2011 Nortel Health & Group Benefits Handbook

Introduction

Nortel is committed to providing you with a comprehensive and valued set of rewards. Your Health & Group Benefits program is an important piece of the Comprehensive Rewards that contribute to your Nortel experience.

Nortel Health & Group Benefits allows you to match your benefits to your personal needs and family circumstances. It also recognizes that your needs and circumstances – and what you value – may change from year to year, which is why you have an opportunity to re-enroll and make certain changes to your Health & Group Benefits selections each year.

An ongoing goal of Nortel Health & Group Benefits is to offer meaningful choices at reasonable costs that reflect the level of coverage provided and how much employees and their eligible dependents use our plans. Our cost-sharing strategy and our annual enrollment process enable the Company to continue providing a wide variety of benefits at a sustainable cost.

This Handbook has been designed to help you understand how Nortel Health & Group Benefits works. It contains information about key program features, as well as details on the annual enrollment process, tax considerations and claims procedures.

The same information is provided in a user-friendly format on the external Nortel Health & Group Benefits Site and on Services@Work. If you require further assistance regarding Nortel Health & Group Benefits or the enrollment process, check out other related materials on the external Nortel Health & Group Benefits Site or call HR Shared Services at ESN 355-9351 or toll-free at 1-800-676-4636. You may also contact HR Shared Services via external e-mail at HRSharedServicesNA@nortel.com or internal e-mail at HR Shared Services, NA.

Did you know: Most of Nortel's Health & Group Benefits, including short-term disability, medical and dental/vision/hearing care, are self-insured. This means that Nortel plays a role similar to that of an insurance company for its employees. In other words, the Company assumes the risks and pays the claims directly from its net income or retained earnings. The insurance company only provides administrative services such as claims processing.

This Handbook provides a summary of Nortel's Health & Group Benefits Program as of January 1, 2011. If there are any discrepancies between the information in this Handbook and the applicable Nortel benefits plan, the actual plan document will, in all cases, govern the details of the benefits coverage and the plan administration. In accordance with each plan, Nortel reserves the right to amend or discontinue the plan described in this Handbook at any time without prior notice to, or consent by, employees.

Table of Contents

Note: Words in *italics* are defined in the Glossary of Terms at the end of this Handbook.

Plan Highlights

How Nortel Health & Group Benefits Work

- **Nortel automatically provides all eligible employees with a set of core benefits. With the exception of Long-term disability (LTD), core benefits are company-paid. Core coverage includes:**
    - Employee life insurance equal to your annual *Benefits Earnings* (a term used throughout Health & Group Benefits that generally equates to your base salary).
    - Short-term disability (STD) coverage equal to 100% of your pre-disability Benefits Earnings for 6 weeks, then 66 $^{2}/_{3}$% of your pre-disability Benefits Earnings for an additional 20 weeks.
    - Long-term disability (LTD) coverage after you've been on STD for 26 weeks equal to 50% of your monthly earnings at the policy effective date (up to a maximum monthly benefit of $8,000).
    - Employee Assistance Program (EAP/WorkLife Services) that provides free confidential short-term counseling services through an EAP counselor.

You cannot opt out of core coverage.

- **The Company also provides you with *Benefits Credits* to use toward the purchase of optional coverage.** Each eligible Canadian employee currently receives Benefits Credits equal to 0.39% of Benefits Earnings, plus any additional health Benefits Credits provided for certain medical and dental/vision/hearing care selections. You can use Benefits Credits to purchase any of the following optional benefits:
    - Optional accidental death and dismemberment (AD&D) insurance for yourself only or for you and your family.
    - Optional medical and dental/vision/hearing care (DVH) coverage (see below).

  If you run out of Benefits Credits, you can purchase any of these benefits with *after-tax dollars* through payroll deductions.

- **You may choose from several Company-subsidized medical and dental/vision/hearing care options.** You can select this 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 choose to opt out of medical coverage if you (or, for Quebec residents, you and your family) have coverage elsewhere. You can also opt out of dental/vision/hearing care coverage if it isn't important to you. However, 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.

The way Nortel's medical and dental/vision/hearing care plans are structured, you may pay a portion of the cost. How much you pay depends on which *plan option* and *dependent coverage level* you select.

When you see $0 under Medical or DVH on the Employee Self Service (ESS) Benefits Enrollment Tool (or on your Personalized Enrollment Worksheet), refer to the amount shown as Employer Costs in the column to the immediate right. These are additional *Benefits Credits* you receive if you select that option. If the amount in the Employee Pre-Tax column is greater than $0, that option represents a cost to you. Coverage may be purchased by using Company-funded Benefits Credits or after-tax payroll deductions (if you exhaust your annual allotment of Benefits Credits).

As you make your selections in the Enrollment Tool, the box at the top of the screen will adjust your Benefits Credits and Cost for Pre-Tax (Section A) coverage (optional AD&D, medical, dental/vision/hearing care) and Post-Tax (Section B) coverage (optional employee and dependent life insurance, and LTD). Remember, you may not use Benefits Credits to purchase Post-Tax coverage. Any Additional Credits noted in the paragraph above will appear as a negative number under Cost. These Additional Credits, if any, can be used toward the purchase of other Pre-Tax benefits.

- **If you have any unused Benefits Credits, you have the option of contributing them 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's health care plans, such as plan *deductibles*, over-the-counter drugs, or professional services where costs exceed the plan maximums. Any Benefits 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 also 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*.

Eligibility & Coverage

Employees

Current employees of Nortel Limited and Nortel Technology Corporation not covered under the provisions of a Collective Labour Agreement and Quebec-based employees of Nortel covered under the COEU Collective Labour Agreement are eligible to enroll in Health & Group Benefits, provided they are:

- Covered by a *provincial health insurance plan* or an equivalent plan,
- Employed either on a regular full-time ("RFT") or on a regular part-time ("RPT") basis,
- Regularly scheduled to work 18 hours or more a week and not employed on a fixed-term contract.

Dependents

If you're eligible to enroll in Health & Group Benefits, your dependents may also be eligible. 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 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 children who meet one of the following criteria:
  - Your natural children,
  - Children legally adopted by you or placed with you for adoption,
  - Your stepchildren,
  - Your legal foster children, or
  - Children for whom you're a legal guardian.

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

- Under age 21,
- Under age 25* 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 age 21, or before age 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.

*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 in full-time attendance at an accredited school, college, or university.

If More Than One Family Member Works for Nortel

If you and your *spouse* both work at Nortel and are eligible for Nortel Health & Group Benefits, you'll both receive full *Benefits Credits* and may select separate optional coverage.

For life insurance and AD&D insurance, 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.

For medical and dental/vision/hearing care, you could select medical coverage for you and your family and waive dental/vision/hearing care coverage, leaving your spouse to select dental/vision/hearing care coverage with his/her Benefits Credits. Or, one of you could select "you and family" coverage under medical and dental/vision/hearing care and the other could receive his/her Benefits 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 Nortel Health & Group Benefits. Remember, if you wish to coordinate claims between yourself and your spouse, you must both select "you and spouse" or "you and family" coverage.

If any of your *children* work for Nortel and are eligible for Nortel Health & Group Benefits, they must enroll as employees. They are not eligible for coverage as your dependents.

When Coverage Begins

If you're a newly hired eligible employee, core coverage begins on your date of hire with the Company. Optional coverage begins on the date that you make the selection, provided you do so within 31 days of your date of hire. Regardless of when you enroll, any life insurance coverage requiring *evidence of insurability (EOI)* will be effective on the date your request is approved by Sun Life Financial. For more information, see "New Hire Enrollment" on page 79.

Any changes you make to your existing Nortel Health & Group Benefits selections during the annual enrollment period will be in effect from January 1 to December 31 of the following year, subject to eligibility and the Company's right to make changes to plans, or to terminate them. You can't make changes to your coverage during the year unless you have a *status change* and notify HR Shared Services within 31 days of the change.

The effective date of any changes you make during the annual enrollment period may also be affected by the following:

- Life insurance coverage that requires EOI will be effective on the date that coverage is approved by Sun Life Financial.
- If you're on short-term disability (STD) on January 1, 2011, regardless of your annual enrollment selections, your 2010 STD, LTD, optional life insurance and optional 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 HR Shared Services at ESN 355-9351 or toll-free at 1-800-676-4636.

Short-Term Disability Benefits

Short-term disability (STD) benefits replace a portion of your income if you're totally disabled for five consecutive days (or the equivalent of your standard work week) due to an approved illness or injury for which you provide supporting medical documentation. STD benefits are payable for up to 26 weeks of absence and are administered for Nortel by Shepell-fgi.

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

Core STD Coverage

Nortel provides you with core STD coverage – at no cost to you – as follows:

- 100% of your pre-disability *Benefits Earnings* for up to 6 weeks from your first day of absence (including the five consecutive days of absence), then
- 66 $^{2}/_{3}$% of your pre-disability Benefits Earnings for up to 20 additional weeks.

If you're going on maternity leave, go to the Maternity and Parental Leave Process document located in Services@Work for more information.

Defining Disability

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

- You have a medical impairment due to injury, illness or disease that 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're 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're 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.

Detailed information on Nortel's STD process, including the Company's philosophy on disability, how to apply for STD benefits, returning to work, and responsibilities of managers and employees, can be found on the Health N-Site.

Work-related injuries and illnesses may be compensable under applicable workers' compensation legislation.

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 is not 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 STD benefits.

STD Payments

Once you qualify and are approved for STD, your 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 *Benefits Earnings* for 6 weeks and then 66 $^{2}/_{3}$% of your pre-disability Benefits Earnings for the additional 20 weeks of coverage. For more information, see "If Your Salary Changes".

