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CANADA - BENEFITS

FLEX 2004 Handbook

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This Handbook provides a summary as of November 2003, of the Nortel Networks Limited (Nortel Networks) FLEX Benefits 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.**

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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. At Nortel

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

The cost-sharing strategy and the practice of having employees choose their optional coverage annually allows 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. The hints will help you become more aware of issues relevant to specific benefits. This knowledge 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 through an individual insurance arrangement. 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 Global Employee Services at ESN 333-4636, 905-863-4636, or toll-free at 1-800-684-4636. You also may contact Global Employee Services via external e-mail at gesna@nortelnetworks.com or internal e-mail at GES, North-America.

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- FLEX Features
- What's Available and Who Pays

FLEX Features

- A core set of benefits currently provided automatically to all eligible employees and fully paid for by the Company. This

What You Will Find Here

- How FLEX Works
- Eligibility
- When Coverage Begins
- Things to Consider When You Enroll

is the coverage you'll receive if you don't enroll.

- Taxing Decisions

- A choice among four options of medical coverage (Basic, Comprehensive, Plus, and Select) and three options of dental/vision/hearing care coverage (Basic, Comprehensive, and Plus). Read on to learn about how to enroll in the medical options you want, and the additional FLEX Credits you get if you buy the "You only" dependent coverage level in the Comprehensive Option; or any level of coverage in the Basic Option; or opt out of medical, dental/vision/hearing care coverage.
- A menu of optional coverage and FLEX Credits to use to buy these benefits. If you want options that cost more than your FLEX Credits will cover, you can pay for them 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 to Quebec residents.

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What's Available And Who Pays

- **The Company currently 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 under STD for 26 consecutive weeks.
  - Employee Assistance Program (EAP/Worklife Services). Provides all FLEX-eligible employees and dependents with free confidential short-term counseling services through an EAP counselor. The EAP provides enhanced worklife services including assistance with legal, financial, parenting, career counseling, elder care and everyday issues, etc.
- **The Company provides you with FLEX Credits to use toward the purchase of optional coverage.** For 2004, each eligible Canadian employee will receive the equivalent of 0.39% of FLEX Earnings, over and above any additional FLEX Credits you may get from certain

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 under STD 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. If you run out of FLEX Credits, you can purchase any of these benefits with after-tax dollars through payroll deductions. For more information, go to "Taxing Decisions."

- **The Company provides you with several subsidized medical and dental/vision/hearing care options.** You select the level of coverage you need.

  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 Benefits Enrollment Tool (or on your Personalized Enrollment Worksheet if you do not have access to the intranet), these are the additional FLEX Credits you get if you select that option . Otherwise, the numbers for that plan option represent a cost and you can purchase the coverage by using Company-funded FLEX Credits, or with after-tax payroll deductions if you run out of FLEX Credits. For more information, 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 you pay will depend on which option you select. To learn more about the Company's cost-sharing arrangement with you for 2004, go to the *FLEX 2004 Roadmap* on Services@Work.

- **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 professional services where costs exceed the plan maximums. 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 Dependents
- If You and Your Spouse Both Work At Nortel Networks

Eligible Employees

To be an eligible employee, you must satisfy all of the following criteria:

Current employees of Nortel Networks Limited and Nortel Networks Technology Corporation, whose benefits are not covered under the provisions of a collective labour agreement, may enroll in the FLEX Benefits Program in Canada ("FLEX"). Effective January 1, 2004, Quebec-based employees of Nortel Networks who are covered under the COEU Collective Labour Agreement, will also be eligible to enroll.

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

If you're an employee who is eligible to enroll, 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 and/or contracted in a civil union (for Quebec residents), or an unmarried partner of either gender, and who meets 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 care plan or an equivalent plan.

- **Your Children** — any 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 or an equivalent 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 enroll 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 also refer to the following:

1. "Optional Employee Life Insurance Coverage"
2. "Coordination of Benefits"

Special Notes on Eligibility
If both you and your spouse work for Nortel Networks and if you're both eligible to participate in life insurance and AD&D insurance, special rules currently apply. 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. In addition, you can both enroll your eligible children as dependents under the medical and dental/vision/hearing care plans.

If your children also work for Nortel Networks and 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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If you are an Eligible Employee, 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. For more information, go to "If You're Hired On or After January 1, 2004."

If you don't complete the online enrollment (or if you don't have intranet access - and you don't return your Personalized Enrollment Worksheet) within 31 days of your date of hire, you'll automatically default to core coverage. For more information, go to "What Happens if I Don't Enroll." You'll waive your right to enroll in optional coverage until the next annual enrollment period or until you experience a Status Change (e.g., if you get married or have a child).

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 or optional long-term disability coverage requiring evidence of insurability (EOI) will be effective on the date your request is approved by Sun Life Financial.

If you're on short-term disability on January 1, 2004, regardless of your annual enrollment selections, your 2003 selections for short-term disability, long-term disability, and your and your dependents' optional life and AD&D insurance will remain in effect until you return to work for 60 consecutive days.

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- About Long-Term Disability (LTD) Coverage
- About Accidental Death and Dismemberment (AD&D) Insurance
- About Medical and Dental/Vision/Hearing Care Coverage
- About Health Care Reimbursement Account (HCRA)
- About Life Insurance

Itinerary for 2004 Annual Enrollment

For enrollment instructions, please see "Your Enrollment Itinerary for 2004 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 up to 26 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 longer 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 certain other sources.

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

To continue to qualify for LTD benefits after you have been disabled for 18 months following the initial date of disability, you must be unable, because of the medical impairment, to perform, in any setting, the essential duties of any occupation (not just your own) for which you have at least the minimum qualifications (or could become qualified) through education, training and experience, and that provides an income that is equal to or greater than 70% of your predisability income, before any reductions of Other Sources of income.

The medical impairment must be supported by objective medical evidence. The availability of work for the member does not affect the determination.

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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 you are injured in an accident AD&D insurance may pay a one-time benefit. 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 2004 to decrease, increase, or stay the same as this year? You may want to refer to the Claim Statement sent to you by Sun Life Financial, and review what was reimbursed for medical and dental/vision/hearing care coverage for you and your eligible dependents in the most recently available 12-month period.

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 plan 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 www.ccra-adrc.gc.ca or request a copy of publication IT-519R2-CONSOLID, Medical Expense and Disability Tax Credits and Attendant Care Expense Deduction, for a complete list. Make sure you're considering only eligible expenses in your estimates.

Ask yourself if you anticipate that your 2004 medical and/or dental/vision/hearing care expenses may be higher or lower than your 2003 expenses. 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 life insurance 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
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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, based on current applicable laws. Company-provided FLEX Credits are allocated first to those benefits that 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 offsetting 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 income tax implications to consider when buying your optional coverage:

Coverage	Current Tax Status of FLEX Credits Used to Buy Coverage	Current 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 AD&D insurance 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 reimbursed, 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 life insurance coverage are not taxable to the beneficiary.
Dependent 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 dependent life insurance 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 in your particular circumstances.**

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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 (Sun Life Financial'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, Plus, or Select coverage because you expect to have only a few or no medical expenses in a plan year, you may select the Basic Option. As a result, you would have a lower taxable benefit than someone else who chooses the Comprehensive, Plus, or Select options.

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

The FLEX Benefits 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. If you are a French language preference employee, you will not be using the enrollment tool. However, you will still be able to access this information on the FLEX 2004 Expected Average Quebec Taxable Benefits Rates, which is available on Services@Work.

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 in your particular circumstances.

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In Brief

This Handbook provides a current summary of STD. It does not supercede the actual plan documents which, in the event of a conflict, will always govern the details of benefit coverage in all cases. The short-term disability plan replaces a portion of your income if you are totally disabled due to an illness or injury.

Nortel Networks currently 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 (this includes the five consecutive days 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 currently provides:

- 100% of your pre-disability FLEX Earnings, for up to 13 weeks from your first day of absence (this includes the five consecutive days of

absence), then

- 90% of your pre-disability FLEX Earnings, for up to 13 additional weeks.

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Defining Disability

You are considered totally disabled for STD purposes when a physician submits objective, clinical documentation (i.e., lab tests, X-rays, medical reports, etc.) that proves you are not able to perform the essential functions of your occupation. This means:

- you have a medical impairment due to injury, illness, or disease which prevents you from performing, in any setting, the essential functions of your occupation performed just before you became totally disabled, and
- you cannot carry out these functions with or without reasonable accommodation for the limitations resulting from your disability.

The availability of work for you does not affect the determination of "totally disabled." You must be under the regular care of a physician throughout the STD period.

You're not considered totally disabled unless you are 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.

No benefit is payable for loss of income due to elective cosmetic or experimental surgery, unless the surgery or treatment is for accidental injuries or unless the surgery is medically necessary as determined by the provincial health care plan in the province where the member resides.

