



**PEARSON EDUCATION, INC.
WELFARE BENEFIT PLAN**

**Plan Document and
Summary Plan Description**

January 2021



Pearson Education, Inc.

Welfare Benefit Plan

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I. Benefits Highlights

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Inside This Document

Because we recognize and value the diversity of our workforce, we have designed a benefits program that helps meet individual needs. The program provides the flexibility to accommodate the different lifestyles of a diverse workforce. We also recognize that people not only differ from one another, but that they have different needs at different times in their lives. Our benefits program offers a range of choices in different benefit areas, so you can protect your health and your family's health and provide for their security both now and in the future.

This document, together with the component benefit documents and contracts, constitutes both the formal plan document and the Summary Plan Description (SPD) for the Pearson Education, Inc. Welfare Benefit Plan, which consists of various health and welfare programs. It describes the options available to you, services that are covered and how benefits are paid. It also includes information on filing claims, on coordinating your benefits with those of other plans and on how to continue coverage if you leave the Company. In addition, there is a chart showing common life events and the changes in benefits you can make as a result of them. Finally, the document describes your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

IMPORTANT: This document constitutes a Summary Plan Description in accordance with the applicable requirements of ERISA, and as such has been written in a manner that is intended to be easily understandable and to summarize the benefits available to you under the Plan. While every effort has been made to ensure the accuracy of this Summary Plan Description, the component benefit documents and contracts will prevail in case of discrepancy between this document and the component benefit documents and contracts. In addition, the Company reserves the right in its sole discretion to amend, modify or terminate any benefit offered under the Plan at any time and for any reason. Also, please keep in mind that the Plan, any changes to it, or any payments to you under its terms, does not constitute a contract of employment of the Company and does not give you the right to be retained in the employment between you and the Company. No one speaking on behalf of the Plan or the Company can alter the terms of the Plan. You and your beneficiaries may obtain copies of the component benefit documents and contracts or examine these documents by contacting the Plan Administrator at the number and address set forth in the *Additional Information About Your Benefits* section of this Summary Plan Description.

Participating Employers

This Summary Plan Description has been prepared for the following Pearson operating companies that participate in this benefits program:

- NCS Pearson
- Pearson Education, Inc.

When the term “the Company” is used, it refers to the companies above, and any subsidiaries and divisions of them that participate in this program.

An Overview of the Benefits Program

The Pearson benefits program is designed to help create a positive environment and to help attract and retain diverse and highly talented employees. In recognition of that diversity, our total benefits program provides a range of choices. Our benefits program is designed around the concept of partnership and requires your participation and involvement.

The Plan Administrator is committed to providing you with benefits information on a continuing basis and to educating you about the programs and your responsibility in using them. This Summary Plan Description is one source of information about your health and welfare benefits, which include:

- Medical coverage (including prescription drugs)
- Dental coverage
- Vision care
- Flexible spending accounts
- Disability insurance
- Life insurance
- Accidental death and dismemberment insurance
- Business travel accident insurance

This section of the Summary Plan Description provides an overview of these benefits. Each of the following sections provides a summary of the individual benefit programs which comprise the Plan.

Benefits-at-a-Glance

The *Benefits-at-a-Glance* matrix below provides you with an overview of the benefits program. It contains important information about participating in the program, including:

- The benefits offered to you
- The options available within each program
- Eligibility requirements
- Cost sharing

- When coverage begins
- When coverage ends

You should refer to the specific sections of this Summary Plan Description for more detailed information about each benefit offered under the program.

Benefits-at-a-Glance

Benefits	Options	Eligibility	Cost Sharing	When Coverage Begins	When Coverage Ends
Medical	<p>You can choose coverage for yourself and your family:</p> <ul style="list-style-type: none"> • \$400 Deductible Option • \$900 Deductible Option • \$1,850 Deductible Option • \$2,850 Deductible option • HMOs (where available) 	You must work at least 20 hours a week to participate.	You and the Company share in the cost of coverage. Your contribution is made generally on a pre-tax basis through payroll deductions.	Coverage begins on your date of hire or the date you become benefits-eligible, if you are actively at work on that date.	Coverage ends at the end of the month in which you terminate employment, are no longer eligible or fail to make required contributions.
Dental	<p>You can choose coverage for yourself and your family:</p> <ul style="list-style-type: none"> • PPO • Dental Health Maintenance Organization (where available) 	You must work at least 20 hours a week to participate.	You and the Company share in the cost of coverage. Your contribution is made generally on a pre-tax basis through payroll deductions.	Coverage begins on your date of hire or the date you become benefits-eligible, if you are actively at work on that date.	Coverage ends at the end of the month in which you terminate employment, are no longer eligible, or fail to make required contributions.
Vision Care	You can choose coverage for yourself and your family	You must work at least 20 hours a week to participate.	You and the Company share in the cost of coverage. Your contribution is made generally on a pre-tax basis through payroll deductions.	Coverage begins on your date of hire or the date you become benefits-eligible, if you are actively at work on that date.	Coverage ends at the end of the month in which you terminate employment, are no longer eligible or fail to make required contributions.
Flexible Spending Accounts	<p>Depending on your medical election, you may make pre-tax contributions to one or more of the following accounts:</p> <ul style="list-style-type: none"> • Combination FSA • Health Care FSA • Dependent Day Care FSA 	You must work at least 20 hours a week to participate.	You set aside pre-tax money, within IRS-set limits, to pay for eligible health care and dependent care expenses.	Participation begins on your date of hire or the date you become benefits-eligible, if you are actively at work on that date.	Participation in the FSAs ends when you terminate employment, are no longer eligible or fail to make required contributions.

Benefits	Options	Eligibility	Cost Sharing	When Coverage Begins	When Coverage Ends
Long-Term Disability	<p>You can elect coverage for yourself.</p> <p>Basic:</p> <ul style="list-style-type: none"> Company-paid: 50% of pay up to \$20,833 per month <p>Employee-Paid Supplemental:</p> <ul style="list-style-type: none"> 10% of pay up to \$25,000 maximum, basic and supplemental combined. 	<p>You must be regularly scheduled to work at least 20 hours a week to participate. Limited Term employees are not eligible for LTD coverage.</p>	<p>With the basic coverage, you do not contribute towards the cost of coverage; however, the benefit will be taxable should you receive it. If you elect the employee-paid option for supplemental coverage, a percentage of your benefit will be taxable should you receive it.</p>	<p>Coverage begins on your date of hire or the date you become benefits-eligible, if you are actively at work on that date. Benefits begin after 180 days of being disabled, subject to proof of disability and acceptance by the insurance company.</p>	<p>Coverage ends when you terminate employment or are no longer eligible for benefits.</p> <p>If you receive LTD benefits, they will end when:</p> <ul style="list-style-type: none"> You are no longer disabled, You reach the end of your maximum benefit period, You no longer qualify for benefits, or You die.
Basic Life Insurance	<p>You receive basic life insurance of two times your annual pay, up to \$1 million.</p> <p>Part-time regular employees receive a benefit of one times annual pay.</p>	<p>You must work at least 20 hours a week to receive coverage.</p>	<p>The Company provides coverage at no cost to you.</p>	<p>Coverage begins on your date of hire or the date you become benefits-eligible, if you are actively at work on that date.</p>	<p>Coverage ends when you terminate employment or are no longer eligible.</p>
Supplemental Life Insurance	<p>You can elect supplemental life insurance for yourself from one to six times your pay, up to \$2 million. You may have to provide evidence of insurability.</p>	<p>You must work at least 20 hours a week to participate.</p>	<p>You pay for coverage on an after-tax basis through payroll deductions.</p>	<p>If you elect coverage when you are first eligible, it begins on your date of hire or the date you become benefits-eligible, if you are actively at work on that date.</p>	<p>Coverage ends when you terminate employment, are no longer eligible or fail to make required contributions.</p>
Dependent Life Insurance	<p>You can elect dependent life insurance for your spouse/partner and your children.</p> <p>Spouse/partner coverage is available in \$5,000 increments up to a maximum of \$100,000</p> <p>For spouse/partner coverage you may have to provide evidence of insurability.</p> <p>Child(ren) coverage is available in \$5,000 increments up to a maximum of \$20,000</p>	<p>You must work at least 20 hours a week to participate.</p>	<p>You pay for coverage on an after-tax basis through payroll deductions.</p>	<p>If you elect coverage when you are first eligible, it begins on your date of hire or the date you become benefits-eligible, if you are actively at work on that date.</p>	<p>Coverage ends when you terminate employment, are no longer eligible or fail to make required contributions.</p>
Basic AD&D Insurance	<p>You receive basic AD&D insurance of two times your annual pay, up to \$1 million.</p> <p>Part-time regular employees receive a benefit of one time annual pay.</p>	<p>You must work at least 20 hours a week to receive coverage.</p>	<p>The Company provides coverage at no cost to you.</p>	<p>Coverage begins on your date of hire or the date you become benefits-eligible, if you are actively at work on that date.</p>	<p>Coverage ends when you terminate employment or are no longer eligible.</p>

Benefits	Options	Eligibility	Cost Sharing	When Coverage Begins	When Coverage Ends
Supplemental AD&D Insurance	Employee only: you can elect supplemental coverage in \$10,000 increments up to a maximum of \$500,000. Family coverage is paid at: <ul style="list-style-type: none"> 50% of the employee amount for your spouse/partner if no children are covered; 40% if children are covered 15% for each child if there is no spouse/partner covered; 10% if spouse/partner is covered; to a maximum of \$50,000 for each child. 	You must work at least 20 hours a week to participate.	You pay for coverage on an after-tax basis through payroll deductions.	If you elect coverage when you are first eligible, it begins on your date of hire or the date you become benefits-eligible, if you are actively at work on that date.	Coverage ends when you terminate employment, are no longer eligible or fail to make required contributions.
Business Travel Accident Insurance	You receive Company-provided business travel accident insurance of three times your pay up to a maximum of \$2 million. Your spouse/partner is covered up to 50,000 GBP and each dependent child is covered up to 50,000 GBP when they travel with you on business.	You must work at least 20 hours a week to receive coverage.	The Company provides coverage at no cost to you.	Coverage begins on your date of hire or the date you become benefits-eligible, if you are actively at work on that date.	Coverage ends when you terminate employment or are no longer eligible.

Eligibility

The *Benefits-at-a-Glance* chart at the beginning of this section presents a summary of the benefit programs available to you as an employee of Pearson. If you have any questions about whether you are eligible to participate in a program, please contact the [Mercer Marketplace](#) at 1-855-237-6421.

Generally, you are eligible to participate in a program if you belong to one of the following classes of employees:

- Full-Time Regular employees: those who are regularly scheduled to work 35 or more hours a week
- Part-Time Regular employees: those who are regularly scheduled to work 20 to 34 hours a week

Independent contractors and other persons who are not treated by the Company as employees for purposes of withholding federal employment taxes are not eligible to participate, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding.

Eligible Dependents

Many of the benefit programs offer coverage for your family members. Family members who are eligible to participate include:

- Your legal spouse
- Your same- or opposite-sex domestic partner (upon you providing and the approval of an [Affidavit of Spousal Equivalent](#))
- Your children, up to the end of the month in which they turn 26.
- A dependent child of any age who is physically or mentally disabled and depends on you for support, if he or she was disabled before age 19 and depended on you for support at the time of disability.

Your eligible dependent children include:

- Your biological children
- Your legally adopted children (and children placed with you for adoption)
- Stepchildren
- Children of your domestic partner
- Foster children (except for dependent life or dependent AD&D coverage)
- Any other child for whom you are a legal guardian, who lives with you in a parent/child relationship, and whom you claim as a dependent on your federal income tax return

If your child is disabled, you must submit proof of his or her disability within 31 days after he or she would otherwise no longer qualify for coverage. Contact [Mercer Marketplace](#) for more information.

Under the Health Care FSA, any dependent you can claim on your federal income tax return (without regard to their gross income) is an eligible dependent. For example, your parent may be an eligible dependent under the Health Care FSA, even though he or she is not an eligible dependent under the medical program.

Under the Dependent Day Care FSA, eligible dependents include (1) your dependent children under age 13 and (2) a disabled spouse or dependent who is physically or

mentally incapable of self-care and who lives with you for more than one-half of the year. To be eligible, you must be able to claim the individual as a dependent on your federal income tax return.

Refer to the definition of Eligible Dependent in the “Important Terms” section of this SPD for more information.

If You and Your Spouse/Partner Both Work for the Company

If you and your spouse/partner both work for the Company, you each need to make benefit decisions. Under the medical, dental and vision care programs, you can each elect Employee only coverage or one spouse/partner can waive coverage and be covered as a dependent under the other spouse’s/partner’s program. You cannot be covered as *both* an employee and a dependent. Employees are not eligible to be insured as a spouse/partner under the life and AD&D program.

If you have eligible dependent children, one of you can waive coverage under the Plan and the other can elect family coverage.

Annual Open Enrollment

Each fall, the Company conducts an open enrollment period during which you choose your benefits for the next calendar year. When you enroll, you make three types of choices. You will need to choose:

- Which plan options you want,
- Which dependents, if any, you will cover, and
- How much coverage you need.

The benefits you choose during the annual open enrollment period will cover you and your family for a full year. You will have the opportunity to change your elections at each annual open enrollment period. If you have benefits available from another source, such as your spouse’s/partner’s employer, you should compare those plans and costs with the Pearson benefits and make a decision based on the best advantage of your combined offerings.

When Coverage Begins

The coverage you elect during the fall annual open enrollment period becomes effective on January 1 of the following year. Your coverage will be in effect for a full calendar year.

If you are a new employee, you must enroll for benefits within 31 days of employment. Your coverage will be retroactive to your first day of work. If you do not enroll within 31

days, you will receive the default package of benefits which is described in the benefits orientation materials.

Making Changes to Your Benefits during the Year

Generally, you can change your benefits elections only during the annual open enrollment period. However, if you have a qualified change in status (“Life Event”), you may be able to change your elections *before the next enrollment period*. Events that the IRS considers to be qualified changes and for the purposes of this Plan, a Life Event include:

- Marriage, divorce, annulment or legal separation when allowed under state law in the state in which you reside
- Establishment or dissolution of a domestic partnership
- Birth or adoption of a child or placement of a child for adoption, gaining a stepchild, becoming legal guardian of a child
- Death of your spouse/partner
- Death of your child or your spouse’s/partner’s child
- A child’s change in dependent status due to age
- Loss of a dependent’s dependent status under the Plan
- Qualification of a Medical Child Support Order
- Your or your spouse’s/partner’s or dependent’s gain or loss of other coverage as a result of a change in employment status or work schedule (including the beginning or end of a leave of absence, including a leave of absence under FMLA)
- Change in coverage under a non-Pearson sponsored plan due to (1) a change in status under that plan or (2) a differing election period (note: these events will not allow a change under the Health Care or Combination FSA)
- Change in your provider for purposes of the Dependent Day Care FSA
- Change in the cost of care for purposes of the Dependent Day Care FSA, if the provider is not your relative
- Change in your employment status resulting in a change in eligibility (e.g., change from full-time to temporary)
- Termination of employer contributions to your spouse’s/partner’s plan (note: this will not allow a change under the Health Care or Combination FSA)

- Change in your or a dependent's residence if the change is in connection with a move outside of a coverage area
- Expiration of non-Pearson sponsored COBRA coverage for yourself or a dependent
- Eligibility for Medicare or Medicaid.

The benefit changes you make must be on account of and correspond with the change in status. The determination of whether you have experienced an event that would permit an election change and whether your requested election change is consistent with such event shall be made in the sole discretion of the Plan Administrator.

Benefit changes under the medical, dental, vision, health care and combination FSA and dependent day care FSA are consistent with the event only if they (i) result in your or your dependent's gaining or losing eligibility to participate in this Plan or the plan of your dependent's employer and (ii) are on account of and correspond with the gain or loss of coverage. For example, if you give birth to or adopt a child, you can add the child to your medical coverage, but you would not be able to drop medical coverage. Elections to increase or decrease long-term disability coverage in response to a Life Event are deemed to correspond with the change.

If you wish to make a change in your benefits, you must do so within 31 days of the Life Event. Any timely election change will be effective as of the date of the event. Please note that Pearson reserves the right to request documentation that supports the qualified status change.

If you do not make any changes within 31 days of your Life Event, you will have to wait until the next annual open enrollment period to do so.

Please refer to the *Life Events Action Chart* beginning at the end of this section for more information.

Once you change your benefit elections due to a Life Event, your payroll deductions may change as well.

Special Enrollment Rights

If you are declining enrollment for medical coverage for yourself or your dependents (including your spouse/partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependent in the Plan, provided that you request enrollment within 31 days after such other coverage ends and such other coverage was lost due to (i) the loss of eligibility for such coverage, (ii) the cessation of employer contributions for such other coverage, or (iii) the cessation of COBRA coverage. In addition, if you have a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage/partnership, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [Mercer Marketplace](#) by calling 1-855-237-6421.

Cost of Coverage

You and the Company share in the cost of some of your benefits. For other benefits, the Company pays the full cost. Your contributions toward the cost of your benefits are determined by several factors. Depending on the benefit, your contribution is based on the program(s) in which you enroll, whom you choose to cover and, in some cases, your age and annual base pay.

Refer to the *Benefits-at-a-Glance* chart at the beginning of this section to review the tax treatment of each benefit option under the Plan.

Any cost for coverage will be deducted from your paycheck in equal amounts throughout the year. If you make pre-tax contributions, your contributions are deducted from your pay before federal and most state taxes are taken out. That means you pay taxes on a smaller amount of money, and your disposable income is higher. However, certain states may not recognize these pre-tax contributions for state income taxes purposes.

Even though pre-tax contributions reduce your taxable income, they will not affect other benefits related to your income. For example, basic life insurance benefits will be calculated using your full base pay before pre-tax contributions are deducted.

However, if you make pre-tax contributions and earn less than the Social Security wage base, your Social Security taxes will be lower, and your Social Security benefits could be reduced slightly. For many employees, however, the immediate tax benefits of participating in the Plan on a pre-tax basis will outweigh any reduced future Social Security benefit. Since each employee's situation is different, you may wish to consult with your personal financial advisor to determine how any such reduction in benefits may affect you.

Definition of Pay

In some cases, the benefit plan options are expressed as a multiple of pay and in some cases, your cost for coverage is based on your pay. The term ***pay*** as it applies to the different coverages is defined in the *Important Terms* section of the Document.

Life Events Action Chart

As a general rule you may not make changes to your benefit elections during the calendar year. You are, however, permitted to make changes during the year if you experience certain life events. These are personal changes such as marriage, the birth of a child, or employment-related changes such as moving from part-time to full-time status.

The following matrix outlines what benefits may be changed during the calendar year due to specific life events. The far-left column shows the event and the remaining columns describe the changes that may be permitted in each benefit plan due to that event. Any changes you make must be consistent with the actual circumstances of your life event.

Bear in mind that all benefit changes must be made within 31 days following the life event (for example, the birth of a child) to be effective for the remainder of the year.

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Life Events Action Chart

Note: This chart is intended as a general guide. Any changes you make must be consistent with the actual circumstances of your status change.

<i>Life Events</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Combo and Health Care FSA</i>	<i>Dependent Day Care FSA</i>	<i>Long-Term Disability</i>	<i>Life Insurance</i>	<i>Accidental Death & Dismemberment</i>
If You Get Married or establish a Domestic Partnership	<p>You can enroll for the first time and add eligible dependents to your medical plan within 31 days.</p> <p>You can drop coverage and enroll in your spouse's/partner's plan within 31 days.</p> <p>You cannot change the option you are enrolled in.</p>	<p>You can enroll for the first time and add eligible dependents to your dental plan within 31 days.</p> <p>You can drop coverage and enroll in your spouse's/partner's plan within 31 days.</p> <p>You cannot change the option you are enrolled in.</p>	<p>You can enroll for the first time and add eligible dependents to your vision plan within 31 days.</p> <p>You can drop coverage and enroll in your spouse's/partner's plan within 31 days.</p>	<p>If you marry, you can enroll in, increase, decrease, or stop your contributions to the Combo and Health Care FSA within 31 days.</p>	<p>If you marry, you can enroll in, increase, decrease, or stop your contributions to the Dependent Day Care FSA within 31 days.</p>	<p>You can purchase supplemental LTD coverage subject to evidence of insurability rules, or drop your supplemental LTD coverage within 31 days.</p>	<p>No change to basic life insurance.</p> <p>You can purchase, increase, decrease or drop supplemental and/or dependent life insurance at any time, subject to evidence of insurability rules.</p> <p>You may update your beneficiary information at any time.</p>	<p>No change to basic AD&D.</p> <p>You can purchase, increase, decrease or drop supplemental and/or family AD&D coverage at any time.</p> <p>You may update your beneficiary information at any time.</p>

<i>Life Events</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Combo and Health Care FSA</i>	<i>Dependent Day Care FSA</i>	<i>Long-Term Disability</i>	<i>Life Insurance</i>	<i>Accidental Death & Dismemberment</i>
If You Get Legally Separated or Divorced or terminate a Domestic Partnership	<p>You can enroll or change coverage categories within 31 days.</p> <p>You cannot change the option you are enrolled in.</p> <p>Your spouse/partner or any children who lose coverage can continue coverage under COBRA/COBRA-like coverage for up to 36 months.</p>	<p>You can enroll or change coverage categories within 31 days.</p> <p>You cannot change the option you are enrolled in.</p> <p>Your spouse/partner or any children who lose coverage can continue coverage under COBRA/COBRA-like coverage for up to 36 months.</p>	<p>You can enroll in or change coverage categories within 31 days.</p> <p>Your spouse/partner or any children who lose coverage can continue coverage under COBRA/COBRA-like coverage for up to 36 months.</p>	<p>If you become legally separated or divorced, or terminate a domestic partnership, you can start, increase, drop or decrease your contributions to the Combo and Health Care FSA within 31 days.</p> <p>Your spouse or any children who lose coverage can continue coverage on an after-tax basis under COBRA through the end of the plan year.</p>	<p>If you become legally separated or divorced, or terminate a domestic partnership, you can start, increase, drop or decrease your contributions to the Dependent Day Care FSA within 31 days.</p>	<p>You can purchase supplemental LTD coverage subject to evidence of insurability rules, or drop your supplemental LTD coverage, within 31 days.</p>	<p>No change to basic life insurance.</p> <p>You can purchase, increase, decrease or drop supplemental and/or dependent life insurance at any time, subject to evidence of insurability rules.</p> <p>Your spouse who loses coverage can exercise the continuation feature to continue coverage under the group plan for up to 12 months coverage. After 12 months of continuation your spouse may elect to convert coverage to an individual policy. .</p> <p>You can update your beneficiary information at any time.</p>	<p>No change to basic AD&D.</p> <p>You can purchase, increase, decrease or drop supplemental and/or family AD&D at any time.</p> <p>You can update your beneficiary information at any time.</p>

<i>Life Events</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Combo and Health Care FSA</i>	<i>Dependent Day Care FSA</i>	<i>Long-Term Disability</i>	<i>Life Insurance</i>	<i>Accidental Death & Dismemberment</i>
If You Gain an Eligible Dependent Child (have a baby, adopt a child, acquire a stepchild or become a legal guardian)	You can enroll and add your new dependent to your medical plan within 31 days. You cannot change the option you are enrolled in.	You can enroll and add your new dependent to your dental plan within 31 days. You cannot change the option you are enrolled in.	You can enroll and add your new dependent to your vision care plan within 31 days.	You can enroll or increase your contribution to the Combo and Health Care FSA within 31 days.	You can enroll or increase your contribution to the Dependent Day Care FSA within 31 days.	You can purchase supplemental LTD coverage, subject to evidence of insurability rules, within 31 days.	No change to basic life insurance. You can purchase, increase, decrease or drop supplemental and/or dependent life insurance at any time, subject to evidence of insurability rules. If you are already purchasing dependent life insurance for your children, your new dependent will be covered automatically. You can update your beneficiary information at any time.	No change to basic AD&D. You can purchase, increase, decrease or drop supplemental and/or family AD&D at any time. You can update your beneficiary information at any time.
When Your Child is No Longer a Dependent	You can change your coverage category within 31 days. You cannot change the benefit option you are enrolled in. Your child can continue coverage under COBRA for up to 36 months.	You can change your coverage category within 31 days. You cannot change the benefit option you are enrolled in. Your child can continue coverage under COBRA for up to 36 months.	You can change your coverage category within 31 days. Your child can continue coverage under COBRA for up to 36 months.	You can drop or decrease your contribution to the Combo and Health Care FSA within 31 days. Your child can continue coverage on an after-tax basis under COBRA through the end of the plan year.	You can drop or decrease your contribution to the Dependent Day Care FSA within 31 days.	You can discontinue your supplemental LTD coverage.	You can purchase, increase, decrease or drop supplemental life insurance at any time, subject to evidence of insurability rules. If you have dependent life insurance for your children, your ineligible dependent will no longer be covered. You may exercise the continuation feature to continue coverage under the group plan for up to 12 months. After 12 months of continuation, conversion to an individual policy is available. You can update your beneficiary information at any time.	No change to basic AD&D. You can purchase, increase, decrease or drop supplemental and/or family AD&D at any time. You can update your beneficiary information at any time.