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 Shepell-fgi to substantiate continued disability.
- You fail to undergo an independent medical exam and/or functional abilities evaluation if requested by Shepell-fgi.
- You fail to participate in a rehabilitation program approved by Shepell-fgi.
- 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.

Other Income Sources

STD benefits are coordinated with any government disability benefits and other disability benefits so that your income from all sources combined does not exceed 100% of your pre-disability Benefits Earnings for the first 6 weeks and 66 $^{2}/_{3}$% (core STD coverage) of your pre-disability Benefits Earnings for the remaining 20 weeks. Determination of income from all sources does not include any benefits paid on behalf of dependent children, any increases in government benefits after payments start, or any individual disability policies.

Right to Subrogate

Subrogation is a legal practice giving Nortel 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 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 for the income benefits Nortel has paid. If you receive an amount for future loss of income, that amount will reduce your future loss of income benefits from Nortel.

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.

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

Rehabilitation/Modified Work

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 important feature because it has been demonstrated consistently that rehabilitative and modified work programs make a difference in the rate of recovery.

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.

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 reviewed by your treating physician and approved by Shepell-fgi. 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 Shepell-fgi.

Limitations and Exclusions

No STD benefits are 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, or
- Military service in any country.

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

You are 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.

Long-Term Disability Benefits

If you're still disabled (according to the definition of disability) after 26 consecutive weeks, you'll begin receiving long-term disability (LTD) benefits. Nortel's LTD benefits are fully insured by Great-West Life Assurance Company.

LTD Coverage

While you remain in Nortel's employ, you will be covered for 50% of your salary (up to a maximum benefit of $8,000 per month) in the unfortunate case that you become disabled for longer than the period covered by the Short-term disability program (STD). Participation in this plan is mandatory and you must pay the full cost of the plan.

LTD Cost

The cost of LTD will be deducted from your bi-weekly pay. The amount deducted will be based on your salary (with a cap at $192,000, reflecting the benefit maximum), and will be 0.96% of each pay period total. Benefit credits cannot be applied to the LTD premium you pay.

For further details on the Great-West Life LTD plan, refer to the policy booklet.

Optional AD&D Insurance

Optional accidental death and dismemberment (AD&D) insurance provides coverage in the event of accidental death or loss of a limb or sight. This coverage is totally employee-paid. You can purchase AD&D insurance for yourself only or for yourself and your eligible *dependents*. You can use *Benefits Credits* and/or after-tax payroll deductions to pay for this coverage.

Employee AD&D Coverage

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

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

Your coverage amount will be rounded up to the next higher $1,000, to a maximum of $1,500,000.

If you die as a result of an accident, your *beneficiary* receives the benefit amount you chose. You receive a portion of your full benefit if you lose a limb or your sight due to an accidental injury (provided the loss occurs 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	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 eligible loss as a result of one accident, the plan will pay a benefit for only one loss. The amount will be the highest payable of the losses you have suffered.

Dependent AD&D Coverage

You can also buy AD&D coverage for your family, including your *spouse* and your eligible dependent *children*. The amount of coverage you can buy for your eligible dependents will depend on the amount you select for yourself and on your family status, as shown in the table below.

If family status is	Dependent AD&D coverage is
Spouse only	60% of your AD&D coverage amount
Child (or children) only	20% of your AD&D coverage amount for each child
Spouse and child (or children)	Spouse: 50% of your AD&D coverage amount Each child: 15% of your AD&D coverage amount

For example, suppose you select optional AD&D coverage of $100,000 for yourself, and you have a spouse but no dependent children. Your spouse will have AD&D coverage of $60,000 ($100,000 x 60%). If a child is subsequently born, your spouse's coverage will reduce to $50,000 ($100,000 x 50%) and your child will be insured for $15,000 ($100,000 x 15%).

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

If both you and your spouse work for Nortel, you can enroll as an employee or as a dependent, but not both as an employee and a dependent. Only one of you can enroll your eligible children as dependents.

Optional AD&D Cost

The cost of optional AD&D insurance depends on whether you select employee only or family coverage. In 2011, the cost is:

- Employee only: $0.02 per $1,000 of coverage per month.
- Family: $0.032 per $1,000 of coverage per month (regardless of the number of eligible dependents you have).

Limitations and Exclusions

No AD&D 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.

Note that AD&D coverage is not in effect while traveling or working in certain countries. Please refer to the travel advisory information published by the Department of Foreign Affairs at **www.voyage.gc.ca** for a list of these countries before traveling.

Medical Benefits

Your *provincial health insurance plan* covers many basic health care expenses, including standard ward hospital accommodation, physicians' and specialists' services and diagnostic procedures.

Nortel's Health & Group Benefits Program offers four Company-subsidized medical options (Basic, Comprehensive, Plus and Select) designed to supplement your provincial health insurance.

You can select medical 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 choose to opt out of medical coverage if you (or, for Quebec residents, you and your family) have medical coverage from some other source, such as your spouse's employer. However, you need to complete a Medical Coverage Waiver form and return it to HR Shared Services by the date indicated on the waiver. Until you complete and return this waiver, you'll automatically be covered under the Basic medical option for you only (you and your family if you're a Quebec resident). If you're a Quebec resident, you also need to submit proof that you and your family have coverage elsewhere.

Health & Group Benefits Medical Options

This table summarizes your Health & Group Benefits medical options. To be eligible for reimbursement, expenses must be *medically necessary* for the treatment of disease or injury and prescribed by a physician (unless otherwise specified). Claims must be submitted within 18 months of the service date (within three months in the event of termination of employment or death).

Benefit	Basic	Comprehensive	Plus	Select
Percentage paid for covered services	80%	90%	95%	100%
Prescription drugs **• *Generic drugs***	Covered under all four options			
• *Brand-name drugs*	Covered only if there is no generic equivalent on the market.			
• *Drug formulary*	Basic, Comprehensive, and Plus options: New drugs are not covered under the plan unless approved by at least one provincial plan first			New drugs covered automatically, subject to plan provisions

Benefit	Basic	Comprehensive	Plus	Select
• ***Prior authorization***	Required for five categories of drugs, plus the drug Wellbutrin™			Required for two categories of drugs
Annual *deductible* for all eligible medical expenses (except drugs) **• Individual** **• Family**	None None	$40 $80	None None	None None
Per-prescription *copayment*	$8	$8	$8	$8
Dispensing fee maximum per prescribed drug	$7	$7	$7	$7
Annual *out-of-pocket maximum* (Once you've paid this maximum per year, the balance of prescription drug expenses will be paid at 100%)	$963 per person[1]	$963 per person[1]	$963 per person[1]	$963 per person[1]
***Hospital* coverage** **• Acute and convalescent care**	None	Semi-private room rate, up to $225 per day for acute and convalescent care, and up to 90 days per calendar year for convalescent care	Semi-private room rate for acute and convalescent care, and up to 90 days per calendar year for convalescent care	Semi-private room rate for acute and convalescent care, and up to 90 days per calendar year for convalescent care
Ambulance	Ground transportation and emergency air ambulance			
Professional services	One combined maximum of $300 for these professionals	Maximums per individual per year		
• Chiropractor[2]		$300	$500	$500
• Osteopath[4]		$300	$500	$500
• Chiropodist		$300	$500	$500
• Speech therapy		$300	$500	$500
• Naturopath		$300	$500	$500
• Massage therapy[3]		$300	$500	$500
• Podiatrist		$300	$500	$500

Benefit	Basic	Comprehensive	Plus	Select
• Acupuncture[4]		$300	$500	$500
• Dietician[3] *contract shows dietician covered under Basic*		$300	$500	$500
Psychologist	$300	$300	$500	$500
Physiotherapy	$300	$300	$500	$500
Private-duty nursing[3] • Maximum per calendar year	$10,000	$12,500	$15,000	$15,000
Out-of-province (within Canada) *emergency* medical expenses and travel assistance while traveling for personal reasons[5]	21 days maximum	31 days maximum	90 days maximum	90 days maximum
Overall maximum per person	$1,000,000 lifetime[1]			

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

[2] Under the Basic and Comprehensive options, chiropractic expenses are covered only after provincial health insurance plan coverage, where applicable, has been exhausted. Under the Plus and Select options, chiropractic coverage begins on the first visit, whether or not your provincial health insurance plan provides coverage.

[3] Requires a referral from a physician.

[4] Services must be performed by a licensed physician (MD) or a licensed acupuncturist approved by the provincial regulating body in your province. Currently, only British Columbia, Alberta and Quebec have provincially regulated acupuncturists. This may be extended to other provinces in the future. In Ontario, osteopathic treatments must be performed by practitioners who are regulated and certified by the College of Physicians and Surgeons of Ontario.

[5] 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.

Cost of Medical Options

Your cost for medical coverage depends on the option and *dependent coverage level* you select. For details, refer to the Health N-Site and online Enrollment Tool (or your Personalized Enrollment Worksheet).

Prescription Drugs

Prescription drug coverage is provided under all medical options. Eligible expenses are limited to:

- Drugs and medicines approved in Canada that are considered *medically necessary*, and
- *Life-sustaining drugs* that bear a Drug Identification Number (DIN), are sold only through prescription from a physician or dentist and relate to illness or injury.

Prescription drug costs are the fastest-growing component of health care expenses. To help manage rising drug costs, a number of provisions have been put in place:

All Medical Options Require Generic Drugs
All medical plan options require *generic drugs*. This requirement will apply even if your physician advises on the prescription that no substitutions are allowed. "Generic drugs" includes life-sustaining drugs; injectible drugs; compound prescriptions, regardless of their active ingredient; and needles, syringes and chemical diagnostic aids for the treatment of diabetes.

