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 programs under the Plan. 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.

Type of Claim	*Where To Get Forms/Info*	*Where To Send Forms*	*Who Should File Claims*	*Time Limit To File Claims*	*Coverage Reminders*
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 for more information 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 Lincoln Financial for more information at 877-321-1015	Call Lincoln Financial for more information at 877-321-1015	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 Lincoln Financial for more information at 877-321-1015	Call Lincoln Financial for more information at 877-321-1015	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 Lincoln Financial for more information at 877-321-1015	Call Lincoln Financial for more information at 877-321-1015	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 special circumstances, the Claims Administrator will notify you within the initial 90-day period that the Claims Administrator needs the additional time 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 special circumstances, the Appeals Administrator will notify you within the initial 60-day period (45 days in the case of a claim involving disability benefits) that the it needs the additional time 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 are 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 claims and appeal processes 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/HSA), 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 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) depend 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, 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, 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 claim 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 COB 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 trusteed 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) coverage.

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 health care program will be offset by benefits from the other plan. This means that if the other plan pays less than the health care 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 the COB provision works

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

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, the Pearson 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 injuries 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. As a condition to your right to benefits under the Plan, 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 programs 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 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 ceases to be 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 coverage period has lapsed 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, or
- 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 coverage to its active employees.

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 Mercer, the firm that Pearson has hired to administer COBRA benefits, within 60 days after the qualifying event occurs. If you are an active employee, notice must be provided to the Company by way of dropping your spouse and/or dependent from your coverage using the life event function at Mercer Marketplace. If you are already on COBRA, notice must be provided to Mercer. 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 in order to qualify for the 11-month disability continuation extension.

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 under COBRA will not be available.

If you elect to continue coverage, you have 45 days from the date of your election to make your first premium 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 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 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 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.

Qualified Medical Child Support Order

If a Qualified Medical Child Support Order (QMCSO) requires the 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 arrangements for the payment of 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 office of the Plan Administrator. 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" 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 document has 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 Health Information Technology for Economic and Clinical Health (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, each of these service providers has 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

Pearson Education, Inc.
221 River Street
Hoboken, NJ 07030

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.

Program	*Group/ Policy No.*	*Source of Contributions*	*Claims Administrator*	*Appeals Administrator*	*Insured/Self-Insured*
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
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	Company and employee pre-tax contributions	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 (WEX) PO Box 6161 Fargo, ND 58108	Mercer Marketplace (WEX) 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

Program	*Group/ Policy No.*	*Source of Contributions*	*Claims Administrator*	*Appeals Administrator*	*Insured/Self-Insured*
Life Insurance	70300	Company and employee after-tax contributions	Lincoln Financial PO Box 2578 Omaha, NE 68172-9688	Lincoln Financial PO Box 2578 Omaha, NE 68172-9688	Insured
Accidental Death & Dismember-ment Insurance	70301	Company and employee after-tax contributions	Lincoln Financial PO Box 2578 Omaha, NE 68172-9688	Lincoln Financial PO Box 2578 Omaha, NE 68172-9688	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, the Company 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, and/or modified to provide higher or lower levels of cost to the Company and/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.