<i>Life Events</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Combo and Health Care FSA</i>	<i>Dependent Day Care FSA</i>	<i>Long-Term Disability</i>	<i>Life Insurance</i>	<i>Accidental Death & Dismemberment</i>
If You Become Eligible for LTD Benefits	The coverage in effect before you became disabled will continue until (1) you are no longer receiving LTD benefits or (2) your employment is terminated or (3) you reach age 65, <i>whichever occurs first</i> . You are required to continue to contribute toward the cost of your coverage.	The coverage in effect before you became disabled will continue until (i) you are no longer receiving LTD benefits or (ii) your employment is terminated or (iii) you reach age 65, <i>whichever occurs first</i> . You are required to continue to contribute toward the cost of your coverage.	The coverage in effect before you became disabled will continue until (i) you are no longer receiving LTD benefits or (ii) your employment is terminated or (iii) you reach age 65, <i>whichever occurs first</i> . You are required to continue to contribute toward the cost of your coverage.	Contributions to your Combo and Health Care FSA cease while you are receiving LTD benefits. You can be reimbursed from your Combo and Health Care FSA for health care expenses incurred while actively employed or on sick leave or short-term disability up to the amount contributed.	Contributions to your Dependent Day Care FSA cease while you are receiving LTD benefits. You can be reimbursed for dependent care expenses incurred through the end of the plan year, up to the amount in your account at the time your contributions were discontinued up to the amount contributed.	Benefits commence.	Basic life insurance coverage continues at the level in effect on the day before you become disabled until you are no longer receiving LTD benefits, or your employment is terminated, or you reach age 65, <i>whichever occurs first</i> . Supplemental life insurance coverage continues at the level in effect on the day you become disabled. You must contribute toward the cost of coverage for the first year, but if you qualify you may be able to apply to the insurance company to have your subsequent premiums waived. You must apply for waiver of premium within 6-12 months of the onset of your disability. A form will automatically be provided to you at the time you qualify for LTD benefits. Dependent life insurance coverage ends after 12 months. You may exercise the portability feature to continue dependent life insurance coverage.	Basic AD&D insurance coverage ceases twelve months after you qualify for LTD benefits. If applicable, benefit is paid.

<i>Life Events</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Combo and Health Care FSA</i>	<i>Dependent Day Care FSA</i>	<i>Long-Term Disability</i>	<i>Life Insurance</i>	<i>Accidental Death & Dismemberment</i>
If You Take an Approved Family and Medical Leave of Absence	Coverage will continue for you and your dependents if you pay the required cost of your coverage.	Coverage will continue for you and your dependents, as long as you pay the required cost of your coverage.	Coverage will continue for you and your dependents, as long as you pay the required cost of your coverage.	No change as long as you continue contributing to your account.	No change as long as you continue contributing to your account.	If you elected supplemental LTD coverage and wish to continue such coverage, you will be required to continue contributing toward the cost of your coverage.	No change to basic life insurance. You can purchase, increase, decrease or drop supplemental and/or dependent life insurance at any time, subject to evidence of insurability rules. If you elected supplemental and/or dependent life insurance and wish to continue such coverage, you will be required to continue contributing toward the cost of your coverage.	No change to basic AD&D. You can purchase, increase, decrease or drop supplemental and/or dependent life insurance at any time, subject to evidence of insurability rules. If you elected supplemental AD&D insurance and wish to continue such coverage, you will be required to continue contributing toward the cost of your coverage.
If You Take an Approved Personal Unpaid Leave of Absence	Coverage may continue for you and your dependents, if you pay the required cost of your coverage.	Coverage may continue for you and your dependents, as long as you pay the required cost of your coverage.	Coverage may continue for you and your dependents, as long as you pay the required cost of your coverage.	You may continue contributing to your account on an after-tax basis. If you do not contribute, you can be reimbursed for health care expenses incurred up until the day before your personal leave of absence.	Contributions will cease. You can be reimbursed for dependent care expenses incurred up until the day before your personal leave, up to the amount in your account at the time your contributions were discontinued.	LTD insurance coverage will cease at the end of the month following the month in which the leave began.	No change to basic life insurance. You can purchase, increase, decrease or drop supplemental and/or dependent life insurance at any time, subject to evidence of insurability rules. If you elected supplemental and/or dependent life insurance and wish to continue such coverage, you will be required to continue contributing toward the cost of your coverage.	No change to basic AD&D. You can purchase, increase, decrease or drop supplemental and/or dependent life insurance at any time, subject to evidence of insurability rules. If you elected supplemental AD&D insurance and wish to continue such coverage, you will be required to continue contributing toward the cost of your coverage.

<i>Life Events</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Combo and Health Care FSA</i>	<i>Dependent Day Care FSA</i>	<i>Long-Term Disability</i>	<i>Life Insurance</i>	<i>Accidental Death & Dismemberment</i>
If You Leave the Company	Coverage ends at the end of the month in which you leave the Company. You can continue coverage for yourself and your eligible dependents for 18 months under COBRA.	Coverage ends at the end of the month in which you leave the Company. You can continue coverage for yourself and your eligible dependents for 18 months under COBRA.	Coverage ends at the end of the month in which you leave the Company. You can continue coverage for yourself and your eligible dependents for 18 months under COBRA.	Contributions will cease. You can be reimbursed for health care expenses incurred while you were an active employee. You can continue participating in the Combo and Health Care FSA on an after-tax basis under COBRA through the end of the plan year up to the amount contributed.	Contributions will cease. You can be reimbursed for dependent day care expenses incurred through the end of the plan year, up to the amount in your account at the time your contributions were discontinued.	Coverage ends on your last day of work. You may be able to convert your LTD coverage to an individual policy within 31 days.	Basic life insurance, supplemental life insurance and dependent life insurance end on your last day of work. Upon loss of eligibility, you may elect the continuation feature to continue coverage under the group plan for up to 12 months. After 12 months of continuation, you can exercise the portability feature to continue supplemental life insurance and dependent life insurance. To port any dependent spouse or child life insurance, you must port coverage for yourself. You can convert your basic, supplemental and dependent life insurance to individual policies within 31 days.	Basic AD&D coverage ends on your last day of work.

<i>Life Events</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Combo and Health Care FSA</i>	<i>Dependent Day Care FSA</i>	<i>Long-Term Disability</i>	<i>Life Insurance</i>	<i>Accidental Death & Dismemberment</i>
If You Retire	Coverage ends at the end of the month in which you retire. You and your dependents can continue medical coverage for 18 months under COBRA. Contact WageWorks to see if you are eligible to participate in a Pearson Retiree Medical program.	Coverage ends at the end of the month in which you retire. You and your dependents can continue dental coverage for 18 months under COBRA.	Coverage ends at the end of the month in which you retire. You and your dependents can continue vision coverage for 18 months under COBRA.	Contributions to the Combo and Health Care FSA will cease. You can be reimbursed for health care expenses incurred while you were an active employee up to the amount in your account. You can continue participating in the Combo and Health Care FSA on an after-tax basis under COBRA through the end of the plan year.	Contributions to the Dependent Day Care FSA will cease. You can be reimbursed for dependent day care expenses incurred through the end of the plan year, up to the amount in your account at the time your contributions were discontinued.	Coverage ends on your last day of work.	Basic life insurance, supplemental life insurance and dependent life insurance end on your last day of work. Upon loss of eligibility, you may elect the continuation feature to continue coverage under the group plan for up to 12 months. After 12 months of continuation, you can exercise the portability feature to continue supplemental life insurance and dependent life insurance. To port any dependent, spouse or child life insurance, you must port coverage for yourself. You can convert your basic, supplemental and dependent life insurance to individual policies within 31 days.	Basic and supplemental AD&D insurance end on your last day of work.

<i>Life Events</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Combo and Health Care FSA</i>	<i>Dependent Day Care FSA</i>	<i>Long-Term Disability</i>	<i>Life Insurance</i>	<i>Accidental Death & Dismemberment</i>
If You Die While You Are Employed	Coverage for your eligible dependents will cease at the end of the month in which you die. Your eligible dependents can continue coverage for 36 months under COBRA.	Coverage for your eligible dependents will cease at the end of the month in which you die. Your eligible dependents can continue coverage for 36 months under COBRA.	Coverage for your eligible dependents will cease at the end of the month in which you die. Your eligible dependents can continue coverage for 36 months under COBRA.	Contributions cease. Your estate can be reimbursed for health care expenses incurred while you were an active employee, up to the amount in your account at the time of your death. Your eligible dependents can continue Combo and participating in the Health Care FSA on an after-tax basis under COBRA through the end of the plan year.	Contributions cease. Your estate can be reimbursed for dependent care expenses incurred through the end of the plan year, up to the amount in your account at the time of your death.	Your beneficiary will receive a three-month survivor benefit if your disability had continued for 180 or more consecutive days and you were receiving or entitled to receive LTD benefits.	Your beneficiary will receive a benefit consisting of your basic life insurance and, if applicable, supplemental life insurance. Dependent life insurance coverage stops. Your dependents may elect the continuation feature to continue coverage under the group plan for up to 12 months. After 12 months of continuation, conversion to an individual policy is available. Application to convert coverage must be made within 31 days. *Suicide exclusion applies to employee supplemental insurance.	If your death is the result of a covered accident, your beneficiary will receive the plan benefit.
If a Dependent Dies	If your spouse/partner dies, you can enroll or change coverage categories within 31 days. If your child dies, you can change coverage categories within 31 days. You cannot change the option you are enrolled in.	If your spouse/partner dies, you can enroll or change coverage categories within 31 days. If your child dies, you can change coverage categories within 31 days. You cannot change the option you are enrolled in.	If your spouse/partner dies, you can enroll or change coverage categories within 31 days. If your child dies, you can change coverage categories within 31 days. You cannot change the option you are enrolled in.	If your spouse/partner or child dies, you can stop or decrease contributions to the Combo and Health Care FSA within 31 days.	If your spouse or child dies, you may start, stop, increase or decrease contributions to the Dependent Day Care FSA within 31 days.	You can discontinue your supplemental LTD coverage. If your spouse dies, you can purchase supplemental LTD coverage, subject to evidence of insurability rules, within 31 days.	If your dependent was covered, the dependent life insurance benefit will be paid to you. You can purchase, increase, decrease or drop supplemental and/or dependent life insurance at any time, subject to evidence of insurability rules. *Suicide exclusion applies to spouse life insurance.	If your dependent was covered and the death was the result of a covered accident, the AD&D benefit will be paid to you. You can purchase, increase, decrease or drop supplemental and/or family AD&D any time.

<i>Life Events</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Combo and Health Care FSA</i>	<i>Dependent Day Care FSA</i>	<i>Long-Term Disability</i>	<i>Life Insurance</i>	<i>Accidental Death & Dismemberment</i>
If You Move	No change unless you move out of the medical plan network area; then you may change your option.	No change unless you move out of the dental plan network area; then you may change your option.	No change	No change	No change	No change	You can purchase, increase, decrease or drop supplemental and/or dependent life insurance at any time, subject to evidence of insurability rules.	You can purchase, increase, decrease or drop supplemental and/or family AD&D any time.
If there is a change in coverage under another employer's health plan	You can enroll for the first time and add eligible dependents to your medical plan within 31 days. You can drop coverage within 31 days. You cannot change the option you are enrolled in.	You can enroll for the first time and add eligible dependents to your dental plan within 31 days. You can drop coverage within 31 days. You cannot change the option you are enrolled in.	You can enroll for the first time and add eligible dependents to your vision plan within 31 days. You can drop coverage within 31 days. You cannot change the option you are enrolled in.	No change	No change	No change	You can purchase, increase, decrease or drop supplemental and/or dependent life insurance at any time, subject to evidence of insurability rules.	You can purchase, increase, decrease or drop supplemental and/or family AD&D any time.
Significant change in cost of dependent day care (if provider is not a relative) or change in dependent care provider	No change	No change	No change	No change	You may start, stop, increase or decrease contributions to the Dependent Day Care FSA.	No change	You can purchase, increase, decrease or drop supplemental and/or dependent life insurance at any time, subject to evidence of insurability rules.	You can purchase, increase, decrease or drop supplemental and/or family AD&D any time.



II. Medical Program

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About This Section

Medical care is an important part of your benefits program. In fact, medical coverage is the benefit people often think about first when they think about their benefits.

Pearson's program offers you the flexibility to choose coverage options based on your needs. This section describes your medical coverage – the options available to you, what is covered, and how benefits are paid. It also has important information about notification procedures you must follow in order to receive maximum benefits from the plan.

Some of the terms and phrases used in this benefits document have a specific meaning. Please refer to the *Important Terms* section of this document for further information.

You should also refer to the *Benefits Highlights* and the *Additional Information About Your Benefits* sections of this document for more important information regarding eligibility, how contributions are made, how elections can be changed, how to file claims and your rights under ERISA.

An Overview of Your Medical Options

In most locations, the Pearson medical program provides you with a choice of medical options:

- National Medical Options
 - \$400 Deductible Option
 - \$900 Deductible Option
 - \$1,850 Deductible Option
 - \$2,850 Deductible Option
- A Health Maintenance Organization (HMO) in select areas

Each of the medical options cover the same types of services – physician’s charges, hospitalization, surgery, emergency treatment, psychiatric treatment and more. The options differ, however, in the amount you pay for the cost of the coverage, your out-of-pocket expenses, the way you access medical care, and whether you need to submit claim forms.

The National Options are administered by Aetna (available in most areas), Anthem BlueCross BlueShield and Cigna. While the plan designs are the same regardless of which administrator you choose, the network of doctors, hospitals and other health care providers may vary. Be sure to check the administrator websites to determine whether the Aetna, Anthem or Cigna network is the most appropriate for you and your family.

The \$400 and \$900 Deductible options offer the greatest predictability of costs through copays for doctor’s visits and prescriptions, along with lower deductibles. These plans offer coverage when you use in-network and non-network providers. You will pay less when you use in-network providers.

The \$1,850 and \$2,850 Deductible options pair high deductible coverages with a tax-free Health Savings Account (HSA) that you can use to pay for eligible health expenses, even in retirement. To learn more about the HSA, please visit the Benefits website at pearsonbenefitsus.com.

And, with the \$1,850 and \$2,850 Deductible options you can see any provider you wish without a referral, but you will pay less when you choose in-network providers.

Deductibles – How They Work

If you enroll in one of the medical options, you will have to satisfy a deductible each year before the Plan begins to pay certain benefits. (Under the \$400 and \$900 options, certain

in-network services, such as office visits, are subject to a copayment rather than a deductible).

Once an individual has met his/her deductible, the Plan will begin to pay benefits for that person. He or she does not have to wait until the family deductible is satisfied before receiving benefits except for the \$1,850 Deductible option. If you enroll in the \$1,850 Deductible option and cover any dependents, the full family deductible must be met before the Plan pays benefits for any family member. Any covered family member can contribute to the family deductible. The individual deductible only applies if you elect the employee-only coverage tier. Please call Mercer Marketplace at 855-237-6421 if you have any questions about the \$1,850 option.

In the case of family coverage, your family's combined expenses can reach the family deductible without each person meeting their individual deductible. Once the family deductible has been met, the Plan will begin to pay benefits for all family members.

Out-of-Pocket Maximums – How They Work

If you enroll in one of the medical options, your out-of-pocket expenses will be limited by an annual out-of-pocket maximum. Once a person meets the individual limit, the Plan will pay 100% of that person's covered expenses for the rest of the year.

If you have family coverage, your family can meet the family out-of-pocket maximum without each person meeting his or her individual out-of-pocket maximum. If you enroll in the \$1,850 Deductible Plan and cover any dependents, the full family out-of-pocket maximum must be met before the Plan pays 100% benefits for any family member. Any covered family member can contribute to the family out-of-pocket maximum. Please call the Mercer Marketplace at 855-237-6421 if you have any questions about the \$1,850 plan.

Deductibles, copayments and coinsurance amounts are applied to the out-of-pocket maximum.

What Does “Cross Apply” Mean?

For the Anthem and Cigna plans, the deductibles and annual out-of-pocket maximums “cross-apply” for in-network services. This means that out-of-network deductibles and out-of-network out-of-pocket maximums apply to in-network deductibles and in-network out-of-pocket maximums. However, in-network deductibles and out-of-pocket maximums do not apply to out-of-network deductibles and out-of-network maximums.

For all Aetna plans, out-of-network deductibles and out-of-network maximums apply to in-network deductibles and out-of-pocket maximums (and vice versa). This means that in-network expenses apply toward your out-of-network limits if you decide to use out-of-network services. Likewise, out-of-network expenses apply toward your in-network limits if you decide to use in-network services.

National Medical Plan Options

How the \$400 Deductible and \$900 Deductible Options Work

The \$400 and \$900 Deductible options let you choose the way you obtain medical care each time you need it. You can receive care through a network of physicians and other health care providers at a significantly lower cost to you, or you can select providers outside the network and pay a greater share of your medical expenses.

In these plans you are not required to choose a primary care physician (PCP) or to get a referral in order to see a specialist. However, to receive in-network benefits (other than in emergency situations), you must obtain care from in-network providers. The medical options have certain notification requirements that apply whether you are using in-network or out-of-network providers, and benefits are reduced if these are not followed. Please see Notification Requirements on page 18.

In-Network

Office visits to your PCP are covered at 100% after you pay a copayment. Office visits to a specialist are covered at 100% after you pay a copayment. Most other services are covered at 80% after you meet a deductible. There are no claim forms to file, and your network provider will generally arrange for any required notifications.

*Certain preventive services are covered at 100% in-network with no copay, deductible or coinsurance. See *Preventive Care* on page 10.

Out-of-Network

When you use an out-of-network provider, you generally must pay a deductible each calendar year before the plan begins to pay benefits. After you pay the deductible, the Plan generally pays 60% of covered expenses. The amount of an out-of-network provider's charge that is eligible for coverage is referred to as the Maximum Allowed Amount. The Maximum Allowed Amount for the Plan is the maximum amount of reimbursement the claims administrator will allow for services and supplies:

- that meets its definition of Covered Services, to the extent such services and supplies are covered under the Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

Maximum Allowed Amounts are based on the reasonable and customary charge for the Covered Service as determined by your claims administrator and are generally determined based on the geographic area where the Covered Service is provided. The

Maximum Allowed Amount under the Plan is determined based on your administrator in accordance with the following: (i) Cigna - 90% of the maximum reimbursable charge (i.e., an amount determined by Cigna based on a percentage of the charges made by health care providers in same geographic area); (ii) Aetna - 80% of the reasonable and customary charge made by health care providers in same geographic area; and (iii) Anthem BlueCross BlueShield – 315% of the Medicare Allowable Rate. .

Important Note: If a provider bills less than the amount calculated using the out-of-network plan rate note above, the Maximum Allowable Amount is the actual amount that the provider bills.

You are responsible for paying the 40% of the Maximum Allowable Amount not paid by the Plan, plus any charge in excess of the Maximum Allowable Amount. You generally need to file a claim form to receive out-of-network benefits, and you are responsible for any required notifications.

The Plan reserves the right to apply its reimbursement policies to all out-of-network services including involuntary services. These reimbursement policies, which the Plan applies in its good faith discretion, may affect a Maximum Allowable Amount.

Under certain circumstances, if the Claims Administrator pays the health care Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from you. You agree that the Claims Administrator has the right to collect such amounts from you. If an Out-of-Network Provider is used, however, you are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. When you receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply the claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim for the Covered Services. Applying these rules may affect the Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator has determined that the claim for the Covered Services was submitted in a manner inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Unlike Network Providers, Out-of-Network Providers may send you a bill and collect the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out-of-Pocket costs to you. Please call Member Services for help in finding a Network Provider or visit the Claims Administrator's website.

Out-of-Pocket Maximums

An annual out-of-pocket maximum limit is the amount you will have to pay for covered services in a calendar year. See the prior page to learn how in- and out-of-network out-of-pocket maximums cross-apply.

Certain expenses do not count toward the out-of-pocket maximum. The out-of-pocket maximum does not include charges greater than covered expense amounts; the amount you pay for emergency room services if used for non-emergency purposes; penalties you pay for not making notification calls when required; and out-of-network charges that exceed the "reasonable and customary" allowance. Deductibles, copayments and coinsurance for eligible medical services and prescription drugs count toward the out-of-pocket maximum

How the \$1,850 and \$2,850 Deductible Options Work

In-Network

You pay 100% of your medical and prescription drug costs until you meet the annual deductible. There are no copayments in the \$1,850 or \$2,850 options. After you pay the deductible, the Plan generally pays 80% for the \$1,850 option and 70% for the \$2,850 option for covered expenses. There are no claim forms to file, and your network provider will generally arrange for any required notifications.

If you enroll in the \$1,850 Deductible Plan and cover any dependents, the full family deductible must be met before the Plan pays benefits for any family member. Any covered family member can contribute to the family deductible. The individual deductible only applies if you elect employee-only coverage. Please call Mercer Marketplace at 855-237-6421 if you have any questions.

*Certain preventive services are covered at 100% in-network with no deductible or coinsurance. See *Preventive Care* on page 12.

Out-of-Network

When you use an out-of-network provider, you pay 100% of a higher deductible each calendar year before the plan begins to pay benefits.

After you pay the deductible, the Plan generally pays 60% (for the \$1,850) option or 50% (for the \$2,850 option) of covered expenses. The amount of an out-of-network provider's charge that is eligible for coverage is referred to as the Maximum Allowed Amount. The Maximum Allowed Amount for the Plan is the maximum amount of reimbursement the claims administrator will allow for services and supplies:

- that meets its definition of Covered Services, to the extent such services and supplies are covered under the Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

Maximum Allowed Amounts are based on the reasonable and customary charge for the Covered Service as determined by your claims administrator and are generally determined based on the geographic area where the Covered Service is provided. The Maximum Allowed Amount under the Plan is determined based on your administrator in accordance with the following: (i) Cigna - 90% of the maximum reimbursable charge (i.e., an amount determined by Cigna based on a percentage of the charges made by health care providers in same geographic area); (ii) Aetna - 80% of the reasonable and customary charge made by health care providers in same geographic area; and (iii) Anthem BlueCross BlueShield – 315% of the Medicare Allowable Rate.

Important Note: If a provider bills less than the amount calculated using the out-of-network plan rate note above, the Maximum Allowable Amount is the actual amount that the provider bills.

You are responsible for paying the 40% in the \$1,850 plan (or 50% in the \$2,850 plan) of Maximum Allowable Amount not paid by the Plan, plus any charge in excess of the Maximum Allowable Amount. You generally need to file a claim form to receive out-of-network benefits, and you are responsible for any required notifications.

The Plan reserves the right to apply its reimbursement policies to all out-of-network services including involuntary services. These reimbursement policies, which the Plan applies in its good faith discretion, may affect a Maximum Allowable Amount.

Under certain circumstances, if the Claims Administrator pays the health care Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from you. You agree that the Claims Administrator has the right to collect such amounts from you. If an Out-of-Network Provider is used, however, you are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. When you receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply the claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim for the Covered Services. Applying these rules may affect the Claims Administrator's determination of the Maximum Allowed Amount. The Claims

Administrator's application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator has determined that the claim for the Covered Services was submitted in a manner inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Unlike Network Providers, Out-of-Network Providers may send you a bill and collect the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out-of-Pocket costs to you. Please call Member Services for help in finding a Network Provider or visit the Claims Administrator's website.

Out-of-Pocket Maximums

An annual out-of-pocket maximum limit is the amount you will have to pay for covered services in a calendar year. See the prior page to learn how in- and out-of-network out-of-pocket maximums cross-apply.

If you enroll in the \$1,850 Deductible Plan and cover any dependents, the full family out-of-pocket maximum must be met before the Plan pays at 100%. Any covered family member can contribute to the out-of-pocket maximum. The individual out-of-pocket maximum only applies if you elect employee-only coverage. Please call Mercer Marketplace at 855-237-6421 if you have any questions.

Certain expenses do not count toward the out-of-pocket maximum. The out-of-pocket maximum does not include charges greater than covered expense amounts; the amount you pay for emergency room services if used for non-emergency purposes; penalties you pay for not making notification calls when required; and out-of-network charges that exceed the "reasonable and customary" allowance. Deductibles, copayments and coinsurance count toward the out-of-pocket maximum

National Programs - Benefit Details

The medical designs described below are offered by three health plan administrators. In order to receive in-network benefits, you must utilize providers and facilities within the network of the plan administrator you choose. You will need to notify your administrator before receiving some benefits. See Notification Requirements on page 15.