If no generic equivalent exists for your prescription, your medical plan option will pay the applicable percentage of the brand-name cost, subject to any required dispensing fee cap and copayment.

Why Generic Drugs?

- 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.

Drugs Must Appear on the Health & Group Benefits formulary (Basic, Comprehensive and Plus options)
Health & Group Benefits has a formulary (a list of covered drugs) that consists of all drugs covered under the program. A new drug is only added when 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 Health & Group Benefits provisions.

Sun Life Financial Drug Look-up Tool

The drug look-up tool accessible on the Sun Life Financial member web site gives you a fast and easy way to determine your Nortel drug coverage. Just go to www.sunlife.ca/member, login with your Sun Life Financial access ID and password, click on 'medical plan' *coverage* on the home page and then select the 'Drug Coverage' tab on Benefits Explorer.

Then type the drug name or Drug Identification Number (DIN) into the tool and you will instantly learn if you or your eligible dependents are covered for the drug, what percentage of the cost your Nortel plan will cover and whether there is a generic available.

$8 Copayment for Each Claim (all medical options)
For every prescription drug claim you have, you must pay the required copayment, over and above any other amount you may pay under a particular option. In 2011, the required copayment is $8 per prescription.

$7 Maximum Dispensing Fee (all medical options; not applicable in Quebec)
The amount the plan pays for dispensing fees is capped at $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.

Prescription Drug Reimbursement Example – Comprehensive Option
Marie fills a generic drug prescription. The drug cost is $50 and the dispensing fee is $10, for a total cost of $60. Marie is in the Comprehensive medical option, which pays 90% of the drug cost and a maximum dispensing fee of $7. Here is what Marie must pay, assuming she has satisfied the annual deductible:

• Dispensing fee ($10 – $7 dispensing fee cap)	$ 3.00
• Prescription drug copayment	$ 8.00
• Remaining payment ($60 – $3 – $8) x 10%	$ 4.90
• Marie's total cost	$15.90

Therefore, Marie pays $15.90 of the total $60 prescription cost and her Nortel medical plan pays the remaining $44.10.

Annual or Lifetime Maximums for Certain Drugs (all medical options)
The maximum amount payable for drugs covered under Health & Group Benefits depends on whether they are classified as Tier 1 or Tier 2 drugs:

- **Tier 1 drugs** 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** are certain therapeutic drugs that bear a DIN, are sold only through prescription, and do not relate to illness or injury. Generally, they are considered medically necessary for 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 for all plans.

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

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

Prior Authorization Required for Certain Drugs (all medical options)
Health & Group Benefits requires *prior authorization* (pre-approval) for certain drugs listed under five categories of prescription drugs, plus the drug Wellbutrin™, for the Basic, Comprehensive and Plus medical options, and under two drug categories for the Select option.

Prior authorization helps ensure that certain prescribed drugs are the best choice (in terms of effectiveness and cost) for the condition being treated. It also ensures that drugs that provide a dual purpose are being adjudicated in accordance with Health & Group Benefits medical plan provisions.

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 in place in provincial formularies. A group of pharmacists at Emergis (our pharmacy benefit manager) uses the provincial guidelines to determine the protocols and assessment criteria for approving a drug that requires prior authorization.

If you're 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.

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. For information about how to submit a claim for any drug that requires prior authorization, see “How Prior Authorization Works” on page 70.

The following categories of drugs currently require prior authorization. Other drugs within each category may be added as they become available on the market and are identified as drugs that require prior authorization according to provincial guidelines.

Basic, Comprehensive and Plus Options:

- Anti-inflammatory therapy:
  - Celebrex™ (celecoxib)
  - This drug act as Cox-II inhibitors (a 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.
- Ulcer or heartburn therapy:
  - 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.
- Migraine headache therapy:
  - Amerge™ (Naratriptan), Axert™ (almotriptan malate), Frova™ (frovatriptan succinate), Imitrex™ (Sumatriptan), Maxalt™ (Rizatriptan), Relpax™ (eletriptan hydrobromide), and Zomig™ (Zolmitriptan),
  - Prior authorization will assist in determining effective use of medication based on provincial guidelines to manage migraine-related conditions.
- Wellbutrin™ (Bupropion), is considered an .anti-depressant with no maximum limit and cannot be prescribed as a smoking cessation drug.

Basic, Comprehensive, Plus and Select Options:

- Erectile dysfunction medication:
  - Viagra™ (Sildenafil), Cialis™ (Tadalafil), Levitra™ (Vardenafil).

- Anti-obesity medication:
  - Xenical™ (XEE-0402), Meridia™ (Sibutramine), Ionamin™ (Phentermine), Sanorex™ (Mazindol), Tenuate™ (Diethylpropion)

↳ **Note to Quebec residents: If you’re covered by the Régie de l'assurance-maladie du Québec (RAMQ), any drug on the RAMQ formulary must be reimbursed up to 68%. Therefore, for RAMQ drugs, prior authorization is only required for the difference between 68% of the cost and the reimbursement level for your medical option.**

Out-of-Pocket Maximum (all medical options)
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 $963. 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 percentage of each prescription drug expense (20% for Basic coverage, 10% for Comprehensive coverage, 5% for Plus coverage) you are required to pay, up to certain maximums for *Tier 2 drugs.*

Pay-Direct Drug Card

No matter which medical coverage option you select, you enjoy the convenience of a pay-direct drug card (provided by 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 applicable reimbursement level and dispensing fee maximum. You'll have to pay your portion of each drug claim, your copayment, 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 cost if you choose to buy the *brand-name drug* (unless no generic equivalent exists).

Your drug card also offers an important health feature. Whenever you use your drug card, the 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.

Semi-Private Hospital

Semi-private hospital accommodation is covered under the **Comprehensive, Plus**, and **Select** medical options only.

Under each option, a “hospital" is defined as 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.

The **Comprehensive** option covers up to $225 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.

The **Plus** option covers 95% and the **Select** option covers 100% of 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.

Did you know: Some 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 Health & Group Benefits 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 Health & Group Benefits. 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 when you requested ward accommodation or didn't authorize semi-private or private accommodation but were placed in semi-private or private rooms anyway,
• Days when semi-private or private accommodation is charged for an infant who is in the same room with the mother, or
• Days when 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).

Ambulance Services

Eligible expenses for all medical options include:

- 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 physical condition or that of your eligible dependents prevents the use of another means of transportation.
- Services and return airfare for a registered nurse if the patient requires the services of a registered nurse during the flight.

Professional Services

All medical options cover the services of a licensed chiropractor, chiropodist, massage therapist, naturopath, osteopath, podiatrist, speech therapist, dietician, and acupuncture performed by a licensed physician or licensed acupuncturist approved by the provincial regulator in your province. Currently, only British Columbia, Alberta and Quebec have provincially regulated acupuncturists. This may be extended to other provinces in the future. All professional services must be *medically necessary* and a physician's written recommendation is required for massage therapy, speech therapy and dietician services. The annual maximum applies to each professional service, 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.

The **Basic** option covers up to $300 per person per year for all these professional services combined. You may submit claims for expenses after you have reached the yearly maximum benefit under your provincial plan. Health & Group Benefits 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, Health & Group Benefits coverage begins for future visits.

The **Comprehensive** option covers up to $300 per person per year for each type of practitioner. Health & Group Benefits will only reimburse you for services rendered after your provincial plan's yearly maximum has been reached.

The **Plus** and **Select** options cover up to $500 per person per year for each type of 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. Health & Group Benefits will only reimburse you for services rendered after your provincial plan's yearly maximum has been reached.

Psychologist Services

All medical options cover the services of a licensed, certified or registered psychologist when medically necessary. Original receipts are required with all claim submissions.

The **Basic** and **Comprehensive** options cover up to $300 per person per year.

The **Plus** and **Select** options cover up to $500 per person per year.

Did you know: You may access psychologist services under the professional services coverage as well as under your Employee Assistance Program. The EAP offers short-term professional counseling through their network of professional counselors 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. Shepell-fgi, the EAP provider, will arrange for an appointment with a counselor nearest to your home or office. Shepell-fgi will maintain your confidentiality.

Physiotherapy Services

All medical options cover the services of a licensed, certified or registered physiotherapist when medically necessary. In addition to the annual maximum under each medical option, a catastrophic provision is available.

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 approval by the *plan administrator*, Sun Life Financial. Any approved additional expenses will be reimbursed at 80%.

The **Basic** and **Comprehensive** options cover up to $300 per person per year.

The **Plus** and **Select** options cover up to $500 per person per year.

Private-Duty Nursing

All medical options cover in-home private-duty nursing 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, so you can obtain immediate assistance on what your Nortel medical plan covers, what the provincial plan covers and what your spouse's plan covers – and 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.

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.

Supplies and Equipment

Rental, or purchase at Sun Life's option, of medically necessary durable equipment that meets the patient's basic medical needs and is approved by Sun Life. If alternate durable equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets the patient's basic medical needs. Eligible durable equipment includes, but is not limited to, items such as:

- Rental or, if deemed appropriate, purchase or repair of a wheelchair, walker, or hospital bed. Electric wheelchairs are covered at the reimbursement level of each medical option (80%, 90%, 95% 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).
- Custom-made 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.
- Insulin pumps, limited to one every 60 months.

- Intrauterine devices (IUD) and contraceptive patches (maximum $300 per calendar year).
- Mastectomy bras (maximum two bras or $300 per calendar year).
- Wigs and hairpieces - $300 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).
- Prostate-specific antigen (PSA) tests for prostate cancer.
- Contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum of one lens per eye.

