum claim amount is $15.

- If you don't know the balance in your HCRA, contact Clarica (see "Appendix I: Contact Directory") or refer to your Explanation of Benefits Statement (attached to your most recent claim cheque).

- The medical and dental claim forms are available from Services@Work.

For a medical, vision or hearing care expense, submit the Medical Claim Form to Clarica. For a dental expense, submit the Dental Plan Claim Form to Clarica for reimbursement. Include your name, policy number and ID, and tick off the "HCRA" box. Any expense listed in the Income Tax Act (Canada) is eligible for reimbursement. Obtain a claim form with your personal information pre-entered (Medical Claim Form or Dental Plan Claim Form) from Customer Access on the Clarica Web site. Alternatively, go to Services@Work. You must attach your original receipts or Explanation of Benefits Statement showing any portion of an eligible expense for which you haven't been reimbursed.

You can claim monthly up to your total year's selected amount - even if your per-pay allocations haven't yet accumulated to the total amount requested for reimbursement.

To Top

Deadline for Submitting Claims

Optional Medical and Dental/Vision/Hearing Care Optional Coverage

You have 18 months to submit an eligible claim to be eligible for reimbursement.

Health Care Reimbursement Account

You must submit claims for any expenses incurred during the plan year by no later than March 31 of the following year or your claims won't be reimbursed by the plan.

To Top

Where to Send a Completed Claim Form

Where to send a completed claim form depends on the nature of your expense:

- Prescription drugs - if you didn't use your pay direct drug card or if you're coordinating claims with your spouse's plan, send claims to Clarica; the address is on the claim form.
- Optional medical coverage (except expenses for prescription drugs), optional dental/vision /hearing care coverage, non-drug-related medical expenses, Health Care Reimbursement Account - send claims to Clarica; the address is on the claim form.
- For employee and dependent life claims and AD&D claims, please contact Employee Services. The information required depends on the nature of your claim.

Hint Always keep a copy of your original receipts and your submitted claim forms for your records.

Claims that are submitted after the deadline submission date won't be paid. Please ensure you adhere to the deadline dates to avoid disappointment.

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Coordination of Benefits

How Coordination of Benefits Works

Your FLEX medical and dental/vision/hearing care coverage contains a coordination of benefits provision. If you and your family members are covered under more than one plan, even if you and your spouse both work at Nortel Networks, the coordination of benefits provision allows you to claim eligible expenses under both plans to maximize the payment you could receive from your eligible expenses.

Hint Note: While many plans offer coordination of benefits, the provisions of your spouse's plan may differ. It's a good idea to check how your spouse's plan works in this area.

Which Plan Pays First

Claims for You and Your Spouse.

It's easy to remember which plan pays first. If both plans have a coordination of benefits provision, the person with the claim submits the claim to his/her own plan first. If there is a remaining balance to be paid on the claim and you or your spouse are eligible under each other's plan, then submit the claim to the other plan for an assessment of any additional payments.

If only one plan has a coordination of benefits provision, then the claim is submitted to the plan without the coordination of benefits provisions first.

Claims for Your Dependent Children.

The plan that pays first depends on the parents' birth dates. Always submit claims first to the plan of the parent whose birth date (month, day) is earlier in the calendar year. (See, "How to Submit a Claim," for more information.)

To TopClarica's Customer Access and Direct Deposit of Claims

Sometime prior to January 1, 2002, Clarica will launch a new service to Nortel Networks employees to allow them to receive reimbursement for medical and dental/vision/hearing care claims directly to their bank account. If you'd like to receive claim reimbursement from Clarica deposited directly to your bank account, all you need to do is apply. Go to the Clarica Customer Access folder on Services@Work for more details.

To TopClaims and Eligibility Review Process

You may request a review of a denied claim or benefit eligibility if you don't believe a correct decision was made in accordance with the provisions of the relevant plan. For denied claims, the review process begins with the plan provider (Clarica). If you require further review upon completion of the review process with the plan provider, you may then submit a request to Employee Services. If you require further review upon completion of this process with Employee Services, you may submit a final request to the Employee Benefits Committee (EBC). For eligibility review, you can go directly to Employee Services to request a review and if required, to the EBC for a final review. Details on the review process for the plan provider, Employee Services and the EBC can be found on Services@Work under "Claims & Eligibility Benefits Review Process" for Non-Negotiated Employees.