Maternity Leave

Go to the Maternity and Parental Leave Process document on Services@Work (Canada, People, Benefits, Non-Union Benefits, Leaves of Absence, Maternity/Parental Leave) for more information on maternity benefits.

Hint Note: Work-related injuries and illnesses may be compensable 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, including the five consecutive days 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 more information, go to "How Salary Changes Affect FLEX."

Benefit payments will not begin and/or will stop if any one of the following occurs:

- You cease to be totally disabled.
- You fail to submit the necessary and required signed forms and medical proof, when requested, to Medcan to substantiate continued disability.
- You fail to undergo an independent medical exam and/or functional abilities evaluation if requested by Medcan.
- You fail to participate in a rehabilitation program approved by Medcan.
- You engage in any occupation that normally involves remuneration or profit.
- You have received 26 weeks of core or optional STD coverage (whichever is applicable).
- 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 STD Payments

STD benefits are coordinated with any government disability benefits so that your income from all sources combined 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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2004 Cost for Optional STD

In 2004, optional STD will remain unchanged at 0.05% of your FLEX Earnings.

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Right to Subrogate

Subrogation is a legal practice giving Nortel Networks the right to be reimbursed for benefits paid to you if you have been compensated by another person who is responsible for your loss. The intent of subrogation is to limit your benefit payments to the amount you actually lost.

Let's assume a person is responsible for your disability and is required to compensate you for any of the loss that results from your disability. If Nortel Networks is also compensating you or has compensated you for your loss of income benefits, you may be receiving more income than you earned before you became disabled. In that case, you would reimburse Nortel Networks for the income benefits Nortel Networks has paid. If you receive an amount for future loss of income, that amount will reduce your future loss of income benefits from Nortel Networks.

Subrogation also applies to any medical and/or dental expenses you have been paid as a result of an injury caused by another person. Once you are compensated by the person who is responsible for your loss, you must reimburse Nortel Networks.

If subrogation applies to your claim, you will be required to sign an undertaking to reimburse Nortel Networks for any amount recovered which exceeds 100% of income or expenses. Before agreeing to a settlement of your claim, you must obtain approval.

Return to "Check Out Your Core and Optional Short-Term Disability (STD) Coverage" Table of Contents
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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 Medcan. Rehab programs can include: assessment, counseling, medical or psychological treatment, or a vocational retraining or education program.

Modified work refers to a change to or modification of job requirements. A modification may mean 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 Medcan.

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 (14 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 14 consecutive days of returning to work (i.e., the 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 if you return to work for longer than 14 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
- Defining Disability
- Your Payments
- 2004 Optional LTD Cost
- Evidence of Insurability (EOI)
- Other Income Sources May Reduce Your LTD Payments
- Rehabilitation/Modified Work and Your LTD Payments
- Maximum Benefit From All Sources While on Rehabilitation/Modified Work
- Cost-of-Living Adjustment (COLA)
- Recurring Disability

In Brief

This Handbook provides a current summary of LTD. It does not supercede the actual plan documents which, in the event of a conflict, will always govern the details of benefit coverage in all cases. Nortel Networks currently 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 currently provides 50% of your pre-disability FLEX Earnings.

If you want to enhance your LTD coverage, you can select optional LTD. Optional LTD coverage provides 70% of your pre-disability FLEX Earnings. Note that the benefit amount will be reduced by any income you receive from certain other sources. You will also have to provide evidence of insurability (EOI) if you select optional LTD coverage during the annual enrollment period and did not already have optional LTD coverage in 2003. This is new for 2004.

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Defining Disability

You are considered totally disabled during the first 12 months on LTD when a physician submits objective, clinical documentation (i.e., lab tests, X-rays, medical reports, etc.) that proves you are not able to perform the essential functions of your occupation. This means that, during the qualifying period (period of time receiving STD benefits) and the 12-month period immediately following it:

- you have a medical impairment due to injury or disease which prevents you from performing, in any setting, the essential functions of your occupation performed just before you became totally disabled, and
- you cannot carry out these functions with or without reasonable accommodation for the limitations resulting from your disability.

The availability of work for you does not affect the determination of "totally disabled." You must be under the regular care of a physician throughout the LTD period.

After the 12 month period, totally disabled means that you are unable, because of the medical impairment, to perform, in any setting, the essential duties of any occupation (not just your own) for which you have at least the minimum qualifications (or could become qualified) through education, training and experience, and that provides an income that is equal to or greater than 70% of your pre-disability income, before any reductions of Other Sources of income.

The medical impairment must be supported by objective medical evidence. The availability of work for the member does not affect the determination.

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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 cannot begin and will stop if any one of the following occurs:

- You cease to be totally disabled.

- You fail to sign appropriate forms and submit medical proof to Sun Life Financial of continued disability when requested.
- You fail to undergo an independent medical exam and/or functional abilities evaluation if requested by Sun Life Financial.
- You fail to participate in a rehabilitation program approved by Sun Life Financial.
- You engage in any occupation that normally involves remuneration or profit, either accruing to you, to your family, to acquaintances, or to any educational program other than in a rehabilitation program approved by your attending physician and Sun Life Financial.
- You are absent from Canada longer than four months for any reason, unless Sun Life Financial agrees in writing in advance to pay benefits during this period.
- 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.

There is a time limit for appealing the Sun Life Financial decision to decline or terminate a claim. An appeal must be made within three months of such a decision, and must be accompanied by new objective medical evidence.

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2004 Optional LTD Cost

In 2004 the cost for optional LTD will increase from 0.40% of FLEX Earnings to 0.45% of FLEX Earnings.

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Evidence of Insurability (EOI)

In 2004, you will have to provide evidence of insurability (EOI) if you are currently enrolled in core LTD coverage only, and want to increase your LTD coverage during the annual enrollment period. If you are currently enrolled in the optional LTD Plan, you will not have to submit EOI if you elect to continue your optional LTD coverage. To submit EOI, you must complete a short medical questionnaire. The form you use is called the Statement of Health form.

Hint — Remember: Providing EOI isn't a guarantee that your request for increased coverage will be accepted. Sun Life Financial will send you notification of acceptance or rejection of your application. Your optional LTD coverage will not become effective until the date Sun Life Financial approves the application.

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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 combined 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, where allowed by legislation, 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.

Right to Subrogate

Subrogation is a legal practice giving Nortel Networks the right to be reimbursed for benefits paid to you if you have been compensated by another person who is responsible for your loss. The intent of subrogation is to limit your benefit payments to the amount you actually lost.

Let's assume a person is responsible for your disability, and is required to compensate you for any of the loss that results from your disability. If Nortel Networks is also compensating you or has compensated you for your loss of income benefits, you may be receiving more income than you earned before you became disabled. In that case, you would reimburse Nortel Networks for the income benefits Nortel Networks has paid. If you receive an amount for future loss of income, that amount will reduce your future loss of income benefits from Nortel Networks.

Subrogation also applies to any medical and/or dental expenses you have been paid as a result of an injury caused by another person. Once you are compensated by the person who is responsible for your loss, you must reimburse Nortel Networks.

If subrogation applies to your claim, you will be required to sign an undertaking to reimburse Nortel Networks for any amount recovered which

exceeds 100% of income or expenses. Before agreeing to a settlement of your claim, you must obtain approval.

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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 Sun Life Financial. Rehab programs may involve but are not limited to: assessment, counseling, medical or psychological treatment, or a vocational retraining or education program.

Modified work refers to a change to or modification of your job requirements. A modification may mean 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 by Sun Life Financial.

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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, riots, 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

To TopCheck Out Your Optional AD&D Coverage

- Optional Employee AD&D Coverage
- Optional AD&D Coverage for Your Eligible Dependents
- Employee and Eligible Dependent Optional AD&D Coverage Rates

What You Will Find Here

- Check Out Your Optional AD&D Coverage
- Exclusions to AD&D Coverage

Optional Employee AD&D Coverage

AD&D coverage is currently 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 a 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 loss must be suffered within 365 days of the accident).

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

If your spouse or eligible dependent dies as the result of an accident, you will be their beneficiary and will receive payment in the amount

applicable. In addition, they will receive a portion of the full benefit applicable if they lose a limb or their sight due to an accidental injury.

If your spouse or eligible dependent dies as the result of an accident, you will be their beneficiary and will receive payment in the amount applicable. In addition, they will receive a portion of the full benefit applicable if they lose a limb or their sight due to an accidental injury. The loss must be suffered within 365 days of the accident.

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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Employee and Eligible Dependent Optional AD&D Coverage Rates

In 2004, the optional employee AD&D coverage rate is $0.02 per $1,000 of coverage per month. The family coverage rate is $0.032 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, and 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 monthly 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 being used for crop dusting, crop spraying, seeding, sky-writing, racing, testing, exploration or any other purpose except transportation.