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 Health & Group Benefits until the provincial plan has reimbursed for services covered under its plan.

Take note of the reasonable and customary provision. The plan will only pay for *medically necessary* expenses. Make sure you ask questions to determine which device or equipment is the most effective choice. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that will meet basic medical needs.

If you're unsure about coverage, call Sun Life Financial and inquire about the reasonable and customary cost before you make a purchase.

Dental Surgery Due to an Accident

All medical options cover charges for dental services required as a direct result of accidental injuries to natural teeth when such treatment is rendered and completed within 12 months of the accident. This excludes services required for a fracture or injury that results from a condition that existed before the accident.

Out-of-Province (Within Canada) Emergencies

All medical options include 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 or economy air fare for return to home province, 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.

Under the emergency medical travel assistance benefit, upfront 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.

Payment will not 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.

The Travel Well benefit (not part of Health & Group Benefits) covers Nortel employees for out-of-country medical emergencies and travel assistance while on Company business. For more information, please contact Travel Well at ESN 333-2710 or 215-701-2933 or **http://travelwell.ca.nortel.com.**

Limitations and Exclusions

No benefit is currently payable under any of the medical options for:

- Contraceptives, other than oral, patch, and/or IUD,
- 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,
- Any portion of expenses for which reimbursement is provided under a government plan,
- 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,
- Out-of-province expenses for elective (non-emergency) medical treatment or surgery,
- Expenses for the services of a homemaker,
- Expenses that are purchased 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,
- Expenses for the treatment of Temporomandibular Joint Syndrome (TMJ),
- Expenses for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit,
- Expenses for services or supplies that are not approved by Health Canada or other government regulatory body for the general public,
- Expenses for services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards,
- Expenses for services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).

Dental/Vision/Hearing Care Benefits

Overview

Nortel's Health & Group Benefits Program offers three Company-subsidized dental/vision/hearing care options (Basic, Comprehensive and Plus). You can select any option you wish, regardless of which medical option you choose. However, dental, vision, and hearing care are bundled together as a package, so you can't select dental coverage alone, vision coverage alone, or hearing care coverage alone.

You can select this 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 choose to opt out of dental/vision/hearing care coverage if you wish.

Dental/Vision/Hearing Care Options

This table summarizes the current dental/vision/hearing care options. Note that eligible expenses are covered only up to reasonable and customary levels and dental coverage is based on the prior year's fee guide for general dental practitioners. Claims must be submitted within 18 months of the service date to be eligible for payment (within three months in the event of termination of employment or death).

Benefit	Basic	Comprehensive	Plus
Dental Care Coverage			
Deductible	None	None	None
Coverage for preventive services (such as exams and cleanings and fluoride treatments for dependent children under age 19)	100%	100%	100%
Coverage for restorative services (such as fillings and extractions)	80%	80%	90%
Coverage for oral surgery	Varies depending on type of service (see detailed listing of dental services)		
Coverage for endodontics (treatment of roots) and periodontics (treatment of gums, including periodontal surgery)	80%	80%	90%

Benefit	Basic	Comprehensive	Plus
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 (excluding orthodontia)	$1,000	$2,000	$2,500
Lifetime maximum per person for orthodontia	N/A	$2,000	$3,000
Dental fee guide (general practitioners)	Prior year	Prior year	Prior year
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

Cost of Dental/Vision/Hearing Care Options

Your cost for dental/vision/hearing care coverage depends on the option and *dependent coverage level* you select. For details, refer to the Health N-Site and online Enrollment Tool (or your Personalized Enrollment Worksheet).

Dental Services

Preventive Services

Preventive (basic) services are procedures intended to assist the dentist in evaluating existing conditions and to eliminate or reduce the need for future dental treatment. Covered services include:

- Routine oral examination and diagnosis – complete oral examinations (once every 60 months), recall oral exams (once every six months), special oral examinations, treatment planning, minor emergency treatment, consultation, house calls, institutional calls and office visits.
- Test and laboratory examinations – biopsy of oral tissue, pulp vitality tests.
- Radiographs (x-rays) – occlusal, bitewing (once every 12 months); extra oral, sialography, radiopaque dyes to demonstrate lesions, temporomandibular films, panoramic (once every 36 months); periapical (complete series once every 5 years); interpretation of radiographs received from another source; tomography.
- Limited/recall examinations once every six months, dental polishing plus two units of scaling once every six months and topical application of fluoride (for dependent children under age 19) once every six months (1 unit of scaling = 15 minutes of treatment time).
- Pit and fissure sealants for dependent children under age 19.
- Space maintainers for missing primary teeth and certain habit-breaking appliances.
- Oral hygiene instruction once per lifetime.
- Appliances to control oral habits.
- In-office laboratory procedures.

Restorative Services

Restorative services are basic procedures intended to restore natural teeth to their normal function. Covered services include:

- Restorations – amalgam, acrylic or composite resin, transitional restoration of fractured anterior, steel crown-primary teeth, prefabricated metal restorations-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 (general anesthesia and deep sedation is covered with all services for dependent children under age 19).
- Repairs and adjustments-porcelain repairs, recementing crowns, denture repairs, bridge repairs, denture relining and rebasing.
- In-office laboratory procedures.

Periodontic Services
Periodontic services are procedures intended to diagnose and treat disease of the gums, tissues and bones supporting the teeth. Covered services include:

- Periodontics (excluding periodontic appliances) – non-surgical services, surgical services, post-surgical treatment, occlusal equilibration (not exceeding six units in a calendar year), scaling and root planing **(**not exceeding 10 units per calendar year – four units of routine scaling and six units of additional scaling).
- Surgical services, surgical excision.
- Anesthesia in conjunction with oral surgery – general anesthesia, deep sedation; conscious sedation (general anesthesia and deep sedation is covered with all services for dependent children under age 19).
- In-office laboratory procedures.

Endodontic Services
Endodontic services are procedures intended to diagnose and treat root canals and pulp. Covered services include:

- 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 (general anesthesia and deep sedation is covered with all services for dependent children under age 19).
- In-office laboratory procedures.

Major Restorative Services
Covered major restorative services include:

- Dentures – complete and partial dentures, addition and adjustments to dentures. (Dentures must be at least three years old to be replaced).
- Bridges – examinations (oral examination, diagnostic casts), fixed bridgework (bridge pontics, retainers, other prosthetic services), anesthesia in conjunction with oral surgery, in-office laboratory procedures. (Fixed bridges must be at least five years old to be replaced).
- 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/onlay restorations; porcelain inlay/onlay restorations; porcelain/ceramic inlay/onlay 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 dependent children under age 19).
- In-office laboratory procedures.
- Antibiotic drug injections (when prescribed by a dentist).

Orthodontic Services
Orthodontic services include treatment and supplies required to correct an improper bite (excluding treatment of Temporomandibular Joint Syndrome) for eligible employees and dependents. Covered services include:

- 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 and adjustment, repairs and alterations, active appliances for tooth guidance of uncomplicated tooth movement; retention appliances.
- Comprehensive treatment.
- Consious sedation, as required
- General anesthesia and deep sedation are covered with all services for dependent children under age 19 and with oral surgery for other patients.
- In-office laboratory procedures.

Limitations and Exclusions
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.

No benefit is payable for:

- Expenses for cosmetic services,
- 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,
- Expenses for permanent splinting,
- Expenses for the treatment of Temporomandibular Joint Syndrome (TMJ),
- Expenses for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit.

Payment of Dental Services

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 previous year's fee guide.

Note to Alberta Residents: As the Alberta Dental Association has not published a fee guide since 1997, *reasonable and customary* reimbursement levels are determined by applying an annual inflation factor to the 1997 fee guide.

Vision Care

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 the "Dental/Vision/Hearing Care options" table on page 42.

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 Examinations
Coverage is available for eye examinations by an ophthalmologist or optometrist, to the extent not covered by your provincial plan.

Did you know: 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. For details, call PVS at 1-800-668-6444.

- **Some provinces have changed coverage for eye exams to once every two years or eliminated coverage altogether, as is the case in Ontario. Your optional dental/vision/hearing care coverage will cover eye exams once per calendar year, if coverage for an eye exam is not available under your provincial plan in that calendar year.**

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 Benefits Credits to the *Health Care Reimbursement Account (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.

Hearing Care

The purchase and repair of hearing aids are currently covered, excluding batteries, to the maximum eligible expense outlined in the "Dental/Vision/Hearing Care options" table on page 43.

Health Care Reimbursement Account

Overview

The Health Care Reimbursement Account (HCRA) can help you save on taxes. With this 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.

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

Once you've selected your optional coverage under Nortel Health & Group Benefits, you may have some *Benefits 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 Benefits 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. The *Canada Revenue Agency (CRA)* doesn't permit you to contribute your own money toward an HCRA.

You may allocate unused Benefits 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. If you don't advise where to direct any unused Benefits Credits during the annual enrollment period or when you make a s*tatus change*, and you are not currently enrolled in the HCRA, your credits will automatically be allocated as taxable pay.

Unique Features of an HCRA

- You can use your Benefits Credits on a before-tax basis, which increases the purchasing power of these Benefits Credits (to a lesser degree in Quebec). See "Tax Considerations" on page 76 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 Health & Group Benefits.
- 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 Health & Group Benefits.

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

How Does the Before-Tax Feature Help Me?
Assume you have unused *Benefits Credits* of $150. If you choose to receive these Benefits 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 Benefits Credits. You make your Benefits Credits go further through improved tax effectiveness.