To TopOther Programs Available to You

As a Nortel Networks employee, you have a wide range of benefits that are not part of FLEX.

These benefits include:

- Business Travel Accident Insurance
- Travel Well
- Education Assistance
- Financial Planning Assistance
- Fitness/Wellness Program and Services
- Home and Auto Insurance
- Matching Gifts
- Paid Time Off - Vacation, Sick Time and Holidays and
- Service Awards.

For more information about any of these plans or services, see Services@Work or call Employee Services at ESN 333-4636, 905-863-4636 or toll-free at 1-800-684-4636.

To TopAppendix I: Contact Directory

	Phone Number	Web Site Address
FLEX On-Line Enrollment Tool		https://eflex.us.nortel.com:49185/
Services@Work		http://services-canada.ca.nortel.com
Employee Services	ESN 333-4636 905-863-4636 1-800-684-4636	External: canic@nortelnetworks.com Internal: InfoCenter, Can
For a NorPASS Password	NT4-HELP ESN 684-4357 1-800-684-4357	http://norpass.ca.nortel.com/
Health Care, Life and AD&D Insurance and Long Term Disability Coverage		
Clarica	1-800-229-7089	http://www.clarica.com/
Home and Auto Program		
PeoplePlus	1-800-47GROUP	http://www.zurichcanada.com/
Employee Assistance Program (EAP)		
Family Guidance Group Inc.	1-800-263-1401	www.fgiworldmembers.com
Preferred Vision Services (PVS)	1-800-668-6444.	
Canada Customs and Revenue Agency		http://www.ccra-adrc.gc.ca/

To TopAppendix II: Glossary Of Terms

Here are some brief explanations of terms that you'll find in your FLEX enrollment materials.

After-tax dollars (after-tax payroll deductions) — Money that is counted as employment income for the purposes of income tax calculation. If an employee does not have sufficient Company-provided FLEX Credits to pay for his/her chosen optional benefits, the difference will be paid out of the employee's salary after the appropriate tax deductions. Optional employee or dependent life insurance coverage must be bought with after-tax dollars.

Annual enrollment period — The time during which you must enroll yourself and your eligible dependents for benefits. Every fall, there is an annual enrollment period during which all employees are asked to consider their selections and enroll in benefits for the next calendar year.

Before-tax dollars — Money that is not counted as employment income for the purposes of income tax calculation. Company-provided FLEX Credits are not counted as employment income if they are used to buy medical, dental/vision/hearing care, short-term disability, long-term disability, and accidental death & dismemberment (AD&D) coverage, or deposited in a Health Care Reimbursement Account (HCRA) and used to cover eligible health expenses. (In Quebec, amounts used to buy optional AD&D, medical, dental/vision/hearing care and amounts reimbursed from the HCRA are subject to provincial income tax.)

Beneficiary — The person (or people) you choose to receive your benefits if you die while you're covered by the life insurance or accidental death & dismemberment insurance plans. You can name more than one person as a beneficiary if you specify how the benefit should be divided among them.

If you're a man residing in Quebec and you designated your legal spouse or your children as beneficiaries before October 20, 1976, you must obtain their written consent to change the beneficiary. The same applies to all Quebec residents of either gender who have identified their legal spouse as beneficiary since that date, unless they specified that the designation was revocable.

Brand-name drug — A prescription drug sold under a trademarked name. Brand-name drugs are typically sold at a higher cost than generic drugs.

Canada Customs and Revenue Agency (CCRA) — The federal agency formerly known as Revenue Canada. The CCRA administers federal tax laws that apply to benefit plans. For example, the CCRA sets rules regarding health spending accounts such as the Nortel Networks Health Care Reimbursement Account. For more information, visit the CCRA Website at http://www.ccra-adrc.gc.ca/.

Children — Dependents who are:

- Your natural children,
- Legally adopted by you or placed with you for adoption,
- Your stepchildren,
- Your legal foster children,
- Your responsibility as a legal guardian, or
- Children of your spouse.

Children must be unmarried, financially dependent on you for support, covered under the provincial health plan, and either:

- Under 21 years of age,
- Under 25 years of age if in full-time attendance at an accredited school, college or university, or

- Physically or mentally handicapped, regardless of age (as long as the disability began before they turned 21, or before 25 if they were full-time students at the time).

