

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Pearson, Inc.: \$900 Deductible w/Copays PPO

Coverage Period: 01/01/2026 - 12/31/2026
Coverage for: Individual/Individual + Family | **Plan Type:** PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at <https://eoc.anthem.com/eocdps/aso> (Anthem), or www.HealthReformPlanSBC.com (Aetna). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call (877) 898-0747 (Anthem), or (877)-350-7923 (Aetna) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For <u>in-network providers</u> : \$900/individual or \$1,800/family For <u>out-of-network providers</u> : \$3,000/individual or \$6,000/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. In-network <u>preventive care</u> & immunizations, office visits	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers \$3,000/individual or \$6,000/family For out-of-network providers \$6,000/individual or \$12,000/family Combined medical/behavioral and pharmacy <u>out-of-pocket limit</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain <u>pre-authorization</u> for services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

* For more information about limitations and exceptions, see **plan** or policy document at <https://eoc.anthem.com/eocdps/aso>, or <https://www.aetna.com>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See Anthem Blue Card PPO, www.anthem.com or call 877-898-0747; Aetna Premier Care, www.aetna.com/docfind or call 1-877-350-7923 for a list of <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /visit <u>Deductible</u> does not apply	40% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	<u>Specialist</u> visit	\$80 <u>copay</u> /visit <u>Deductible</u> does not apply	40% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	<u>Preventive care/ screening/ immunization</u>	No charge/visit** No charge/screening** No charge/immunizations** ** <u>Deductible</u> does not apply	40% <u>coinsurance</u> /visit 40% <u>coinsurance</u> /screening 40% <u>coinsurance</u> /immunizations	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

* For more information about limitations and exceptions, see **plan** or policy document at <https://eoc.anthem.com/eocdps/aso>, or <https://www.aetna.com>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs (Tier 1)	Retail \$10 copay / Mail Order \$25	Retail only: \$10 copay plus difference between cost of the drug and CVS negotiated price	Carved out to CVS/Caremark Deductible does not apply Rx costs accumulate toward the Out of Pocket Plan Max
	Preferred brand drugs (Tier 2)	30% coinsurance Retail (\$25 min, \$50 max) / Mail Order (\$62.50 min, \$125 max)	Retail only: 30% coinsurance (\$25 min, \$50 max) plus difference between cost of the drug and CVS negotiated price	
	Non-preferred brand drugs (Tier 3)	45% coinsurance Retail (\$40 min, \$80 max)/Mail Order (\$100 min, \$200 max)	Retail only: 45% coinsurance (\$40 min, \$80 max) plus difference between cost of the drug and CVS negotiated price	
	Specialty drugs (Tier 4)	Subject to applicable copays/coinsurance based on preferred or non-preferred status	Subject to applicable copays/coinsurance, plus difference between cost of the drug and CVS negotiated price	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of- network emergency use paid the same as in- network . No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of- network emergency use paid the same as in- network . Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	20% coinsurance	20% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	\$500 penalty for no precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

Common Medical	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay/office visit** 20% coinsurance/all other services ** <u>Deductible</u> does not apply	40% <u>coinsurance</u> /office visit 40% <u>coinsurance</u> /all other services	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$500 penalty for no precertification.
If you are pregnant	Office visits	\$40 first visit to confirm pregnancy; then 100% coverage	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). \$500 penalty for no precertification.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage is limited to 120 days annual max. (The limit is not applicable to mental health and substance use disorder conditions.) \$500 penalty for no precertification.
	Rehabilitation services	\$40 <u>copay</u> /visit** ** <u>Deductible</u> does not apply	40% <u>coinsurance</u>	*Coverage is limited to annual max of: 30 days for Chiropractic care Services, 60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	\$40 <u>copay</u> /visit** ** <u>Deductible</u> does not apply	40% <u>coinsurance</u>	*See therapy services section
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$500 penalty for no precertification. Coverage is limited to 120 days annual max.

	Durable medical equipment	20% coinsurance	40% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% coinsurance/inpatient or outpatient services	40% coinsurance/inpatient or outpatient services	\$500 penalty for no precertification.

* For more information about limitations and exceptions, see **plan** or policy document at <https://eoc.anthem.com/eocdps/aso>, or <https://www.aetna.com>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)			
• Cosmetic surgery • Dental care (Adult & Children) • Glasses (Children)	• Long-term care • Non-emergency care when traveling outside the US • Private duty nursing	• Routine eye care (Adult & Children) • Routine foot care (unless diagnosed with diabetes) • Weight Loss programs	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
• Acupuncture • Bariatric Surgery (in-network only Surgeon Charges Lifetime max \$25,000)	• Chiropractic care (30 visits per benefit period) • Hearing aids (1 hearing aid per ear every three Calendar Years). Includes over the counter hearing aids	• Infertility treatment (Lifetime max \$15,000)	

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

Anthem

ATTN: Grievance and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219

Additionally, a consumer assistance program can help you file your appeal. Contact California Consumer Assistance Program, Operated by the California Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhc.ca.gov/>

Aetna:

If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>

For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact information is at:

<http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$900
- Specialist copayment \$80
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (ultrasounds and blood work)
 Specialist visit (anesthesia)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$900
Copayments	\$0
Coinsurance	\$2,100
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$3,070

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$900
- Specialist copayment \$80
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
 Diagnostic tests (blood work)
 Prescription drugs
 Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,900

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$900
- Specialist copayment \$80
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
 Diagnostic test (x-ray)
 Durable medical equipment (crutches)
 Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$900
Copayments	\$400
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$1,510

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services: (TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 ይደውሉ።

(877) 898-0747 (Anthem),

(888) 982-3862 (Aetna)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և

տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

Bassa (Bàsɔ̀ wùdù): M̃ dyi dyi-diè-dɛ̀ bɛ̀ bédé bá cée-dɛ̀ nìà kɛ dyí ní, ɔ̀ mò nì dyí-bédèin-dɛ̀ bɛ̀ m̃ kɛ gbo-kpá-kpá kè bɔ́ kpɔ́ dɛ̀ m̃ bídí-wùdùùn bó pídyi. Bɛ̀ m̃ kɛ wuɖu-ziin-nyò dò gbo wùdù kɛ, d́á (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).
-তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (877) 898-0747 (Anthem), (888) 982-3862 (Aetna) သို့ ခေါ်ဆိုပါ။

Chinese (中文) : 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

Dinka (Dinka): Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wēr alēu bē gēer yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin col (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. ب (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

Language Access Services: (TTY/TDD: 711)

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

Gujarati (ગુજરાતી): જો આ દ તાવેજ અંગે આપને કોઈપણ ે હોય તો, કોઈપણ ખચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

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Language Access Services: (TTY/TDD: 711)

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ນລັກກັບລາມແບພາສາ, ໃຫ້ໂທຫາ (877) 898-0747 (Anthem), (888) 982-3862 (Aetna).

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