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

Special Rules

Use It or Lose It
The *Canada Revenue Agency (CRA)* will allow Benefits Credits to be treated on a before-tax basis only if this benefit is deemed to be 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 Benefits Credits and/or medical expenses. CRA allows a plan to either carry forward Benefits Credits or carry forward expenses. The Nortel plan operates on a carry forward expense basis.

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

For eligible expenses incurred between January 1 and December 31 of the Nortel Health & Group Benefits plan year, you have until March 31 of the following year to submit claims for reimbursement from your HCRA allocation. You'll forfeit any Benefits Credits allotted for a given year that remain in the HCRA after March 31 of the following year.

Canada Revenue Agency doesn't permit cash-out of unused amounts.

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.

Carry Forward Eligible Expenses for One Year
If you have more eligible expenses in a given year than Benefits Credits allocated to your account for that year, you may carry forward into the next year expenses for which you weren't reimbursed. You may be reimbursed for these expenses from Benefits Credits you allocate to your HCRA for the following year. This way, you can determine how much of any unused Benefits Credits to allocate to your HCRA to cover unpaid health expenses from the previous year.

An example of carry-forward expenses for one year:

Year One	
Eligible HCRA expenses:	$150
Minus	
Benefits Credit allocation	$125
Equals	
Unreimbursed expenses	$25
Year Two	
Unreimbursed eligible expenses from Year One:	$25
Plus	
Potential eligible expenses in Year Two:	$100
Equals	
Potential Benefits Credit allocation:	$125

Eligible Expenses

You can use the HCRA to reimburse yourself for expenses that are listed as "eligible" under the Income Tax Act. Eligible expenses include deductibles and copayments. The Canada Revenue Agency does not allow reimbursement for some types of expenses, for example, health club memberships, humidifiers and hot tubs. Visit the CRA Web site at **www.cra-arc.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.

Tax Considerations

If you're 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.

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.

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

Life Insurance

Your life insurance helps protect your family's finances if you die. You automatically receive core coverage equal to 1 X your annual *Benefits Earnings*, fully paid for by Nortel.

You can supplement your core coverage by purchasing optional life insurance with *after-tax payroll deductions*. You can purchase optional coverage for yourself, your *spouse* and your eligible dependent *children*.

Core Life Insurance

Core coverage provides your *beneficiary* with a benefit amount equal to 1 X your annual Benefits Earnings up to a maximum of $750,000, rounded to the next $1,000, if you die while you're covered. For example, if your annual Benefits Earnings are $60,300, your core coverage is $61,000. Note that evidence of insurability is required for life insurance coverage in excess of $600,000.

In 2011, the monthly rate for core life insurance is $0.183 per $1,000 of coverage. Nortel currently pays the premium for core employee life insurance, and you pay the taxable benefit, which is based on the rate and the amount of your coverage.

If you're an active employee on January 1 following the year you turn 65, your core coverage will be reduced by 50%.

If you leave Nortel, there is an option to convert your coverage to an individual policy within 31 days of your termination date. See Conversion Option on page 58 for details.

Optional Employee Life Insurance

If you think you need more life insurance than your core coverage provides, you can buy additional coverage. Optional life insurance is available in the following multiples of your annual Benefits Earnings:

- 1 X Benefits Earnings,
- 2 X Benefits Earnings,
- 3 X Benefits Earnings,

The maximum amount of your optional life insurance is $500,000 effective January 1, 2011.

Determining Your Coverage Amount
Your core life coverage is 1 X your *Benefits Earnings*, rounded to the next higher $1,000. To determine your optional employee life insurance coverage amount, first multiply your Benefits 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 annual Benefits Earnings of $60,300:

Multiple	Benefit	Coverage Amount
1 X Benefits Earnings =	$60,300	$61,000
2 X Benefits Earnings =	$120,600	$121,000
3 X Benefits Earnings =	$180,900	$181,000

Optional life insurance ends at retirement or on your 65th birthday – whichever comes first. There is an option to convert your coverage to an individual policy within 31 days of your last date of employment or your retirement date. The maximum amount you can convert for each of core and optional life insurance is the lesser of your coverage at the time you leave Nortel or $200,000.

Optional Dependent Life Insurance

Coverage for Your Spouse
You can buy life insurance coverage for your *spouse* in the following amounts:

- $ 10,000
- $ 25,000
- $ 50,000
- $100,000
- $150,000
- $200,000
- $250,000
- $300,000
- $350,000
- $400,000
- $450,000
- $500,000

Spousal coverage in excess of $50,000 requires *evidence of insurability (EOI).*

If both you and your *spouse* work for Nortel, 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.

Coverage for Your Dependent Children
You can buy life insurance coverage for your *dependent children* in the following amounts:

- $ 5,000
- $10,000
- $15,000
- $20,000
- $25,000

Optional Life Insurance Costs

Employee and Spouse
Optional life insurance rates for you and your spouse are based on gender, age and "smoker status." (see next page) You and/or your spouse are eligible for the "non-smoker" rate if you and/or your spouse haven't smoked or used a tobacco product in the previous 12 consecutive months.

Nortel does not require proof of your non-smoking status, but if you 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. 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. Notify HR Shared Services immediately if you and/or your spouse change from non-smoker to smoker status anytime during the year.

The Employee Self-service (ESS) Benefits Enrollment Tool will show you what it will cost you to buy optional life insurance for you and your *spouse*. If you don't have intranet access, you can calculate the cost by using this table. Each rate shown is the cost for $1,000 of coverage.

Employee/ Spouse's Age	Smoker				Non-Smoker			
	Male Monthly	Male Bi-Weekly	Female Monthly	Female Bi-Weekly	Male Monthly	Male Bi-Weekly	Female Monthly	Female Bi-Weekly
Under 25	$0.1020	$0.0471	$0.0420	$0.0194	$0.0510	$0.0235	$0.0210	$0.0097
25-29	$0.0980	$0.0452	$0.0510	$0.0235	$0.0500	$0.0231	$0.0260	$0.0120
30-34	$0.0980	$0.0452	$0.0730	$0.0337	$0.0500	$0.0231	$0.0370	$0.0171
35-39	$0.1140	$0.0526	$0.1070	$0.0494	$0.0570	$0.0263	$0.0540	$0.0249
40-44	$0.1780	$0.0822	$0.1620	$0.0748	$0.0900	$0.0415	$0.0820	$0.0378
45-49	$0.2880	$0.1329	$0.2570	$0.1186	$0.1450	$0.0669	$0.1290	$0.0595
50-54	$0.4910	$0.2266	$0.4050	$0.1869	$0.2470	$0.1140	$0.2040	$0.0941
55-59	$0.8020	$0.3701	$0.6160	$0.2843	$0.4040	$0.1865	$0.3100	$0.1431
60-65	$1.10	$0.5077	$0.7850	$0.3623	$0.5540	$0.2557	$0.3960	$0.1828

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.

$0.0263 (from the table) X ($100,000 ÷ $1,000) = $2.63 every two weeks

Dependent children

In 2011, your cost to cover all your eligible dependent children is $0.475 per $5,000 of coverage. For example, if you choose $25,000 of coverage, your cost is:

$0.475 X ($25,000 ÷ $5,000) = $2.38 per month

$2.38 X (12 ÷ 26) = $1.10 per pay (based on 26 pay periods)

Evidence of Insurability

When you're 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.

- **EOI is not 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 dependent 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 will be required to submit EOI if you want to increase the amount of your current optional employee life insurance.

You will be required to submit EOI for your spouse if you did not select optional spousal life insurance 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 must download the Statement of Health form from the Health N-Site and send it to Sun Life Financial, along with your Confirmation Statement (which you print yourself). If you don't 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.

Note: Evidence of insurability is also required for basic life insurance coverage in excess of $600,000.

If You're a New Hire
You will be required to provide EOI and 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 Benefits Earnings.

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 you make your status change selections.

Naming Your Beneficiary

Your core and optional employee life insurance coverage is payable to one or more designated beneficiaries. Unless you indicate otherwise, the Company will assume that you intend the same *beneficiary* or beneficiaries to be designated for your core and optional life 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 the Health N-Site.

There are two kinds of beneficiary designations:

- **A revocable** designation means you can change whom you designate as a beneficiary at any time without authorization from your designated beneficiary.
- **An irrevocable** designation means you're giving authority to your designated beneficiary. You cannot change your beneficiary designation on your own – you must have agreement and signed consent from your designated beneficiary to make a change.

If you do not 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 Nortel Health & Group Benefits.

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.

Conversion Option

If you leave the Company or experience a reduction in your coverage due to the 2011 changes, you have the right to convert your current core and/or optional employee life insurance coverage to an individual policy through Sun Life Financial without being required to submit *evidence of insurability (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 or experience a reduction in coverage. 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.

If you leave the Company, you should 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 Health & Group Benefits. To obtain additional information about conversion or purchasing additional coverage, contact Sun Life Financial at 1-877-893-9893 or to request a conversion form contact HRSS at 1-800-676-4636.

You may also convert your optional dependent life insurance coverage for your *spouse* to an individual policy through Sun Life Financial 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 will 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 dependent children.

Limitations and Exclusions

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.

There are no exclusions relating to acts of war or terrorism for core life insurance coverage or for optional employee or dependent life insurance coverage.

Employee Assistance Program

You and your eligible dependents automatically receive access to the Employee Assistance Program (EAP/WorkLife Services) — at no cost to you. You do not have to enroll to have this benefit.

EAP counselling and worklife services are provided by Shepell-fgi. Services include expert counselling and access to research and referral for child/elder care, legal/financial assistance, education, and lots more.

