

Guidebook to Nielsen Health Care Benefits

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Benefits Administration by Fidelity

Nielsen provides all retirees with the convenience of enrolling in benefits and obtaining information about benefits through one source: Fidelity. The preferred method for contacting Fidelity is through the Internet. By using Fidelity NetBenefits® at <http://netbenefits.fidelity.com>, benefit services are available at your fingertips 24 hours a day.

If you don't have access to the Internet, or if you require personal assistance, the Fidelity Benefits Service Center will help you enroll, obtain benefits information, get answers to questions, and resolve problems related to eligibility and enrollment. Please call **1-800-500-2363**, Monday through Friday (excluding New York Stock Exchange holidays) between 8:30 am and 8:30 pm Eastern time to speak with a service representative.

If you have questions about specific benefit plan provisions or if you're having problems with claims payments, you should contact the individual insurance carrier directly.

Making Your Elections

This *Guidebook* will assist you in making the best benefit elections for you and your family. Think about your own personal circumstances, the kinds of coverage you and your family need, and how much the plans cost. It is important to remember that the total cost of health care is the sum of your premium contribution plus the un-reimbursed expenses you pay out-of-pocket when you receive medical services. We suggest that you keep this *Guidebook* handy during the year as a reference to your health care benefits.

To make your elections either:

- Enroll online by logging on to Fidelity NetBenefits at <http://netbenefits.fidelity.com> or,
- Call the Fidelity Benefits Service Center at **1-800-500-2363** to speak with a representative. Representatives are available from 8:30 am to 8:30 pm, Monday through Friday on business days (excluding New York Stock Exchange holidays).

For help in choosing a medical plan or navigating the health care system, call Health Advocate at 1-866-695-8622.

If you choose to discontinue your retiree medical and/or dental coverage, you will not be able to re-enroll at a later date.

Changing Elections During the Year

Under Internal Revenue Service (IRS) regulations, you can make benefits changes outside of an Annual Enrollment period only if you meet specified conditions. These conditions are defined as "qualified status changes," and regulations allow you to make changes within 31 days of the status change. Examples of qualified status changes are marriage, divorce or birth of a child. Please contact the Fidelity Benefits Service Center if you experience a life event that you believe may be considered a qualified status change and you wish to make applicable changes to your coverage. If you do not contact the Fidelity Benefits Service Center within 31 days, you will not have the opportunity to change your elections until the next Annual Enrollment period.

Adding or Dropping Dependents

You can drop dependents from retiree medical and/or dental coverage during the Annual Enrollment period or if you experience a qualified status change. Generally, however, you may not add dependents to your retiree coverage whom you have either dropped since you have retired or who were not covered under a medical and/or dental option during your active employment immediately preceding your retirement. If you acquire a new dependent during retirement through marriage (but not via a domestic partnership), birth or adoption, federal regulations allow you to add that dependent during a special enrollment period for 31 days following the event (provided you are already enrolled for coverage). In the event of the birth or adoption of a child, your spouse may also enroll for coverage (provided you are already enrolled).

Levels of Coverage

When you enroll, you can choose medical and/or dental coverage for:

- Yourself only
- Yourself + one dependent
- Yourself + two or more dependents

When Coverage Begins

Your new elections made during Annual Enrollment will begin on January 1 of the plan year, and will continue through December 31 of that plan year, provided you continue to make timely payments. The plan will allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these new enrollment opportunities, you will have 60 days—instead of 31—from the date of the Medicaid/CHIP eligibility change to request enrollment in the plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

Paying for Coverage

You will continue to pay for your coverage either via deduction from your Retirement Plan payment or via Fidelity billing statements (if you are not currently receiving a benefit from the Retirement Plan or if your Retirement Plan benefit is not large enough to cover the deduction). You can also set up automatic bank withdrawal if you prefer. Your Retirement Plan deduction will be adjusted automatically at the beginning of the year to reflect the new contribution. If you are paying via Fidelity billing statement, you will receive an updated statement prior to January 1 of the plan year, based on the medical and/or dental plans you elect. Payment mailing instructions will be included. If you do not receive your Fidelity billing statement by January 1 of the plan year, call the Fidelity Benefits Service Center immediately.

Three Choices for Medical Care

Most Nielsen retirees and any dependents who are under age 65 have a choice of three medical plans through Anthem BCBS, Nielsen's national medical care provider. These three medical plans range in cost and coverage level from the Anthem BCBS High Coverage Plan to the Anthem BCBS Health Savings Plan. All three plans cover the same services, but vary in deductible, copayment/coinsurance and out-of-pocket maximum amounts. No matter which Anthem BCBS medical plan you select, you will automatically have prescription drug coverage. If you do not enroll in a medical plan, you will not have prescription drug coverage.

Nielsen offers you three meaningful choices; and you will notice a tradeoff between larger premium payments with more predictable reimbursements and smaller premium payments with less predictable reimbursements. When selecting a plan, remember that your total cost of medical care is the sum of your premium contribution plus the un-reimbursed expenses you pay out-of-pocket. Depending on the frequency and types of medical services you expect to use during the year as well as your personal tolerance for risk, one choice may feel better to you than another.