Anthem

Network: BlueCard PPO
(Residents of Utah only: Traditional)
Group #: 3330054
www.anthem.com
1-877-898-0747

Cigna

Network: Open Access Plus with Carelink
(Residents of Utah only: PPO Network)
Group #: 3176426
www.myCigna.com
1-800-842-4221

Aetna

Network: APCN Choice
POSII
Group # 868808
www.aetna.com
1-855-237-6421

	\$400 Option		\$900 Option		\$1,850 with HSA**		\$2,850 with HSA	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Deductible (Single / Family)	\$400 / \$800	\$2,500 / \$5,000	\$900 / \$1,800	\$3,000 / \$6,000	\$1,850 / \$3,700	\$3,700 / \$7,400	\$2,850 / \$5,700	\$5,700 / \$11,400
Out-of-Pocket Max (Single / Family)	\$2,200 / \$4,400	\$4,400 / \$8,800	\$3,000 / \$6,000	\$6,000 / \$12,000	\$3,500 / \$6,500	\$7,000 / \$13,000	\$5,500 / \$11,000	\$11,000 / \$22,000
Coinsurance	80%	60%	80%	60%	80%	60%	70%	50%
Preventive Care	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Plan pays 60% after deductible	Plan Pays 100%	Plan pays 60% after deductible	Plan pays 100%	Plan pays 50% after deductible
PCP Office Visit	You pay \$20	Plan pays 60% after deductible	You pay \$40	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Specialist Office Visit	You pay \$40	Plan pays 60% after deductible	You pay \$80	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
MDLive telehealth consultation	You pay \$10		You pay \$10		You pay \$40, or \$10 after you have met your deductible		You pay \$40, or \$10 after you have met your deductible	
Prenatal Office Visits	You pay \$40 1st visit, then covered in full	Plan pays 60% after deductible	You pay \$80 1st visit, then covered in full	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Urgent Care Visit	You pay \$50		Plan pays 80% after deductible		Plan pays 80% after deductible		Plan pays 70% after deductible	
Lab/Radiology - Annual Preventive	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Plan pays 60% after deductible

	\$400 Option		\$900 Option		\$1,850 with HSA**		\$2,850 with HSA	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
- Other	Plan pays 100% in doctor's office, copay applies; 80% after deductible outside doctor's office (including maternity)	Plan pays 60% after deductible	Plan pays 100% in doctor's office, copay applies; 80% after deductible outside doctor's office (including maternity)	Plan pays 60% after deductible	Plan pays 80% after deductible (including maternity)	Plan pays 60% after deductible	Plan pays 70% after deductible (including maternity)	Plan pays 50% after deductible
Emergency Room	You pay \$150 copay & deductible, then Plan pays 100% Non-emergency care is not covered		Plan pays 80% after deductible Non-emergency care is not covered.		Plan pays 80% after deductible Non-emergency care is not covered.		Plan pays 70% after deductible Non-emergency care is not covered.	
Ambulance (emergency only)	Plan pays 80% after deductible		Plan pays 80% after deductible		Plan pays 80% after deductible		Plan pays 70% after deductible	
Hospitalization (including maternity)	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Surgery (Inpatient & Outpatient)	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Mental Health / Substance Abuse – Inpatient	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Mental Health / Substance Abuse – Outpatient	You pay \$20	Plan pays 60% after deductible	You pay \$40	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Chiropractic Services	You pay \$40	Plan pays 60% after deductible	You pay \$80	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
	30 visits/year max (in and out-of-network combined)		30 visits/year max (in and out-of-network combined)		30 visits/year max (in and out-of-network combined)		30 visits/year max (in and out-of-network combined)	
Physical, Speech, Occupational, Pulmonary, Cognitive Therapies (unlimited)	You pay \$40	Plan pays 60% after deductible	You pay \$80	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Acupuncture	You pay \$40	Plan pays 60% after deductible	You pay \$80	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible

	\$400 Option		\$900 Option		\$1,850 with HSA**		\$2,850 with HSA	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Allergy Care / Injections	100% in doctor's office, copay may apply; 80% after deductible outside doctor's office	Plan pays 60% after deductible	100% in doctor's office copay may apply; 80% after deductible outside doctor's office	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Assisted Reproductive Techniques (Includes artificial insemination, GIFT, ZIFT and in-vitro)	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
	\$15,000 lifetime maximum (in and out-of-network combined)		\$15,000 lifetime maximum (in and out-of-network combined)		\$15,000 lifetime maximum (in and out-of-network combined)		\$15,000 lifetime maximum (in and out-of-network combined)	
Home Health Care	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
	120-day max per year; (in and out-of-network combined)		120-day max per year; (in and out-of-network combined)		120-day max per year; (in and out-of-network combined)		120-day max per year; (in and out-of-network combined)	
Skilled Nursing Facility, Rehab Hospital, Sub-Acute Facility	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
	120-day max per year; (in and out-of-network combined)		120-day max per year; (in and out-of-network combined)		120-day max per year; (in and out-of-network combined)		120-day max per year; (in and out-of-network combined)	
Durable Medical Equipment	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Breast feeding Equipment and Supplies – limited to one rental or purchase of one breast pump per birth	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered
Hearing Aids for adults and children one per ear every 3 years	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
PCP Referral Required?	No		No		No		No	

Prescription Drugs Administered by CVS Caremark ⁽¹⁾				
	\$400 Option	\$900 Option	\$1,850 with HSA	\$2,850 with HSA
Retail (you pay) Generic Preferred Brand Non-Preferred Brand-	ACA Prev Drugs - Plan pays 100% \$10 \$30 \$60	ACA Prev Drugs - Plan pays 100% \$10 30% (min \$25/max \$50) 45% (min \$40/max \$80)	ACA Prev Drugs - Plan pays 100% 20% after deductible 20% after deductible 20% after deductible	ACA Prev Drugs - Plan pays 100% 30% after deductible 30% after deductible 30% after deductible
Mail Order (you pay) Generic Preferred Brand Non-Preferred Brand	ACA Prev Drugs - Plan pays 100% \$25 \$75 \$150	ACA Prev Drugs - Plan pays 100% \$25 30% (min \$62.50/max \$125) 45% (min \$100/max \$200)	ACA Prev Drugs - Plan pays 100% 20% after deductible 20% after deductible 20% after deductible	ACA Prev Drugs - Plan pays 100% 30% after deductible 30% after deductible 30% after deductible

**out-of-network reimbursement up to Reasonable and Customary limits*

(1). CDHP Preventive Drug list (separate from the Affordable Care Act – ACA - preventive drug list) is covered at the applicable coinsurance level. This drug list does not apply to the \$400 or \$900 Deductible plans.

Covered Services

Preventive Care

Preventive care services include annual routine physicals for adults age 19 and above, well child visits for children under age 19 (in accordance with United States Preventive Service Task Force recommendations), immunizations and annual routine gynecological exams for women (“annual” means once per calendar year, regardless of whether 12 months have passed since your last annual physical.).

Other preventive services include annual hearing and vision screenings, routine colonoscopies, routine bone density screenings, skin cancer screenings, routine mammograms (including 3D mammograms), Pap smears and PSA tests, Cholesterol screening, lung cancer screening for adults ages 55 to 80, chlamydia screening, HIV screening and counseling, genetic counseling/evaluation BRCA1/2 testing for those at risk, breast-feeding supplies, counseling and support, purchase/rental of manual or electric breast pumps & contraceptive devices, including female condoms, and barrier methods (i.e. IUDs, diaphragms).

Most preventive care services are covered at 100% in-network. Check with your medical plan administrator as to which preventive services fall into this category as the list may change from time to time.

Specialized Care and Specialty Programs

If you need specialized care, there is a copayment for an office visit to an in-network specialist if you are enrolled in the \$400 or \$900 options. If you are enrolled in the \$1,850 or \$2,850 option, covered services are subject to the applicable deductible and coinsurance to visit an in-network specialist.

Specialist visits for non-network providers for all medical options are subject to the applicable deductible and coinsurance.

If your condition requires the services of a specialist who does not participate in the network, your network provider may obtain special approval for you to see an out-of-network physician. In this case, the Plan will cover the specialist's charges on the same basis as a network doctor, as long as you have received the proper referral.

All three administrators offer specialty programs for certain conditions at Centers of Excellence (also known as Blue Distinction Centers at Anthem). To be considered a Center of Excellence, a facility must have proven experience and expertise at delivering quality care for a particular condition. Aetna, Anthem and Cigna offer these programs for organ transplants, cardiac care, bariatric surgery and other services. Contact your administrator to find out about the specific specialty programs they offer.

Hospital Services

The Plan pays for room and board for a semi-private room, and for ancillary services and supplies.

In order to receive maximum benefits, you will need to be admitted to a network hospital. All in-network hospitals are responsible for handling pre-admission notification.

For inpatient services at an out-of-network hospital, you must call your administrator at the number on the back of your ID card for pre-admission notification. If you do not notify your administrator before a scheduled admission, your benefits will be reduced by \$500.

Emergency Care

Emergency care is defined as medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which is severe enough that the lack of immediate medical attention could reasonably be expected to result in:

- The patient's health being placed in serious jeopardy
- Bodily function being seriously impaired
- A serious dysfunction of a bodily organ or part

Ambulance service, including approved emergency air transport, is covered the same as emergency treatment. In addition, emergency care includes immediate mental health treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency room treatment is subject to the in-network deductible and coinsurance at any emergency room, in- or out-of-network. Please note that no benefits are payable for non-emergency use of the emergency room.

Urgent Care Centers

Sometimes you need to see a doctor right away, but it is not an emergency. For example, ear infections, high fever and minor burns are considered urgent but not emergency situations.

In these cases, you can see your PCP, or if your PCP is not available, you can go to an Urgent Care Center. These facilities are usually open in the evening and on the weekend, and you do not need to make an appointment.

If you use an in-network facility, treatment at an Urgent Care Center is covered at 100% after a copay for the \$400 Deductible option and subject to the in-network deductible and coinsurance for the other options. Treatment at an out-of-network Urgent Care Center is subject to the applicable deductible and coinsurance.

Mental Health Care

Inpatient and outpatient mental health care are covered as part of your mental health benefits.

Inpatient Treatment

Inpatient psychiatric care is subject to the applicable deductible and coinsurance, and pre-admission notification is required. If you use an in-network hospital, pre-admission notification is handled by your provider.

If you use an out-of-network hospital, you or someone on your behalf, must call and notify your administrator before receiving inpatient treatment. If the notification call is not made, your benefits will be reduced by \$500.

Outpatient Treatment

Notification is not required for outpatient mental health care.

When you use network providers, outpatient treatment is covered at 100% after you pay a copayment for each visit for the \$400 and \$900 medical options and subject to the in-network deductible and coinsurance for the other options. Treatment received from out-of-network providers is subject to the applicable deductible and coinsurance.

Substance Abuse Treatment

Inpatient and outpatient substance abuse treatment are covered as part of your mental health benefits.

Inpatient Treatment

Inpatient substance abuse treatment is subject to the applicable deductible and coinsurance, and pre-admission notification is required. If you use an in-network hospital, pre-admission notification is handled by your provider.

If you use an out-of-network hospital, you or someone on your behalf, must call and notify your administrator before receiving inpatient treatment. If the notification call is not made, your benefits will be reduced by \$500.

Outpatient Treatment

Notification is not required for outpatient substance abuse care.

When you use network providers, outpatient treatment is covered at 100% after you pay a copayment for each visit for the \$400 and medical options and subject to the in-network deductible and coinsurance for the other options. Treatment received from out-of-network providers is subject to the applicable deductible and coinsurance.

Maternity Care

Covered expenses include prenatal office visits, the infant's delivery and care during the hospital stay and the mother's hospital stay and care. The first prenatal visit is covered at 100% after you pay a copayment for the \$400 and \$900 medical options and subject to the in-network deductible and coinsurance for the other plans. All other prenatal visits are covered in full. The delivery charge and hospital stay are subject to the applicable deductible and coinsurance.

Group health plans and plan providers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). Notification and continued approval for inpatient care for either the mother or child is required if the hospitalization continues beyond the 48- or 96-hour limits stated above.

Family Planning

Family planning expenses, including tests, counseling, contraceptive devices and sterilization, are covered. Birth control pills are covered under the prescription drug program. Surgical reversal of sterilization (tubal ligation or vasectomy) is not covered.

Infertility Treatment

The national medical options cover infertility treatment, which includes testing to determine the diagnosis of an infertility condition as well as treatment of the underlying condition. Surgery is limited to procedures for the correction of the underlying condition. Infertility treatment is subject to the \$15,000 lifetime maximum per covered individual.

Assisted Reproductive Techniques

Assisted Reproductive Techniques (ART) include in vitro fertilization (IVF), artificial insemination (AI), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). There is a \$15,000 lifetime maximum per covered individual that includes all hospital stay facility fees, physician medical and surgical care, and diagnostic tests and scans. The maximum is combined for in- and out-of-network care.

Fertility medication is covered under the prescription drug program and does not count toward the \$15,000 lifetime maximum.

Home Health Care

Home health care enables you to recuperate from a serious illness or injury in your home while receiving the necessary medical services and supplies from a certified home health care agency. The Plan covers the following services:

- Home infusion therapy
- Temporary or part-time nursing care by or supervised by a licensed nurse
- Temporary or part-time care by a home health aide
- Physical therapy, speech therapy or occupational therapy
- Dressings and medical treatment prescribed by a doctor

Home health care requires pre-notification. If you use in-network providers, your provider will handle the required notification.

If you use out-of-network providers, you must call and notify your administrator before receiving out-of-network home health care. There is a \$500 non-notification penalty if you do not call.

The annual maximum for home health care is 120 visits, in-and out-of-network combined. A *visit* is equal to four hours of covered home health care services provided by a member of the home health care team. Service must be provided through an approved, certified home health care agency.

Skilled Nursing Facility

A skilled nursing facility provides you with medical care when you no longer need the full services of a hospital but aren't yet well enough to go home.

Admission to a skilled nursing facility requires pre-notification. If you use an in-network facility, your provider will handle the required notification.

If you use an out-of-network facility, you must call and notify your administrator before admission to a skilled nursing facility. There is a \$500 non-notification penalty which will be applied against the amount you are eligible to receive for your claim if you do not call.

The maximum benefit is 180 days per calendar year, in- and out-of-network combined.

Hospice Care

Hospice care is a coordinated plan of home and inpatient care for a terminally ill patient. It is designed to meet the special needs of the patient, and members of the family who are covered by the Plan, during the final stages of terminal illness (life expectancy of six months or less).

The Plan covers the usual medical care required by a terminally ill patient and other services provided through an approved program of hospice care including:

- Room and board
- Other services and supplies, including in-home lab and IV therapy
- Part-time nursing care by or supervised by a registered nurse (R.N.)
- Home health care services as shown under *home health care*
- Counseling for the patient and covered family members
- Bereavement counseling for covered family members (services must be given within six months after the patient's death and covered services are limited to a total of 15 visits for each family).

Charges are considered a hospice expense when they are billed by or through a certified hospice care agency. Counseling services must be given by a licensed counselor. Any

counseling services given in connection with a terminal illness will not be considered as Mental Health treatment.

Hospice care requires pre-notification. Your provider will handle pre-notification for in-network hospice care. For out-of-network hospice care, you must call and notify your administrator before receiving hospice care. There is a \$500 non-notification penalty if you do not call.

Organ Transplants

The national medical options provide coverage for organ transplants that are qualified and non-experimental. Pre-notification is required before receiving any transplant services.

The following are qualified transplant procedures:

- Eye / Cornea
- Heart transplant
- Lung transplant
- Heart/lung transplant
- Liver transplant
- Kidney transplant
- Pancreas transplant
- Kidney/pancreas transplant
- Bone marrow/stem cell transplant
- Small bowel transplant.

Certain lodging and meal expenses may be covered for accompanying family members. Some meal expenses reimbursed by the Plan may be subject to income tax under federal income tax rules.

To obtain complete information about transplant services, contact Aetna, Anthem or Cigna at the number on the back of your ID card.

Notification Requirements

Generally, your network provider will handle any medical notifications that may be required when you access care in-network.

If you use an out-of-network provider or facility for any of the services below, you must call the Member Services Department at the number on the back of your ID card. If you do not notify your administrator before the service is performed, your benefits will be reduced by \$500. If it is determined that the hospitalization, procedure or other service is not performed for the treatment of illness or injury, no benefits will be paid.

Your administrator must be notified in advance of:

- Hospitalization
- Skilled Nursing Facility confinement
- Hospice Care
- Organ and tissue transplants
- Home health care

This list is continually reviewed and updated to reflect current medical trends. If you are uncertain whether a procedure or service requires notification, call your administrator rather than risk receiving reduced benefits.

Surgical Decision Support (“SDS”) Requirement

The Plan imposes a \$1,000 penalty which will be applied against the amount you are eligible to receive for your claim if a covered Employee or spouse/partner has one of the five surgeries listed below and does not enroll in and complete the Surgical Decision Support program at least 30 days prior to having the surgery:

- Hysterectomy
- Gastric bypass/bariatric procedures
- Knee Replacement
- Hip Replacement
- Low Back Surgery

To avoid the \$1,000 penalty, you must enroll at least 30 days prior to the date of the scheduled surgery and complete the following steps before the surgery is performed:

1. If your doctor has recommended one of the elective surgeries above, call ConsumerMedical at least 30 days before your scheduled surgery (1-888-361-3944, Monday through Friday, 8:30 a.m. to 5:00 p.m. ET) and speak with an SDS program specialist, who will take the information necessary to enroll you in the SDS program; and
2. Review the personalized materials you receive and participate in at least two telephone consultations with the SDS program specialist; and
3. Complete a brief telephone survey with the program specialist.

Completion of the SDS program will be valid for surgery performed during the 12-month period following completion of the SDS program.

A member's requirement to consult with ConsumerMedical is not waived or satisfied by virtue of a member's provider having received a pre-authorization or pre-certification for the subject procedure(s). A provider must go through its own independent process for obtaining said pre-authorization or pre-certification, and a provider's receipt of an approval for the subject procedure(s) does not satisfy a member's requirement to consult with ConsumerMedical prior to undergoing their procedure(s). As such, a failure by a member to consult with ConsumerMedical, even in a situation where the member's provider has received a pre-authorization or pre-certification for the procedure(s), will result in the application of the \$1,000 pre-certification penalty against the member.

Please note that the \$1,000 penalty does not count for the purposes of satisfying the deductible or out-of-pocket maximum under the Plan.

Emergency surgeries are not subject to the SDS requirement.

Prescription Drug Benefits

The prescription drug program is administered by CVS/caremark. See *Prescription Drug Benefits* on page 23.

Other Covered Services

The national medical options cover medical services other than those described on the previous pages. Covered services and supplies must be prescribed by a physician and given for the diagnosis or treatment of an accidental injury or sickness. You can request a pre-determination as to whether a particular service is covered by contacting your administrator. Covered services are payable subject to applicable deductibles, coinsurance and copayments. These include:

- Acupuncture, if performed by a licensed physician or licensed acupuncturist, for pain management, or for the prevention and treatment of nausea associated with surgery, chemotherapy or pregnancy.
- Ambulance services for emergency purposes only. Air ambulance is covered only if ground transportation is impossible or would put your life or health in serious jeopardy.
- Anesthetics and the cost of its administration
- Bariatric surgery if all of the following requirements are met:
 - A Body Mass Index (BMI) of greater than 40. BMI of 35-40 will be considered when there is documentation of a co-morbid condition,
 - Participation in at least one medically supervised attempt to lose weight within the past two years. The medically supervised weight loss attempt(s) must have been at least six months in duration.

- Completion a pre-surgical psychological evaluation
- Confirmation by the physician that the member's treatment plan includes pre- and post-operative dietary evaluations.
- Blood and blood plasma, when it is not donated or replaced
- Birthing center costs, including room and board and services and supplies when furnished in a lawfully operating birthing center
- Chemotherapy and radiation treatment
- Cochlear implants
- Dental care and treatment if required as the result of an injury of sound, natural teeth sustained while covered under the medical plan, and if the services are provided within six months of the injury
- Medical services performed by Christian Science Practitioners
- Durable Medical Equipment, which meets all the following conditions:
 - It is for repeated use and is not a consumable or disposable item
 - It is used primarily for a medical purpose
 - It is appropriate for use in the home

Some examples of Durable Medical Equipment are appliances which replace a lost body organ or part, or help an impaired one to work; insulin pumps; orthotic devices such as arm, leg, neck or back braces; hospital-type beds; equipment needed to increase mobility, such as a wheelchair, respirators or other equipment for the use of oxygen; and monitoring devices. If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the most cost-effective piece of equipment.

- Foot care and treatment of the feet, if needed due to severe systemic disease
- Gender reassignment surgery and related services, subject to World Professional Association for Transgender Health (WPATH) standard guidelines
- Hearing screenings for adults and children, one per year
- Hearing aids for adults and children, one hearing aid for each ear every three years
- Nutritional counseling, up to three visits per year. No diagnosis necessary.
- Nutritional formula, limited to the treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid

metabolism) or enteral feeding for which the nutritional formulae (a) under state or federal law can be dispensed only through a physician's prescription and (b) is medically necessary as the primary source of nutrition. Charges for oxygen, including the equipment for its administration

- Artificial limbs, eyes and other prosthetic devices
- Adjustments, repair and replacement of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition
- Casts, splints, trusses, crutches and braces (except dental braces)
- Physical, occupational and speech therapy, given by a licensed therapist. See "Services Not Covered" for speech therapy restrictions.
- Surgical supplies required for the treatment of an illness or injury
- Surgical or medical care for treatment of an eye disease or injury
- Orthoptic training (eye muscle exercise) by a licensed optometrist or orthoptic technician, up to 30 visits per year.
- Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of a birth defect, sickness, surgery to treat a sickness or accidental injury
- Reconstructive surgery to remove scar tissue on the neck, face or head if due to sickness or accidental injury
- Reconstructive surgery and prostheses following a mastectomy, including:
 - Reconstruction of the breast on which the mastectomy has been performed
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance
 - Prostheses
 - Treatment of physical complications of all stages of mastectomy, including lymphedemas

These services shall be provided in a manner determined in consultation with the attending physician and the patient. Coverage for these medical services is subject to any applicable deductibles and coinsurance amounts.

- Temporomandibular Joint Dysfunction (TMJ). Covered services include:
 - Evaluation and diagnosis

- Surgery of the jaw
- Injections
- Transcutaneous Electrical Nerve Stimulator (TENS)
- Biofeedback
- Facility and laboratory x-rays applicable to the above

Appliances are limited to a \$1,000 maximum lifetime benefit.

- Voluntary sterilization including vasectomy and tubal ligation.

Services Not Covered

The following list is intended to give you a general description of the services and supplies not covered by the medical program. There may be services and supplies in addition to these that are not covered by the medical program. You can request a pre-determination as to whether or not a particular service is covered by contacting your administrator.

- Services or supplies received from a non-participating provider that exceed “covered expense” guidelines as determined by your administrator
- Abdominoplasty and/or Panniculectomy
Following surgery for morbid obesity these procedures are considered cosmetic and are not covered, except under certain limited, medically necessary, circumstances.
- Chelation therapy, except in the treatment of the following conditions:
 - Control of ventricular arrhythmias or heart block, when associated with digitalis toxicity
 - Emergency treatment of hypercalcemia
 - Extreme conditions of metal toxicity (e.g., lead toxicity in adults, iron toxicity)
 - Wilson's degeneration (hepatolenticular degeneration)
 - Pediatric lead poisoning
- Completion of claim forms or missed appointments
- Cosmetic, reconstructive surgery or treatment, unless:
 - A person receives an injury which results in bodily damage requiring surgery

- It qualifies as a reconstructive surgery following a covered surgical procedure
- It is plastic or reconstructive surgery for a dependent child to treat a birth defect or congenital disease
- Custodial care, including:
 - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment
 - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional
- Ecological or environmental medicine, diagnosis and/or treatment
- Education, training and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as covered services
- Expenses and associated expenses incurred for services and supplies for experimental, investigational or unproven services, treatments, devices and pharmacological regimens
- Eyeglasses or contact lenses
- Herbal medicine, holistic or homeopathic care
- Liposuction
- Membership costs for health clubs, weight loss clinics and similar programs
- Occupational injury or sickness (an occupational injury or sickness is an injury or sickness that is covered under a Workers' Compensation act or similar law)
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs
- Private duty nursing services, other than care in the patient's home provided by a licensed Home Health Care Agency
- Reversal of sterilization
- Services and supplies which the covered person is not legally required to pay as determined by your administrator

- Services given by a pastoral counselor
- Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services or supplies given in connection with or related to the surgery
- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a covered person under this plan and is undergoing a covered transplant
- Services related to learning disabilities or educational therapy
- Sensitivity training, educational training therapy or treatment for an educational requirement
- Services, supplies, medical care or treatment given by a member of the employee's immediate family
- Charges made by a hospital for confinement in a special area of the hospital that provides non-acute care, by whatever name called, including but not limited to the type of care given by the facilities listed below:
 - If that type of facility is otherwise covered under this plan, then benefits for that covered facility which is part of a hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a hospital
 - Adult or child day care center
 - Ambulatory surgical center
 - Birth center
 - Half-way house
 - Hospice
 - Skilled nursing facility
 - Treatment center
 - Vocational rehabilitation center
 - Any other area of a hospital that gives service on an inpatient basis for other than acute care of sick, injured or pregnant persons
- Therapeutic devices or appliances and support garments, regardless of intended use (note: insulin syringes with needles, blood testing strips – glucose, urine testing strips – glucose, ketone testing strips and tablets, lancets and lancet devices are covered under the prescription drug program)

- Care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak
- Telephone consultations
- Services in connection with smoking cessation (drugs for smoking cessation are covered under the prescription drug program)
- Services or supplies received as a result of war, declared or undeclared, or international armed conflict
- Weight reduction or control (unless there is a diagnosis of morbid obesity)
- Special foods, food supplements, liquid diets, diet plans or any related products (other than nutritional formula as described under Covered Services)
- Speech therapy except to treat speech dysfunction resulting from one of the following conditions: sickness, injury, stroke, autism, cerebral palsy, congenital anomaly, developmental delay or if needed following the placement of a cochlear implant.
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury), hair transplants, hair weaving or any drug if such drug is used in connection with baldness
- Services given by volunteers or persons who do not normally charge for their services
- Any other services not described under Covered Services, above.

This list gives you a description of the services and supplies not covered by the national medical options. Some expenses not covered by the medical program may be covered under the dental or vision care programs, and some may be eligible for reimbursement through the health care flexible spending account. See the applicable sections of this document for more information.