Online information resources such as educational information, helpful Web links, assessment tools, online requests for services and much more are available. If you would like more information on EAP counseling or other EAP work/life services, visit www.fgiworldmembers.com. When you reach the site, you will need to enter the user name (nortel) and password (networks). Alternatively, you can call Shepell-fgi at 1-888-859-5263 (English) or 1-888-859-5256 (French).

What Happens If

What Happens if – You Have a Status Change

During the Plan Year
You may change your benefit selections between *annual enrollment periods* if you experience a status change. It's your responsibility to notify HR Shared 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 when you can change your Nortel Health & Group Benefits 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.

If you have a status change, you must ensure all eligible dependents you want covered under Health & Group Benefits are listed on the Employee Self-Service (ESS) Benefits Enrollment Tool.
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.

Here are the status change procedures:

- Contact HR Shared 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 Nortel Health & Group Benefits.
- If you don't have access to the intranet, HR Shared 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 Employee Self-Service (ESS) Benefits Enrollment Tool on the home page of the external 2011 Nortel Health & Group Benefits Site 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.

Remember to choose a *beneficiary* for your life insurance. It's important to determine who will receive your insurance 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. Also, any life insurance requiring *evidence of insurability (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.

If you have a *Health Care Reimbursement Account (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.

Between Annual Enrollment and January 1
If you need to change your Nortel Health & Group Benefits selections due to a status change that occurs after you've made your annual enrollment selections but before January 1, you'll need to contact HR Shared Services and advise them of the status change.

You'll also need to re-enroll. An HR Shared Services representative will initiate the online process and provide you with instructions on how to re-enroll for the coming year. HR Shared Services will send you an e-mail (if you have intranet access) or a letter (if you don't have intranet access) further explaining this special enrollment process.

What Happens if – Your Salary Changes

If your salary changes during the year, any payroll deductions, *Benefits Credits* or costs for optional coverage won't change. However, salary changes during the year do affect the amount for which you're covered under life insurance and short-term disability benefits, which will be calculated and paid out based on your *Benefits Earnings* at the time of the event.

Benefits Earnings are generally your base salary from Nortel. If you're eligible for sales incentives, your Benefits Earnings include your base salary and targeted incentives as defined each year by the Company.

For purposes of determining *Benefits Credits* and premiums for earnings-related benefits, the calculation for 2011 will be based on *Benefits Earnings* as of January 1, 2011. If your Benefits Earnings change between the time you enroll and January 1, 2011, your Benefits Credits will be adjusted accordingly. If you were hired after January 1, 2011, your Benefits Earnings will be based on your salary as of your hire date. Your premiums for long-term disability coverage are calculated based on your monthly earnings as of the LTD policy effective date of August 1, 2010.

If you're a part-time employee, Company-provided Benefits 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 Benefits Earnings based on a 25-hour workweek.

What Happens if – You Become Disabled

When on Short-Term Disability
Your Benefits Credits and applicable employee contributions through payroll deductions will continue.

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

AD&D Benefits: Your current optional employee and/or dependent AD&D insurance coverage continues.

Medical and Dental/Vision/Hearing Care: 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 any current optional employee and dependent life insurance coverage continue.

While on STD, you can't make changes to your current AD&D insurance and life insurance selections during the *annual enrollment period* or if you have a *status change*.

If you make new selections during the annual enrollment period, but are on STD on January 1 when the benefit year begins, you will not receive the AD&D insurance and life insurance coverage you selected until you return to work for 60 consecutive days. You must notify HR Shared 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 during the annual enrollment period 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.

When on Long-Term Disability
Your contributions toward any optional AD&D insurance and life insurance coverage will be waived.

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

AD&D Benefits: Your current optional employee and/or dependent AD&D coverage continue.

Medical and Dental/Vision/Hearing Care: While you're on LTD, you'll automatically receive Comprehensive coverage for medical and dental/vision/hearing care at no cost to you – even if you were enrolled in the Basic option or 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 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. If you're in the Basic or Comprehensive options when you go on LTD, you can't upgrade to the Plus or Select options.

Life Insurance: Your current optional employee and/or dependent life insurance coverage continues.

While on LTD, you will not be eligible to make any changes to any of your current coverage selections during the *annual enrollment period* or if you have a *status change*, until you return to work for a period of 60 consecutive days. You must notify HR Shared 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 during the annual enrollment period, 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 HR Shared 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.

What Happens if – You're On Leave

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 will accrue 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 will accrue 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.

When on a Leave of Absence

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.

For more information on what happens to your benefits while on STD or LTD, see "If You Become Disabled" on page 63.

What Happens if – You Leave Nortel

STD/LTD: Eligibility for 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.ca/member**.

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 through Sun Life Financial 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 through Sun Life Financial 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 dependent children.

What Happens if – You Retire

STD/LTD: Your 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 coverage under the Nortel Health & Group Benefits Program ends on the last day of the month in which you retire. You may have access to health care coverage at your own cost through Sun Life Financial.

Life Insurance: Your coverage under the Nortel Health & Group Benefits Program ends on your last day of employment (although you will have 31 days to convert your coverage to an individual policy through Sun Life Financial without having to provide evidence of insurability).

What Happens if – You Die

Medical and Dental/Vision/Hearing Care: Your coverage under the Nortel Health & Group Benefits Program ends on the last day of the month in which you die. Your eligible dependents may have access to health coverage at their own cost through Sun Life Financial.

Making Claims

Online Access

Through the Sun Life Financial Plan Member Services Web site at **www.sunlife.ca/member**, you may:

- Submit vision, certain dental and Health Care Reimbursement Account claims electronically,
- View information about your most recent claim payments, next dental recall exam date, available vision care benefit, and HCRA balance using the Quick View screen,
- Register for direct deposit of claims payments into your bank account,
- Sign up to receive an email notice that your claim has been processed and that your Explanation of Benefits (EOB) is available online,
- Obtain personalized claim forms,
- Check the status of your recently submitted claims,
- View your claims history to help you make annual enrollment decisions and print a copy, if necessary, to submit with your tax return, and
- 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.

Submitting Claims

If you are an active employee, you have 18 months to submit a claim to Sun Life Financial for eligible medical and dental/vision/hearing care expenses. In the event of your termination of employment or death, claims must be submitted within **three** months of the event. **Claims that are submitted after the deadline submission date will not be paid. Please ensure you adhere to the deadlines to avoid disappointment.** (See Health Care Reimbursement Account claims on page 73 for claims procedures pertaining to the HCRA).

Sun Life Financial will process your claims and pay any eligible amounts to you as the primary covered individual. You will also receive an Explanation of Benefits, explaining the amounts paid, and for use in coordinating benefits with a spouse's plan.

You may submit claims electronically for the following categories of eligible expenses:

- Prescription drug expenses – Where possible, use your pay direct drug card at the pharmacy for claims adjudication at the point of purchase. Your out-of-pocket expense is only that portion of the cost not covered by your medical plan option. The pay direct drug card cannot be used in the following circumstances:
    - If your prescription is not considered an eligible expense.
    - If your initial prescription requires prior authorization. If approved through the prior authorization process, you can use your card for subsequent prescriptions
    - If you are utilizing coordination of benefits with your spouse's plan and your spouse does not have a pay direct drug card.
- Dental expenses – Your dental office may be able to submit your dental claim electronically to Sun Life Financial.
- Vision, Dental and HCRA expenses – You can use the Sun Life Financial e-claims feature to submit your claims online. Note that you must be registered for Direct Deposit and Electronic Explanation of Benefits notification in order to use e-claims. Just follow these steps:
    - Go to the Sun Life Financial Member Services Web site at **www.sunlife.ca/member** and enter your Access ID and password to access the Web site.
    - Select the Submit a Claim feature and follow the online instructions.
    - Depending on the nature of your claim, you may need to submit a paper claim – refer to the limitations by benefit posted on the site.
    - Your claim reimbursement will be deposited directly into your bank account within 48 hours after your claim is processed.
    - Retain your original receipts for 12 months following online submission in the event that your claim is audited. If your claim is audited, you will need to submit your receipts to Sun Life Financial for review. Note that you should retain HCRA receipts for 7 years for income tax purposes.

For other eligible expenses, you must submit a paper claim to Sun Life Financial for reimbursement. Just follow these procedures for paper claims submission:

- 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. You can also print a non-personalized claim form from the external 2011 Nortel Health & Group Benefits Site and on Services@Work. For employee and dependent life insurance claims and AD&D insurance claims, please contact HR Shared Services

- Submit the completed claim form, along with original bills or receipts. You'll be required to indicate the Nortel Benefit Plan Policy Number (#150060) and your member number (your Global ID) on the claim form. **Always keep a copy of your original receipts and your submitted claim forms for your records.**

- Where you send the completed 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.
    - Non-drug related medical claims, dental/vision/hearing care claims, and HCRA claims – Send paper claims to Sun Life Financial. The address is on the claim form.

How Prior Authorization Works

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

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. You will then have to return to your doctor to get the prior authorization form completed, which will delay the approval process. **Note that Nortel Health & Group Benefits does not cover fees charged by your doctor for the completion of forms.**

If you complete the prior authorization process and 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 – from the Health N-Site. 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 update the folder on the Health N-Site that details the current drugs requiring prior authorization. This folder lists the new drugs that have been added since the previous update. Prior authorization forms are 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 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 Benefits 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're 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.
- 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, Richard will not be reimbursed from Health & Group Benefits
        - If Wellbutrin™ is prescribed to treat depression, there is currently 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.

Health Care Reimbursement Account Claims

You must submit claims under your HCRA for any expenses incurred during the plan year no later than March 31 of the following year to be reimbursed by the plan. 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.