For retirees and their dependents who are under age 65 and who live in areas where Nielsen has large numbers of employees and retirees and adequate network coverage is currently unavailable through Anthem BCBS, or where Nielsen has been able to successfully negotiate highly favorable group rates, a local health plan or the Anthem BCBS Out-of-Area Plan may be available.

Once a retiree or a covered dependent reaches age 65, he or she must enroll in individual coverage in the Anthem BCBS Post-65 Medical Plan. For covered participants who are over age 65, the Anthem BCBS Post-65 Medical Plan coordinates with Medicare Part A and B. The Anthem BCBS Post-65 Plan provides creditable prescription drug coverage. For this reason, you will not be eligible to participate in the Anthem BCBS Post-65 Medical Plan if you enroll in Medicare Part D, the part of Medicare that provides prescription drug coverage.

Terminology Explained

- **Your Total Cost**—You pay for health care in two ways when you enroll in a health insurance plan. The first is the amount you pay toward the cost of your health insurance coverage (your premium contribution). The second is your out-of-pocket expenses when you use the health plan. These expenses include deductibles, coinsurance, copayments, and costs over Reasonable and Customary (R&C) limits.
- **Deductible**—The amount of money you must pay out-of-pocket each year before the plan begins to pay benefits toward the covered health care services you use. "Copayments" (see below) cannot be used to satisfy the deductible amount.
- **Coinsurance**—The portion of expenses you are required to pay for covered health care services after you have met your annual deductible. Your coinsurance portion is expressed as a percentage of the total covered expense. Nielsen pays the remaining percentage of covered expenses up to the annual out-of-pocket limit.
- **Copayment**—The flat fee you pay your health care provider for certain services, for example, a \$20 copayment for an annual physical exam in a doctor's office visit.

- **Out-of-Pocket Maximums**—The most money you will be required to pay toward the cost of covered services that you receive during a calendar year. The amount you pay for deductibles and coinsurance is used to meet the respective out-of-pocket maximum for covered in-network or out-of-network services. Once the out-of-pocket maximum has been reached, the plan pays 100%. A combination of in- and out-of-network deductibles can be used to help meet either the in-network or out-of-network maximums for the plan. However, charges for out-of-network services that exceed the maximum non-network reimbursement limit do not apply toward the out-of-pocket maximum. Copayments do not apply toward the out-of-pocket maximum.
- **In-Network**—Health care providers who have signed contracts with Nielsen insurers belong to a network of providers that guarantee they will bill you at the reduced rates specified in their contracts (the contract amount). Using one of these providers for your health care is known as going “in network.” You can easily find a network provider by checking the insurance carriers’ Web sites, or by calling their Member Services departments.
- **Reasonable and Customary (R&C) Charges**—R&C charges are the rates that medical providers in your geographic area usually charge for services similar to those you receive. When you receive out-of-network care, you pay for any medical charges above R&C charges, and these expenses don’t count toward any deductibles or out-of-pocket maximums.

Anthem Blue Cross and Blue Shield Plans

How the Anthem BCBS Plans Work

All three Anthem BCBS medical plans offer benefits whether you use an in- or out-of-network medical provider. You pay less out-of-pocket if you use an in-network provider for medical care, because these providers discount fees for service according to their contracts with Anthem BCBS.

You do not need to select a primary care physician and you do not need referrals. Each time you need medical care, you can choose to go either in or out-of-network. When you go to an in-network provider, you will pay either a copayment or coinsurance as outlined below, and your provider will submit claims for you. If you go out-of-network, you will pay higher coinsurance, and you must submit a claim form for reimbursements to Anthem BCBS. (You can print claim forms for reimbursement from NetBenefits®.)

When the amount of the deductible plus the coinsurance you pay out of pocket for in-network or out-of-network services reaches the annual out-of-pocket maximums shown below, the plan will pay 100% of the reasonable and customary charges for the rest of the year, except for copayments.

Online Resources for Anthem Blue Cross and Blue Shield

To learn more about your Anthem BCBS plan and about other resources offered to Anthem BCBS participants, go to www.anthem.com/nielsen. You may also call the Anthem BCBS Customer Service line at 1-800-875-9176, Monday through Friday from 8:00 am to 8:00 pm Eastern time. Health Savings Plan members call 1-800-992-4815.

