IX. Important Terms

About This Section

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

Important Terms

Accelerated Death Benefit

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

Actively at Work

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

After-tax

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

Annual Open Enrollment Period

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

Base Pay

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

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

Before-tax

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

Beneficiary

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

Change in Status (Life Event)

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

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 For a more detailed explanation of your rights under COBRA, see the *Additional Information* section.

Coinsurance

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

Copayment

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

Covered Service

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

Custodial Care

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

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

Deductible

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

Dental Health Maintenance Organization (DHMO)

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

Disability

See definition of Disability in the LTD section of this SPD.

Domestic Partner (or "Partner")

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

Durable Medical Equipment

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

Eligible Dependents

For Medical, Dental, Life and Vision Coverage:

- Your legal spouse

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

Your eligible dependent children include:

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

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

For the Dependent Day Care FSA:

You can claim dependent care expenses for:

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

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

For the Health Care and Combination FSA:

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

For Dependent Life Insurance/Supplemental AD&D

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

For Business Travel Accident

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

Eligible Employee

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

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

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

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

Emergency

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

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

ERISA

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

Explanation of Benefits (EOB)

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

Fiduciary

A person or entity responsible for the discretionary administration of an employee benefit plan covered by ERISA. Among other duties, a fiduciary must act solely in the interest of the Plan participants and beneficiaries.

Generic Drug

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

Health Care Provider

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

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

Health Maintenance Organization (HMO)

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

Home Health Aide

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

Home Health Care Agency

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

Home Health Care Plan

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

Hospice Care Agency

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

Hospice Care/Hospice Care Program

Coordinated, interdisciplinary plan of care designed to meet the physical, psychological, spiritual and social needs of dying persons and their families. A hospice care program provides palliative and supportive medical, nursing and other health services through home or inpatient care during a terminal illness (life expectancy of six months or less). Care should be provided through a certified Hospice Care agency.

Hospital

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

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

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

Hospital Confinement

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

Immediate Family

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

Imputed Income

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

In-Network – See Network

Lifetime Maximum Benefit

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

Limited-Term Employee

Employees who are hired to work for Pearson for a defined period of time not to exceed 24 consecutive months. Limited-Term Employees are ineligible for disability coverage.

Maximum Allowed Amount

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

Medically Necessary

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

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

Medicare

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

Medicare Allowable Rates

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

laboratory and medications which are paid or covered as medical benefits rather than as prescription drug benefits.

Network

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

Non-Preferred Brand Name Drug (Non-Formulary)

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

Nurse

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

Occupational Therapy

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

Out-of-Network

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

Out-of-Pocket Maximum

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

Pay – See Base Pay

Physical Therapy

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

Physician

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

Preferred Brand Name Drug (Formulary)

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

Preferred Provider Organization (PPO)

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

Prescription Drug

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

Preventive Care

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

Primary Care Physician (PCP)

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

Qualified Medical Child Support Order (QMCSO)

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

Reasonable and Customary (R&C)

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

Sickness

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

Skilled Nursing Facility

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

Speech Therapy

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

Spouse

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

Summary Plan Description

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

Terminal Illness

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

Treatment

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