Hint Also note that the AD&D benefit is not covered while traveling or working in certain countries. Please refer to the travel advisory information published by the Department of Foreign Affairs for a list of these countries before traveling at http://www.voyage.gc.ca/destinations/menu_e.htm.

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.

What You Will Find Here

- Check Our Your Core Medical Coverage
- Check Our Your Optional Medical Coverage
- Exclusions to Medical Coverage

Provincial Hospital/Health Insurance

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 currently required, the Company currently 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 Global Employee Services to request a copy of the commencement form. The form must be returned to Global Employee Services for processing.

With FLEX, you can select from among four 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	250-952-3456
Alberta	Alberta Health Insurance Plan	1-780-422-1212
Saskatchewan	Saskatchewan Medical Care Insurance Branch	1-800-667-7581 (Drug) 1-800-667-7523 (Physician and Hospital)
Manitoba	Manitoba Health Insurance Services Plan	1-800-392-1207
Ontario	Ontario Health Insurance Plan	416-314-7444
Quebec	Quebec Health Insurance Plan	418-646-4636
New Brunswick	Medicare New Brunswick	506-453-2415
Nova Scotia	Nova Scotia Medical Services Insurance Plan	902-424-5818 1-800-387-6665 (toll free in Nova Scotia)
Newfoundland	Newfoundland Medical Care Plan	709-292-4000
Prince Edward Island	Prince Edward Island Hospital & Health Services Plan	902-368-4900

Employee Assistance Plan (EAP)/Worklife Services

EAP/Worklife Services currently provides all FLEX-eligible employees and dependents with free

confidential short-term counseling services through an EAP counselor. The EAP currently provides enhanced worklife services including assistance with legal, financial, parenting, career counseling, elder care and everyday issues, etc.

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- Optional Medical Coverage Table
- Eligible Expenses
- Semi-Private Hospital Accommodation
- Ambulance Services
- Prescription Drugs
- Private Duty Nursing
- Professional Services
- Psychologist Services
- Physiotherapist Services
- Miscellaneous Supplies and Durable Medical Equipment
- Dental Surgery Due to an Accident
- Out-of-Province (within Canada) Emergency Medical Expenses and Travel Assistance Benefit
- Maximum Lifetime Benefits
- Cost of Medical Options
- If You Leave the Company

Optional Medical Coverage Table

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

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

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 are covered only after provincial health care plan maximums have been reached - except for those under the Plus and Select options. Under these options, coverage begins at the first visit, where permitted by law. Information regarding your province's

maximums and processing requirements can be located on your province's government Web site.

For example, in Ontario, if you select the Plus Option or the Select Option and if you have a chiropractic expense, FLEX will reimburse the full eligible expense up to the applicable plan maximum. You do not have to wait until the yearly maximum amount from the Ontario health care plan has been reached.

Hint *** Services must be performed by a licensed physician (MD) or a licensed acupuncturist approved by the provincial regulating body in your province. In 2004, only Alberta and Quebec have provincially regulated acupuncturists. This may be extended to other provinces in the future.

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

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 Global Employee Services by the date indicated on the waiver. If you don't complete this waiver, you'll automatically be covered under the Basic medical care coverage for you only (you and your family 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 the medical Comprehensive, Plus, and Select options only)

Comprehensive Option

The Comprehensive Option covers $200 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 calendar year.

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 calendar year.

Select Option

The Select 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 calendar year.

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 that 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, Sun Life Financial. This doesn't include nursing homes, homes for the aged, rest homes or other places providing similar care.

HINT

Did you know that certain provincial plans currently cover 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 medical options)

- 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 that are considered medically necessary and life-sustaining drugs that bear a DIN are sold only through prescription from a physician or dentist and relate to illness or injury.

"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.

Prescription drug coverage is provided under all medical options and is subject to the following provisions:

Generic Drugs (for all medical options)

"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 above; injectible drugs; compound prescriptions, regardless of their active ingredient; and needles, syringes and chemical diagnostic aids for the treatment of diabetes. Dispensing fee cap and reimbursement level apply as noted in "Optional Medical Coverage Table."

- All medical plan options require generic-only drugs, unless your physician advises on the prescription that no substitutions are allowed. You may ask why you should support a generic-only approach. 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 plan option will pay at the brand-name costs, subject to the required copayment, reimbursement level, deductible and dispensing fee caps.

New Drugs Not Automatically Covered Under FLEX (for medical Basic, Comprehensive, and Plus options)

Up until now, any new drugs that require a prescription and meet FLEX provisions have been considered eligible for reimbursement.

In 2004, new drugs will no longer be covered automatically (for the Basic, Comprehensive, and Plus options). FLEX will now have a formulary (a list of covered drugs), which will consist of all drugs covered as of December 31, 2003. A new drug will not be added until at least one of the provincial drug plans adds the drug to its list of covered drugs and the drug is an eligible expense under FLEX provisions. Once a new drug has been added to at least one provincial health care plan (not necessarily in your province of resident) and is an eligible expense under FLEX provisions, it will be added to the FLEX formulary.

$7 Copayment - Paying a Fixed Cost for Each Prescription Drug Claim (for medical Basic, Comprehensive, and Plus options)

For every prescription drug claim you have, you will now pay $7 for the prescription (referred to as a "$7 copayment"), over and above any other amount you may pay under a particular option.

2004 Prescription Drug Reimbursement Example - Comprehensive Option

- Marie has a $60 prescription drug expense - the $60 cost includes the actual cost of the drug and the dispensing fee (drug is not on the prior

authorization list and is generic).
- The cost of the drug is $50.
- The dispensing fee at Marie's pharmacy is $10.
- Marie is enrolled in the Comprehensive Option, which covers 90% of the drug cost and has a $7 per-prescription copayment and $7 dispensing fee cap.

Marie's costs
Dispensing fee = $3 ($10 - $7 dispensing fee cap paid by FLEX)
Marie's copayment = $7
Remaining drug cost = $60 - $3 - $7 = $50
Marie's 10% of $50 ($50 x 10%) = $5

Marie's total costs = $15

FLEX costs
Eligible drug cost ($60 minus Marie's $3 portion of the dispensing fee) = $57
Subtract Marie's $7 copayment = $50
FLEX pays 90% of the balance of the drug cost (90% of $50) = $45

Total Nortel Networks FLEX costs = $45

Maximum Dispensing Fees (for all medical options - including the new Select Option)

The amount the plan pays for dispensing fees is capped at $7, but there are pharmacies that charge dispensing fees lower than $7. 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 1 and Tier 2 Drugs (for all medical options - including the new Select Option)

Regardless of the option you choose (Basic, Comprehensive, Plus, or Select), 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.
- **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 prior authorization is required for certain classes of drugs to demonstrate that

they are medically necessary.

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

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 (prior-authorization required)
• Smoking-cessation drugs	• $500 maximum
• Anti-obesity drugs	• $1,000 per calendar year (prior-authorization required)
• Preventive vaccines	• $500 per calendar year

Prior Authorization (Basic, Comprehensive, and Plus options for all listed drug categories - and Select Option for two listed drug categories)

Last year, we told you that we were considering some alternatives to more effectively manage rising drug costs. In 2004, FLEX will require pre-approval - prior authorization - for certain drugs listed under three new categories of prescription drugs, plus the drug Wellbutrin™, for the following medical options: Basic, Comprehensive, and Plus. Prior authorization is a process that requires you to be approved for certain drugs before they are covered under FLEX.

Prior authorization has been selected as a viable option for FLEX, as it builds on a program already in place. Since 2000, FLEX has required prior authorization for certain drugs under two categories of drugs - those prescribed to treat obesity (Xenical™) and those prescribed to treat erectile dysfunction (Viagra™).

The prior authorization process is in place to ensure that certain prescribed drugs are the best choice for the condition being treated, from the perspective of both effectiveness and cost. It also ensures that drugs that provide a dual purpose are being adjudicated in accordance with FLEX Medical Plan provisions.

Our prior authorization process is similar to the one used by the provincial health care plans, which require pre-approval for several categories of drugs.

Drugs that require prior authorization are only eligible for reimbursement if certain criteria are satisfied. The protocols used in the prior authorization program are based on guidelines that are currently in place in provincial formularies (a formulary is a list of covered drugs). A group of pharmacists at BCE Emergis (our pharmacy benefit manager) uses these provincial guidelines to determine the protocols and assessment criteria for approving a drug that requires prior authorization.

The prior authorization forms require very specific and detailed information. If the approval process determines that the prescribed drug meets the established protocols and criteria, your prescription will be approved.

Hint Note: If you are already taking a drug that is on the prior authorization list - or have done so in the past 100 days - you will **not** be required to submit a prior authorization form, nor will you need approval for this drug to be covered.