For Quebec residents, Bill 33 legislation stipulates that eligible dependent children are covered for prescription drugs listed under the Régie de l'assurance-maladie du Québec (RAMQ) formulary, to the age of 26 if in full-time attendance at an accredited, school, college or university.

Copayment — A specified dollar amount that you pay when you receive drug benefits under the Basic medical coverage plan.

Core FLEX Benefits coverage (Core) — Benefits fully paid by the Company. You're automatically enrolled in Core coverage and have no choices to make with respect to these benefits:

- Company paid premiums for provincial health plans, where applicable,
- Employee life insurance coverage equal to 1 X FLEX Earnings (your base salary - see the definition of FLEX Earnings for more on what is or is not included in this amount),
- Short-term disability coverage equal to 100% of your pre-disability FLEX Earnings for 13 weeks, then 70% of your pre-disability FLEX Earnings for up to an additional 13 weeks,
- Long-term disability coverage equal to 50% of your pre-disability FLEX Earnings after you have been disabled for 26 consecutive weeks, and
- Employee Assistance Program (EAP), which offers up to 10.5 hours of individual or family counseling as well as information services.

Covered expenses — Charges for health care services and supplies for which the plan pays benefits.

Deductible — The amount you pay out of your pocket before the plan begins paying for covered expenses.

Dependent — For your life insurance, medical, and dental/vision/hearing care coverage, dependents include:

- Your spouse (see definition of spouse) and
- Your children (see definition of children).

For the Health Care Reimbursement Account, a dependent is:

- Your spouse (see definition of spouse) or
- Any member of your household with whom you're connected by blood relationship, marriage, or adoption and for whom you may claim a medical expense tax credit on your income tax return.

Dependent Coverage level — Optional coverage for medical and dental/vision/hearing care offers four dependent coverage levels to choose among. Your coverage level will be based on the eligible dependents you select to cover under medical and/or dental/vision/hearing care optional coverage.

The Company funds each individual to the Comprehensive level of medical and dental/ vision/hearing

care coverage for you and your spouse or for you and your children. You can opt out of dental/vision /hearing care coverage if that's not important to you, and you can opt out of medical coverage if you have coverage elsewhere. In either case, you will get FLEX Credit rebates. If you don't have alternate medical coverage, you must choose at least Basic coverage for yourself (for you and your family if you're a Quebec resident with eligible dependents). You will still get a FLEX Credit rebate, but it will be smaller than the opt-out rebate.

Emergency — A sudden, serious, and unexpected medical condition that requires (or you have good reason to believe requires) immediate attention to prevent death or functional loss. Apparent heart attacks, loss of consciousness, excessive bleeding, severe or multiple injuries, or serious burns are all examples of an emergency.

Evidence of insurability — Before you're accepted for life insurance coverage, the insurance company may require you to complete a medical questionnaire to make sure you're in good health. Depending on the information you provide, you may be required to submit further medical information. If a medical exam is required, you're responsible for your own expenses.

Core life insurance:
Evidence of insurability is required for amounts over $600,000.

Optional life insurance for the employee:

- When you are first eligible to select optional life insurance, evidence of insurability is required for total amounts over 3 X FLEX Earnings or $1 million, whichever is less.
- Evidence of insurability is also required for any increases in coverage unless you have a Status Change. In this case, evidence of insurability is required for increases of more than one increment or for total amounts over 3 X FLEX Earnings or $1 million, whichever is less.

Dependent life insurance:
Evidence of insurability for your spouse is required where the total amount exceeds $50,000. This limit applies when you are first eligible to select this coverage or when you request increases at annual enrolment or because of a Status Change.

Evidence of insurability is not required for any coverage selected for your children.

FLEX Benefits Program (FLEX) — A benefits program established by the Company that offers core coverage and optional coverage.

FLEX Credits — Company-provided money that is intended to assist employees in buying benefits. The Company calculates and allocates FLEX Credits in two ways:

1. Each employee is funded to the market-competitive level of medical and dental/vision/hearing care coverage - currently the Comprehensive option for your and your spouse or you and your children, but can get rebates if this level of coverage is not required, and

2. Each employee gets FLEX Credits equal to 0.39% of FLEX Earnings to apply towards the purchase of optional benefits, and/or to put into a Health Care Reimbursement Account, and/or to take as taxable pay.