In order to submit an HCRA claim, please either access the e-claims feature on the Sun Life Financial Plan Member Services Web site or follow these procedures for paper claims submission:

- Check your HCRA balance by going to Sun Life Financial's Plan Member Services Web site or refer to your last Explanation of Benefits.
- Obtain a claim form with your personal information pre-entered (Medical/HCRA Claim Form or Dental/HCRA Claim Form) from the Sun Life Financial Web site or a non-personalized form from the Health N-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 global ID, and tick off the "HCRA" box.
- Attach your original receipts or Explanation of Benefits Statement showing any portion of an eligible expense for which you haven't been reimbursed.

Any expense listed under the Income Tax Act (Canada) is eligible for reimbursement. Visit the *Canada Revenue Agency* Web site at **www.cra-arc.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.

If you have an HCRA and you record a status change such that you'll be selecting the HCRA again, you have 31 days to submit claims against your existing HCRA balance.

Coordination of Benefits

Your Health & Group Benefits 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, the coordination of benefits provision allows you to claim eligible expenses under both plans to maximize the payment you could receive for your eligible expenses.

Which Plan Pays First
Claims for You and Your Spouse

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's 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.

While most 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.

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.

Short-Term Disability (STD) Claims

To submit a claim for STD benefits, you or your manager needs to complete the STD notification form located at: **https://secure.fgiworld.com/login.asp** (login and password are both nortel) or call the toll free number (1-888-522-7368). More information on the STD claims process can be found on the Health N-Site. Once Shepell-fgi receives your form, they will contact you within 48 hours and send you the appropriate paperwork to complete to help adjudicate your claim.

Long-Term Disability (LTD) Claims

To apply for LTD benefits, you must first be approaching the maximum duration on STD (26 weeks). Shepell-fgi will work with Great-West Life to begin the transfer of your file from STD for consideration of LTD benefits. HR Shared Services will send you an LTD application package and you will be required to read, complete, sign and return a copy of the LTD Plan Member Statement.

Life and AD&D Insurance Claims

Please contact HR Shared Services. The information required depends on the nature of your claim.

Claims 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 Medical and Dental/vision/hearing care claims, the review process begins with the *plan administrator* (Sun Life Financial). If you require further review upon completion of the review process with the plan administrator, you may then submit a request to HR Shared Services. If you require further review upon completion of this process with HR Shared Services, you may submit a final request to the Employee Benefits Committee (EBC).

For denied STD claims, the review process is with the plan administrators, Shepell-fgi. For denied Life, AD&D claims, the review processes are with Sun Life. For denied LTD claims, the review process is with Great-West Life.

If you require an eligibility review of the Life and AD&D benefits, you may submit a request to HR Shared Services.

For details on the review process for the plan administrator, HR Shared Services and the EBC go to “Claims & Eligibility Benefits Review Process" located in Services@Work.

Tax Considerations

Overview

One of the great features about Nortel Health & Group Benefits is the additional buying power you can achieve by making tax-effective selections.

Health & Group Benefits has been structured to be as tax effective as possible, based on current applicable laws. Company-provided *Benefits Credits* are allocated first to those benefits that can be bought with *before-tax dollars*. If there are Benefits Credits left over after the cost for these selections has been calculated, you can further the tax advantages by directing these credits 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 Benefits Credits allocated to the account. Only Company contributions (Benefits Credits) can be allocated to an HCRA.

Since only *after-tax dollars* can be used to buy optional life insurance, if you have any unused Benefits Credits, you can direct them to taxable pay and use the after-tax amount toward the purchase of your optional life insurance.

Please note that 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.

Tax Rules

This table summarizes the current income tax implications to consider when buying your optional coverage.

Coverage	Current Tax Status of Benefits Credits Used to Buy Coverage	Current Tax Status of Benefits Paid
Short-Term Disability (STD) Coverage	This is a company provided benefit at no cost to you.	Benefits are taxed as regular earned income.
Long-Term Disability (LTD) Coverage	You pay the full cost of this benefit and benefits credits cannot be used to pay for LTD coverage.	Benefits paid to you are not taxed.
Accidental Death & Dismemberment (AD&D) Coverage	Company-provided Benefits Credits 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 are not taxable.
Medical Coverage	Any Benefits Credits you use to pay for medical coverage	Benefits are not taxable, except in Quebec, where

Coverage	Current Tax Status of Benefits Credits Used to Buy Coverage	Current Tax Status of Benefits Paid
	are not taxable to you.	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 Benefits 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 Benefits 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 Benefits Credits to buy this benefit. If you want to use Benefits Credits to assist you in buying life insurance, the Benefits Credits will be first converted to your pay and taxed as regular income. The remainder can help offset your after-tax payroll deductions for this coverage.	Benefits are not taxable to the beneficiary.
Dependent Life Insurance	You can't directly use Company-provided Benefits Credits to buy this benefit. If you want to use Benefits Credits to assist you in buying life insurance, the Benefits Credits will be first converted to your pay and taxed as regular income. The remainder can help offset your after-tax payroll deductions for	Benefits are not taxable to you, the beneficiary.

Coverage	Current Tax Status of Benefits Credits Used to Buy Coverage	Current Tax Status of Benefits Paid
	this coverage.	

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.

Quebec Employees

In Quebec, provincial tax is payable on Company-paid medical and dental/vision/hearing care benefits. Under Nortel Health & Group Benefits, 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) 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 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 Employee Self-Service (ESS) 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.

Look for "Expected Average Quebec Taxable Benefit Rates".

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

If you decide to allocate Company-provided Benefits Credits to an HCRA, the amount you claim for reimbursement under this account, plus expenses and provincial premium and sales tax, will be deemed to be a taxable benefit for provincial income tax purposes.

Enrolling in Nortel Health & Group Benefits

New Hire Enrollment

You have 31 days from your date of hire to enroll in Nortel Health & Group Benefits. Please ensure that you have all the required documentation and forms for the new hire enrollment process by referring to the checklist enclosed in your new hire package.

If you have intranet access, you'll enroll online. Go to the Health N-Site for new hire enrollment process. If you don't have intranet access, you should contact HR Shared Services.

If you don't enroll within 31 days of your date of hire:

- You'll automatically default to *core coverage*.
- You'll waive your right to enroll in optional coverage until the next *annual enrollment period* or until you experience a *status change* (e.g., if you get married or have a child).
- You'll default to Basic medical coverage for you only (you and your family in Quebec).
- Any *Benefits Credits* available to you as a result of receiving default coverage will automatically be allocated to your taxable pay.

Annual Enrollment

Each year during annual enrollment, you have the opportunity to reassess your needs and make changes to your Health & Group Benefits selections. If you have intranet access, you'll enroll online. Refer to the Health N-Site for detailed instructions and things to consider.

If you don't enroll by the annual enrollment deadline – whether intentionally or not – you'll default to your current coverage at next year's rates and Benefits Credits. If you had unused Benefits Credits after your last enrollment that you allocated to the *HCRA*, and the same selections would generate unused Benefits Credits for the coming year, these Credits will be directed to your HCRA for the coming year (minimum $1 per pay period).

If you don't have intranet access, contact HRSS to obtain your Personalized Enrollment Worksheet and enrollment instructions in the mail. Mail the completed document to HR Shared Services using the enclosed return envelope or fax it to ESN 355-9301 or 919-905-9301. You'll receive a Confirmation Statement outlining your selections.

Online Enrollment Steps

Step 1 — Review your dependent information before beginning your Enrollment Selections for the coming year. To review your dependents, login to the Tool using your Norpass ID and Password. Under the Employee Self Service tab you will see another tab labeled, **Personal Information.** Click on the **Change Family Members/ Dependent** hyperlink to determine if it needs updating. Even if you choose to waive coverage under the Medical Plan and/or the Dental/Vision/Hearing Care Plan, it's important that all your dependents are listed accurately.

Step 2 — You can review your current benefits online or print your annual enrollment options:

Online - click on the Employee Self Service tab. Click on the tab labeled **Benefits** or the **Benefits** hyperlink. Then click the hyperlink labeled **Current Benefits Selections**. You'll be taken to your **Current Benefits** screen.

Print - select **Benefits** and you will see **Open Enrollment - Print Version.** This will allow you to print a worksheet to review. **Please note, the print version will contain employee confidential information so please print in a secure location.**

Step 3 — When you are ready to enroll, click on Employee Self Service tab. Click on the **Benefits** tab or **Benefits** hyperlink. Under **Benefits**, click on the **Annual Enrollment** hyperlink.

Step 4 — The **Annual Enrollment** screen appears containing all the benefits you are eligible to enroll in. Click on the first Benefit plan in which you wish to enroll using the button ○ to the left of the Benefit plan. Scroll to the bottom of the screen and click **Edit** or **Add Plan**. If a selection is listed for the benefit, you will use the **Edit** button. If no selection is listed and the word **Enroll** appears for the benefit, you will use the **Add Plan** button. A list of Benefit options will appear. Select the option you wish to edit from the list of Benefit options.

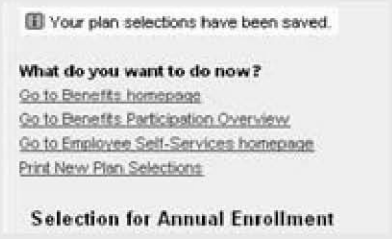
Step 5 — The **Nortel User License Agreement** screen appears. It will appear every time you Edit a plan. Click on the Confirm/Confirmer button. Repeat this step for all benefits until you have finished your selections.