Prescription Drug Benefits

The prescription drug benefit, administered by CVS/caremark, allows you to obtain prescription drugs at a low cost through a national network of participating retail pharmacies or by mail. This program applies to participants in both PPOs and you will receive a separate CVS/caremark ID card for your prescription drug coverage. If you are an HMO participant, you should check with your HMO to find out what your prescription drug benefits are.

Prescription Drug Coverage for the National Medical Programs ⁽¹⁾				
	\$400 Deductible Plan	\$900 Deductible Plan	\$1,850 Deductible Plan	\$2,850 Deductible Plan
Retail (you pay)	ACA Prev Drugs - Plan pays 100%	ACA Prev Drugs - Plan pays 100%	ACA Prev Drugs - Plan pays 100%	ACA Prev Drugs - Plan pays 100%
Generic	\$10	\$10	20% after deductible	30% after deductible
Preferred	\$30	30% (min \$25/max \$50)	20% after deductible	30% after deductible
Brand				
Non-Preferred	\$60	45% (min \$40/max \$80)	20% after deductible	30% after deductible
Brand-				
Mail Order (you pay)	ACA Prev Drugs - Plan pays 100%	ACA Prev Drugs - Plan pays 100%	ACA Prev Drugs - Plan pays 100%	ACA Prev Drugs - Plan pays 100%
Generic	\$25	\$25	20% after deductible	30% after deductible
Preferred	\$75	30% (min \$62.50/max \$125)	20% after deductible	30% after deductible
Brand				
Non-Preferred	\$150	45% (min \$100/max \$200)	20% after deductible	30% after deductible
Brand				

(1). CDHP Preventive Drug list (separate from the Affordable Care Act – ACA - preventive drug list) is covered at the applicable coinsurance level. This drug list does not apply to the \$400 or \$900 Deductible Plans.

Retail Pharmacies

Your CVS/caremark ID card can be used at participating retail pharmacies. When you present your card and depending on what medical plan you are enrolled in, you will pay a copay, coinsurance or 100% of the cost until you meet the annual deductible. You can purchase up to a 31-day supply of medication at one time. If the cost of your prescription is less than the copayment, you will pay only the cost of the prescription. There are no claim forms to file when you obtain your prescription drugs through a participating pharmacy.

You can obtain a list of pharmacies participating in the network by calling the Customer Service number on the back of your CVS/caremark ID card, or via the internet at www.caremark.com.

If you use a non-participating pharmacy, you will pay the full retail price of your prescription and you will not be reimbursed for your prescription drug costs.

Mail Order

You can take advantage of additional savings by using the mail order feature of the prescription drug program. You can order up to a 90-day supply of your prescription medication by mail. You get a three-month supply for the price of two and a half times the retail copay. If the cost of the prescription is less than the copayment, you will pay only the cost of the prescription.

The mail order feature is most often used to purchase maintenance drugs. Generally, these are drugs you take on a regular basis for an extended period of time or for chronic

conditions. Examples include medications for conditions such as high blood pressure, diabetes, anti-depressants and birth control pills. To obtain prescriptions through the mail, complete the [order form](#) available from the benefits website at pearsonbenefitsus.com or call Mercer Marketplace at 1-855-237-6421. Return the form along with your prescription and your payment to the address on the form.

Out-of-Pocket Maximum

The annual out-of-pocket maximum limits the amount you will have to pay for covered prescriptions in a calendar year. The annual out-of-pocket maximum varies depending on the national medical option in which you are enrolled. The out-of-pocket maximum does not include charges greater than covered expense amounts and charges you incur at a non-network retail pharmacy. Deductibles, copayments and coinsurance for eligible medical services and prescription drugs count toward the out-of-pocket maximum.

Contraception for Women

The following chart outlines what and how women's contraception will be covered under the prescription drug program:

Item	Coverage
<i>Hormonal (Oral Contraceptives)</i>	\$0 copayment for over-the-counter items (prescription required) Generic & single source brand contraceptives (multi-source brand contraceptives available when requested by the physician) for women through age 50.
<i>Emergency contraception</i>	\$0 copayment (prescription required)

Preventive care drugs, covered at 100%

Preventive care drugs are covered at 100%. A prescription is required from your provider for over-the-counter preventive medications to be covered at 100%. Check with CVS/caremark to see which drugs are covered at 100% as the list may change periodically.

<i>Aspirin</i>	- To prevent cardiovascular events in men and women ages 50 to 59 - To prevent morbidity and mortality for Preeclampsia in women ages 12 to 59
<i>Oral Fluoride</i>	Applies to children between birth - 5 yrs.
<i>Folic Acid</i>	Applies to women under age 50
<i>Iron Supplements</i>	Applies to children 6-12 months
<i>Smoking Cessation</i>	Applies to ages 18+; limit of 168-day supply of each product in one year of treatment
<i>Vitamin D</i>	Applies to men and women age 65+
<i>Bowel Prep Agents for colonoscopy prep</i>	Applies to all ages
<i>Statins</i>	Applies to men and women ages 40-75 for the primary prevention of Cardiovascular disease; generic only, only low to moderate intensity statins

Prescription Drugs That Are Generally Not Covered

The following list is intended to give you a general description of the drugs and supplies not covered under the prescription drug benefit. While the list is intended to be inclusive, the Plan Administrator may supplement or modify the list from time to time.

- Prescriptions filled by a person who is not licensed to fill them
- Charges for any prescriptions dispensed in excess of the number specified by the physician or any refill dispensed after one year from the order of the physician
- Replacement drugs resulting from a lost, stolen, broken or destroyed prescription order or refill
- Drugs (other than insulin) available over the counter that do not require a prescription order or refill by federal or state law before being dispensed and any drug that is therapeutically equivalent to an over-the-counter drug
- Drugs which are considered investigational because they do not meet generally accepted standards of medical practice in the United States

- Drugs given while confined in a hospital, nursing home or similar place that has its own drug dispensary
- Charges for the administration of any medication
- Allergens and/or allergy serum
- Appetite suppressants and other weight loss products
- Cosmetic drugs, even if ordered for non-cosmetic purposes
- General and injectable vitamins (this exclusion does not apply to prenatal vitamins, vitamins with fluoride and B-12 injections, which are covered)
- Immunization agents, biological sera, blood or blood plasma
- Progesterone suppositories
- Therapeutic devices or appliances, including colostomy supplies and support garments, regardless of intended use (this exclusion does not apply to disposable insulin needles, syringes, lancets, swabs and strips which are covered under this plan)
- Charges for which the covered employee or dependent is entitled to receive reimbursement under Workers' Compensation Laws, or is entitled to without charge under any local, state or federal government program
- Drugs that have not been approved by the FDA for the specific treatment for which they are being prescribed.
- Women's contraceptive devices and barrier methods

Health Maintenance Organizations

You may be able to enroll in a Health Maintenance Organization (HMO) if one is available in your area.

HMOs are a network of health care providers and facilities that provide medical care on a prepaid basis. They also provide prescription drug benefits and other services. When you need non-emergency medical care, you must use the services of providers or facilities affiliated with your HMO. If you use providers outside the HMO network, you will not receive any benefits from the Plan.

In an HMO there are generally no deductibles to meet, no claim forms to file and small copayments for office visits. Many services are covered at 100%.

The covered items previously described pertain to the national medical options. Because coverage can differ among HMOs, be sure you understand the coverage available to you before enrolling.

If you elect coverage in an HMO you will automatically receive a full description of the coverage provided by the HMO. If you want advance information about a specific HMO, please check the [benefits website](#) at pearsonbenefitsus.com or call Mercer Marketplace at 1-855-237-6431.



III. Dental Program

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About This Section

Good dental care is essential to your good health, but it can be expensive. By seeing your dentist regularly for routine check-ups, you can often identify minor problems before they become serious and more costly. The dental program options help protect your health by encouraging preventive and diagnostic dental care. This section describes the dental coverage available to you and your family.

Some of the terms and phrases used in this benefits document have a specific meaning. Please refer to the *Important Terms* section of this document for further information.

You should also refer to the *Benefits Highlights* and the *Additional Information About Your Benefits* sections of this document for more important information regarding eligibility, how contributions are made, how elections can be changed, how to file claims, your right to continue health care coverage when coverage is lost and your rights under ERISA.

An Overview of Your Dental Program Options

The dental program pays all or part of the cost toward a wide range of dental services and supplies for treatment of dental disease, dental defect and accidental injury to the teeth or mouth. You have a choice of coverage through Delta Dental and Cigna (where available). You also have the option of waiving coverage under the Plan.

Each option covers the same types of services, which fall into four broad categories.

- **Preventive and Diagnostic Services** – including routine oral exams, cleanings, fluoride treatment for children under age 19, full-mouth x-rays, bitewing x-rays and space maintainers
- **Basic Services** – including periodontics (gum treatment), root canal therapy, restorative dentistry including fillings and denture repairs.
- **Major Services** – including crowns, bridges and dentures.
- **Orthodontic Services** – including braces and other treatments and appliances to straighten teeth (for adults and dependent children).

The Cigna plan is a dental health maintenance organization (DHMO). The chart below compares the dental options available under the program.

Services	Delta Dental PPO (Premier Network or PPO Network)		Cigna DHMO
	In-Network	Out-Network (up to R&C)	In-Network Only
Annual Deductible Does not apply to preventive and diagnostic services	\$50 individual \$150 family	\$50 individual \$150 family	None None
Annual Maximum	\$2,000		None
Prev & Diagnostic Services	100% in-network	100% in-network	100%
Basic Services (including endodontics, periodontics & simple surgery)	80% after deductible	80% after deductible	Copays vary by service. Please refer to the Cigna DHMO Patient Charge Schedule available at pearsonbenefitsus.com
Major Services (including prosthetics and repairs/adjustments & complex surgery)	50% after deductible	50% after deductible	
Ortho (children & adults)	50%, no deductible	50%, no deductible	
Ortho Lifetime Maximum	\$2,500 per person		

Delta Dental Option

The covered services and applicable limits below apply to Delta Dental.

Preventive/Diagnostic Care

- Oral examinations: two per calendar year
- Prophylaxis (cleanings): two per calendar year
- Topical fluoride applications: one treatment per calendar year for dependent children up to the 19th birthday
- Bitewing x-rays: Twice per calendar year
- Full mouth x-rays: one per 60 months
- Space maintainers: for dependent children up to age 19
- Sealants: one application of sealant material every 60 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to age 19

Basic Restorative Care

- Fillings
- Simple extractions
- Consultations twice per year
- Crown, denture and bridge repair
- Endodontics: root canal treatment limited to once per tooth per 24 months
- Periodontics: periodontal scaling and root planning one per quadrant, every 24 months; periodontal surgery once per quadrant, every 36 months. Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year.
- Injections of antibiotic drugs
- Relining and rebasing of existing removable dentures, but not more than once per 36 months.

Major Restorative Care

- General anesthesia: when dentally necessary in connection with oral surgery, extractions or other covered dental services
- Oral Surgery
- Bridges and dentures: initial placement to replace one or more natural teeth which are lost while covered by the Plan; dentures and bridgework replacement once every seven years; replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed; dentures or bridges to replace congenitally missing teeth if member has been continuously enrolled for 24 months.
- Crowns/inlays/onlays: replacement limited to once every seven years.
- Dental implants – every seven years

Orthodontics

- Diagnostic procedures and appliances to realign the teeth.

How the Plan Works

When you enroll in Delta Dental, you have a choice of using in-network or out-of-network dental providers. The Plan will pay a percentage of covered services as outlined in the chart on page 2, up to a maximum benefit of \$2,000 per person per year. There is no deductible for preventive or diagnostic care, but you must meet an annual deductible before the plan begins to pay for most other services.

In-network services are based on a discounted fee, so you will save money by paying a percentage of the discounted fee. In network dentists have agreed to accept the Delta Dental payment as payment in full. You will not be responsible for any charges above Delta Dental's discounted fee. Using an in-network provider is an easy way to save money. You have access to two Delta networks: the Delta PPO network and the Delta Premier network. The difference in networks is the size. If you choose a provider in the smaller Delta PPO network, you will pay less out of pocket. If you use the larger Delta Premier network, you will have slightly higher costs. You can obtain a list of current Delta Dental participating providers at www.deltadentalmn.org or by calling 1-800-448-3815.

Out-of-network services are based on the reasonable and customary (R&C) charge for a service. You are responsible for any charges in excess of R&C.

Pre-treatment Estimate

If your dentist recommends treatment that is likely to cost \$300 or more, you should ask your dentist to submit a pre-treatment estimate. A pre-treatment estimate enables you and your dentist to know how much the Plan will pay before the treatment starts. This is especially prudent if you are considering major services or orthodontic procedures. Both you and your dentist will know beforehand which services will be approved and the benefit amounts that will be paid.

Your dentist can obtain a “real-time” pre-treatment estimate online or over the phone within minutes, detailing what your plan will cover and at what payment level. Alternatively, you can obtain a pre-treatment estimate by submitting a completed dental claim form, leaving the dates of service blank and checking the box called “Pre-Treatment Estimate.” The form should be submitted to Delta Dental, at the address on the claim form, prior to the commencement of the course of treatment. You or your dentist can contact Delta Dental at 1-800-448-3815 with any questions about the pre-treatment estimate process.

Orthodontia

Orthodontic treatment is covered for adults and dependent children. Benefits are payable at 50% with no deductible. There is a lifetime maximum of \$2,500 per person. (Orthodontic related tooth extractions do not count toward this maximum.) Under Delta Dental, benefit payments are made in equal amounts: (1) when treatment begins (appliances are installed), and (2) at six-month intervals thereafter, until treatment is completed or until the lifetime maximum benefits are exhausted. Orthodontic benefits end at cancellation of coverage or when the lifetime maximum benefit has been paid.

Work in Progress

Delta Dental pays benefits based on the service completion date, including work-in-progress.

Extension of Coverage

Under Delta Dental, benefits end on the day your coverage ends. You may elect COBRA continuation to extend your benefits.

Claiming Benefits

If you use a network provider, the provider will file for reimbursement for you. If you choose a non-network provider, you or your provider must file the claim after receiving the care or service. You can obtain a Delta Dental out-of-network claim form at www.deltadentalmn.org or by calling 1-800-448-3815.

If a claim is denied, you may request a review of the denial. See the *Benefits Highlights* section of this document for more information on filing claims.

Dental Health Maintenance Organization (DHMO)

The Dental Health Maintenance Organization (DHMO), administered by Cigna, covers a full array of dental treatment and services.

How the Plan Works

The DHMO generally covers the same services as the Delta Dental option. However, you must use providers associated with the DHMO (except in the case of emergencies) in order to receive benefits. If you do not use a DHMO provider, you will not receive benefits from the Plan.

Under the DHMO, you have no deductibles to meet, no annual maximums, and no claim forms to complete.

Most preventive and diagnostic care, as well as certain restorative procedures, are covered at 100%. For other services, you are generally responsible for a copayment, the amount of which varies based on the specific procedure. You can obtain a [Patient Charge Schedule](#) that lists covered procedures and the corresponding patient charges from the benefits website or by calling Cigna at 1-800-842-4221.

Using Participating Providers

You select your DHMO primary care dentist during enrollment. You may select a different primary care dentist for each covered family member. After enrollment, you will receive an ID card, which lists your DHMO dentist's name and phone number. In order to obtain care from a network specialist, you must obtain a referral from your primary care dentist, and your treatment plan must be approved by Cigna.

Emergency treatment by any licensed dentist is covered if you are out of your service area and need to see a dentist right away.

You can obtain a list of current participating providers online at www.cigna.com or by calling 1-800-842-4221.

Orthodontia

The DHMO covers diagnostic procedures and appliances to realign the teeth for adults and dependent children. Payment information is listed on the [Patient Charge Schedule](#).

Work in Progress

Generally, the DHMO plan does not cover work-in-progress, including:

- Crowns and fixed bridgework when the teeth were prepared prior to the start date of your coverage in this Plan
- Appliances when the impression was taken prior to the start date of your coverage in this Plan
- Root canal therapy when the pulp chamber was opened prior to the start date of your coverage in this Plan
- Orthodontic treatment when an active appliance has been placed prior to the effective date of your coverage in this Plan.

Extension of Coverage

If your coverage ends during a course of treatment, you and your covered dependents are eligible for limited dental benefits after you stop working for the Company. To be covered, the treatment must be delivered within the timeframe specified by Cigna and must not be covered through another employer. Eligible charges include the following:

- Charges for an appliance, or alteration if the impression was made while you or your dependents were covered by the Plan
- Charges for a crown, bridge or gold restoration if the tooth was prepared while you or your dependents were covered by the Plan
- Charges for root canal therapy if the pulp chamber was opened while you or your covered dependents were covered by the Plan.

Services Not Covered

The following list is intended to give you a general description of the services and supplies not covered under any of the dental options. There may be services and supplies in addition to these that are not covered by the Plan. Some expenses not covered by the Plan may be eligible for reimbursement through the health care flexible spending account. See the *Flexible Spending Accounts* section of this document for more information.

Services not covered under any of the dental program options include:

- Services not reasonably necessary or not customarily performed
- Treatment not furnished by a dentist. This does not apply if the service is performed by a licensed dental hygienist under the direction of a dentist

- Services furnished by government plans
- Replacement or modification of a denture or a bridge, for adding teeth to either, or for a replacement or modification of a cast or processed restoration, including crowns, within five years after installed
- A denture or bridge if it includes replacement of one or more natural teeth missing before the person became covered. This does not apply if the denture or bridge also includes replacement of a natural tooth that (i) is removed while the person is covered, or (ii) was not an abutment to a partial denture or removable or fixed bridge installed during the prior five years
- An appliance, crown, bridge, cast or processed restoration or root canal therapy started before the person became eligible; a cast or processed restoration or crown unless it is for decay or traumatic injury and cannot be restored with a filling material or the tooth is an abutment to a fixed bridge; and an active appliance for orthodontics installed before the person became eligible
- Crown lengthening
- Cosmetic treatment, except for certain accidental injuries. Facings on molar crowns or pontics will always be considered cosmetic
- Replacement of lost or stolen appliances
- Appliances or restorations needed to alter vertical dimension or restore occlusion, or for the purpose of splinting or correcting attrition or abrasion; or treatment for problems of the jaw joint (e.g., TMJ)
- Work-connected sickness or injury
- Care provided under any other program paid for in full or in part, directly or indirectly by the employer. This includes insured and uninsured programs. If a program provides benefits in the form of services, the cash value of each service rendered is considered the benefit provided for that charge
- Expenses above the reasonable and customary charge for the service area.



IV. Vision Care Program

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About This Section

In addition to the Medical and Dental benefits, the Plan also provides Vision Care benefits. Under the Vision Care program, you can use network or non-network providers, so you have choice and flexibility in obtaining the vision care you need. This section describes your benefits and options under the Vision Care program.

Some of the terms and phrases used in this benefits document have a specific meaning. Please refer to the *Important Terms* section of this document for further information.

You should also refer to the *Benefits Highlights* and the *Additional Information About Your Benefits* sections of this document for more important information regarding eligibility, how contributions are made, how elections can be changed, how to file claims, your right to continue health care coverage when coverage is lost and your rights under ERISA.

An Overview of the Vision Care Program

The Vision Care program, administered by Vision Service Plan (VSP), helps pay for the cost of visually necessary and appropriate vision expenses such as exams, lenses and frames, or contact lenses.

VSP has contracted with an extensive network of optometrists and ophthalmologists across the country to provide professional vision care. You can use VSP network providers, or providers outside the VSP network.

Below is a comparison of the network and non-network benefits available to you under the Vision Care program.

	<i>VSP Provider</i>	<i>Non-VSP Provider</i>
<i>Vision exam (once annually)</i>	100% after \$10 copay	\$45 allowance
<i>Prescribed lenses (once annually)</i>		
<i>Single vision</i>	100%	up to \$30
<i>Lined bifocal</i>	100%	up to \$50
<i>Lined trifocal</i>	100%	up to \$65
<i>Contacts instead of glasses (once annually)</i>	Up to \$60 copay for exam \$175 allowance for contacts & contact lens fitting	up to \$105
<i>Frames (once annually; not all frames are covered)</i>	\$175 allowance for a selection of frames \$195 allowance for featured frame brands 20% savings on the amount over the allowance	up to \$70

How the Vision Care Program Works

When you receive care, you can choose to use providers in the vision care network or obtain services from non-network providers. When you choose an in-network provider, you must pay a copay per individual for an exam.

Benefits under the Vision Care program are separate from benefits under the medical program. Your out-of-pocket vision care expenses do not count toward any out-of-pocket limit in the medical program.

Network Benefits

Your benefits are greater when you use VSP network providers. Once you have paid your deductible, most services are covered at 100%.

Your vision benefits will also cover in full the choice of one of the following lens enhancements for you and each covered dependent when you use an in-network provider.

- Additional \$75 frame allowance or \$25 elective contact lens allowance
- Progressive lenses – Plastic (Standard, Premium & Custom)
- Tints/Photochromic adaptive lenses
- Anti-reflective coating

For all other lens enhancements, you will enjoy a 25-35% discount off the reasonable and customary charge.

The VSP provider network consists of a large network of optometrists, ophthalmologists and opticians nationwide. To obtain a list of current network providers near you, call 1-800-877-7195 or visit the website at www.vsp.com.

When making an appointment with a network provider, identify yourself as a VSP member. The VSP provider will contact VSP directly to verify your eligibility and plan coverage and to obtain authorization for services and eyewear. There are no claim forms to complete when using a network provider. Your provider will submit the necessary paperwork directly to VSP for reimbursement.

Non-Network Benefits

If you use non-network providers, you can choose any optometrist, ophthalmologist or optician you wish. However, you'll receive a lesser benefit and typically pay more in out-of-pocket expenses. You must pay the provider in full for vision care services and submit a claim for reimbursement. Once you have met the deductible, the plan will pay up to the scheduled amounts as described in the previous chart. You are responsible for any charges in excess of the amount paid by the Plan.

Claiming Benefits

If you use a VSP network provider, the provider will file for reimbursement from VSP. If you choose a non-network provider, you must file the claim with VSP within six months after receiving the care or service. You can obtain an out-of-network claim form at pearsonbenefitsus.com or you can call VSP at 1-800-877-7195.

If a claim is denied by VSP, you may request a review of the denial. See the *Benefits Highlights* section of this document for more information on reviewing denied claims.

Covered Expenses and Services

The Vision Care program provides benefits for the following up to once annually:

- Eye examination
- Medically necessary lenses
- Frames
- Contact lenses in lieu of lenses and a frame.

If you use a VSP network provider, you are also eligible for certain discounts, including discounts on the purchase of additional prescription glasses and sunglasses, scratch resistant and anti-reflective coatings, and discounts for laser vision correction.

These discounts are available only from a VSP network doctor within 12 months of the last examination by that VSP doctor.

Low Vision Benefit

Members who have severe visual problems that are not correctable with regular lenses may be eligible for the Low Vision Benefit. If the patient uses a VSP network doctor, supplementary testing is covered in full and supplemental care is covered at 75% of the cost, to a maximum of \$1,000 every two years. The network doctor is responsible for gaining prior approval from VSP. For Low Vision Benefits obtained from a non-network doctor, the patient pays the non-network doctor his full fee. VSP will reimburse the patient the amount VSP would have paid a network doctor.

Expenses and Services Not Covered

The following list is intended to give you a general description of the services and eyewear not covered by the vision plan. There may be services and supplies in addition to these that are not covered by the plan. Some expenses not covered by the vision plan may be eligible for reimbursement through the health care flexible spending account. See the *Flexible Spending Accounts* section of this document for more information.

The following types of services are not covered under the Vision Care program:

- Treatment for medically related eye conditions
- Costs beyond the basic cost allowed for services and supplies, including frames over the plan allowance, oversize lenses, progressive multifocal lenses, coating, laminating or UV protection of lens or lenses, and blended or cosmetic lenses
- Services or eyewear from the company's medical department

- Orthoptics, vision training or aniseikonia
- Expenses for services or eyewear incurred for fashion reasons
- Non-prescription sunglasses, safety lenses or goggles
- Replacement of lenses or frames that are lost or broken
- Eye exam or corrective eyewear required as a condition of employment
- Corrective vision treatment of an experimental nature, such as radial kerotomy
- Injury or sickness compensable under Workers' Compensation or the Occupational Disease Act
- Injury from declared or undeclared war
- Intentionally self-inflicted injury or sickness.



V. Flexible Spending Accounts

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About This Section

This section describes the Flexible Spending Accounts (FSAs). Flexible spending accounts enable you to save on taxes while providing a convenient way to budget for certain health care and dependent care expenses. There are three types of FSAs:

- The Health Care FSA
- Combination (Combo) FSA
- The Dependent Day Care FSA

Each year, you may direct a portion of your pay into one, two or both, accounts on a pre-tax basis. You may use the money in your account(s) to reimburse yourself for qualified expenses throughout the year.

This section explains how these accounts work and what expenses are eligible for reimbursement.

Some of the terms and phrases used in this benefits document have a specific meaning. Please refer to the *Important Terms* section of this document for further information.

You should also refer to the *Benefits Highlights* and the *Additional Information About Your Benefits* sections of this document for more important information regarding eligibility, how contributions are made, how elections can be changed, how to file claims and your rights under ERISA.