See more on how you can efficiently manage the approval process under "How Prior Authorization Works - Making It Simple."

Hint Note: if you are a Quebec employee, any drug on the Régie de l'assurance-maladie du Québec (RAMQ) formulary must be reimbursed up to 72%. Therefore, for drugs that require prior authorization, these drugs will not need to go through this process to receive reimbursement up to 72% of the eligible expense.

What Drugs Require Prior Authorization?

In 2004, certain drugs under five categories, plus the drug Wellbutrin™, will require prior authorization. Other drugs within each category could be added as they become available on the market and are identified as drugs that require prior authorization according to provincial guidelines.

- NEW - Anti-inflammatory medication. Current drugs requiring prior authorization under this category:
  - Celebrex™, Vioxx™, Bextra™
  - These drugs act as Cox-II inhibitors (a new class of pain relievers and anti-inflammatory drugs for arthritis and pain). Prior authorization is required because there are other equally effective, non-steroidal, anti-inflammatory drugs that are less expensive and proven to be safe. They are currently available generically to treat signs and symptoms of rheumatoid arthritis and osteoarthritis.
- NEW - Anti-ulcer and heartburn medication. Current drugs requiring prior authorization under this category:
  - Losec™ (Omeprazole), Nexium™ (Esomeprazole), Pantoloc™ (Pantoprazole), Prevacid™ (Lansoprazole)
  - In the late 1990s, drugs such as Losec™ greatly improved the treatment of stomach ulcers and other acid-related diseases. However, alternative conservative treatments can be effective for a majority of individuals before they turn to long-term therapy provided by the above list of anti-ulcer and heartburn medications.
- NEW - Migraine therapy. Current drugs requiring prior authorization under this category:
  - Amerge™ (Naratriptan), Imitrex™ (Sumatriptan), Maxalt™ (Rizatriptan), Zomig™ (Zolmitriptan)
  - Prior authorization will assist in determining effective use of medication based on provincial guidelines to manage migraine-related conditions.
- NEW - Wellbutrin™ (Bupropion), which is both an anti-depressant and a smoking cessation drug. Currently, FLEX has a $500 maximum on

smoking cessation drugs, but no maximum on anti-depressants.

- CURRENT - Erectile dysfunction medication. Current drug requiring prior authorization under this category: (for all medical options, including the Select Option)
  - Viagra™ (Sildenafil)
  - Viagra was given full approval by Health Canada in March 1999, and will be covered if you meet the criteria on the forms.
- CURRENT - Anti-obesity medication. Current drug requiring prior authorization under this category: (for all medical options, including the Select Option)
  - Xenical™ (XEE-0402)
  - Xenical was approved by Health Canada in June 1999, and will be covered if you meet the criteria on the forms.

For information about how to submit a claim for any drug that requires prior authorization, refer to "How Prior Authorization Works - Making It Simple".

HINT

Your Prescription Drug Needs

Before enrolling, think carefully about your prescription drug needs in the coming year - for both you and your family. If you want medical coverage at a higher level, you have the Plus and Select options to choose from. These two options provide similar coverage. The Select Option's major distinction is the prescription drug plan. The other three options have some provisions that are not applicable to the Select Option:

- Five categories of drugs, plus the drug Wellbutrin™ require prior authorization (Select Option only has two categories of drugs that are subject to prior authorization)
- $7 per prescription copayment
- Drug formulary that only adds a new drug when at least one of the provincial drug plans adds the drug to its list of covered drugs. (New drugs are automatically added to the Select Option.)

If you expect a high number of drug claims or if having the highest level of prescription drug coverage is important to you, the Select Option may be the choice for you.

Just keep in mind that you pay for choice - the Select Option will cost you more than the Plus Option.

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 $839. 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 $839 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 copayment (if applicable), and any dispensing fee that exceeds the dispensing fee cap. You also pay for ineligible drugs 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 (for Basic, Comprehensive, Plus, and Select options)

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. Services for personal and/or custodial care are not covered under the plan.

Through our plan administrator, Sun Life Financial, 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 Sun Life Financial 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 (for Basic, Comprehensive, Plus, and Select options)

This includes the services of a licensed chiropractor, chiropodist, massage therapist, naturopath, osteopath, podiatrist, speech therapist, or provincially regulated acupuncturist. In 2004, 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 reached 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 when your provincial plan's annual maximum has been reached. 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.

Select Option

The Select Option covers a maximum of $500 per person annually for each practitioner. For chiropractic* services only, you may submit claims immediately, regardless of when your provincial plan's annual maximum has been reached. 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 the maximum yearly benefit under your Alberta Provincial Health Care Plan has been reached. This would apply to all medical options.

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Psychologist Services (for all medical options)

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.

Select Option

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

HINT

Employee Assistance Program/Worklife Services

Did you know you may access psychologist services under the professional services coverage as well as under your Employee Assistance Program (EAP)? EAP is provided by the Company at no cost to you.

The phone number for EAP and worklife services is 1-888-859-5263.

Simply call to arrange for an appointment. FGI, the EAP provider, will arrange for an appointment with a counselor nearest to your home or office. FGI will maintain your confidentiality.

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Physiotherapist Services (for all medical options)

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 that 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 (Sun Life Financial). 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.

Select Option

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

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Miscellaneous Supplies and Durable Medical Equipment (for all medical options)

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.

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
- Prostate-specific antigen (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 Sun Life Financial and inquire about the reasonable and customary cost before you make a purchase.

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Dental Surgery Due to an Accident (for all medical options)

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 (for all medical options)

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 1-800-511-4610.

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 option; 31 days for the Comprehensive Option and 90 days for the Plus and Select options.

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 within 24 hours. 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 Sun Life Financial.

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 215-701-2933 or http://travelwell.ca.nortel.com.

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Maximum Lifetime Benefits (for all medical options)

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

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Cost of Medical Options

The 2003/2004 Plan Option Cost Comparison can assist you with assessing your costs for 2004. It provides a comparison of 2003 and 2004 plan option costs for each option, for both medical and dental/vision/hearing care coverage. Your actual costs will depend on the selections you make.

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If You Leave the Company

You have the option of converting your medical and dental/vision/hearing care coverage to an individual policy within 60 days of your termination date. If you are under the age of 69, you may apply for a policy called "Health Coverage Choice," which is provided by Sun Life Financial. If you would like to convert to an individual policy, enroll in Health Coverage Choice by completing the enrollment form at www.sunlife.com/pfs.

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Exclusions to Medical Coverage (for all medical options)

No benefit is currently payable for:

- Contraceptives, other than oral,
- Food and food supplements, including dietary supplements,
- Vitamins, minerals, protein supplements, and therapeutic nutrients except those that can only be purchased with a written prescription from a physician or dentist,
- Cosmetic or hygienic products,
- Products, that 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 that 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 that 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 that 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 that 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

- Check Out your

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

Eligible Expenses

Optional Dental/Vision /Hearing Care Coverage

- Dental Care Services
- Vision Care Services
- Hearing Care Services

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

The following chart outlines the current 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. Note that Fluoride treatments are restricted to children.)	100%	100%	100%
Coverage for restorative services (such as fillings and extractions)	80%	80%	90%
Coverage for oral surgery (see detailed listing of dental services)	Varies depending on type of service		
Coverage for endodontics (treatment of roots) and periodontics (treatment of gums, including periodontal surgery)	80%	80%	90%
Coverage for major services (such as crowns, dentures, and bridges)	N/A	50%	50%
Coverage for orthodontia (treatment to correct tooth or bite alignment)	N/A	50%	50%
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.

To TopDental Care Services

- Covered Dental Services
- Payment of Dental Services
- Limitations
- Exclusions to Dental Coverage
- If You Leave the Company

Covered Dental Services

Preventive (basic) services currently include:

- Limited/recall examinations once every 6 months, dental polishing plus two units of scaling once every 6 months) and topical application of fluoride-phosphate (for children only) once every six months. (1 unit of scaling =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.
- Pit and fissure sealants for dependent children under age 19, and
- Space maintainers for missing primary teeth and certain habit-breaking appliances,
- Oral hygiene instruction once per lifetime.

Restorative services include:

- Removal of teeth, including surgical extraction of impacted teeth,
- Fillings, including amalgam, silicate, acrylic and composite fillings,
- Anesthesia only if 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) and root planing limited to 6 units per calendar year (1 unit = 15 minutes of treatment time).

Hint Note: 10 units overall scaling maximum per calendar year (4 units routine scaling and 6 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.

Hint Note: If you use the "alternate benefit provision" the plan will pay partial reimbursement for implants. For more information, go to "Payment of Dental Services."