Step 6 — The **Edit Plan** screen appears for the benefit plan you selected to Edit. You will see the options available to you for that benefit plan, your cost and Nortel's cost. Make your selection by clicking the button ○ beside the option. If you choose to make no changes, click on the **Review Enrollment** button at the bottom of the screen. **DO NOT CLICK SAVE from the Review Enrollment page UNTIL you have finished making all your selections. If you click SAVE, this will submit your final enrollment elections and you will NOT be able to make any additional changes.**

Step 7 — You will return to the **Annual Enrollment** screen. The benefit plan you just modified will indicate the change just made or show that you are making no change. Return to step 4 to select the next Benefit Plan to enroll in.

Step 8 — When you are ready to enroll, click the Review Enrollment ▸ button. The **Review** screen will return with a summary of all your Benefit selections. If you are not satisfied with your selections you can click on the **PREVIOUS** button to continue modifying your plans. Once you are satisfied with the selections, click Review Enrollment ▸ and then click on Save. **NOTE:** after you click **SAVE** you will NOT be able to make any further changes even though the enrollment period may still be open.

Step 9 — The following screen will appear as confirmation that the enrollment process is complete:



The system returns with a note that indicates the plan selections have been saved. Click on **Print New Plan Selections** to obtain a printed copy of the selections you made. This is very important to ensure you have a record of your saved selections. **Please note, the print version will contain employee confidential information so please print in a secure location.**

Step 10 — Click on **Annual Enrollment Survey**. You will be taken to an external internet site to complete the Annual Enrollment Survey. Return to Employee Self-Service to complete another task in Employee Self-Service or exit.

Forms Required

When you enroll in Health & Group Benefits, you must complete the appropriate forms for certain selections and return them as instructed on the form. You can find these forms on the 2011 Nortel Health & Group Benefits Site**.**

- **Statement of Health Form** – If you're required to submit *evidence of insurability (EOI)* for life insurance, go to the **"Explore Plans/Services"** section of the Health N-Site to download the form. If you don't have intranet access, you'll receive a Statement of Health form in the mail, along with your Confirmation Statement. Regardless of when you enroll, any life insurance coverage requiring EOI will be effective on the date of approval by Sun Life Financial.
- **Beneficiary Designation form for Employee Life, Accidental Death & Dismemberment and Business Travel Accident Insurance** – If you need to name a beneficiary for your life insurance and AD&D insurance, go to the **"Explore Plans/Services"** section of the Health N-Site to download the form, complete it and return it to HR Shared Services. If you don't have intranet access, you should contact HR Shared Services for a copy of the form.
- **Medical Coverage Waiver Form** (Quebec/Other Provinces) – If you're waiving medical care coverage because you (you and your family in Quebec) have coverage elsewhere, you'll need a Medical Coverage Waiver form (Quebec/Other Provinces). Go to the "**Explore Plans/Services** " section of the Health N-Site to download the form, complete it and return it to HR Shared Services by the deadline stipulated on the form. If you don't have intranet access, you should contact HR Shared Services for a copy of the form. Note that this is not required if you have submitted the form and waived coverage the previous year.

Additional Resources

Other Programs

As a Nortel employee, you have a wide range of programs available to you that are not part of Nortel Health & Group Benefits.

These benefits include:

- Business Travel Accident Insurance,
- Financial Planning Education,
- Fitness/Wellness Program and Services,
- Home and Auto Program,
- Paid Time Off – Vacation, Sick Time and Holidays,
- Travel Well,
- Critical Illness Insurance, and
- Company-paid premiums for provincial health insurance (where applicable).

For more information about any of these plans or services, go to **Services@Work** or call HR Shared Services toll-free at 1-800-676-4636, or at ESN 355-9351. You may also contact HR Shared Services via external e-mail at **HRSharedServicesNA@nortel.com** or internal e-mail at HRSharedServices, NA.

Glossary of Terms

Here are some brief explanations of terms that you'll find in your Nortel Health & Group Benefits enrollment materials.

After-tax dollars (after-tax payroll deductions) - Money that is counted as employment income for the purposes of income tax calculation. If you don't have sufficient Company-provided Benefits Credits to pay for your chosen optional benefits, the difference will be paid out of your salary after the appropriate tax deductions. Optional employee or dependent life insurance coverage may only 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 where 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 Benefits Credits are not counted as employment income if they are used to buy medical, dental/vision/hearing care, 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.

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

Currently, each employee gets Benefits Credits equal to 0.39% of Benefits 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. Employees can get additional health Benefits Credits if they waive medical and/or dental/vision/hearing care coverage, select any of the dependent coverage levels under the Basic option, or select "you only" coverage under the Comprehensive option.

Benefits Earnings - Your annual base salary as of January 1 of the Nortel Health & Group Benefits plan year (or as of your date of hire or change to Health & Group Benefits-eligible status). If you're eligible for sales incentives, your Benefits Earnings include your base salary and targeted incentives as defined each year by the Company.

Benefits Earnings don't include:

- Overtime pay,
- Shift differentials,
- Relocation payments, or
- Bonuses.

For a part-time employee, Benefits Earnings, Benefits Credits and costs are based on a 25-hour work week. Payment of Benefits Earnings-related benefits (life insurance, AD&D insurance) are paid based on actual salary.

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 Revenue Agency (CRA) - The federal agency formerly known as Revenue Canada. The CRA administers federal tax laws that apply to benefit plans. For example, the CRA sets rules regarding health spending accounts such as the Nortel Health Care Reimbursement Account. For more information, visit the CRA Web site at **www.cra-arc.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, or
- Your responsibility as a legal guardian.

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

- Under age 21,
- Under age 25* 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 age 21, or before age 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 -The specified dollar amount (not a percentage of the cost) you are required to pay when you receive drug benefits under any medical option.

Core Health & Group Benefits coverage (Core) - Benefits fully paid by the Company or in the case of Long-term disability, the employee. You're automatically enrolled in core coverage and have no choices to make with respect to these benefits:

- Employee life insurance coverage equal to 1 X Benefits Earnings.
- Short-term disability coverage equal to 100% of your pre-disability Benefits Earnings for 6 weeks, then 66 $^{2}/_{3}$% of your pre-disability Benefits Earnings for up to an additional 20 weeks.
- Long-term disability coverage after you have been disabled for 26 consecutive weeks equal to 50% of your monthly earnings as of the policy effective date up to a maximum monthly benefit of $8,000.
- Employee Assistance Program (EAP)/Worklife Services which provides all Benefits-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're required to 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 from which to choose:

- 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).

Drug formulary - A list of drugs that are covered by the Nortel Health & Group Benefits program for the Basic, Comprehensive, and Plus medical options (but not the Select option). A new drug is not added to the formulary 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, 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 Benefits Earnings or $1 million, whichever is less.
- EOI is also required if you wish to increase your coverage during the annual enrollment period, unless you have a status change. If you have a status change, EOI is only required for increases of more than one increment.

Dependent life insurance:
EOI for your *spouse* is required if 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 dependent children.

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 will 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 previous year's fee guide.

Health & Group Benefits Program - A benefits program established by the Company that offers core coverage and optional coverage.

Generic drug -A prescription medicine sold under its chemical name after the brand-name manufacturer's patent expires. While a generic drug may be a different shape or color than the brand-name drug, the active ingredients are the same. In addition, the law requires that generic manufacturers meet the same quality standards as original brand-name manufacturers.

The cost of a generic drug is typically much lower than that of a comparable brand-name drug because generic manufacturers do not have to spend money on research and advertising costs.

HR Shared Services - Contact HR Shared Services for your benefit-related needs. There are several ways you can reach HR Shared Services:

- ESN 355-9351
- Toll-free at 1-800-676-4636
- Via internal email at HRSharedServices,NA
- External e-mail at HRSharedServicesNA@nortel.com

Health Care Reimbursement Account (HCRA) - An account to which Company-provided Benefits 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.

Hospital -Under each option, a "hospital" is defined as 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.

Life-sustaining drugs - 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.

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

Optional Health & Group Benefits – Benefits you can choose to purchase each year under the Health & Group Benefits program to enhance your core coverage, including:

- Optional accidental death and dismemberment (AD&D) insurance,

- Optional medical and dental/vision/hearing care coverage, and
- Optional life insurance coverage.

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 administers payment of benefit claims for Nortel.

Prior Authorization - A process that requires certain drugs to be adjudicated and pre-approved before you can claim them under Health & Group Benefits.

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.

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.

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 change in your personal situation that affects your benefit needs and triggers a 31-day period during which you can change your Nortel Health & Group Benefits 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.

Tier 1 drugs - 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 - 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. Tier 2 drugs have reimbursement maximums. Prior authorization is required for certain therapeutic classes to demonstrate that these drugs are medically necessary.

Contact Directory

	Phone Number	Web Site Address
ESS Benefits Enrollment Tool		https://selfservice.us.nortel.com
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
HR Shared Services	ESN 355-9351 919-905-9351 Toll-free 1-800-676-4636 Fax 919-905-9301 or ESN 355-9301	
Short-Term Disability Coverage		
Shepell-fgi	1-888-522-7368 Fax 905-278-7317 or 1-877-562-9126	General - www.fgiworld.com Claims - https://secure.fgiworld.com/login.asp
Long-Term Disability Coverage		
Great-West Life Assurance Company	1-866-325-6413	
Health Care, Life Insurance, AD&D Insurance		
Sun Life Financial	1-800-229-7089	www.sunlife.ca/member
Preferred Vision Services (PVS)	1-800-668-6444	
Home and Auto Program		
BELAIRdirect	Ontario and Quebec residents : 1-866-423-5247 All other provinces: 1-866-845-4464	
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”
Canada Revenue Agency		
		www.cra-arc.gc.ca