An Overview of the Flexible Spending Accounts

You can choose to participate in one of the health flexible spending accounts, the Health Care FSA or the Combination (Combo) FSA and the Dependent Day Care FSA, or you can choose not to participate. You can deposit money on a pre-tax basis into the Health Care or Combo FSA to be reimbursed for certain health care expenses for you and your dependents. You can deposit money into the Dependent Day Care FSA on a pre-tax basis to be reimbursed for expenses related to the care of any dependent you claim on your federal income tax return.

How Flexible Spending Accounts Work

Ordinarily, you pay for unreimbursed health care and dependent care expenses with after-tax dollars. FSAs allow you to pay for certain expenses with pre-tax dollars. The money you deposit in the accounts is deducted from your pay before federal income taxes, social security and most state and local taxes are taken out, and you don't need to pay taxes on the reimbursements you receive from the accounts. That means you pay taxes on a smaller amount of money, and your disposable income is higher. However, certain states do not recognize these contributions for state income tax purposes. For example, if you are a resident of New Jersey, you will pay personal income taxes on your pre-tax contributions. If you are a resident of Pennsylvania, you will pay personal income taxes on your pre-tax contributions to the Dependent Day Care FSA.

Here's how FSAs work:

1. Each year you decide how much money you want to deposit in the accounts.
2. The money is deducted from your pay in equal amounts each pay period throughout the year and goes into your account before federal and, in most cases, state and local income taxes are deducted.
3. After you pay for an eligible health care, combo or dependent care expense, you submit a claim and are reimbursed with tax-free money from your account. You can submit claims for expenses incurred during the year until March 31 of the following year.
4. You can also use your Mercer Marketplace Visa® Debit card to pay for expenses with amounts contributed to your FSAs.

Remember, the health care, combo and dependent care accounts are all separate. You *cannot* use money in the Health Care FSA or Combo FSA for your dependents' day care expenses, and you *cannot* use money in the Dependent Day Care FSA for your or your dependents' health care expenses.

Your Deposits – Use It or Lose It

It is important that you plan carefully and contribute only as much money as you are sure to use. If you do not use all of the money you deposit in your FSA accounts during the year, you will forfeit the unused balance. Your unused balance will not be refunded to you or carried over to the next year – you either use it or lose it.*

To be reimbursed as an active employee, your eligible expenses must be incurred during the plan year (January 1 through December 31) and while you were making FSA contributions. You can submit claims for these expenses until March 31 of the following year. After March 31, you forfeit any unused amount in your accounts.

See Life Events Action Chart in the Benefits Highlights section for reimbursement rules following termination of employment.

** The sole exception to this rule is if you are a qualified reservist who is called to active duty for more than 180 days, in which case unused funds from your health care FSA may be distributed to you in accordance with the terms of the HEART Act.*

How Other Benefits Are Affected

Even though participation in the flexible spending accounts reduces your taxable income, it will not affect other benefits related to your income, for example, life insurance.

However, if you earn less than the Social Security wage base your Social Security taxes will be lower, and your Social Security benefits could be reduced slightly. For many employees, however, the immediate tax benefits of participating in the accounts will outweigh the slightly reduced future Social Security benefit. Since each employee's financial situation is different, you should consult with your tax advisor to determine how this reduction in Social Security benefits will affect you.

Special Rules for Flexible Spending Accounts

Specific Treasury regulations govern benefit plans such as flexible spending accounts. These regulations and laws place stringent requirements on the Company to monitor and regulate the amounts that different groups of employees may contribute. To comply with these regulations, the Company may at times need to change contribution levels under the Plan. Therefore, while there are certain contribution limits shown in this section of the document, all flexible spending account participants may not be able to contribute up to the limit, or the amount they have elected to contribute may be reduced.

Health Care FSA

The Health Care FSA allows you to set aside money from your pay on a pre-tax basis to pay for eligible health care expenses not covered by any medical, dental or vision

program. After you pay these expenses and submit a claim, you can be reimbursed with tax-free money. However, you may not set aside money in the Health Care FSA if you are enrolled in a high deductible health plan. Instead, you may set money aside in the Combo FSA (described below).

How Much You Can Deposit

You can deposit between \$120 and \$2,750 (in 2021), as indexed, each calendar year in the Health Care FSA. Your deposit is subtracted from your pay in equal amounts each pay period before income taxes and social security taxes are taken out.

Eligible Dependents

Besides yourself, you can claim health care expenses for:

- Your spouse
- Your dependent children
- Any other person who can be claimed as your dependent for federal income tax purposes (without regard to their gross income).

You do not have to cover your Eligible Dependents under the medical, dental or vision plans to use the Health Care FSA for their eligible expenses. Similarly, you do not have to enroll in health care coverage to use this account.

Consult the definition of Eligible Dependent in the *Important Terms* section of this SPD for more information.

Eligible Expenses

Expenses eligible for reimbursement through the Health Care FSA are those health care expenses not covered or only partly covered by any health care plan you may have. They include:

- Medical, dental and vision deductibles
- Coinsurance amounts
- Copayments and fees
- Expenses not reimbursed because they are greater than reasonable and customary amounts
- Certain services or treatment not covered by your health care plans
- Amounts over scheduled payments.

In general, any health care expenses, excluding insurance premiums and certain long-term care expenses, that the IRS considers to be deductible on your income tax return and not covered by any health care plan, are eligible for reimbursement from the Health Care FSA.

The following is a partial list of some specific expenses eligible for reimbursement through the Health Care FSA. Refer to IRS Publication 502, “Medical and Dental Expenses,” (available on the IRS website at www.irs.gov) for more information regarding eligible and ineligible expenses.

- Adapters for telephone and TV for the deaf
- Alcoholism treatments
- Artificial limbs, eyes
- Braille books and magazines
- Child-birthing classes
- Contact lens solution
- Crutches, splints and braces
- Fees for smoking cessation (including classes, nicotine gum and patches)
- Fertility treatment
- Guide dogs for the blind or deaf (including the cost of buying, training and maintaining the dog)
- Hearing aids
- Medical supplies and equipment
- Nurse’s board and wages, including employment-related taxes paid
- Orthopedic shoes
- Podiatrists
- Psychotherapy
- Remedial reading lessons for dyslexic child
- Repair of medically necessary equipment
- Telephone for the deaf

- Travel expenses related to medical treatment
- School costs for mentally or physically handicapped children
- Wheelchair
- Wigs purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from a disease.

Ineligible Expenses

According to the IRS, some expenses are not considered deductible health care expenses, and therefore are not eligible to be reimbursed through the Health Care FSA. Ineligible expenses include:

- Amounts reimbursed by any health plan
- COBRA premiums
- Cosmetic surgery, unless expenses are necessary to correct a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.
- Covered expenses incurred before the effective date of your participation in the plan
- Covered expenses you also claim as a deduction on your federal income tax return
- Custodial care
- Fees for fitness or exercise classes, except when prescribed by a doctor as medically necessary
- Fees for weight loss programs, except when prescribed by a doctor as medically necessary
- Funeral and burial expenses
- Health and beauty supplies
- Health club memberships
- Marriage counseling
- Maternity clothing
- Over-the counter medications to treat illness or injury, unless ordered by a physician and accompanied by a prescription.

- Plan premiums or contributions for your coverage or that of your dependents under the Pearson medical, dental and vision plans
- Premiums for another health plan (such as your spouse's plan) or any other insurance policy
- Wigs (except when purchased upon the advice of a physician for the mental health of a patient who has lost all his or her hair from a disease).

Note: The eligibility of a deduction for these expenses is always subject to IRS review. Therefore, the Company cannot guarantee that the same expenses will always be eligible (or ineligible) for reimbursement from an account. Should the IRS change its ruling concerning the eligibility of a particular expense, the Plan will accept the ruling effective on the date the IRS publishes its rule. However, any such change by the IRS in the tax-deductible status of an expense does not allow you to stop or start contributions to an account.

Reimbursement

With the Health Care FSA, you can be reimbursed for eligible expenses up to the full amount you choose to deposit for the year – whether or not your current balance is sufficient to cover the amount to be reimbursed.

The IRS requires you to keep documentation associated with reimbursement from your FSA. Make sure you keep copies of all invoices, receipts and claim forms as you might be required to produce them in the event you are asked to verify a claim by Mercer or are audited by the IRS.

How To File A Claim

To receive reimbursement from your Health Care FSA, you can use your Mercer Marketplace Debit Card.

Tax Considerations

The IRS allows you to deduct unreimbursed health care expenses on your federal income tax return if they exceed 7.5% of your adjusted gross income. Health care expenses, to the extent reimbursed through your Health Care FSA or through any other health plan, cannot be deducted on your federal income tax return.

You should consult with your personal tax advisor to determine whether the Health Care FSA makes sense for you.

Combination (Combo) FSA

The Combination (Combo) FSA allows you to set aside money from your pay on a pre-tax basis to pay for eligible health care expenses not covered by any medical, dental or vision care program.

Employees enrolled in a Health Savings Account (HSA) may also enroll in the Combination FSA for additional tax savings on dental and vision services. Once you meet the IRS-required deductible amounts of \$1,400 for individual coverage or \$2,800 if you cover dependents for medical services, you can then use your Combination FSA for medical and prescription expenses, too. Please keep in mind that just like the Health Care FSA, the Combo FSA has a “use it or lose it” rule. This means you will forfeit any money left in your FSA at the end of the year. Because of this, it’s smart to estimate your 2021 expenses before locking in your FSA contribution amount.

How To File A Claim

To receive reimbursement from your Combo FSA, you can use your Mercer Marketplace Debit Card or log into the Mercer Marketplace at <https://auth.mercer.com/PEAR23/login>.

Health Spending Accounts Overview

When choosing your plan, it's important to consider the tax-free accounts each plan might be paired with. The health spending accounts you are eligible for depend on the medical plan you choose. See the chart below to see how the health spending accounts work.

	Health Savings Account (HSA)	Combination FSA (Pairs with the HSA)	Health Care FSA
Who's eligible?	Employees enrolled in the \$1,850 medical option or the \$2,850 medical option	Employees enrolled in an HSA looking for additional tax savings	Employees enrolled in the \$400 medical option or the \$900 medical option and others not enrolled in an HSA
Who contributes?	You and Pearson	You	You
What does it cover?	Eligible medical, prescription, dental, and vision expenses	Eligible dental and vision expenses only, until IRS deductible* is met then medical/Rx	Eligible medical, prescription, dental, and vision expenses
What is the 2021 employee contribution annual limit?	\$3,600 single/\$7,200 family; add \$1,000 if you are age 55 or older	\$2,750	\$2,750
Use it or lose it at year-end?	No	Yes	Yes
Can you use it to save for future health expenses?	Yes	No	No
Can you invest your money?	Yes, for additional tax-free earning potential once your account has reached a minimum balance	No	No
Is the money always yours to keep?	Yes, even if you leave Pearson or enroll in a non-CDHP option in the future	No	No

**Once you meet the 2021 IRS-required deductible amounts of \$1,400 for individual coverage or \$2,800 if you cover dependents, for medical/Rx services, you can then use your Combination FSA for medical and prescription expenses.*

Dependent Day Care FSA

The Dependent Day Care FSA allows you to set aside money from your pay before taxes are taken out to pay for eligible dependent care expenses. The expenses must be necessary to allow you – or if you are married, you and your spouse – to work or to enable your spouse to attend school full-time (unless your spouse is disabled). After you pay for these expenses, you can be reimbursed with tax-free money from your dependent day care account.

How Much You Can Deposit

You can deposit between \$120 and \$5,000 each calendar year in the Dependent Day Care FSA (but see the next section on the maximum tax-free reimbursement you can receive). Your deposit is deducted from your paycheck in equal amounts each pay period before income taxes and Social Security taxes are taken out.

Maximum Tax-Free Reimbursement

Generally, amounts reimbursed from your Dependent Day Care FSA are tax-free to you. However, federal law provides that the amount excluded from your gross income cannot exceed the lesser of:

- \$5,000 (\$2,500 if you are married and filing separate federal income tax returns);
- Your annual income; or
- Your spouse's annual income.

If your spouse is (1) a full-time student for at least five months during the year or (2) physically and/or mentally handicapped, there is a special rule to determine his or her annual income. To calculate the income, determine your spouse's actual taxable income (if any) earned each month that he or she is a full-time student or disabled. Then, for each month, compare this amount to either \$250 (if you claim expenses for one dependent) or \$500 (if you claim expenses for two or more dependents). The amount you use to determine your spouse's annual income is the greater of the actual earned income or these assumed monthly income amounts of either \$250 or \$500. By making an election under the Plan to contribute to a Dependent Day Care FSA, you are representing to the Company that your contributions to the Dependent Day Care FSA are not expected to exceed these limits.

If you are married and filing separate federal income tax returns, the \$2,500 limit described above will not apply if you are (1) legally separated or (2) your spouse did not reside with you for the last six months of the calendar year, you maintained a household

that was your dependent's primary residence for more than six months during the year and you paid more than half of the expenses of that household.

The \$5,000 maximum limit is a household limit if you are married filing a joint federal income tax return. Therefore, if both you and your spouse participate in a dependent care assistance plan (through Pearson or through another employer), your combined maximum tax-free benefit is \$5,000 in a calendar year.

To qualify for tax-free treatment, you are required to list on your federal income tax return the names and taxpayer identification numbers of any person who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. The identification number of a care provider who is an individual and not a care center is that individual's social security number. Your care provider should be made aware of this reporting requirement.

The amount of your Dependent Day Care FSA deposit will automatically be reported on your W-2 form.

Eligible Dependents

You can claim dependent care expenses for:

- Any child under age 13 who can be claimed as your dependent for federal income tax purposes
- Your spouse who is physically or mentally unable to care for himself or herself and who lives with you for more than one-half of the year
- Any other person who is physically or mentally unable to care for himself or herself, who lives with you for more than one-half of the year and who can be claimed as your dependent for federal income tax purposes (without regard to gross income).

For expenses related to services outside your home to be eligible, a dependent (other than a child under age 13) must spend a minimum of eight hours a day in your home.

Eligible Expenses

You can use the money you deposit in this account to pay dependent day care expenses you incur in order to work. If you are married, your spouse must also work, be a full-time student or be disabled.

The following expenses for dependent care are eligible for reimbursement through the Dependent Day Care FSA:

- Childcare in your home or someone else's home

- Dependent care center that meets all state and local licensing requirements, if the center cares for more than six individuals
- Pre-school, up to but not including first grade; provided, that coverage for kindergarten requires documentation that the costs incurred are not educational expenses
- Summer day camp
- Certain expenses for a live-in, full-time housekeeper who provides dependent care in your home
- A relative who provides care, as long as the relative is not your dependent and is not your child under age 19
- After-school childcare
- Adult day care, either in your home or in an adult day care center.

To make sure your situation and the type of care being provided meet IRS requirements, refer to IRS Form 2441 and IRS Publication 503, “Child and Dependent Care Expenses.” In addition, you should know that if you use a dependent care provider inside your home you may be considered the employer of that individual and may be responsible for withholding and paying employment taxes. For more information, refer to IRS Publication 926, “Employment Taxes for Household Employees.” These forms and publications are available on the IRS’ website (www.irs.gov).

Ineligible Expenses

According to the IRS, some expenses are not eligible for reimbursement through a Dependent Day Care FSA. These include:

- Health care expenses for your dependents
- Education expenses for a child in the first grade or above, or the portion of the costs of kindergarten which relate to the education of the dependent
- Twenty-four-hour nursing home care
- Overnight camp
- Care provided by someone you claim (or could claim) as a dependent on your federal income tax return
- Care provided by your child who is under age 19
- Transportation to and from school or day care

- Baby-sitting expenses during non-working hours
- Expenses incurred while you are not working due to vacation or illness
- Food or clothing expenses
- Dependent care expenses you claim on your federal income tax return
- Expenses incurred when you were not contributing to the Dependent Day Care FSA
- Care in an unlicensed day care center, if the center cares for six or more individuals.

Reimbursement

With the Dependent Day Care FSA, you can be reimbursed only up to your current account balance. If your claim is for an amount greater than what is currently in your account, your claim will be held until there is enough money in your account to cover your claim.

After you have claimed reimbursements totaling your deposit for the plan year so that your account balance is zero, no remaining or additional claims for that plan year will be paid.

How To File A Claim

To receive reimbursement from your Dependent Day Care FSA, you can use your Mercer Marketplace Debit Card or log into Mercer Marketplace.

Comparing the Dependent Day Care FSA and Tax Credit

A federal tax credit is available for the same dependent care expenses that can be reimbursed through the Dependent Day Care FSA. The tax credit is an alternative to reimbursement from the FSA. As a general rule, the higher your gross family income, the less valuable the tax credit becomes to you. Whether it is better for you to contribute to an FSA or take advantage of the tax credit depends on your individual circumstances. Here is a general approximation of how they compare:

- The tax credit allows you to subtract a part of your expenses directly from the federal income taxes you owe. With the FSA you reduce your taxable income by the amount of your contributions. This, in turn, reduces the total taxes you owe. The tax advantage of the FSA depends on you being able to exclude any reimbursement from your gross income for tax purposes (see above). In general, you can exclude up to \$5,000, unless you are married filing a separate income tax return, in which case you can exclude only \$2,500.
- The expenses you can apply toward the tax credit are limited to \$3,000 if you have one dependent and \$6,000 if you have more than one. With the FSA, your IRS filing

status, rather than the number of dependents you have, determines the amount of reimbursement that you can exclude from your gross income.

Determining whether the Dependent Day Care FSA is more advantageous than the tax credit is a determination which depends on several factors. You should consult your personal tax advisor before making your election.

Another tax credit available under current tax law is the earned income credit. This credit also reduces dollar-for-dollar the federal tax you have to pay but is calculated somewhat differently from the childcare credit. Again, you should consult your personal tax advisor to determine whether the Dependent Day Care FSA makes sense for you.



VI. Long-Term Disability Program

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About This Section

The Long-Term Disability (LTD) program provides continuing income to help you meet your financial obligations should you remain disabled and be unable to work after your period of short-term disability. This section describes the benefits available to you under the Long-Term Disability program.

Some of the terms and phrases used in this benefits document have a specific meaning. Please refer to the *Important Terms* section of this document for further information.

You should also refer to the *Benefits Highlights* and the *Additional Information About Your Benefits* sections of this document for more important information regarding eligibility, how contributions are made, how elections can be changed, how to file claims and your rights under ERISA.

An Overview of the Long-Term Disability Program

The Long-Term Disability (LTD) program is designed to provide financial protection if you are unable to work as a result of an illness or injury – suffered on or off the job – for an extended period. You may receive LTD benefits if you have been disabled for more than 180 days and if your disability began after you became covered under the program.

To be eligible for LTD benefits, you must be continuously disabled during the elimination period and under the regular care of a physician. LTD coverage is not available to Limited-Term employees.

Definition of Disability

During the first 24 months of long-term disability payments, you are disabled when the insurance carrier determines that:

- You are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
- You have a 20% or greater loss in your indexed monthly earnings due to the same sickness or injury.

After 24 months of long-term disability payments, you are disabled when the insurance carrier determines that due to the same sickness or injury, you are unable to perform the duties of any gainful employment for which you are reasonably fitted by training, education or experience.

You must be under the regular care of a physician to be considered disabled.

For purposes of this definition:

- “gainful occupation” means an occupation that is or can be expected to provide you with an income at least equal to your gross disability payment within 12 months of your return to work; and
- “regular occupation” means the occupation you are routinely performing when your disability begins.

Long-Term Disability Benefit Options

Your benefit options under the Long-Term Disability program are described as a percentage of your pay. Your pay in effect just prior to the start of your disability is the basis for determining your LTD benefit. Your pay includes your income before taxes, as well as contributions made to your 401(k) plan, your savings and spending accounts, and your medical, dental and vision coverage. Pay does not include income from commissions, bonuses, overtime pay, or any other extra compensation. For sales

employees, pay includes sales commissions and/or sales bonuses paid in the previous calendar year.

Basic LTD Insurance

The Company pays for and provides a benefit equal to 50% of pay, up to a maximum monthly benefit of \$20,833. If you become eligible for LTD benefits, you would pay income taxes on the benefits you receive.

Supplemental LTD Insurance

Supplemental LTD insurance is also available. This option is equal to an additional 10% of coverage, which makes your total disability benefit equal to 60% of pay, up to a maximum of \$25,000 per month. Supplemental coverage is employee paid on an after-tax basis, which means that the benefits you receive for this portion of your coverage will not be subject to income tax. The basic portion of your benefits will be subject to income tax.

Evidence of insurability (EOI) is not required if you elect supplemental LTD insurance when you are first eligible. EOI is required if you elect supplemental LTD at a later date, and the additional benefit will not be effective until approved by the insurance company.

Pre-existing Condition Limitation

You will not receive LTD benefits if you had a pre-existing condition from which you became disabled within the first 12 months after your effective date of coverage. You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the three months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

In addition, the plan will not cover an increase in your coverage made at an annual open enrollment period or change in status if you have a pre-existing condition. You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three months just prior to the date your coverage increased; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the three months just prior to your coverage increase; and

- the disability begins in the first 12 months after your coverage increased.

Reduction in LTD Benefit

The long-term disability payment you receive is reduced by income payable to you from other sources, including but not limited to:

- State disability laws or an automobile liability insurance policy
- Social Security, Canadian pension plan or other law (including without limitation, the Railroad Retirement Act and the Jones Act) that provides you, your spouse or your children with benefits due to your total disability or your retirement
- Workers' Compensation or other laws (including without limitation, an occupational disease law) with similar intent
- Group insurance plans or other company-sponsored disability benefits, company retirement plans or government retirement systems
- Wages you receive while disabled (see *Benefits While You Are Working* on page 7)
- Company-paid disability and/or salary continuation benefits
- Amounts received from a third party, as a result of a judgment or settlement
- Any amount you receive from any unemployment benefits

The income listed above (except retirement benefits and wages) must be payable as a result of the same disability for which you receive the LTD benefit for it to reduce your LTD benefit.

Regardless of any payments you receive from other sources, your minimum monthly benefit from the LTD plan will be the greater of \$100, or 10% of your gross disability benefit before any reductions.

When you apply for LTD benefits, you must submit proof of your disability as well as proof you have applied for other disability income to which you may be entitled, as described above.

Duration of Benefits

LTD benefits are payable for a maximum period depending on your age when your disability begins. Assuming you remain disabled and have a covered disability, benefits are payable according to the following schedule:

<i>Age at Disability</i>	<i>Maximum Benefit Period</i>
Less than age 60	Greater of Social Security Normal Retirement age or to age 65, but not less than 5 years
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

LTD benefits will be paid as long as your disability is considered a covered disability and you provide satisfactory evidence of your continuing disability to the insurance company when requested. While you are disabled, the insurance company may require that you be examined by one of its physicians. This exam will be at no cost to you, but if you refuse, your LTD benefits may stop.

Limitations for Mental Illness

If you are disabled because of mental illness, the Plan will pay benefits for up to 24 months. The Plan will continue to pay LTD benefits if, at the end of the 24-month period, you are confined in a hospital or institution.

If you are still disabled when you are subsequently discharged, the Plan will pay benefits for a recovery period of up to 90 days. If you are confined again during the recovery period for at least 14 consecutive days, the Plan will pay benefits during the confinement and for one additional recovery period of up to 90 days.

The Plan will not pay beyond the shorter of the limited mental illness or the maximum benefit period as indicated in the chart above.

Mental illness as a result of the following conditions will not be subject to the above limitation:

- Stroke
- Trauma
- Viral infection

- Alzheimer's disease
- Other conditions and protocols not typically treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar treatments.

How Disability Affects Your Other Benefits

For information on how medical, dental, vision, life insurance and other benefits are affected, please refer to the *Life Events Action Chart* in the Benefits Highlights section of this document.

When Disability Benefits End

In addition to the limitation for mental illness, your monthly LTD benefit will end on the earliest of:

- During the first 24 months of payments, when you are able to work in your regular occupation on a part-time basis, but you choose not to
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis, but you choose not to
- The end of your maximum period of payment
- The date you are no longer disabled under the terms of the plan
- The date you fail to submit proof of continuing disability
- After 12 months of payments if you are considered to reside outside the United States or Canada for a total of six months or more during any 12 consecutive months of benefits
- The date your disability earnings exceed the amount allowable under the Plan
- The date you die.

Recurring Disabilities

If you recover from a disability, return to work and become disabled again for the same or a related condition within the next six months, the second disability will be treated as an extension of the prior disability, and you will not need to satisfy a new 180-day waiting period.

If you have been back at work for six months or more and your disability recurs, it will be treated as a new disability. You will need to complete a 180-day waiting period before disability benefits begin.

Benefits While You Are Working

If you are disabled and working and have at least a 20% loss in earnings, you may continue to receive LTD benefits.

You will continue to receive your LTD benefits during the first 12 months of employment. However, the maximum you can receive from the Long-Term Disability program and rehabilitative employment combined is 100% of your pre-disability pay. If the combined total is more than your pre-disability earnings, the monthly LTD benefit will be reduced by the excess amount.

After the first 12 months of payments, your monthly benefit will be determined by the percentage of income you are losing due to your disability. During the first 24 months of disability payments, if your monthly disability wages are more than 80% of your LTD benefit, your benefit will cease. Beyond 24 months of disability payments, your benefit will cease if your earnings are greater than your disability payment.