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:
  - Limited/recall examinations once every 6 months, dental polishing plus two units of scaling once every 6 months and topical application of fluoride (for children only) once every six months. 1 unit of scaling =15 minutes of treatment time. Ten units overall scaling maximum per calendar year.
  - 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.
  - Pit and fissure sealants for dependent children under age 19, and
  - Space maintainers for missing primary teeth and certain habit-breaking appliances,
  - Oral hygiene instruction once per lifetime.
  - Appliances to control oral habits
  - Space maintainers
  - 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
  - Anesthesia for children allowed
- 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 6 time units in a calendar year); scaling and root planing (not exceeding 10 time units in a calendar year under preventive services and periodontic services).
- Surgical Services; surgical excision
- Anesthesia in conjunction with oral surgery
  - General anesthesia; deep sedation; conscious sedation
  - Anesthesia for children
- 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
        - Anesthesia for children
    - 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
    - Anesthesia in conjunction with oral surgery
        - General anesthesia; deep sedation; conscious sedation
        - Anesthesia for children
    - 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.

The plan only pays up to the amount recommended by the current fee guide. Some dentists charge more than the current fee guide. If your dentist is doing this, ask why the charges are more than the fee recommended by the provincial dental association.

Note to Alberta Residents

Hint The Alberta Dental Association has not published a fee guide since 1997. However, in 2004, based on industry benchmarking results, the inflation factors used for 2003 will be updated for 2004. For the latest information, please read the "2003 Insurance Industry Inflation Factor Applicable to the 2002 Reasonable and Customary Reimbursement Amounts for Employees in Alberta" on Services@Work.

No Assigning of Payments to Your Dentist

You cannot assign your reimbursement for dental claims directly to your dentist. Instead, you pay the dental fees and then claim reimbursement from Sun Life Financial 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 Sun Life Financial 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. Remember, your dentist can still submit the claim electronically to Sun Life Financial for assessment.

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 Sun Life Financial 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 for an existing denture 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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If You Leave the Company

You have the option of converting your medical and dental/vision/hearing care coverage to an individual policy within 60 days of your termination date. If you are under the age of 69, you may apply for a policy called "Health Coverage Choice," which is provided by Sun Life Financial. If you would like to convert to an individual policy, enroll in Health Coverage Choice by completing the enrollment form at www.sunlife.com/pfs.

Return to "Dental Care Services" Table of Contents
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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.
- Expenses for the treatment of Temporomandibular Joint Syndrome (TMJ).

Return to "Dental Care Services" Table of Contents

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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

This procedure is currently an eligible expense and paid according to the reimbursement level and annual maximums for the applicable plan option - Comprehensive or Plus - you choose. 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

To TopHearing Care Services

Hearing Aids

The purchase and repair of hearing aids are currently covered, excluding batteries, to the maximum eligible expense as outlined in "Optional Dental/Vision/Hearing Care Coverage Table."

To TopHealth Care Reimbursement Account (HCRA)

Hint Note that your Claim Statement and other printed information from Sun Life Financial will use the term "Health Spending Account" (HSA). HCRA and HSA are interchangeable.

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. After you pay for an eligible expense, you claim for reimbursement from your HCRA.

What You Will Find Here

- Check Out Your Health Care Reimbursement Account
- Unique Features of an HCRA
- Carry Forward Eligible Expenses For One Year
- Some Eligible and Ineligible Expenses

You may allocate unused FLEX Credits to the HCRA, or take them as taxable pay, but not a combination of both. The minimum amount you can allocate 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

- can use your FLEX Credits on a before-tax basis, which increases the purchasing power of these FLEX Credits (to a lesser degree in Quebec). 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, Plus, or Select 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, copayments, 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 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, 2005, to submit claims for eligible expenses incurred between January 1, 2004, and December 31, 2004, for reimbursement from your year 2004 HCRA allocation. You'll forfeit any FLEX Credits allotted for 2004 that remain in the HCRA after March 31, 2005.

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 if you record a Status Change such that you'll be selecting HCRA again, you have 31 days to use up your existing balance in the HCRA.

To TopCarry Forward Eligible Expenses For One Year

If you have more eligible expenses in 2004 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 2004 expenses from FLEX Credits you allocate to your 2005 HCRA. You can budget ahead and know what dollar amount is required to be allocated in 2005 to cover unpaid health expenses from 2004.

An example of carry-forward expenses for one year:

Year 2004	
Over-the-counter (OTC) drug expenses:	$150
Minus	
FLEX Credit allocation:	$125
Equals	
Unreimbursed expenses:	$25
Year 2005	
Unreimbursed expenses from year 2004:	$25
Plus	
Potential OTC drug/other expenses:	$100
Equals	
Potential FLEX Credit allocation:	$125

To TopSome 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 www.ccra-adrc.gc.ca or request a copy of publication IT519R2-CONSOLID, Medical Expense and Disability Tax Credits and Attendant Care Expense Deduction, 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.

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 in your particular circumstances.

To TopLife Insurance

To TopCheck Out Your Core Life Insurance Coverage

Core Life Insurance for You

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

Core coverage provides your beneficiary with a benefit amount equal to your FLEX Earnings if you die while you're covered.

The monthly rate for core life insurance effective January 1, 2004 is $0.35 per $1,000 of coverage. Nortel Networks currently pays the premium for core employee life insurance, and you pay the taxable benefit, which is based on the rate.

If you're an active employee on January 1 following the year you turn 65, 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.

What You Will Find Here

- Check Out Your Core Life Insurance Coverage
- Check Out Your Optional Life Insurance Coverage
- Determining Your Benefit Amount
- Optional Life Insurance Coverage Rates
- Evidence of Insurability (EOI)
- Naming Your Beneficiary
- Your Conversion Option
- Exclusions to Life Insurance Coverage
- Life Insurance Benefit Checklist

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

Remember: You may also convert your medical and dental/hearing/version care coverage to an individual policy within 60 days of your termination date. If you are under the age of 69, you may apply for a policy called "Health Coverage Choice," which is provided by Sun Life Financial. If you would like to convert to an individual policy, enroll in Health Coverage Choice by completing the enrollment form at www.sunlife.com/pfs.

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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 EOI), or
- 5 X FLEX Earnings (requires EOI).

Optional life insurance ends at retirement or on December 31 of the year you turn 65 - 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
- $100,000
- $150,000
- $200,000
- $250,000
- $300,000
- $350,000
- $400,000
- $450,000
- $500,000

The cost will be based on your spouse's gender, your spouse's age on December 31 of the plan year, whether or not your spouse smokes, and the

amount of coverage selected for your spouse.

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.

To TopDetermining 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

To TopOptional Life Insurance Coverage Rates

- Optional Life Insurance Coverage Rates for You and Your Spouse
- Determining Your Cost for Employee or Spousal Life Insurance Coverage
- Optional Dependent Life Insurance Coverage Rates for Your Children

Optional Life Insurance Coverage Rates for You and Your Spouse

Optional employee and spousal life insurance coverage rates are as follows:

	Smoker				Non-Smoker			
Employee/Spouse's age on Dec 31, 2004	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 Spousal 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 and/or your spouse haven't smoked or used a tobacco product in the previous 12 consecutive months.

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

The FLEX Benefits Enrollment Tool will show you what it will cost for you and your spouse to buy optional life insurance.

If you don't have intranet 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.

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

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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:

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

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

Return to "Optional Life Insurance Coverage Rates" Table of Contents
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To TopEvidence of Insurability (EOI)

When you are first eligible to buy optional life insurance, or when you increase the amount of coverage you already have, Sun Life Financial may ask you for information about your health before approving your request. This is called providing evidence of insurability (EOI). To submit EOI, you complete a short medical questionnaire. The form you use is called the Statement of Health form. It's important that you complete the form entirely and accurately, and return it to Sun Life Financial within 31 days from the date you submit your Status Change selections.

Hint **Remember: Providing EOI isn't a guarantee that your request for increased coverage will be accepted. Sun Life Financial will send you notification of acceptance or rejection of your application.**

Both you and your spouse may be required to provide EOI, depending on the amount of coverage requested. You won't be required to provide EOI

for optional dependent life insurance coverage for your children.

Sun Life Financial 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 EOI if you want to increase the amount of your current **optional employee life insurance**.

You'll be required to submit EOI for your spouse if you're selecting **optional spousal 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.

If you have intranet access, you need to download the Statement of Health form from Services@Work and send it to Sun Life Financial, along with your Confirmation Statement (which you print yourself.) If you do not have intranet access, the Statement of Health form will be mailed to your home, along with your Confirmation Statement. You must return the completed form to Sun Life Financial 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 EOI if your core life insurance coverage will be more than $600,000.

You will be required to provide EOI 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 EOI 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 new hire date.

If you're selecting **optional spousal life insurance**, you'll not be required to submit EOI 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 Sun Life Financial within 31 days from the date you make your new hire selections.

If you have a Status Change
You will be required to provide EOI 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 EOI if you want to increase optional spousal life insurance coverage to an amount that is more than $50,000.

