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 pays100%	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)	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 Brand	$30	30% (min $25/max $50	20% after deductible	30% after deductible
Non-Preferred Brand-	$60	45% (min $40/max $80)	20% after deductible	30% after deductible
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 Brand	$75	30% (min $62.50/max $125)	20% after deductible	30% after deductible
Non-Preferred Brand	$150	45% (min $100/max $200)	20% 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
  - Transcytaneous Electrical Nerve Stimular (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
- Abdominoplastys and/or Panniculectomys
  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 Brand	$30	30% (min $25/max $50	20% after deductible	30% after deductible
Non-Preferred Brand-	$60	45% (min $40/max $80)	20% after deductible	30% after deductible
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 Brand	$75	30% (min $62.50/max $125)	20% after deductible	30% after deductible
Non-Preferred Brand	$150	45% (min $100/max $200)	20% after deductible	30% after deductible

(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
Hormonal (Oral Contraceptives)	$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.
Emergency contraception	$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.

Aspirin	- 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
Oral Fluoride	Applies to children between birth - 5 yrs.
Folic Acid	Applies to women under age 50
Iron Supplements	Applies to children 6-12 months
Smoking Cessation	Applies to ages 18+; limit of 168-day supply of each product in one year of treatment
Vitamin D	Applies to men and women age 65+
Bowel Prep Agents for colonoscopy prep	Applies to all ages
Statins	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.