FLEX Earnings — Your annual base salary from Nortel Networks. If you're eligible for sales incentives, your FLEX Earnings include your base salary and targeted incentives as defined each year by the Company.

For a part-time employee, FLEX Credits and costs are based on a 25-hour work week. Payment of FLEX Earnings-related benefits are paid based on actual salary. Earnings-related benefits are life insurance, accidental death and dismemberment insurance, short-term disability insurance, and long-term disability coverage.

If you're enrolling:	Your FLEX Earnings are your base salary as of:
• For 2002 annual enrollment/Status Change	• September 28, 2001
• As a new hire	• Your hire date
• Part-time to full-time or vice versa	• The effective date of your employment Status Change

FLEX Earnings don't include:

- Overtime pay,
- Shift differentials,
- Relocation payments, or
- Bonuses (for example, SUCCESS and PRIDE awards).

Generic drug — A prescription medicine sold under its chemical name. Generic drugs are typically sold at a lower price than brand-name drugs.

Health Care — A collective term referring to medical care coverage and dental/vision/ hearing care coverage.

Health Care Reimbursement Account (HCRA) — An account in which Company-provided FLEX Credits are allocated to reimburse yourself for eligible health care expenses on a before-tax basis. If you're a Quebec resident, amounts reimbursed from your account will be taxed at the provincial level.

Major Restorative services — For purposes of your dental coverage, major services include:

- Crowns and crown repairs,
- Inlays and onlays,

- Bridges, and
- Dentures.

Refer to "Detailed Listing of Dental Services Covered" for more information on major restorative services and plan maximums. Limits apply.

Medically necessary — Broadly accepted and recognized by the Canadian medical profession as meaning effective, appropriate, and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

Optional Benefits

Optional Short-Term Disability	• Core coverage of 100% of your pre-disability FLEX Earnings for up to 13 weeks from your date of disability • Then increase coverage from 70% to 90% of your pre-disability FLEX Earnings for up to 13 additional weeks
Optional Long-Term Disability	• Increase core coverage from 50% to 70% of your pre-disability FLEX Earnings • After two years of benefit payments, your benefits will increase each January based on a cost-of-living formula
Medical Care Coverage	• 3 levels: Basic, Comprehensive, and Plus options • Company funds Comprehensive level; you can opt to lower coverage and receive a rebate in the form of FLEX Credits • Medical Coverage Waiver required to opt out
Dental/Vision/Hearing Care Coverage	• 3 levels: Basic, Comprehensive, and Plus options • Company funds Comprehensive level; you can opt to lower coverage and receive a rebate in the form of FLEX Credits
Health Care Reimbursement Account	• Contribute unused FLEX Credits to pay for eligible expenses not fully reimbursed by the FLEX plan
Optional Employee Life Insurance	• 1 X FLEX Earnings • 2 X FLEX Earnings • 3 X FLEX Earnings • 4 X FLEX Earnings • 5 X FLEX Earnings Maximum benefit for core plus optional coverage: $3,000,000

<table>
<tr><td></td><td colspan="4">Go to "Evidence of Insurability" for details on evidence of insurability requirements</td></tr>
<tr><td>Optional Dependent Life Insurance</td><td colspan="2">Spouse
$10,000
$25,000
$50,000
$100,000
From $100,000 to $500,000,in units of $50,000
Go to "Evidence of Insurability" for details on evidence of insurability requirements.</td><td colspan="2">Dependent Child
Units of $5,000, to a maximum of $25,000</td></tr>
<tr><td rowspan="2">Optional Accidental Death & Dismemberment (AD&D)</td><td>For You</td><td colspan="3">For Your Family</td></tr>
<tr><td>1 X FLEX Earnings
2 X FLEX Earnings
3 X FLEX Earnings
4 X FLEX Earnings
5 X FLEX Earnings</td><td>Spouse
60% of your Optional AD&D coverage amount</td><td>Child
For each child, 20% of your Optional AD&D coverage amount</td><td>Spouse and Child
Spouse: 50% of your Optional AD&D coverage amount
Each child: 15% of your Optional AD&D coverage amount</td></tr>
</table>

Optional coverage — Optional coverage can be selected to enhance core benefits. Each optional benefit has its own cost. For certain health benefits, you can receive additional FLEX Credits in the form of rebates if you choose below the Company-funded level of coverage (See Section 2).