You must submit the form to Sun Life Financial within 31 days from the date of you make your status change selections.

To TopNaming 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 insurance, AD&D insurance, and Business Travel Accident insurance. The beneficiary(ies) you currently have on file will remain in effect until you file a new Beneficiary Designation Form for Employee Life, Accidental Death & Dismemberment and Business Travel Accident Insurance. If you're enrolling for the first time or if you wish to change your beneficiary designations, you can obtain the 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 - spousal and child coverage under FLEX.

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

To TopYour 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 EOI. The amount you can convert is your current level of coverage 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 EOI. The amount you can convert is your spouse's current level of coverage 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 Sun Life Financial and have no relationship to the group contract that covers FLEX Benefits. Contact Sun Life Financial for further information regarding conversion.

To TopExclusions 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 to AD&D Coverage" for more details.

To TopLife 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, Making 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, 2004". If you are experiencing a Status Change, go to "What To Do If You Have A Status Change During the Year."

Whether or not you're new to FLEX, refer to the *FLEX 2004 Action Steps* for details about how to enroll. This document provides you with all the "how-to" information you need, including who needs to enroll, what tools you can use and what happens if you do not enroll. It also tells you what you need to do if you have a Status Change.

To TopActions to Take

- Getting Ready To Enroll
- Your Enrollment Itinerary for 2004 Annual Enrollment
- Your Enrollment Options

Getting Ready To Enroll

As you think about your FLEX selections:

- Check the cost of coverage - use the FLEX Benefits Enrollment

What You Will Find Here

- Actions to Take
- Forms Required
- Your Confirmation
- What Happens If You Don't Enroll
- Enrolling Your Dependents and

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 additional FLEX Credits you receive for certain medical options and for the dental/vision/hearing care options you have chosen.

Recording Information Online
- If You And Your Spouse Both Work at Nortel Networks

- Compare the options carefully and check for additional information at Services@Work.
- 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.

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, 2004."
- When you have a Status Change. 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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Your Enrollment Itinerary for 2004 Annual Enrollment

- **Review your Current Coverage online.** If you do not have intranet access, you will receive a Personalized Enrollment Worksheet reflecting the current costs only. You can use the *2003/2004 Plan Option Cost Comparison* table to view the changes in costs from 2003 to 2004. If you have intranet access, review your Current Coverage on the enrollment tool.

Remember:

- The coverage you select during the annual enrollment period will be effective from January 1, 2004, through December 31, 2004, subject to eligibility and the Company's reserves the right to make changes to plans, and even to terminate plans. You can't make changes to your

- **Review the Roadmap.** This resource outlines what's new, helps you determine if you need to enroll.
- **Follow the *Action Step*** to find out what you need to do 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 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 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. If you don't have intranet access, the costs are provided on your Personalized Enrollment Worksheet. You may also refer to the *2003/2004 Plan Option Cost Comparison*, which will be available before the annual enrollment period.
- **Check the detailed Claim Statement sent to** you by Sun Life Financial. Review the statement to assess the extent to which you and your family used the plans in 2003.

coverage during the year unless you have what's known as a Status Change. Status Changes include, but aren't limited to, events such as marriage, divorce, and the birth or adoption of a child.

- If you have a Status Change during the year, you must notify Global 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 (EOI) is required for life insurance. Any life insurance coverage requiring EOI will be effective on the date of approval by Sun Life Financial. If you submit the Status Change after 31 days, the enrollment selections won't become effective because you will have missed your enrollment window. **Any new dependents will not be added automatically to your medical or dental/vision/hearing care coverage, even if you're already enrolled for dependent coverage. You must take action to ensure they are enrolled.**

Return to "Actions to Take" Table of Contents
Return to Main Table of Contents

Your Enrollment Options

1. **Enrolling Online** - use the FLEX Benefits Enrollment Tool.
2. **Enrolling On Paper**

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

   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
Return to Main Table of Contents

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 (EOI) for life insurance or for Optional LTD, and if you don't have intranet access, you'll receive a Statement of Health form in the mail, along with your Confirmation Statement. If you have intranet access, go to FLEX 2004 Benefits Forms Folder available Services@Work to download the form. If you need to name a beneficiary for your life insurance and AD&D insurance, complete and return a Beneficiary Designation form for Employee Life, Accidental Death & Dismemberment and Business Travel Accident Insurance. If you have intranet access, go to the FLEX 2004 Benefits Forms Folder available on Services@Work, to download the form.

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

- 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). If you have intranet access, go to the FLEX 2004 Benefits Forms Folder available on Services@Work, to download the form. Complete and return it to Global 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

If you have access to the intranet, you must print your own Confirmation Statement when you finish enrolling. You should print a Confirmation Statement even if you don't want to make changes because you won't receive one in the mail.

If you don't have access to the intranet or have selected French as your language of preference, a Confirmation Statement will be mailed to your home after the enrollment period ends - whether or not you make any changes.

If discrepancies appear on this statement, please contact Global Employee Services immediately.

Any changes you make during this annual enrollment period will be effective from January 1, 2004 to December 31, 2004, unless your eligibility changes or you change your selections due to a Status Change. If you have a Status Change, go to "What To Do If You Have A Status Change During the Year."

The following disability, life insurance, and AD&D insurance effective date exceptions also apply:

- Life insurance or optional LTD coverage that requires EOI will be effective on the date that coverage is approved.
- If you're on short-term disability on January 1, 2004, regardless of your annual enrollment selections, your 2003 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.

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

To TopWhat Happens If You Don't Enroll

If you don't make your FLEX Benefits selections for 2004, the coverage you have in 2004 will depend on whether or not you were enrolled in FLEX in 2003.

If you don't make changes:

- Your disability and your and/or your spouse's life and/or AD&D insurance coverage amounts and costs could change if your FLEX Earnings increased or decreased from last year.
- Your and/or your spouse's life insurance cost may change based on your and/or your spouse's age or change in life insurance smoker status.

Your default coverage for this plan	If you were enrolled in FLEX for 2003	If you were NOT enrolled in FLEX for 2003
Medical Plan (Note: If you default to Basic coverage, you'll receive the appropriate health FLEX Credits)	Company-paid provincial premiums (where applicable) and EAP/Worklife Services Your 2003 option and dependent coverage level	Company-paid provincial premiums (where applicable) and EAP/Worklife Services Basic medical coverage for you only (you and your family in Quebec)
Dental/Vision/Hearing Care Plan (Note: If you default to "no	Your 2003 option and dependent coverage level	No coverage

coverage," you'll receive the appropriate health FLEX Credits)		
Employee life insurance	Core coverage plus your 2003 coverage level for optional life insurance	Core coverage only
Dependent life insurance Spouse Dependent children	 Your 2003 coverage level Your 2003 coverage level	 No coverage No coverage
Accidental death and dismemberment (AD&D) insurance	Your 2003 option and dependent coverage level	No coverage
Short-Term Disability (STD) Plan	Your 2003 option	Core coverage only
Long-Term Disability (LTD) Plan	Your 2003 option	Core coverage only
Health Care Reimbursement Account (HCRA)	If you had unused FLEX Credits in 2003 and allocated them to the HCRA, and if the same selections for 2004 generate unused FLEX Credits, these Credits will be directed to your HCRA (minimum $1 per pay period).	Any unused FLEX Credits will be directed to taxable pay

To Top**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, 2004."

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 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 Global Employee Services.

Only the eligible dependents you have on record will be eligible for coverage. If a claim is made for a dependent who is not listed in our Human Resources database, then Sun Life Financial will not have the correct information and the claim will be declined (even if you have selected and are paying for a coverage level under medical and/or dental/vision/hearing care that indicates dependent coverage).

To TopIf 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. For more information, go to "Eligibility," "Evidence of Insurability (EOI)," "Co ordination of Benefits," "Accidental Death & Dismemberment," or "Life Insurance."

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 amount for which you are covered 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 2004 will be based on FLEX Earnings as of September 27, 2003. If you were hired after September 27, 2003, 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.

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, 2004

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 (EOI).
- Regardless of when you enroll, any life insurance coverage requiring EOI will be effective on the date of approval by Sun Life Financial.

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 (Change in Family or Work Circumstances) During The Year

You may change your benefit selections between annual enrollment periods if you experience a Status Change. It's your responsibility to notify Global 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, and/or civil union (for Quebec residents), or completion of 12 months of continuous cohabitation with an unmarried partner of either gender
- Divorce, legal separation, dissolution of a civil union (for Quebec residents) or discontinuation of an unmarried partner of either gender
- 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 based on the type of Status Change.

Here's what to do if you have a Status Change:

- Contact Global Employee Services to initiate your Status Change.

- You must 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.
- If you don't have access to the intranet, Global Employee Services will provide you with the required forms and process steps necessary to complete the Status Change.
- If you do have access to the intranet, go to the enrollment tool to update your dependent information and 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.