What is Not Covered by the LTD Program

Benefits will not be paid for disabilities caused by, contributed to by, or resulting from:

- War, declared or undeclared, or any act of war
- Intentionally self-inflicted injuries
- Active participation in a riot
- Your participation in a felony
- Cosmetic surgery unless such surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part in connection with an injury or sickness sustained while you are covered under this plan.

Recovery of Benefit Overpayments

If, for some reason, the insurance company has overpaid your benefit, they have a right to recover the excess amount, or to reduce future benefit payments until reimbursement is made. This includes recoveries due to overpayments because you were entitled to Workers' Compensation benefits, Social Security benefits, or related payments that were not deducted from your benefits under the Plan.

Survivor Benefits

If you die while receiving LTD benefits, your surviving spouse will be eligible for a benefit from the Plan. If your spouse is not living at the time of your death, the Plan will

pay benefits to your dependent children under age 25. If there is no eligible survivor, payment will be made to your estate, unless there is none. In this case, no benefits will be paid.

The Plan will pay a lump sum benefit equal to three times the gross monthly disability payment, if on the date of your death:

- Your disability had continued for 180 or more consecutive days, and
- You were receiving or were entitled to receive payments under the Plan.

If the survivor benefit is payable to your children, payment will be made in equal shares to the children, including stepchildren and legally adopted children. However, if any of said children are minors or incapacitated, payment will be made on their behalf to the court-appointed guardian of the children's property. This payment will be valid and effective against all claims by others representing or claiming to represent the children. If there is no eligible survivor, the benefit is payable to the estate.

Conversion of Coverage

When you leave the Company, you may be eligible to continue your basic and supplemental disability coverage. The coverage may not be identical to the coverage you had while employed by the Company, and you will have to pay premiums to the insurance company directly. To be eligible, you must have been covered under the LTD program for at least 12 consecutive months, and you cannot be covered by another employer's group LTD plan within 31 days of your leaving the Company.

You will receive information about conversion of coverage when you leave the Company.



VII. Life & Accident Insurance Programs

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About This Section

Life and accident insurance play a vital role in your and your family's financial security. This insurance coverage gives your family a foundation of support in the event your income is no longer available. It can also provide financial assistance if you suffer the loss of a family member. No one likes to consider the need for life and accident insurance. However, it is a valuable safety net for the financial well-being of you and your family.

This section describes the benefits available to you through the life and accident insurance programs.

Some of the terms and phrases used in this benefits document have a specific meaning. Please refer to the *Important Terms* section of this document for further information.

You should also refer to the *Benefits Highlights* and the *Additional Information About Your Benefits* sections of this document for more important information regarding eligibility, how contributions are made, how elections can be changed, how to file claims and your rights under ERISA.

An Overview of the Life and Accident Insurance Programs

The life and accident insurance programs include the following coverage:

- **Basic Life Insurance** of two times your annual pay (multiplied and then rounded up to the next higher \$1,000) up to a maximum of \$1,000,000. Part-time regular employees scheduled for 20 or more hours per week receive a benefit equal to one times annual pay. This coverage is provided by the Company at no cost to you.
- **Supplemental Life Insurance** of up to six times your annual pay up to a maximum of \$2,000,000.
- **Dependent Life Insurance** is available for your spouse and dependent children.
- **Basic Accidental Death & Dismemberment Insurance** of two times your annual pay (multiplied and then rounded up to the next higher \$1,000) up to a maximum of \$1,000,000. Part-time regular employees scheduled for 20 or more hours per week receive a benefit equal to one times annual pay. This coverage is provided by the Company at no cost to you.
- **Supplemental Accidental Death & Dismemberment Insurance** is available for employees who wish to purchase additional coverage. You may elect Supplemental Accidental Death & Dismemberment Insurance for yourself and your family.
- **Business Travel Accident Insurance** provides life and accident protection when you are traveling on company-related business.

How Benefits Are Paid

In the event of your death while insured and actively employed, the amount of your life insurance will be paid to the person you named as your beneficiary. Before the benefit is paid, the insurance company must receive written proof of your death. If there is more than one beneficiary, each receives an equal share unless you have requested otherwise in writing. You are automatically the beneficiary for dependent life insurance.

If there is no eligible beneficiary or you did not name one, your benefit will be paid, in this order, to:

- Your lawful spouse, if living, or
- Your natural or legally adopted child (children) in equal shares, if living, or
- Your parents in equal shares; or
- The personal representative of your estate.

Basic Life Insurance

The basic life insurance plan provides a death benefit in the amount of two times your annual pay up to a maximum benefit of \$1,000,000. Part-time regular employees scheduled for 20 or more hours per week receive a benefit equal to one times annual pay. Refer to the *Important Terms* section of this document for a definition of annual pay.

Basic life insurance coverage is provided by the Company at no cost to you.

Imputed Income

Federal tax law requires that employees pay income taxes on the value of Company-provided life insurance above \$50,000. If your pay is greater than \$25,000, your basic life insurance will be above \$50,000, and an additional amount of income representing the value of this insurance will be added to your W-2 form. This added income is called *imputed income*. For example, if you are age 30 and your pay is \$40,000, your basic life insurance amount would be \$80,000 and (under current IRS tables) you would have \$72.90 in imputed income. The older you are, the more imputed income you would have. You pay taxes on this imputed income, but this is not the amount of the tax itself. You can cap your basic life insurance at \$50,000 and avoid imputed income by completing a waiver form available from [Mercer Marketplace](#) by calling 1-855-237-6421. Please note that if you waive basic life insurance above \$50,000, you cannot reinstate your coverage at a later date without providing evidence of insurability to the insurance company.

You pay for supplemental and dependent life insurance coverage on an after-tax basis. Under current tax regulations, there is no imputed income on these benefits.

Reduction in Coverage Due to Your Age

Once you reach age 65, your basic life insurance benefits are reduced. Between the ages of 65 and 69, the benefit will be 65% of the original basic life insurance benefit.

At age 70 or older, your benefit will be reduced to 50% of the regular amount. Age reductions apply on the date of your birthday. The basic life and basic AD&D insurance are not rounded following the age reduction.

Supplemental Life Insurance

You may also purchase supplemental life insurance coverage. This coverage is in addition to your basic life insurance coverage provided by the Company. You can elect supplemental coverage equal to one to six times your annual pay up to a maximum of \$2,000,000.

Coverage elections made within 31 days of initial eligibility do not require evidence of insurability unless the amount of supplemental insurance elected is greater than four times your annual earnings or exceeds \$1,000,000 (whichever is less). Elections above these

amounts, and elections made outside of a period of initial eligibility may require evidence of insurability. Coverage for the amounts that require Evidence of Insurability will not be effective until approved by the insurance company. See *Evidence of Insurability* on page 12.

You pay for supplemental life insurance coverage on an after-tax basis. Your cost depends on the amount of coverage you choose and your age. In addition, the cost of coverage will be higher if you smoke or use tobacco in any form.

Reduction in Coverage Due to Your Age

Once you reach age 65, your supplemental life insurance benefits are reduced. Between the ages of 65 and 69, the benefit will be 65% of the original basic life insurance benefit.

At age 70 or older, your benefit will be reduced to 50% of the regular amount. Age reductions apply on the date of your birthday. Supplemental life insurance is not rounded following the age reduction.

Waiver of Premium

If you become disabled while you are covered by supplemental life insurance and before you are 60 years old, you contribute toward the cost of coverage during the first year of long-term disability. However, you may apply to the insurance company for a waiver of premium for the period of long-term disability beyond nine months. You will automatically receive a waiver of premium form at the time you qualify for long-term disability benefits. You should submit your completed waiver of premium application form as soon as possible, but no later than 12 months from the date of your disability. The insurance company may require you to have a physical exam by a doctor it chooses. If the insurance company approves a waiver of premium, it will be effective as of the date of such approval.

Supplemental Life Suicide Provision

The suicide exclusion applies to supplemental employee life insurance and spouse life insurance. Supplemental employee life benefits or spouse life benefits will not be paid if you or your insured spouse/domestic partner die by suicide, while sane or insane, within two years from the original effective date of coverage. When applicable, the suicide exclusion limits the benefit amount to the amount of premiums paid.

If you or your spouse die by suicide more than two years after the original effective date of your coverage, but within two years of any increase in supplemental life benefits, the increased amount will not be paid. Instead, benefits will be limited to the amount of premium paid for the portion of insurance subject to the suicide exclusion.

Dependent Life Insurance

In addition to life insurance coverage for yourself, you can also elect coverage for your spouse/ and/or children. You are automatically the beneficiary for dependent life insurance. See the *Important Terms* section of this document for the definition of eligible dependents.

Life Insurance for your Spouse/Partner

You can elect life insurance for your spouse/partner in increments of \$5,000 to a maximum of \$100,000 or six times your annual earnings, whichever is less.

Coverage elections made within 31 days of initial eligibility do not require evidence of insurability unless the amount of spouse/partner life insurance elected is greater than \$50,000. Elections above this amount, and elections made outside of a period of initial eligibility for your spouse/partner may require evidence of insurability. If you choose coverage for your spouse/partner your cost will depend on the option you choose, the age of your spouse/partner, and whether he/she smokes or uses tobacco in any form. The maximum amount of coverage for your spouse/partner is \$100,000. If the amount of his/her coverage exceeds \$50,000, your spouse/partner will have to provide Evidence of Insurability. See *Evidence of Insurability* on page 12.

Life Insurance for your Children

You can elect life insurance for your child(ren) in increments of \$5,000 to a maximum of \$20,000.

If you choose coverage for your children or the children of your spouse, the Plan covers all eligible children from live birth (stillborn and unborn children are not eligible) to the end of the month in which the child attains age 26. Children age 26 or older are also eligible if they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and are financially dependent on you for more than one-half of their support and maintenance. No matter how many children you cover, you will pay the same amount for coverage. If an employee's first eligible child dies within 31 days of live birth, but prior to your enrolling in child life insurance a \$5,000 death benefit will be paid. Evidence of insurability is never required of a child, regardless of when application is made.

You pay for all dependent life insurance coverage on an after-tax basis.

Evidence of Insurability may be required before dependent coverage becomes effective. See *Evidence of Insurability* on page 12.

Reduction in Coverage Due to Age

Once an eligible child reaches age 26, his/her coverage will terminate at the end of the month in which he/she turns 26. Children age 26 or older are also eligible if they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26, and are financially dependent on you for more than one-half of their support and maintenance.

Once your spouse/partner reaches age 65, your supplemental life insurance benefits are reduced. Between the ages of 65 and 69, the benefit will be 65% of the original spouse/partner insurance benefit. At age 70 or older, the benefit will be reduced to 50% of the regular amount. Age reductions apply on the date of your spouse's/partner's birthday. Spouse/partner life insurance is not rounded following the age reduction.

If You and Your Spouse/Partner Both Work for the Company

If you and your spouse/partner both work for the Company, each of you are eligible for basic and supplemental employee insurance. You are not eligible for spouse/partner coverage if you are eligible as an employee. If you have dependent children, they can only be covered as the dependent of one parent.

Accidental Death & Dismemberment Insurance

The Company provides basic Accidental Death & Dismemberment (AD&D) insurance at no cost to you. AD&D insurance provides a benefit if you die or are seriously injured as the result of an accident that occurred while you were covered. The death or loss must occur within 365 days of the accident. In the event of your death, as a result of a covered accident, your beneficiary will receive benefits from both the life insurance plan and the AD&D plan.

The basic AD&D benefit equals two times your annual pay, up to \$1,000,000. Part-time regular employees scheduled for 20 or more hours per week receive a benefit equal to one times annual pay.

In addition to basic AD&D insurance, you have the option of purchasing supplemental AD&D insurance for yourself or yourself and your family. Supplemental AD&D insurance options include:

- **Employee only** coverage in \$10,000 increments up to a maximum of \$500,000
- **Family** coverage, provided according to the following schedule:
 - 50% of the employee amount for the spouse/partner (if there are no children insured); the maximum benefit for spouse/partner coverage is \$250,000
 - 40% of the employee amount for the spouse/partner (\$250,000 maximum) and 10% for each child insured, to a maximum of \$50,000 for each child; or

- 15% of the employee amount for each child (if there is no spouse/partner insured) to a maximum of \$50,000 for each child.

If both you and your spouse/partner work for the Company, you may both elect employee coverage, but only one of you may elect family coverage. You are not eligible for coverage as a spouse/partner if you are eligible as an employee. You pay for supplemental AD&D insurance with after-tax dollars.

The chart below shows the standard losses and benefit amounts paid under the Plan. In addition, there are several ancillary benefits payable. See Other AD&D Benefits.

How AD&D Benefits Are Paid

If you die as a result of an accident, the Plan pays your beneficiary the full amount of your coverage. If you lose a limb or your sight in one or both of your eyes as the result of an accident, the Plan pays a benefit to you. The benefit is equal to all or part of your coverage amount, depending on the nature of your loss. For losses within 365 days of a covered accident, the Plan pays benefits as follows:

<i>Covered Losses</i>	<i>Benefit Amounts</i>
Life	100% of the full amount
A hand	50% of the full amount
A foot	50% of the full amount
Sight of an eye	50% of the full amount
Sight of both eyes	100% of the full amount
Any combination of a hand, a foot or sight of an eye	100% of the full amount
Thumb and index finger of same hand	25% of the full amount
Speech and hearing	100% of the full amount
Speech or hearing in both ears	50% of the full amount
Quadriplegia	100% of the full amount
Paraplegia	75% of the full amount
Hemiplegia	50% of the full amount

Loss of hands or feet means complete severance at or above the wrist of ankle joints. Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical or by artificial means. Loss of thumb and index finger means complete severance of both thumb and the index finger at or above the metacarpophalangeal joints. Quadriplegia means total paralysis of both upper and lower limbs. Paraplegia means total paralysis of both lower limbs. Hemiplegia means total paralysis of upper and lower limbs on one side of the body.

A benefit is not payable for both loss of thumb and index finger of one hand and the loss of one hand or injury to the same hand as a result of any one accident.

Benefits may be paid for more than one accidental injury, but the total amount of insurance payable for all losses will not be more than your full amount of insurance.

Other AD&D Benefits

Both basic and supplemental AD&D coverage include an exposure benefit, a disappearance benefit and a seat belt benefit.

Exposure Benefit - If an insured is unavoidably exposed to the elements by reason of a covered accident and suffers a loss that is included in the list of covered losses as a result of such exposure, the loss will be covered under the terms of this benefit.

Disappearance Benefit - Under the disappearance benefits, if an insured's body has not been found after one year from the date of the conveyance in which he or she was traveling disappeared, exploded, sank, became stranded, made a forced landing or was wrecked, it will be assumed that the insured has died as a result of an accidental injury which was unintended, unexpected and unforeseen and a death benefit may be payable.

Seatbelt Benefit - The seat belt benefit pays an additional benefit equal to 10% of the full benefit, up to a maximum of \$25,000 if a covered person dies from injuries sustained while driving or riding in a private passenger car, if the covered person's seat belt was properly fastened.

Hospital Benefit – If an insured requires hospitalization as a result of a covered accident, an additional benefit will be paid during such hospitalization. After a four-day waiting period, a monthly benefit equal to 1% of the insured's amount of insurance will be paid subject to a maximum of \$2,500 per month for up to 12 months.

Contact [Mercer Marketplace](#) or call 1-855-237-6421 for more information about these ancillary benefits.

Reduction in AD&D Coverage Due to Age

Once you reach age 65, your basic and supplemental AD&D coverage is reduced. Between the ages of 65 and 69, your benefit will be 65% of the original benefit. At age 70 or older, your benefit will be reduced to 50% of your regular amount. AD&D is not rounded following the age reduction.

What Is Not Covered by the Plan – Basic and Supplemental AD&D

The Plan will not pay basic AD&D benefits for a loss connected to the

insured's death or dismemberment is caused directly or indirectly by, results from, or where there is a contribution from any of the following:

- Self-inflicted injury or self-destruction, whether sane or insane; or
- Suicide or attempted suicide, whether sane or insane; or
- your participation in a felony; or
- your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician; or
- aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; or
- War or any act of war, whether declared or undeclared; or
- Service in the armed forces or units auxiliary thereto, except as provided under the Reserve-National Guard benefit

Business Travel Accident Insurance

The Business Travel Accident Insurance program, insured by Zurich, pays benefits if you die or are injured as the result of an accident while traveling on Company business, or if your spouse/partner or child dies or is injured as the result of an accident while traveling on an approved business or relocation trip.

Because this program is automatically provided by the Company, you do not need to enroll in it. Coverage under the program begins automatically on your date of hire. If you are not actively at work on your hire date, your coverage will become effective when you start work.

How Business Travel Accident Benefits Are Paid

The Plan provides benefits of four times your annual pay up to a maximum benefit of \$2,000,000. The Plan also provides maximum benefits of the US dollar equivalent of £50,000 for your spouse/partner and each dependent child.

Coverage for an authorized business trip starts when you leave your home or normal place of employment, whichever occurs later. Coverage continues until you return to either of these locations. Coverage is not provided for commuting to or from work, or when you are on vacation, on a leave of absence, or otherwise not actively at work. However, you are covered for personal trips of up to seven days during a business trip.

Also, your spouse/partner and dependent children are covered, whether traveling together with you or not, during an authorized relocation trip that starts when they leave their

former place of residence for purposes of relocating and ends when they arrive at the new place of residence. Dependent children mean your unmarried children under age 19 (or under age 23 if attending school) who are dependent on you for support.

This Plan pays benefits as follows if a loss occurs because of and within one year of an accident while on an authorized trip:

<i>For Loss of:</i>	<i>Employee</i>	<i>Sp/Partner/Child</i>
Life, loss of limb (one or both), loss of eye (one or both), permanent total disability, total loss of speech and/or total loss of hearing in both ears	4x Salary	£50,000 (US dollar equivalent)
Total Loss of hearing in one ear	25% of 4x salary	£12,500 (US dollar equivalent)
Permanent partial disability	Continental scale applied up to 4x salary	Continental scale applied up to £50,000 (US dollar equivalent)

All losses should be reported as soon as possible along with appropriate proof to benefits.answers@pearson.com.

If you incur more than one loss as the result of the same accident, the Plan will pay only one benefit. This will be the higher benefit payable.

The aggregate limit for losses to more than one person in the same accident is \$20,000,000 per accident. For example, in the case of multiple deaths, the amount paid per individual death would be prorated depending upon the number of covered individuals involved in the incident.

What is Not Covered by the Plan

Business travel accident insurance does not cover injury or death resulting from:

- Intentionally self-inflicted injuries
- Suicide or attempted suicide
- Disease of any kind
- Bacterial infections
- Hernia of any kind

- War or act of war, declared or undeclared
- Injury while in the armed forces of any country or international authority
- Injury while on an aircraft when you are serving as a pilot or crew member of any plane, unless you are specifically named in the policy, or a flight in an aircraft of any military authority. However, travel by Military Air Transport Service (MATS) of the United States or a similar air transport of another country is covered. And, there is no coverage during a flight in an aircraft being used for any of the following activities:
 - Acrobatics or stunt flying
 - Racing or any endurance test
 - Flying in a rocket-propelled aircraft
 - Crop dusting or seeding
 - Spraying
 - Exploration
 - Pipe or power line inspection
 - Any form of hunting
 - Bird or fowl herding
 - Aerial photography or banner towing
 - Any test or experiment
 - Firefighting
 - Any flight that requires a special permit or waiver from the FAA
 - Flying in an aircraft owned or operated by the Company.

Additional Information About the Life and Accident Insurance Programs

Following is some additional information about your life, AD&D, and business travel accident insurance coverage.

Naming a Beneficiary

When you enroll in your benefits, you need to name a beneficiary for your life and accident insurance benefits. You can name different beneficiaries for each of these programs if you wish, and you can change your beneficiary designations at any time. You are automatically the beneficiary of dependent life insurance.

If you name more than one beneficiary to receive benefits from a program, each beneficiary receives an equal share unless you have requested otherwise in writing.

You'll be contacted separately by Securian to identify a beneficiary(ies) for Business Travel Accident. Beneficiaries for basic life/AD&D and supplemental life/AD&D must be entered into [Mercer Marketplace](https://auth.mercer.com/PEAR23/login) enrollment site at <https://auth.mercer.com/PEAR23/login>.

If there is no eligible beneficiary or you did not name one, your benefit will be paid, in this order, to:

- Your lawful spouse/partner, if living, otherwise
- Your natural or legally adopted child (children) in equal shares, if living, otherwise
- Your parents in equal shares, if living, otherwise
- The personal representative of your estate.

Evidence of Insurability

For each life insurance program, except Business Travel Accident insurance, you will need to provide Evidence of Insurability if your coverage exceeds a specified amount. Evidence of Insurability is also required if you do not elect coverage within 31 days of becoming eligible, but you choose it later. You may need to provide Evidence of Insurability (EOI) if:

- You increase the amount of your current supplemental or spouse/partner life insurance coverage
- You are electing an increase in your supplemental life insurance coverage to an amount that exceeds four times your annual base pay or \$1,000,000, whichever is less
- Your combined basic life insurance and supplemental life insurance totals more than \$2,000,000
- You were eligible to elect supplemental life or dependent life insurance in the past and you did not apply for coverage within 31 days of eligibility
- Life insurance for your spouse/partner exceeds \$50,000, unless he or she has already provided proof of good health.

- The insured receiving the increase was previously declined any amount of insurance by the insurance company due to failure to provide satisfactory evidence of insurability.

You can complete an Evidence of Insurability form online (contact Securian at 1-866-293-6047). Insurance in excess of the evidence limit will not be effective until it is approved by the insurance company.

If you have a wage increase which results in an increase in your spouse's/partner's dependent life insurance over \$50,000, he or she will need to provide Evidence of Insurability on the amount of coverage that exceeds \$50,000.

Accelerated Death Benefit

If you have a life expectancy of 12 months or less, you can request an accelerated death benefit from your basic and supplemental employee life insurance plans. Similarly, if your insured dependent spouse/partner or child has a life expectancy of 12 months or less, you can request an accelerated death benefit from the dependent life insurance plan.

To qualify for an accelerated benefit, you or your covered dependent must:

- Have coverage in force and all premiums due must be fully paid; and
- Supply the application in writing. Call Securian at 1-866-293-6047 to find out what information is required; and
- Be the sole owner of the certificate; and
- Not have an irrevocable beneficiary; and
- Be terminally ill (life expectancy of 12 months or less).

If you qualify, you may choose a full or a partial accelerated benefit. A partial benefit can only be requested if the remaining amount after the early payout is at least 25% of your initial amount of insurance or \$50,000 (whichever is less). If a partial benefit is chosen, coverage will remain in force and the amount remaining will be the full amount prior to the early payout minus the amount that was accelerated. If a full benefit is paid, the coverage will end. If your employee life coverage ends due to taking a full benefit, then any coverage on your dependents will also end at that time, though they will have the right to continue coverage for 12 months, and then convert to an individual policy as described in the continuation and conversion sections of the Group Term Life Certificate of Insurance.

An accelerated benefit will be made available on a voluntary basis only. An accelerated benefit under this supplement is not intended to cause an involuntary reduction of the death benefit ultimately payable to the named beneficiary. Therefore, payment of the death benefit cannot be accelerated under this supplement if the insured:

1. Is required by law to use this portion to meet claims of creditors, whether in bankruptcy or otherwise; or

2. Is required by a government agency to use this option in order to apply for, obtain or keep a government benefit or entitlement.

The maximum amount that can be accelerated is \$1 million or 50% of the insured's death benefit, whichever is less.

Continuation of Life Insurance

If your coverage ends due to any of the terminating events allowing conversion, you may elect to continue such insurance under the group policy prior to porting or converting by paying premiums directly to the insurance company. You must elect to continue your insurance within 31 days of the date your coverage would otherwise cease. You may continue your group term life insurance for a period of up to one year, at which time you may be eligible to port your coverage under the Group policy (individual term policy), or convert your life insurance to an individual policy of whole life insurance with the insurance company.

Conversion of Life Insurance

You may convert all or a part of your basic and any supplemental and dependent life insurance coverage to an individual life insurance policy when your coverage terminates.

You must pay the full cost of this coverage. Your premium rates will be based on your age (or the age of your spouse/partner in the case of spouse life insurance) and the amount of coverage requested at the time of conversion.

You must apply for conversion directly with the insurance company within 31 days from the date your coverage would otherwise cease. You will not be required to submit medical Evidence of Insurability. If you die during the 31-day conversion period, you will be deemed to have elected to convert and the death benefit will be paid (subject to any applicable exclusions).

Portability Feature for Supplemental Life Insurance

If you should leave or retire from the Company, you may take your supplemental life insurance up to \$1,000,000 and dependent life insurance coverage with you. Rates are based on age and differ from the rates you paid as an active employee. The insurance company will continue to service your policy on an individual basis, and you will pay premiums directly to them. No Evidence of Insurability is required. To continue your coverage, you must elect the portability option within 31 days of the date:

- You retire
- Your employment is terminated
- You or a covered dependent (if applicable) cease to be eligible under the Plan.

You will not be eligible to port coverage under the group policy if:

- You have attained age 80
- You converted insurance to an individual life policy
- You lose eligibility due to termination of group policy.

If you elect to port your own coverage, you may also elect to port insurance for your insured spouse/partner or child.

For more information concerning the continuation, portability or conversion options please contact the insurance company.

Plan Benefits That Are Not Convertible or Portable

Accidental death and dismemberment and business travel accident insurance cease when your coverage terminates. Portability and/or conversion features are not available for these coverages.