Out-of-pocket maximum — The highest amount you have to pay out of your own pocket toward covered prescription drug expenses annually. Your deductibles and the portion of eligible drug

expenses that you pay count toward satisfying the out-of-pocket maximum. Any amounts you pay above reasonable and customary limits, the dispensing fee maximum, and drugs not covered by the plan don't count toward the out-of-pocket maximum. When you have reached the out-of-pocket maximum, the plan pays 100% of your covered drug expenses for the rest of the calendar year, up to the plan's maximum benefit amount. (In Quebec, there is no maximum for drugs on the Régie de l'assurance-maladie du Québec (RAMQ) formulary.)

Plan Administrator — The Company that pays benefit claims.

Plan option — The name of each option, for example, Basic, Comprehensive, and Plus under medical and dental/vision/hearing care plans.

Preventive services — For purposes of your dental coverage, preventive services include:

- Check-ups,
- X-rays,
- Cleanings,
- Space maintainers,
- Fluoride treatments, and
- Sealants for children under age 19.

Refer to "Detailed Listing of Dental Services Covered" for more information on preventive services and plan maximums. Limits apply.

Provincial health insurance plan — Health insurance provided by the province. This insurance varies by province, but generally covers standard hospital ward accommodation, physicians' and specialists' services, and diagnostic procedures. In Alberta and British Columbia, where individual premiums are required, the Company pays the full cost for you and your eligible family members. In Newfoundland, Quebec, Ontario, and Saskatchewan, the Company supports the cost of the plans through a payroll tax. (In all other provinces, the plans are supported by general tax revenues.)

Reasonable and customary — A charge for a covered expense under the medical plan that is the normal fee made by a licensed practitioner for a similar service and does not exceed the normal charge made by most providers in the geographic area where the service is provided.

Restorative services — For the purposes of your dental coverage, restorative services include:

- Fillings,
- Oral surgery, and
- Minor restorations.

Refer to "Detailed Listing of Dental Services Covered" for more information on restorative services and plan maximums. Limits apply.

Spouse — The person to whom you're legally married, or an unmarried partner of either gender, who:

- Is not related to you by blood that would prohibit legal marriage,

- Is age 18 or older,
- Shares responsibility for your living expenses and general welfare,
- Has been living with you for at least 12 consecutive months in a conjugal relationship, and
- Is covered under a provincial health insurance plan.

Status change — A Status Change is a change in your personal situation that affects your benefit needs, and triggers a 31-day period during which you can change your FLEX options outside of the annual enrollment period. The list of Status Changes includes but is not limited to:

- Marriage, or completion of 12 months of continuous cohabitation with a domestic partner of either gender,
- Divorce, legal separation, or discontinuation of a domestic partner relationship,
- Birth, adoption or change in custody of a dependent child,
- Loss, commencement or change in your spouse's employment affecting benefits coverage,
- Your child's change in dependent status, and
- Death of spouse or dependent child.

If you become disabled, it isn't considered a Status Change.

When you have a Status Change during the year, you may add (or remove) dependents and you may change your coverage selections as long as the change is consistent with the Status Change event.

Tier 1 drugs — These are medically necessary, life-sustaining drugs that bear a Drug Identification Number (DIN), are sold only through prescription, and relate to illness or injury. Generally, there are no maximums connected to these classes of drugs, other than a lifetime maximum for overall medical care coverage, including prescription drugs. In Quebec, drugs listed under Quebec's basic drug formulary are not subject to the lifetime maximum.

Tier 2 drugs — These are certain therapeutic drugs that bear a Drug Identification Number, are sold only through prescription, and don't relate to illness or injury. Generally, they are considered medically necessary in improving the quality of life. Tier 2 drugs have reimbursement maximums. Pre-authorization is required for certain therapeutic classes to demonstrate that these drugs are medically necessary.

This Handbook provides a summary of the Nortel Networks Limited (Nortel Networks) FLEX Benefit Program. It does not supersede the actual plan documents, which in the event of a conflict, will always govern the details of benefits coverage in all cases. While the Company hopes to continue the benefit plans described in this Handbook, it reserves the right to change, amend, reduce or even terminate any of the plans described in this Handbook at any time without prior notice to, or consent by, employees.