Hint
- 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.

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 EOI will be effective on the date approved by Sun Life Financial.

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.

Hint Note: 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 your existing balance in the HCRA.

About Your Dependent Enrollment: You must ensure all eligible dependents you want covered under FLEX are listed on the FLEX Benefits Enrollment Tool (Nortel Networks Human Resources database). **Any new dependents will not be added automatically to your medical or dental/vision/hearing care coverage, even if you're already enrolled for dependent coverage. You must take action to ensure they are enrolled.**

If You Have a Status Change Between Annual Enrollment and January 1, 2004: If you need to change your FLEX selections for 2003 due to a Status Change that occurs *after* you've made your FLEX 2004 annual enrollment selections but before January 1, 2004, you'll need to contact Global Employee Services and advise them of the Status Change. Additionally, you'll need to **re-enroll** for FLEX 2004. A Global Employee Services representative will initiate the online process so that you can make the changes for FLEX 2003 and provide you with instructions on how to re-enroll for FLEX 2004. Global Employee Services will send you an e-mail (if you have intranet access) or a letter (if you do not have intranet access) further explaining this special enrollment process.

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.

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

What You Will Find Here

- When on Short-Term Disability
- When on Long-Term Disability
- When on Maternity/Parental Leave
- When on a Leave of Absence
- When You Leave Nortel Networks
- 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 insurance and life insurance selections during annual enrollment or if you have a Status Change.

If you make new selections at annual enrollment, but are on STD January 1 when the benefit year begins, you won't receive the STD, LTD, AD&D insurance and life insurance coverage you selected until you return to work for 60 consecutive days. You must notify Global Employee Services within 31 days of satisfying the 60-day 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.

To TopWhen 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. At the time of disability, if you are in the Plus or Select options for medical coverage and/or the Plus option for dental/vision/hearing care coverage, and if

you choose to remain in the Plus or Select 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 or Select options, you will be covered under the Comprehensive Option and you won't be required to make any contributions.

Your Benefits

STD and LTD: The STD and LTD options you are covered under at the time of disability will continue during your period on LTD.

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 or Select options 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 or Select options. If you don't choose to remain in the Plus or Select options at the time of disability, you can't select Plus or Select 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 for a period of 60 consecutive days. You must notify Global Employee Services within 31 days of satisfying the 60-day period if you wish to make a change.

While on STD, if 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 Global Employee Services within 31 days of satisfying the 60-day 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.

To Top**When on Maternity/Parental Leave**

STD, LTD and Life Insurance 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 or in the case of adoption, 31 days from the day the child arrives at your home. 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 Insurance, 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 or in the case of adoption, 31 days from the day the child arrives at your home. 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.

To TopWhen 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 the sections above.

STD/LTD and Life Insurance 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 Insurance, 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.

To TopWhen 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 of 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.

You have the option of converting your medical and dental/vision/hearing care coverage to an individual policy within 60 days of your termination date without evidence of insurability. If you are under the age of 69, you may apply for a policy called "Health Coverage Choice," which is provided by Sun Life Financial. If you would like to convert your coverage to an individual policy, enroll in Health Coverage Choice by completing the enrollment form at www.sunlife.com/pfs.

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

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 EOI. The amount you can convert is your current level of coverage 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 EOI. The amount you can convert is your spouse's current level of coverage 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.

To TopWhen 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 the first of the month following your retirement date 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 CARP.

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 (CARP) 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 Capital Accumulation Retirement Program 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 if 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 TopMaking a Claim

To TopMaking a Claim

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

- Obtain a claim form with your personal information pre-entered (Medical/HCRA Claim Form or Dental/HCRA Claim Form) from Plan Member Services on the Sun Life Financial Web site or from the FLEX 2004 Benefits Forms Folder on Services@Work.
- Submit the completed claim form, along with original bills or receipts. You'll be required to indicate the Nortel Networks Benefit Plan Policy Number (#25654) and your member number (your Global ID) on the claim form.

What You Will Find Here

- Making a Claim
- How Prior Authorization Works - Making It Simple
- Health Care Reimbursement Account Claims
- Deadline for Submitting Claims
- Where to Send A Completed Claim Form
- Coordination of Benefits
- Sun Life Financial's Plan Member Services Web Site and Direct Deposit of Claims

- Access the Sun Life Financial Plan Member Services Web site at www.sunlife.ca/member. On the site, you can:
  - View information about your group medical and dental/vision/hearing care plans.
  - Have direct deposit of claims payments into your bank account.
  - Obtain personalized claim forms.
  - Check the status of your recently submitted claims.
  - View your claims history.
  - ***NEW*** - Find out your HCRA balance.
  - ***NEW*** - Look up when you are eligible for your next pair of eyeglasses or dental recall exam.
  - ***NEW*** - Sign up for a paperless explanation of benefits (EOB).
  - ***NEW*** - Use "Quick View Summary" (which shows your most recent claims payments, next recall exam date, vision amount available, and your HCRA balance).
  - ***NEW*** - Access both your group benefits and group retirement services on one convenient Web site.

If you have any questions, call Sun Life Financial at 1-800-229-7089 Monday to Friday, 7 a.m. to 8 p.m., EST.

E-claims will be available sometime in the first half of 2004. E-claims gives you the ability to submit claims electronically for certain

expenses (vision care, certain dental care, and all HCRA expenses) through the Sun Life Financial Plan Member Services Web site. It provides a fast, easy, and convenient way to submit these claims.

To TopHow Prior Authorization Works - Making It Simple

If your doctor prescribes a drug for you that requires prior authorization, he/she will need to complete a prior authorization form and then submit it to Sun Life Financial. Sun Life Financial will then send the form to BCE Emergis for assessment and approval.

If the drug is approved, you can buy it at the pharmacy using your pay direct drug card as you usually would, and you will not have to go through the prior authorization process again - unless you stop taking the medication for more than 100 days.

To help ensure the process is quick and easy, simply do the following:

1. Print all six prior authorization forms - or the ones that you think may be applicable to you in 2004 - from Services@Work. The names of the drugs are at the top of the form. Take them to your doctor on your next visit and ask your doctor to keep them in your file in case you need them in the future. Remember, more drugs could be added to the list during the year. Every quarter, we will update the folder on Services@Work that details the current drugs requiring prior authorization. This folder will list the new drugs that have been added since the previous update. Prior authorization forms will be updated whenever there is a change, so you may want to review the forms every few months and print new versions as they become available.
2. Be familiar with the applicable five categories of drugs, plus the drug Wellbutrin™. If your doctor prescribes a drug under one of these categories, you can remind him/her to check the form in your file to see if it is one of the required drugs listed.
3. (a) Before going to the pharmacy, send the prior authorization form to Sun Life Financial, which forwards it to BCE Emergis for assessment. Your doctor may also fax the form directly to Sun Life Financial at the fax number provided on the prior authorization form. The assessment should take 7-10 business days.

   (b) Alternatively, you can fill the prescription immediately and pay for the drug at the pharmacy. If the drug is approved, you can submit a paper claim for reimbursement for the initial expense. Then, you can use your pay direct drug card at the pharmacy for future expenses.
4. If your prescription is not approved, you may want to discuss alternative treatment or medications with your doctor. Or, if you do not want to consider alternative treatment or medication, you also have the option of claiming this expense under your HCRA, if you have allocated any excess FLEX Credits to an HCRA. As long as you have a doctor's prescription, you may use your HCRA to help pay the cost, even if the drug requires prior authorization and is not approved.

If you do not give your doctor the forms ahead of time, and try to submit the drug claim using your pay direct drug card, the pharmacist will tell you that your prescription has not been approved and you will have to return to your doctor to get the prior authorization form completed. Besides delaying the approval process, this could cost you additional doctor's fees. FLEX does not cover additional fees charged by your doctor for the completion of forms.

Hint Note: If you are already taking a drug that is on the prior authorization list - or have done so in the past 100 days - you will **not** be required to submit a prior authorization form and get approval for this drug to be covered.

An Example of the Prior Authorization Process

- Richard goes to the doctor to discuss treatment for depression. His doctor gives him a prescription for Wellbutrin™.
- Richard has brought all the prior authorization forms with him because he was not sure if he would be prescribed a drug from the applicable categories. He knows the forms are updated quarterly on Services@Work, so he checked to ensure new versions were not posted before his appointment.
- The doctor reviews the forms, and sees that Wellbutrin™ does require prior authorization. He completes the form for Richard.
    - Wellbutrin™ requires prior authorization because it is a dual purpose drug. It is an anti-depressant, as well as a smoking cessation drug. It's important for Richard's doctor to specify why he prescribed Wellbutrin™.
        - If Wellbutrin™ is prescribed to act as a smoking cessation drug, there is a maximum on how much Richard will be reimbursed from FLEX - currently $500 per year.
        - If Wellbutrin™ is prescribed to treat depression, currently there is no maximum.
    - Either way, Richard's claim requires prior authorization.
- Richard decides that he cannot pay for the drug himself up front, and instead asks his doctor to fax the form to Sun Life Financial. Richard then waits for the prescription to be assessed.
- His claim is assessed, and Wellbutrin™ is approved to treat Richard's depression.
- Richard returns to the pharmacy with his pay direct drug card to pick up his prescription.