VIII. Additional Information About Your Benefits

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About This Section

This section provides general information and certain details required by ERISA concerning the benefits program. If you have any questions concerning your rights or privileges under the benefits program, the operation of the program, or the forms and information you need to submit in order to claim your benefits, please contact [Mercer Marketplace](#) at 1-855-237-6421 or at <https://auth.mercer.com/PEAR23/login>.

Some of the terms and phrases used in this benefits document have a specific meaning. Please refer to the *Important Terms* section of this document for further information.

How to File a Claim

Information on how and when to file a claim for each of the benefit programs is provided in the chart below. If you need additional information, please contact Mercer Marketplace at 1-855-237-6421 or at <https://auth.mercer.com/PEAR23/login>.

<i>Type of Claim</i>	<i>Where To Get Forms/Info</i>	<i>Where To Send Forms</i>	<i>Who Should File Claims</i>	<i>Time Limit To File Claims</i>	<i>Coverage Reminders</i>
Medical					
Anthem Plans	www.anthem.com	Anthem BlueCross BlueShield to the address on the claim form	Employee or Provider	For out-of-network services, 15 months from date of service	File only for out-of-network services. Attach itemized bills.
Cigna Plans	www.cigna.com	Cigna to the address on the claim form	Employee or Provider	For out-of-network services, 15 months from date of service	File only for out-of-network services. Attach itemized bills.
Aetna Plan	www.aetna.com	Aetna to the address on the claim form	Employee or Provider	For out-of-network services, 15 months from date of service	File only for out-of-network services. Attach itemized bills.
HMOs	Claim forms not required.				
Prescription Drugs (National Medical Plans only) Retail pharmacy	N/A	N/A	N/A	N/A	You do not have to file claims; however, you must use a participating pharmacy to receive benefits.
Mail Order	www.caremark.com	CVS/caremark to the address on the claim form	Employee	N/A	You may order up to a 90-day supply.
Dental					
Delta Dental	www.deltadentalmn.org	Delta Dental of MN to the address on the claim form	Employee or Provider	For out-of-network services, 12 months from date of service	Have your dentist provide an estimate in advance if treatment will cost \$300 or more.
DHMO	Claim forms not required				
Vision Care	www.vsp.com	Vision Service Plan to the address on the claim form	Employee	180 days from the date of service	File only for non-network services. Attach itemized bills.

Type of Claim	Where To Get Forms/Info	Where To Send Forms	Who Should File Claims	Time Limit To File Claims	Coverage Reminders
Health Care FSA or Health Savings Account	Mercer Marketplace (855) 237-6421	To file a claim other than using your debit card, log into the Mercer Marketplace and click on "Your Savings and Spending Accounts" under Quick Links; Click on "File A Claim" and follow the directions as noted	Employee	March 31 for expenses incurred through December 31 of the prior year	Minimum check amount: \$25 If the expense is partly covered by a health care plan, you must first file a claim and then submit a copy of the Explanation of Benefits (EOB).
Dependent Day Care FSA	Mercer Marketplace (855) 237-6421	To file a claim, log into the Mercer Marketplace and click on "Your Savings and Spending Accounts" under Quick Links; Click on "File A Claim" and follow the directions as noted	Employee	March 31 for expenses incurred through December 31 of the prior year	Minimum check amount: \$25 Attach the original bill, a receipt or canceled check. Include the caregiver's tax identification or Social Security number.
Long-Term Disability	Lincoln Financial	Call Lincoln Financial at 800-210-0268	Employee	Within 30 days after your disability begins, but no later than 90 days after the 180-day waiting period, or as soon as reasonably possible	Proof of disability will be requested. Physical examination may be required.
Life Insurance	Call Securian for more information at 888-658-0193	Call Securian for more information at 888-658-0193	Employee or beneficiary	Written notice of claim must be provided within 90 days after the loss on which claim is based or as soon as reasonably possible	Proof of loss must include a certified Death Certificate.
Dependent Life Insurance	Call Securian for more information at 888-658-0193	Call Securian for more information at 888-658-0193	Employee	Written notice of claim must be provided within 90 days after the loss on which claim is based or as soon as reasonably possible	Proof of loss must include a certified Death Certificate.

Type of Claim	Where To Get Forms/Info	Where To Send Forms	Who Should File Claims	Time Limit To File Claims	Coverage Reminders
Accidental Death & Dismemberment Insurance	Call Securian for more information at 888-658-0193	Call Securian for more information at 888-658-0193	Employee or beneficiary	Written notice of claim must be provided within 90 days of loss; written proof of loss must be provided within 90 days or as soon as reasonably possible.	Death claims must include a certified Death Certificate.
Business Travel Accident Insurance	Pearson People Services	Pearson People Services. Put in a ticket with myHR or send an email to ppsmhr@pearson.com	Pearson will submit claims to the insurance company	Written notice of claim must be provided within 20 days of loss; written proof of loss must be provided within 90 days or as soon as reasonably possible	Death claims must include a certified Death Certificate.

Claim Filing Procedures

The materials that describe a particular benefit under the Plan (i.e. Summary of Benefits Coverage) generally will contain a specific set of claims and appeals procedures that you must follow to make a claim to receive that particular benefit and/or to appeal a denied claim for that particular benefit. Although these separate claims and appeals procedures will be very similar in most respects, there may be important differences. As such, you should follow the specific claims and appeals procedures for a particular benefit very carefully. If the booklets and other materials that describe a particular benefit do not contain a specific set of claims and appeals procedures, the Plan's default procedures as described below will apply. If you have any questions about which set of claims and appeals procedures to follow or any other questions about making a claim, you should contact the Plan Administrator immediately.

For purposes of this section of the SPD describing the Plan's default claims and appeals procedures, the Plan Administrator (or any third party to whom the Plan Administrator has delegated the authority to review and evaluate claims, such as an insurance company) shall be referred to as the "Claims Administrator" at the initial claim level and the "Appeals Administrator" at the appeal level.

A request for benefits is a "claim" subject to these procedures only if it is filed by you or your authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made

orally) with the applicable provider identified in ***Legal Information*** below. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a “claim” under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a “claim” under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to allow the Claims Administrator to process the claim, you will be given an opportunity to provide the missing information.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation acceptable to the Claims Administrator and/or the Appeals Administrator identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

Claims Not Involving Health Benefits

In the case of a claim not involving health benefits (e.g., Life, AD&D, LTD, and Dependent Day Care FSA), initial claims for benefits under the Plan shall be made by you in writing to the Claims Administrator identified in ***Legal Information*** below.

- **Time Periods for Responding to Initial Claims:** If you bring a claim for benefits under the Plan, the Claims Administrator will respond to you within 90 days (45 days for a claim involving disability benefits) after receipt of the claim. For claims other than claims involving disability benefits, if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 90-day period that the Claims Administrator needs up to an additional 90 days to review your claim. In the case of a claim involving disability benefits, the Claims Administrator will notify you within the initial 45-day period that the Claims Administrator needs up to an additional 30 days to review your claim. If the Claims Administrator determines that the additional 30-day period is not sufficient and that additional time is necessary to review your claim for disability benefits, the Claims Administrator may notify you of the need for an additional 30-day extension.
- **Notice and Information Contained in Notice Denying Initial Claim:** If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial. This notice will include the following:
 - *Reason for the Denial* - the specific reason or reasons for the denial;
 - *Reference to Plan Provisions* - reference to the specific Plan provisions on which the denial is based;

- *Description of Additional Material* - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
 - *Description of Any Internal Rules* - in the case of any claim involving disability benefits, a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the determination and that a copy of such rule will be provided to you free of charge at your request; and
 - *Description of Claims Appeals Procedures* - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal, and that such action must be brought within three years of the date on which your claim arose).
- **Appealing a Denied Claim for Benefits:** If your initial claim for benefits is denied by the Claims Administrator, you may appeal the denial by filing a written request with the Claims Administrator within 60 days (180 days in the case of a claim involving disability benefits) after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that are relevant to your appeal.
 - **Time Periods for Responding to Appealed Claims:** If you bring an appeal of a denied claim for benefits under the Plan, the Appeals Administrator will respond to you within 60 days (45 days in the case of a claim involving disability benefits) after receipt of the claim. If the Appeals Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Appeals Administrator will notify you within the initial 60-day period (45 days in the case of a claim involving disability benefits) that it needs up to an additional 60 days (45 days in the case of a claim involving disability benefits) to review your claim.
 - **Notice and Information Contained in Notice Denying Appeal:** If the Appeals Administrator denies your appeal (in whole or in part), it will provide you with written notice of the denial. This notice will include the following:
 - *Reason for the Denial* - the specific reason or reasons for the denial;
 - *Reference to Plan Provisions* - reference to the specific Plan provisions on which the denial is based;

- *Statement of Entitlement to Documents* - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;
- *Description of Any Internal Rules* - in the case of a claim involving disability benefits, a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- *Statement of Right to Bring Action* - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits, and that any such action must be brought within two years of the date on which your claim arose.

The decision of the Appeals Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Appeals Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in federal court. Any federal court action must be commenced no later than two years after the date your claim arose. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

Claims Involving Health Benefits

In the case of a claim involving health benefits (e.g., medical, dental, vision and Health Care FSA), initial claims for benefits under the Plan shall be made by you in writing to the Claims Administrator identified in the chart at the end of this section of the SPD, under the heading Legal Information.

- **Types of Claims:** There are several different types of claims that you may bring under the Plan. The Plan's procedures for evaluating claims (for example, the time limits for responding to claims and appeals) depends upon the particular type of claim. The types of claims that you generally may bring under the Plan are as follows.
 - *Pre-Service Claim* - A "pre-service claim" is a claim for a particular benefit under the Plan that is conditioned upon you receiving prior approval in advance of receiving the benefit. A pre-service claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service or product for which approval is being requested.

- *Post-Service Claim* - A “post-service claim” is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable provider.
- *Urgent Care Claim* - An “urgent care claim” is a claim for benefits or services involving a sudden and urgent need for such benefits or services. A claim will be considered to involve urgent care if the Claims Administrator or a physician with knowledge of your condition determines that the application of the claims review procedures for non-urgent claims (i) could seriously jeopardize your life or your health, or your ability to regain maximum function, or (ii) in your physician’s opinion, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.
- *Concurrent Care Review Claim* - A “concurrent care review claim” is a claim relating to the continuation/reduction of an ongoing course of treatment.
- **Time Periods for Responding to Initial Claims:** If you bring a claim for health benefits under the Plan, the Claims Administrator will respond to your claim within the following time periods.
 - *Pre-Service Claim* - In the case of a pre-service claim, the Claims Administrator shall respond to you within 15 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 15-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
 - *Post-Service Claim* - In the case of a post-service claim, the Claims Administrator shall respond to you within 30 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
 - *Urgent Care Claim* - In the case of an urgent care claim, the Claims Administrator shall respond to you within 72 hours after receipt of the claim. If the Claims Administrator determines that it needs additional information to review your claim, the Claims Administrator will notify you within 24 hours after

receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this notice to provide the requested information. Once you provide the requested information, the Claims Administrator will evaluate your claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information. There is a special time period for responding to a request to extend an ongoing course of treatment if the request is an urgent care claim. For these types of claims, the Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided, that you make the claim at least 24 hours prior to the expiration of the ongoing course of treatment).

- *Concurrent Care Review Claim* - If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination on review before the treatment is reduced or terminated.
- **Notice and Information Contained in Notice Denying Initial Claim:** If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally). This notice will include the following:
 - *Reason for the Denial* - the specific reason or reasons for the denial;
 - *Reference to Plan Provisions* - reference to the specific Plan provisions on which the denial is based;
 - *Description of Additional Material* - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
 - *Description of Any Internal Rules* - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
 - *Description of Claims Appeals Procedures* - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal, that such action must be brought within two years of the date on which your claim arose, and a description of any expedited review process for urgent care claims).

- **Appealing a Denied Claim for Benefits:** If your initial claim for benefits is denied by the Claims Administrator, you may appeal the denial by filing a written request (or an oral request in the case of an urgent care claim) with the Appeals Administrator within 180 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that are relevant to your appeal.
- **Time Periods for Responding to Appealed Claims:** If you appeal a denied claim for benefits, the Appeals Administrator will respond to your claim within the following time periods:
 - *Pre-Service Claim* - In the case of an appeal of a denied pre-service claim, the Appeals Administrator shall respond to you within 30 days after receipt of the appeal.
 - *Post-Service Claim* - In the case of an appeal of a denied post-service claim, the Appeals Administrator shall respond to you within 60 days after receipt of the appeal.
 - *Urgent Care Claim* - In the case of an appeal of a denied urgent care claim, the Appeals Administrator shall respond to you within 72 hours after receipt of the appeal.
 - *Concurrent Care Review Claim* - In the case of an appeal of a denied concurrent care review claim, the Appeals Administrator shall respond to you before the concurrent or ongoing treatment in question is reduced or terminated.
- **Notice and Information Contained in Notice Denying Appeal:** If the Appeals Administrator denies your appeal of a denied claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial (although initial notice of an appeal of a denied urgent care claim may be provided to you orally or via facsimile or other similarly expeditious means of communication). This notice will include the following:
 - *Reason for the Denial* - the specific reason or reasons for the denial;
 - *Reference to Plan Provisions* - reference to the specific Plan provisions on which the denial is based;
 - *Statement of Entitlement to Documents* - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;

- *Description of Any Internal Rules* - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- *Statement of Right to Bring Action* - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits, and that any such action must be brought within two years of the date on which your claim arose.

The decision of the Appeals Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Appeals Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in Federal court. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

Coordination of Benefits

Many people are covered by more than one group health plan. The health care programs under the Plan include a Coordination of Benefits (COB) provision, which is designed to prevent duplication of benefits. The provision coordinates benefits from all group health plans –including employer and government-sponsored plans – covering you and your covered dependents.

Insurance plans that will be coordinated with your benefits include:

- Any group insurance plan
- Any hospital or medical service plan or any group practice or pre-payment plan
- Any union-welfare or labor-management trusteesd insurance plan
- Any government insurance plan or coverage required by law such as Medicare and Medicaid
- Any insurance plan required by a Motor Vehicle Accident Reparation Act (no-fault auto plan) or similar law
- Student insurance plans sponsored by or provided through an educational institution.

The following types of plans will not be coordinated with your benefits:

- A state plan under Medicaid

- Benefits under a law or plan whose benefits are in excess of those of any private insurance plan
- Medicare coverage for an active employee or the active employee's eligible spouse who is age 65 or over
- Contributory school accident coverage, such as those for grammar, high school and college students, either on a 24-hour basis or on a "to and from school" basis
- American Association of Retired Persons (AARP).

In coordinating the benefits available to you, one benefit plan is considered the *primary* plan and pays first, and the other plan or plans are considered *secondary* and pay, if at all, after the primary plan pays.

How Does Coordination of Benefits Work?

If you, your spouse, or your eligible dependent children have coverage under a Pearson health care program, and that program is the *secondary* payer (for example, if your spouse has coverage elsewhere, your spouse's plan will be the *primary* payer for your spouse's health care expenses), benefits from the Pearson plan will be offset by benefits from the other plan. This means that if the other plan pays less than the option you have chosen under the Pearson plan, your Pearson plan will pay the difference – but only up to what you would have received if the Pearson plan had been the primary payer. The Pearson plan will not duplicate any benefits paid by another plan.

Take a look at the chart below to see an example of how COB works

	<i>Primary Plan</i>	<i>Secondary Plan</i> <i>(Pearson \$400 Option In-network)</i>
<i>Eligible expense</i>	\$100	\$100
<i>Plan coverage</i>	70% after deductible	100% after \$20 copay
<i>Plan pays without COB</i>	\$70 <i>(70% of \$100)</i>	\$80 <i>(100% of \$100 minus \$20 copay)</i>
<i>Plan pays under COB</i>	\$70	\$10 <i>(\$80 minus \$70)</i>

Which Plan is the Primary Plan?

The following are some general guidelines for determining which plan is the primary plan and pays first.

- If *you* (the employee) are the patient, this Plan will be primary and will pay first in most cases.
- If *your spouse/partner* is the patient, your spouse's/partner's plan generally will be the primary plan and pay first.
- If a *dependent child* is the patient, usually the plan covering the parent whose birthday comes earlier in the calendar year is the primary plan and will pay first (birthday rule).
 - If not otherwise specified by a court decree, benefits for children of divorced or legally separated parents will be determined first by the plan covering the child as a dependent of the parent with custody. (If the parent with custody remarries, the plan covering the child as a dependent of the stepparent is the secondary plan and pays after the primary plan. The plan of the parent without custody would pay after the secondary plan.)
 - If the other plan provides for the father's plan to pay before the mother's plan when a dependent child is the patient (gender rule), this plan will follow the gender rule rather than the birthday rule.
 - If the other plan does not have a coordination of benefits provision, that plan will be the primary plan and will pay first for your covered dependents, in all cases.

If payment responsibilities still are unresolved after applying these rules, the plan that has covered the patient for the longest time is the primary plan and pays first.

Third Party Recovery

If your injury or illness was caused by the action or inaction of another person or party, that person or party may be responsible for your hospital or medical bills. Automobile accident injuries or personal injury suffered on another's property are examples.

Since collecting payments for these expenses from the third party may take a long time, the Plan will provide the appropriate benefits and then seek repayment from any settlement you may receive. You may be asked to sign a form which acknowledges the Plan's right to be reimbursed and verifies that you will help the Plan secure its rights to reimbursement or recovery. If you bring a liability claim against a third party, benefits payable under the Plan must be included in the claim. When the claim is resolved, you must reimburse the Plan for the cost of the benefits provided. The Plan will have first priority in any recovery regardless of the manner in which the recovery is structured or worded and regardless of whether you have been "made whole" by the settlement. The Plan's reimbursement will not be reduced by attorney's fees, unless agreed to by the Plan. Any so-called "fund doctrine" or "common fund doctrine" or "attorney's fund doctrine" shall not defeat the right of the Plan to recover under this section without paying attorney's fees or costs. Further, the Plan will not recognize any attempt to apply the

“collateral source” rule or the “common fund” rule as legal theories intended to prevent or limit the Plan’s recovery from any payment you may receive from a third party.

You are legally obligated to avoid doing anything that would prejudice the Plan’s rights of reimbursement. However, the Plan shall be entitled to recover in accordance with these rules, even if you do not sign or return its forms. Your failure to cooperate may result in your disqualification from receipt of further benefits from the Plan. In addition, the Plan may offset any future benefits otherwise payable.

This provision does not apply to an individual insurance policy covering you or your dependents for which you or your dependent paid the premium.

Recoupment

The Plan has the right to recover any mistaken payment, overpayment or any payment that is made to any individual who was not eligible for that payment. The Plan, or its designee, may withhold or offset future benefit payments, sue to recover such amounts, or may use any other lawful remedy to recoup any such amounts. Future payments and offsets may involve any of the medical plans administered by this Plan’s third-party administrators. The person receiving benefits must produce any information necessary to ensure this right of recovery.

No Assignment of Benefits

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the covered person and will not constitute an assignment of benefits under the Plan. The exception to this rule is the irrevocable assignment of life insurance benefits.

Extending Your Health Care Coverage Under COBRA

Under a federal law known as “COBRA” (for the “Consolidated Omnibus Budget Reconciliation Act of 1985”), you have a right to continue the same coverage available to active employees under the Company medical, dental and vision programs and the Health Care FSA if you have a “qualifying event” that results in the loss of coverage under the Pearson Education, Inc. Welfare Benefit Plan.

You can continue coverage if any of the following qualifying events occur and you lose coverage as a result of such event:

- Your employment with the Company ends (for any reason other than gross misconduct)
- Your regularly scheduled work hours are reduced so that you become ineligible for coverage.

Your dependents can continue coverage if any of the following qualifying events occur and your dependents lose coverage as a result of such event:

- You die
- You get divorced or obtain a legal separation from your spouse
- Your dependent children no longer meet the eligibility requirements
- You become entitled to Medicare benefits.

How Long Coverage Can Continue

If you elect continuation coverage under COBRA, it will begin on the day you lose your coverage as a result of one of the events listed above. The length of time you can continue your coverage depends on your situation.

- You or your dependents may continue coverage for up to 18 months if your employment with the Company ends or your regularly scheduled work hours are reduced.
- You and your dependents may extend the 18-month period to 29 months if you or any dependent are disabled (as determined under the Social Security Act) as of the date coverage ended or within the first 60 days of COBRA coverage.
- Your dependents may continue coverage for up to 36 months if they lose coverage because of your death, legal separation or divorce or because they no longer meet the eligibility requirements. The term “dependents” includes a child born to you or placed with you for adoption while you are covered by COBRA.
- You or your dependents may continue coverage under the Health Care FSA up until the end of the calendar year in which the qualifying event occurs.
- An 18-month or 29-month period of COBRA coverage may be extended for your dependents if another qualifying event occurs during that time period. In this case, your dependents who are on COBRA (but not you) will become entitled to a maximum of 36 months of coverage from the date of the original qualifying event. This extension may be available if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or get divorced or legally separated, or if a dependent child stops being eligible for coverage as a dependent child, but only if the event would have caused a loss of coverage had the original qualifying event not occurred.
- If you become entitled to Medicare benefits while an active employee and subsequently lose coverage under the Plan due to a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment, all of your dependents (but not you) will be entitled to a maximum of 36 months of coverage from the date of your Medicare entitlement.

Continuation coverage will end before the maximum time period if:

- You do not pay your premium within 30 days of the date it is due
- You or your dependents become entitled to Medicare after electing continuation coverage (in this case, continuation coverage will end only for the person who becomes entitled to Medicare)
- You or your dependents become covered under another group health care plan after electing continuation coverage and such plan does not contain exclusions or limitations with respect to pre-existing conditions
- The Company ends its health care coverage for active or retired employees
- You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled
- An event occurs (e.g., submission of fraudulent claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

Cost of Continued Coverage

The cost of continuing your coverage under COBRA is based on the group rate the Company is charged for medical, dental and vision care benefits for active employees. During the 18- or 36-month continuation period, your cost is 102% of the total cost of coverage. This includes the amount you paid as an active employee, the amount the Company contributed for you as an active employee, and a 2% administrative fee.

If you or your covered dependents qualify for the 11-month disability continuation extension, your cost during this extension will be 150% of the cost of coverage.

Your premiums for continued coverage must be paid in advance, on the first day of each month. However, you have a grace period of at least 30 days in which to pay. The cost for continued coverage will be adjusted annually to reflect changes in the Company's cost for providing this coverage.

Notification

If your dependent's status changes because you get divorced or legally separated from your spouse, or because your dependent becomes ineligible for coverage, you must notify the appropriate party within 60 days after the qualifying event occurs. If you are an active employee, notice must be provided to Pearson by way of dropping your spouse and/or dependent from your coverage using the life event function on the Pearson Employee Portal, or by contacting Pearson People Services. If you are already on COBRA, notice must be provided to Mercer, the firm that Pearson has hired to administer COBRA

benefits. If timely notice is not given, no continuation coverage will be available. The address for Mercer is PO Box 2280, Omaha, NE 68103-2280. Its telephone number is (877) 248-0510. You must also notify Mercer of an applicable Social Security disability determination prior to the end of an original 18-month continuation period.

The Plan Administrator will notify Mercer if the qualifying event is your termination of employment or reduction in hours.

Once Mercer has been notified, you and/or your dependents will be notified of the right to purchase continued coverage under COBRA.

In order to protect your family's rights, you should keep the Plan Administrator (or COBRA administrator if you are currently on COBRA) informed of any changes in the mailing addresses for your spouse, children or former spouse.

How to Purchase Continued Coverage

Once you are notified of your eligibility for COBRA, you and/or your dependents have 60 days in which to elect continuation coverage. Mercer will send you all the COBRA information, election forms and payment instructions you'll need to elect continuation coverage. The 60-day period starts on the date your coverage under the Plan ends, or on the date you are notified of your right to elect continuation coverage, whichever is later. If you fail to make a timely election, continuation coverage will not be available.

If you elect to continue coverage, you have 45 days from the date of your election to make your first payment. Once your continued coverage begins, you need to make payments to Mercer on a monthly basis. You do not need to submit proof of good health to purchase continued coverage.

Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). You are entitled to:

- Examine, without charge, at the Plan Administrator's office and specified locations during normal working hours, all documents governing the Plan including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor.
- Obtain copies of all documents governing the operation of the Plan including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 series) and an updated Summary Plan Description. The Plan Administrator can charge you a reasonable amount for the copies.

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

Duties of the Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for the operation of the Plan. These people are called “plan fiduciaries.”

- They have a duty to operate the Plan prudently and in the interest of you and the other participants and beneficiaries.
- No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
- If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Steps You Can Take to Enforce Your Rights

ERISA specifically provides for circumstances under which you may take legal action as a Plan participant.

- If your claim for a benefit is ignored or denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim. If your claim for benefits is ignored or denied, in whole or in part, you may file suit in a federal or state court, but only after you have exhausted the Plan’s claims and appeals procedure, as described under **Claim Filing Procedures** at the beginning of this section. In addition, if you disagree with the Plan Administrator’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal or state court.
- If you submit a written request for copies of any Plan documents or other Plan information to which you are entitled under ERISA and you do not receive them within 30 days, you may file suit in a federal court. The court may require the Plan Administrator to provide the materials and to pay up to \$110 for each day’s delay until you receive the materials. This provision does not apply, however, if the materials were not sent to you for reasons beyond the control of the Plan Administrator.
- If the Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court.