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 coordination of benefits 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 plan 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.

To TopHealth 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, go to Sun Life Financial's Plan Member Services Web site 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 or Sun Life Financial's Plan Member Services Web site.

For a medical, vision or hearing care expense, submit the Medical/HCRA Claim Form to Sun Life Financial. For a dental expense, submit the Dental/HCRA Claim Form to Sun Life Financial for reimbursement. Include your name, policy number and ID, and tick off the "HCRA" box. Any expense listed under the Income Tax Act (Canada) is eligible for reimbursement. Visit the Canada Customs and Revenue Agency Web site at www.ccra-adrc.gc.ca or request a copy of publication IT519R2-CONSOLID, Medical Expense and Disability Tax Credits and Attendant Care Expense Deduction, for a complete list of eligible expenses. Obtain a claim form with your personal information pre-entered (Medical/HCRA Claim Form or Dental/HCRA Claim Form) from Plan Member Services on the Sun Life Financial 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 allocated amount - even if your per-pay allocations haven't yet accumulated to the total amount requested for reimbursement.

To TopDeadline 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.

Hint Note: 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 your existing balance in the HCRA.

To TopWhere 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 Sun Life Financial. The address is on the claim form.
- If your spouse has a pay direct drug card you may submit the balance of your drug claim using your spouse's card at the pharmacy.
- 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 Sun Life Financial. The address is on the claim form.
- For employee and dependent life insurance claims and AD&D insurance claims, please contact Global 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.

To Top

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 by mailing in your Explanation of Benefits (EOB) to the other plan for 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 TopSun Life Financial's Plan Member Services Web Site and Direct Deposit of Claims

Sun Life Financial's Plan Member Services Web site provides many features, which allow you to view the status of your current claims, print personalized claim forms and see when your next preventive dental recall is eligible. For a full list of features, see "Making a Claim." If you'd like to access any of these services, go to the Sun Life Financial Plan Member Services 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 life, AD&D, LTD, medical, and dental/vision/hearing care claims, the review process begins with the plan provider (Sun Life Financial). For denied STD claims, the review process begins with Medcan Health Management Inc. For claims other than STD claims, if you require further review upon completion of the review process with the plan provider you may then submit a request to Global Employee Services. If you require further review upon completion of this process with Global Employee Services, you may submit a final request to the Employee Benefits Committee (EBC). For STD claims, if you require further review upon completion of review process with Medcan, you may submit a final request to the Employee Benefits Committee (EBC).

For eligibility review, you can go directly to Global 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, Global 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,
- Financial Planning Assistance,
- Fitness/Wellness Program and Services,
- Home and Auto Program,
- Paid Time Off - Vacation, Sick Time, and Holidays,
- Service Awards, and
- Travel Well.

For more information about any of these plans or services, see Services@Work or call Global Employee Services at 905-863-4636, toll-free at

1-800-684-4636, or at ESN 333-4636. You also may contact Global Employee Services via external e-mail at gesna@nortelnetworks.com or internal e-mail at GES, North-America.

To TopAppendix I: Contact Directory

	Phone Number	Web Site Address
FLEX Benefits Enrollment Tool		https://eflex.us.nortel.com:49185
For a NorPASS Password	NT4-HELP ESN 684-4357 1-800-684-4357	http://norpass.ca.nortel.com
Services@Work		http://services-canada.ca.nortel.com
Global Employee Services	ESN 333-4636 905-863-4636 Toll-free 1-800-684-4636 Fax 905-863-8550	Email Internal: GES, North-America External: gesna@nortelnetworks.com
Health Care, Life Insurance, AD&D Insurance, and Long-Term Disability Coverage		
Sun Life Financial	1-800-229-7089	http://www.sunlife.com
Home and Auto Program		
ING Novex	1-866-845-4ING (4464)	http://www.ingcanada.com
Employee Assistance Program (EAP)/ Worklife services		
Family Guidance Group Inc.	1-888-859-5263 (English) 1-888-859-5256 (French)	www.fgiworldmembers.com username "nortel" and password "networks"
Preferred Vision Services (PVS)	1-800-668-6444	

Canada Customs and Revenue Agency (CCRA)		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 Web site 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 or equivalent 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 medical Basic, Comprehensive, and Plus options.

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)/Worklife Services. Provides all FLEX-eligible employees and dependents with free confidential short-term counseling services through an EAP counselor. The EAP provides enhanced worklife services including a nurse advice line and assistance with legal, financial, parenting, career counseling, elder care, everyday issues, etc.

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.

Drug formulary - a list of drugs that are covered by the FLEX program for the Basic, Comprehensive, and Plus options (but not the Select Option).

In 2004, new drugs will not be automatically covered. The FLEX formulary will consist of all drugs covered as of December 31, 2003. A new drug will not be added until at least one of the provincial drug plans adds the drug to its list of covered drugs.

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 (EOI) - Before you're accepted for life insurance coverage or optional long-term disability 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:
EOI is required for amounts over $600,000.

Optional life insurance for the employee:

- When you are first eligible to select optional life insurance, EOI is required for total amounts over 3 X FLEX Earnings or $1 million, whichever is less.
- EOI is also required for any increases in coverage unless you have a Status Change. In this case, EOI 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:
EOI 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 enrollment or because of a Status Change.

EOI is not required for any coverage selected for your children.

Optional LTD

If you want to enhance your long-term disability (LTD) coverage, you can select optional LTD. 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. You will also have to provide evidence of insurability (EOI) if you select optional LTD coverage during the annual enrollment period and did not already have optional LTD coverage in 2003. This is new for 2004.

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

FLEX Credits - Company-provided contribution that is intended to assist employees in buying optional coverage.

Currently, each employee gets FLEX Credits equal to 0.39% of FLEX Earnings to apply toward the purchase of optional benefits, and/or to put into a Health Care Reimbursement Account, and/or to take as taxable pay. In addition, employees can get additional FLEX Credits if they buy "you only" dependent coverage level under the Comprehensive Option, or the Basic Option, or waive medical and dental/vision/hearing care coverage completely.

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 2004 annual enrollment/Status Change	• September 27, 2003
• 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.

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

Health Coverage - 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 • Evidence of insurability could be required. Go to "Evidence of Insurability (EOI)"

<table>
<tr><td>Medical Care Coverage</td><td colspan="4">4 levels: Basic, Comprehensive, Plus, and Select options
Medical Coverage Waiver form required to opt out</td></tr>
<tr><td>Dental/Vision/Hearing Care Coverage</td><td colspan="4">3 levels: Basic, Comprehensive, and Plus options</td></tr>
<tr><td>Health Care Reimbursement Account</td><td colspan="4">Contribute unused FLEX Credits to pay for eligible expenses not fully reimbursed by the FLEX plan</td></tr>
<tr><td>Optional Employee Life Insurance</td><td colspan="4">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

Go to "Evidence of Insurability (EOI)" 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 (EOI)" 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</td><td>Spouse only
60% of</td><td>Child only
For each</td><td>Spouse and Child</td></tr>
</table>

	• 2 X FLEX Earnings • 3 X FLEX Earnings • 4 X FLEX Earnings • 5 X FLEX Earnings	your Optional AD&D coverage amount	child, 20% of your Optional AD&D coverage amount	• Spouse: 50% of your Optional AD&D coverage amount • Each child: 15% of your Optional AD&D coverage amount

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, Plus, and Select under the Medical Plan, and Basic, Comprehensive, and Plus under the Dental/Vision/Hearing Care plan.

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

- Check-ups,
- X-rays,
- Cleanings,
- Space maintainers,
- Fluoride treatments for children, 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.

Prior Authorization - a process that requires certain drugs to be adjudicated and pre-approved before you can claim them under FLEX.

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, and/or contracted in a civil union (for Quebec residents), 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,
- Is covered under a provincial health insurance plan or an equivalent 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 selections outside of the annual enrollment period. The list of Status Changes includes but is not limited to:

- Marriage, and/or civil union (for Quebec residents), or completion of 12 months of continuous cohabitation with a domestic partner of either gender,
- Divorce, dissolution of a civil union (for Quebec residents), 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. Prior authorization is required for certain therapeutic classes to demonstrate that these drugs are medically necessary.

This Handbook provides a current summary of the Nortel Networks Limited (Nortel Networks) FLEX Benefits 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.