In any of these circumstances, the court will decide who will pay court costs and legal fees. If you are successful, the court may order the party you have sued to pay these costs

and fees. If you lose, the court may order you to pay the costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact Pearson People Services or the Plan Administrator. If you have any questions about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You can also contact the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington DC 20210.

If it should ever become necessary for you or your dependents to take legal action to enforce your rights under ERISA or the terms of a plan, legal process should be served on Pearson Education, Inc., 221 River Street, Hoboken, NJ 07030; Attn: General Counsel.

Qualified Medical Child Support Order

If a Qualified Medical Child Support Order (QMCSO) requires the medical and/or dental plan to provide a benefit for your child(ren), you will have no right to that portion of your benefit. A QMCSO involving the Plan must be sent to the Plan Administrator to implement. A QMCSO will not be implemented before being issued by a court or through a state administrative process; however, submitting a draft for review in advance may prevent amendments which may be difficult and time-consuming. For more information about QMCSOs, including sample language, please contact the Plan Administrator. You may receive from the Plan Administrator, without charge, a copy of the Plan's QMCSO procedures.

Family and Medical Leave

If you are granted an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must make any required contributions. Other employee benefits under any other contributory welfare plan will continue as long as you make the required employee contributions.

Military Leave of Absence

The Plan complies with the rules applicable to employees on military leaves of absence under the Uniformed Services Employment and Reemployment Rights Act (USERRA). For absences of 30 days or less, health insurance coverage continues, as long as the required contributions are made. Check with your HR representative for benefits information about military leaves beyond 30 days.

Privacy of Health Information

The receipt, use and disclosure of protected health information (including electronic information) is governed by regulations issued under the Health Insurance Portability and Accountability Act (HIPAA). In accordance with these regulations, the Plan Administrator, certain employees working with, and on behalf of, the health benefit programs under the Plan (collectively, the “Health Programs”) and the Health Programs’ business associates may receive, use and disclose protected health information in order to carry out the payment, treatment and health care operations under the Health Programs. These entities and individuals may use protected health information for such purposes without your authorization. If your protected health information is used or disclosed for any other purpose (other than as specifically required or authorized under HIPAA), the Health Programs must first obtain your written authorization for such use or disclosure. Amendments to the Health Programs relative to medical records privacy are available for examination in the Benefits Department. A HIPAA Notice of Privacy Practices is sent to all employees meeting the eligibility requirements under the Health Programs.

The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

Disclosure of Summary Health Information to the Company

In accordance with HIPAA’s Standards for Privacy of Individually Identifiable Health Information (the “privacy standards”), the Plan may disclose summary health information to the Company, if the Company requests the summary health information for the purpose of:

- (1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- (2) Modifying, amending or terminating the Plan.

“Summary health information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (“PHI”) to the Company for Plan Administration Purposes

In order that the Company may receive and use PHI for Plan administration purposes, the Company agrees to:

- (1) Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);

- (2) Ensure that any agents, including a subcontractor, to whom the Company provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such PHI;
- (3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company, except pursuant to an authorization which meets the requirements of the privacy standards;
- (4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Company becomes aware;
- (5) Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
- (6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
- (7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
- (8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”) or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
- (9) If feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- (10) Ensure that adequate separation between the Plan and the Company, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - (a) The Company shall only allow certain named employees or classes of employees or other persons under control of the Company who have been designated to carry out plan administration functions, access to PHI. You may contact the Company for a list of those persons. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Company performs for the Plan.
 - (b) In the event any of the individuals described in above do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its

discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

“Plan administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Company only upon receipt of a certification by the Company that:

- (1) The Plan documents have been amended to incorporate the above provisions; and
- (2) The Company agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Company

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Company information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Company.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Company hereby authorizes and directs the Plan, through the Plan Administrator or a third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the privacy standards.

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Company for Plan Administration Functions

To enable the Company to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Company agrees to:

- (1) Implement Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- (2) Ensure that adequate separation between the Plan and the Company, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
- (3) Ensure that any agent, including a subcontractor, to whom the Company provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and
- (4) Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined in this description of HIPAA security practices shall have the meanings set forth in the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI.

Health Information Technology for Economic and Clinical Health (HITECH) Act

The Plan will comply with all applicable requirements of final regulations issued by the Department of Health and Human Services pursuant to Subtitle D of the HITECH Act and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan. If there is any conflict between the requirements of Subtitle D of the HITECH Act and any provision of this Plan, applicable law will control. Any amendment or revision or authoritative guidance relating to Subtitle D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with such guidance.

The Company will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Legal Information

Under ERISA, each employee must be given certain details about the Company's benefit plans. This information is provided in the chart below. If you need additional information, please contact the Plan Administrator.

In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to delegate certain of its

powers and duties to third parties. The Plan Administrator has delegated certain administrative functions under the Plan to various service providers. As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Plan relating to benefit claims, including determinations as to the medical necessity of any service or supply.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties.

Plan Administrator and Agent for Service of Legal Process

Pearson Education, Inc.
221 River Street
Hoboken, NJ 07030
Attn: General Counsel

Employer Identification Number

22-1603684

Plan Year

January 1 – December 31

Plan Number

510

Plan Type

The Plan is comprised of separate welfare benefit programs providing the following types of benefits: (1) medical coverage, dental coverage, and vision coverage, (2) basic life insurance, (3) supplemental life insurance, (4) accidental death and dismemberment insurance, (5) business travel accident insurance, (6) long-term disability insurance, and (7) health care and dependent care flexible spending accounts. The benefits described in items (1) and the health care FSA described in (7) are provided under a "group health plan" within the meaning of ERISA.

<i>Program</i>	<i>Group/ Policy No.</i>	<i>Source of Contributions</i>	<i>Claims Administrator</i>	<i>Appeals Administrator</i>	<i>Insured/Self- Insured</i>
Medical: Anthem BlueCross Blue Shield	3330054	Company and employee pre-tax contributions	Anthem BlueCross Blue Shield PO Box 105187 Atlanta, GA 30348- 5187	Anthem BlueCross Blue Shield PO Box 105568 Atlanta, GA 30348	Self-Insured

Program	Group/ Policy No.	Source of Contributions	Claims Administrator	Appeals Administrator	Insured/Self- Insured
Cigna	3176426	Company and employee pre-tax contributions	Cigna PO Box 182223 Chattanooga, TN 37422	Cigna PO Box 182223 Chattanooga, TN 37422	Self-Insured
Aetna	868808	Company and employee pre-tax contributions	Aetna PO Box 14463 El Paso, TX 79998-1106	Appeal Resolution Team PO Box 14463 Lexington, KY 40512	Self-Insured
Prescription Drugs for the National medical options: CVS/caremark	Pearson	N/A	You do not have to file claims; however, you must use a participating pharmacy to receive benefits.	Caremark, Inc. Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084 CVS/caremark Specialty Guideline Management Appeals 800 Biermann Court Ste. B Mt. Prospect, IL 60056	Self-Insured
Delta Dental	655331	Company and employee pre-tax contributions	Delta Dental of MN National Dedicated Service Center P.O. Box 59238 Minneapolis, MN 55459	Delta Dental of MN Attention: Appeals Unit PO Box 551 Minneapolis, MN 55440-0551	Self-Insured
Vision Care	12081498	Employee pre-tax contributions	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670	Insured
Flexible Spending Accounts	Pearson	Employee pre-tax contributions	Mercer Marketplace	Participant Services Specialist Team PO Box 6161 Fargo, ND 58108	Self-Insured
Long-Term Disability	457913	Company pre-tax contribution and employee after-tax contributions	Lincoln Financial 2211 Congress Street Portland, ME 04122	Lincoln Financial Group Benefits Disability Claims P.O. Box 7207 London, KY 40742-7207	Insured
Life Insurance	70300	Company and employee after-tax contributions	Securian Group Claims 400 Robert St. North St. Paul, MN 55101-2098	Securian Benefit Services PO Box 64114 St. Paul, MN 55164-0114	Insured

<i>Program</i>	<i>Group/ Policy No.</i>	<i>Source of Contributions</i>	<i>Claims Administrator</i>	<i>Appeals Administrator</i>	<i>Insured/Self- Insured</i>
Accidental Death & Dismemberment Insurance	70301	Company and employee after-tax contributions	Securian Group Claims 400 Robert St. North St. Paul, MN 55101-2098	Securian Benefit Services PO Box 64114 St. Paul, MN 55164-0114	Insured
Business Travel Accident Insurance	GTU-4379392	Company-paid	Zurich American 1400 American Lane Schaumburg, IL 60196	Plan Administrator	Insured

Future of the Plan

Pearson Education, Inc. has established its benefits program with the intent of continuing it indefinitely. However, Pearson Education, Inc. reserves the right, in its discretion, to amend, modify or terminate the Plan, or any part of it, at any time and for any reason. This means that any benefit provided through the Plan may be discontinued in its entirety, modified to provide higher or lower levels of covered benefits, or modified to provide higher or lower levels of cost to the Company or covered employees.

You will be informed of the effect any changes to the Plan have on your rights to the Plan benefits. This document is not an employment contract or a promise to always provide these benefits. Participating in the Plan does not give you the right to remain employed by the Company. Also, you cannot sell, transfer or assign either voluntarily or involuntarily the value of your benefits (other than an irrevocable assignment of your life insurance benefits).

Contact Information

Addresses and phone numbers for the health care administrators, as well as contact information for the HMOs, is available on the benefits [website](#).



IX. Important Terms

About This Section

This section provides you with the definitions of some of the terms and phrases used throughout this benefits document. For further information, please contact Mercer Marketplace.

Important Terms

Accelerated Death Benefit

A portion of life insurance that you choose to receive to help you financially if you or your insured spouse or dependent child become terminally ill. In this case “terminally ill” means a life expectancy of no more than 12 months. See the *Life & Accident Insurance Programs* section for more information on this benefit.

Actively at Work

Physically present at your customary place of work with the intent and ability of working the scheduled hours and doing the normal duties of your job on that day.

After-tax

Money from which federal, Social Security, and most state and local taxes have been withheld.

Annual Open Enrollment Period

Period during which you can make new benefit elections for the upcoming calendar year, also known as “open enrollment”.

Base Pay

For most of the benefit programs under the Plan, pay is defined differently depending upon your job classification, as described below.

- For full-time regular employees, except sales employees, annual pay is defined as base compensation, excluding overtime, commissions, bonuses and any other additional compensation.
- For sales positions that normally earn commissions/bonuses in the marketplace, annual pay is defined as current base pay plus sales commissions and/or sales bonuses paid in the prior calendar year.
- For part-time regular employees scheduled for 20 or more hours per week, annual pay is defined as the product of an hourly rate times 1,820 (based on a 35-hour week).

Before-tax

Money from which federal, Social Security, and most state and local taxes have not been withheld.

Beneficiary

The person or persons you name to receive benefits from your life insurance, AD&D, and Business Travel Accident coverages if you die while employed by the Company. You are the beneficiary for dependent life insurance, if you elect coverage.

Change in Status (Life Event)

A change in your family or employment situation that may allow you to make a change in your benefits during the year. As defined by Treasury regulations, changes in status include marriage, divorce, the birth or adoption of a child, the death of a spouse or dependent, and the loss of a dependent's coverage because of age. Refer to the *Life Events Action Chart* in the *Benefits Highlights* section of this document for more information.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), in general, ensures that employees and their covered dependents can continue certain benefits after the employee has left the Company or after a dependent has lost coverage because he or she is no longer eligible for specified reasons. Employees or dependents pay the full cost for this coverage plus an administration fee. For a more detailed explanation of your rights under COBRA, see the *Additional Information* section.

Coinsurance

The percentage of eligible charges you pay for a covered service. For example, if the Plan pays 80% of eligible charges, your coinsurance is 20%.

Copayment

The amount, usually a flat fee, you must pay for certain services.

Covered Service

A medical service, drug or supply that is eligible for payment under the terms of the Plan because it is (i) medically necessary for the treatment of illness or injury, or it is for preventive care benefits that are specifically stated as covered; (ii) provided under the order or direction of a Physician, and (iii) prescribed by a licensed and accredited

healthcare Physician practicing within the scope of their license in the state where the license applies. Custodial Care

Care designed to help a person in the activities of daily living. Continuous attention by trained medical or paramedical personnel is not necessary for this type of assistance. Custodial care may involve:

- Preparation of special diets
- Supervision over medication that can be self-administered
- Assistance in getting in or out of bed, walking, bathing, dressing, eating and using the toilet
- Services that do not need to be performed by trained or skilled medical or paramedical personnel.

Deductible

The amount you or a covered dependent must pay for covered services each calendar year before the Plan begins to pay certain benefits.

Dental Health Maintenance Organization (DHMO)

A network of dentists that gives dental care services to members at a lower cost than out-of-network dentists. DHMOs typically do not cover dental services provided by dentists who are not in the network.

Disability

See definition of Disability in the LTD section.

Domestic Partner

A person who has chosen to share his/her life in an intimate and committed relationship with another person, reside together, and share a mutual obligation of support for the basic necessities of life as if married but are not legally married. The [Affidavit of Spousal Equivalency](#) must be submitted and approved to add coverage for a domestic partner.

Durable Medical Equipment

Medical equipment that is not disposable and is only related to care for a medical condition, for example, wheelchairs and home hospital beds.

Eligible Dependents

For Medical, Dental, Life and Vision Coverage:

- Your legal spouse
- Your same- or opposite-sex domestic partner.
- Your children up to the end of the month in which they turn 26
- A dependent child of any age who is physically or mentally disabled and receives more than one-half of their support from you, if he or she was disabled before age 19 and depended on you for support at the time of disability. For purposes of the support requirement, special rules apply for separated or divorced parents pursuant to Internal Revenue Code section 152. Contact your tax advisor or refer to IRS Publication 502 for more information.

Your eligible dependent children include:

- Your biological children
- Your legally adopted children (and children placed with you for adoption)
- Your stepchildren
- Children of your domestic partner
- Your foster children (note that foster children are not eligible under the Life/AD&D program)
- Any other child for whom you are a legal guardian, who lives with you in a parent/child relationship and whom you claim as a dependent on your federal income tax return.

If a child's parents are both employed by the Company, the child is considered the eligible dependent of only one parent, not both.

For the Dependent Day Care FSA:

You can claim dependent care expenses for:

- Any child under age 13 who you can claim as your dependent for federal tax purposes.
- Your spouse who is physically or mentally unable to care for himself or herself and who lives with you for more than one-half of the year.

- Any other person who is physically or mentally unable to care for himself or herself, who lives with you for more than one-half of the year and who you can claim as a dependent for federal income tax purposes (without regard to their gross income).

For expenses related to services outside your home to be eligible, a dependent (other than a child under age 13) must spend a minimum of eight hours a day in your home.

For the Health Care and Combo FSA:

You can claim reimbursement for health care expenses for yourself, your spouse, your dependent children and any other person who can be claimed by you as a dependent on your federal income tax return (without regard to their gross income).

For Dependent Life Insurance/Supplemental AD&D

Same as for medical, dental and vision care plans; however, foster children are not eligible. Stillborn and unborn children are not eligible.

For Business Travel Accident

Your spouse/partner and your unmarried children under age 19 (or under age 23 if attending an accredited school or university on a full-time basis) who are dependent on you for support.

Eligible Employee

Generally, an employee who belongs to one of the following categories:

- Regular, Casual/Seasonal, and Limited-term full-time employees: those who are regularly scheduled to work 35 or more hours a week
- Regular, Casual/Seasonal, and Limited-term, part-time employees: those who are regularly scheduled to work 20 to 34 hours a week
- Limited-term employees are not eligible for disability coverage

Eligibility may vary by benefit program. See the *Benefits-at-a-Glance* matrix in the *Benefits Highlights* section of this document for eligibility requirements for specific programs.

Independent contractors and other persons who are not treated by the Company as employees for purposes of withholding federal employment taxes are not eligible to participate, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding.

Emergency

A bodily injury or other medical condition that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy;
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, an extensive federal statute that governs the operation of private pension and welfare benefit plans. Under ERISA, employees are entitled to certain rights and protections. See the *Additional Information* section of this document for more information.

Explanation of Benefits (EOB)

A statement sent to you after you file a claim and the claim has been processed. The EOB gives specific details about the expenses submitted, the amount paid by the Plan, the remaining balance, if any, and other details about how and why benefit payments were or were not made.

Fiduciary

A person or entity responsible for the operation of employee benefit plans. Among other duties, such person must act solely in the interest of the plan participants and beneficiaries.

Generic Drug

Prescription medication containing the same components and formulation as the brand name drug but manufactured by one of many pharmaceutical companies, not just the original manufacturer of the medication.

Health Care Provider

A licensed practitioner of the healing arts acting within the scope of his or her applicable license or, in the absence of licensing requirements, certified by the appropriate professional association.

Charges will not be considered eligible for benefits if they are made by a health care provider who is a covered person, who lives with a covered person, or who is a member of a covered person's immediate family.

Health Maintenance Organization (HMO)

A network of doctors, hospitals, and other health care providers that offer comprehensive medical services for a fixed cost. HMOs typically do not cover non-emergency services from providers outside the HMO network.

Home Health Aide

A person who provides home care of a medical or therapeutic nature. A home health aide must report to and be under the direct supervision of a home health care agency.

Home Health Care Agency

An appropriately licensed agency or organization with a valid operating certificate that provides home care and other therapeutic services, under the supervision of a doctor or registered graduate nurse (R.N.). The agency must be approved under Medicare.

Home Health Care Plan

A program established by the covered person's attending doctor for care and treatment of the patient in his or her home by a home health care agency. The doctor must approve the program in writing before it begins, and he or she must also certify that if home care were not provided, a hospital or skilled nursing facility stay would be necessary.

Hospice Care Agency

A full-time licensed or certified agency whose main purpose is to provide skilled nursing services, medical social services and psychological and dietary counseling for terminally ill patients. In order to qualify, the agency must also provide doctors' services, physical or occupational therapy, home health aide services, and inpatient care when needed to control pain or other medical symptoms and it must develop a program of care and maintain records for each of its patients. The services must be provided on a 24-hours-a-day, seven-days-a-week basis under the direct supervision of a physician. The agency must be approved under Medicare.

Hospice Care/Hospice Care Program

Coordinated, interdisciplinary plan of care designed to meet the physical, psychological, spiritual and social needs of dying persons and their families. A hospice care program provides palliative and supportive medical, nursing and other health services through

home or inpatient care during a terminal illness (life expectancy of six months or less). Care should be provided through a certified Hospice Care Agency.

Hospital

An institution licensed as a hospital that maintains, on the premises, all facilities necessary for medical and surgical treatment, provides such treatment on an inpatient basis under the supervision of doctors and provides 24-hour service by registered graduate nurses.

A hospital is not an institution that is primarily a rest or convalescent home, a nursing home or a home for the aged. A stay in a special unit of a hospital, which is primarily a nursing, rest or convalescent home or skilled nursing facility will not be considered a stay in the hospital.

A hospital also includes an institution that specializes in the treatment of mental illness, substance abuse or other related illness, provides residential treatment programs and is licensed in accordance with the laws of the appropriate legally authorized agency. In addition, a hospital is an institution that qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital and a provider of services under Medicare.

Hospital Confinement

A registered bed patient in a hospital upon the recommendation of a physician. A person can be considered partially confined for treatment of mental illness, substance abuse or other related illness. Partially confined means continually treated for at least three hours but not more than 12 hours in any 24-hour period. To determine benefits payable, two days of being partially confined in a hospital will be equal to one day of being confined.

Immediate Family

The spouse/partner, children, brothers, sisters or parents of a covered person. Medical expenses for services provided by a member of your immediate family are not covered expenses. See *Services Not Covered* in the *Medical Program* section of this document.

Imputed Income

The amount of additional income imputed to a covered person based on the value of Company-provided life insurance over \$50,000. This amount of additional income is determined from government rate tables and generally has a minimal effect on your taxes.

In-Network – See Network

Lifetime Maximum Benefit

The maximum amount the Plan will pay for a benefit (e.g., orthodontia) for each covered individual in their lifetime. The lifetime maximum benefit includes benefits received both in- and out-of-network.

Maximum Allowed Amount

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Plan, are Medically Necessary, and are provided in accordance with the Plan.

Medically Necessary

Needed for the diagnosis, care or treatment of a physical, mental or dental condition. Coverage is provided only for medically necessary services or supplies – in other words, care that is widely accepted professionally in the United States as effective, appropriate and essential, based on recognized standards of the health care specialty involved.

Peer review organizations or other professionals may be used to evaluate the medical necessity, quality, frequency and length of the treatment and care. No treatment or service that is experimental in nature will be considered medically necessary treatment.

Medicare

Benefits under Title XVIII of the Social Security Act of 1965, as amended.

Medicare Allowable Rates

The rates that the Center for Medicare Services (CMS) establishes for services and supplies provided to Medicare enrollees. These rates are generally updated within 180 days of when CMS announces a change. If CMS has not announced an allowable rate for a service or supply, the Plan determines that rate based on market standards for such determination. The Plan retains the right to make exceptions in determining the benefit payable for certain supplies and services including, without limitation, for anesthesia, laboratory and medications which are paid or covered as medical benefits rather than as prescription drug benefits.

Network

A group of hospitals and physicians that contract with employers, insurance companies or other third-party administrators to provide comprehensive medical services at negotiated charges.

Non-Preferred Brand Name Drug (Non-Formulary)

The first version of a drug made by a specific drug manufacturer. These drugs are exclusive and protected by a patent for 20 years and are more costly due to associated research and development, and marketing and advertising costs.

Nurse

A registered graduate nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation “R.N.,” “L.P.N.” or “L.V.N.”

Occupational Therapy

Services of a licensed occupational therapist. The therapy must be ordered and monitored by a physician and must be given in accordance with a written treatment plan approved by the physician. The therapist must submit progress reports at the intervals stated in the treatment plan.

Out-of-Network

Any hospital, physician or other health care provider outside the group that has contracted to provide services at negotiated rates. For example, a hospital or physician that does not participate in the PPO network is considered an out-of-network provider. See the *Medical Plan* section of this document for more information.

Out-of-Pocket Maximum

The most you (or you and your covered family members) have to pay for covered services in a year. Certain expenses do not count toward the out-of-pocket maximum, including charges greater than covered expense amounts, the amount you pay for emergency room services if used for non-emergency purposes, penalties you pay for not making notification calls when required, and out-of-network charges that exceed the “reasonable and customary” allowance.

Pay – See Base Pay

Physical Therapy

Services of a licensed physical therapist. The therapy must be ordered and monitored by a physician and must be given in accordance with a written treatment plan approved by the physician. The therapist must submit progress reports at the intervals stated in the treatment plan.

Physician

A licensed medical practitioner who is practicing within the scope of his license. A physician is licensed to prescribe and administer drugs and to perform surgery.

Preferred Brand Name Drug (Formulary)

Preferred brand name drugs that have been selected by CVS/caremark and a group of physicians and pharmacists based on safety, efficacy and unique qualities of the medication, as compared to available alternatives.

Preferred Provider Organization (PPO)

An option that includes both a network of doctors, hospitals and other health care providers that typically offer services at a rate that is lower than services from providers outside the network, as well as the ability to use health care providers outside the network (i.e., out-of-network coverage).

Prescription Drug

Any drug or medicine that can be obtained only by prescription from your physician and cannot be purchased “over-the-counter” without a prescription.

Preventive Care

Comprehensive care for the early detection and prevention of medical (defined by the United States Preventive Services Task Force and as required by the Patient Protection and Affordable Care Act – PPACA) or dental conditions. Examples of preventive medical care are routine annual physicals, diagnostic tests and immunizations. Dental preventive care includes, for example, oral exams and cleanings.

Primary Care Physician (PCP)

A physician who qualifies as a provider in general practice, internal medicine, family practice or pediatrics whom you select to coordinate your medical care.

Qualified Medical Child Support Order (QMCSO)

A court order that requires a child's coverage under a group health plan.

Reasonable and Customary (R&C)

The normal charge made by the provider for a similar service or supply, but not more than the usual amount charged by most providers of such services or supplies in the geographic area where the service is received.

Sickness

A physical or mental illness. It also includes pregnancy for employees and dependent spouses/partners and complications of pregnancy for dependent children. Expenses incurred for routine hospital and pediatric care of a newborn child prior to discharge from the hospital nursery will be considered to be incurred as a result of sickness.

Skilled Nursing Facility

A licensed facility operating under applicable laws and operating under the full-time supervision of a licensed physician or registered graduate nurse (R.N.). The facility should regularly offer room and board and provide 24-hour-a-day skilled nursing care of sick and injured persons during the convalescent stage of an injury or sickness. The facility should maintain a daily record of each patient who is under the care of a licensed physician. It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill. The facility must be approved under Medicare as a Skilled Nursing Facility.

Speech Therapy

Services of a licensed speech therapist. The therapy must be ordered and monitored by a physician and must be given in accordance with a written treatment plan approved by the physician. The therapist must submit progress reports at the intervals stated in the treatment plan.

Spouse

Your legal husband or wife (not your legally separated or divorced spouse).

Summary Plan Description

A document describing the basic provisions of a benefit plan covered by ERISA and identifying the persons and entities responsible for the operation of the plan. This document acts as the summary plan description for the Plan.

Terminal Illness

An illness diagnosed by a physician that gives an individual a prognosis of 12 months or less to live.

Treatment

Consultation, care or services provided by a doctor including diagnostic measures and prescribing drugs and medicines.