	ANTHEM BCBS HEALTH SAVINGS PLAN		ANTHEM BCBS MODERATE COVERAGE PLAN		ANTHEM BCBS HIGH COVERAGE PLAN	
	In-Network Single/Family	Out-of-Network Single/Family	In-Network Single/Family	Out-of-Network Single/Family	In-Network Single/Family	Out-of-Network Single/Family
Deductibles	\$1,500/\$3,000	\$3,000/\$6,000	\$500/\$1,000	\$1,000/\$2,000	\$250/\$500	\$500/\$1,000
Office Visits	\$0 copayment for wellness visits only 80% all other	60%	\$20 copayment for wellness visits only 80% all other	60%	\$20 GPs/OBs/Peds. \$30 Specialist	70%
Coinsurance	80%	60%	80%	60%	90% (non-office visits)	70%
OOP Maximum (includes deductibles)	\$3,500/\$7,000	\$5,100/\$10,200	\$2,500/\$5,000	\$5,000/\$10,000	\$1,000/\$2,000	\$2,000/\$4,000
Health Savings Account (HSA) Contribution	Nielsen Contributes \$500/\$1,000 ¹ You can contribute up to \$3,050/\$6,150		Only available for the Health Savings Plan	Only available for the Health Savings Plan	Only available for the Health Savings Plan	Only available for the Health Savings Plan
ER Visit	80%	80%	80%	80%	90%	90%
Urgent Care Visit <i>Benefit will be the same as office visits or ER visits, depending how claim is submitted.</i>	80%	60%	80%	60%	90%	70%
Lifetime Maximum	\$2,000,000		\$2,000,000		\$2,000,000	
Prescription Drugs	Covered at 80% after paying the deductible amount Generic Incentive Policy applies*		In-network You pay \$10/\$30/\$45 (generic/formulary/non-formulary) at a pharmacy for short-term prescriptions (30-day supply). For long-term prescriptions you pay \$25/\$75/\$112.50 for a 90-day supply via mail order Out-of-Network You pay 100% and get reimbursed the negotiated fee less the applicable copayment. Generic Incentive Policy applies.*		In-network You pay \$10/\$30/\$45 (generic/formulary/ non-formulary) at a pharmacy for short-term prescriptions (30-day supply). For long-term prescriptions you pay \$25/\$75/\$112.50 for a 90-day supply via mail order Out-of-Network You pay 100% and get reimbursed the negotiated fee less the applicable copayment. Generic Incentive Policy applies.*	

*See page 9 for details on the Generic Incentive Policy

¹In an HSA with ACS|BNY Mellon

Retirees Who Do Not Have Access to an Anthem BCBS Network of Providers

If you do not have access to a fully developed Anthem BCBS network of providers, Nielsen offers an additional plan: the Anthem BCBS Out-of-Area Plan. If you enroll in the Anthem BCBS Out-of-Area Plan, you can use any provider and you submit claim forms directly to Anthem BCBS. For out-of-network providers, you pay 20% of the Reasonable and Customary (R&C) costs of your medical expenses after you meet the annual deductible. You also are responsible for paying all charges above the R&C limit. Any time you are able to use an in-network provider, you get the benefit of a discounted fee for service because Anthem BCBS network providers must charge the same fee to everyone insured by Anthem BCBS. (You can print claim forms from NetBenefits®.)

For the following kinds of wellness care, you pay \$0 toward the first \$250 of charges per family member: one routine annual physical, one annual mammogram, one annual well-woman exam (including pap smear), and childhood immunizations. You pay 20% of any wellness charges exceeding the \$250 limit per person per year. No deductible is applicable to wellness charges, but you are responsible for paying all charges above the R&C limit.

When the amount of coinsurance you pay meets the annual out-of-pocket maximums shown below, the plan will pay 100% of the R&C charges for the rest of the year, except for copayments.

PLAN FEATURE	OUT-OF-AREA PLAN BENEFIT
Annual Deductible (Individual/Family)	\$400/\$800
Annual Out-of-Pocket Maximum (Individual/Family)	\$3,000/\$6,000
Wellness Care (as specified above)	You pay \$0 toward the first \$250 of charges per person, and then 20% coinsurance for amounts over \$250
Other Office Visits	You pay 20% coinsurance after deductible
All Other Medical Expenses	You pay 20% coinsurance after deductible

If You or a Covered Dependent Turns Age 65

If you or a covered dependent turns 65 between now and the end of the year, your online election options will indicate your 2010 eligibility for the Anthem BCBS Post-65 Medical Plan only.

NOTE: All retirees eligible for the Anthem BCBS Out-of-Area Plan also have the option of enrolling in any of the other three Anthem BCBS plans, which offer both in- and out-of-network benefits. These plans are offered because some retirees are willing to travel a distance to use an in-network provider, and also because retirees can enroll in these plans, use only the out-of-network benefit, and pay a lower premium contribution than for the Out-of-Area Plan.

You must consider the total cost of medical care in choosing the right medical plan for you. The premium contribution and the deductible, out-of-pocket maximum, and the coinsurance percentage you pay differ by plan. In the Anthem BCBS Out-of-Area Plan, you pay 20% coinsurance; in the out-of-network portion of the other plans, you pay anywhere from 30% to 40% coinsurance depending on the plan you choose.

Anthem BCBS Post-65 Medical Plan

The Anthem BCBS Post-65 Medical Plan is offered to all eligible retirees and dependents over age 65. It is identical to the Anthem BCBS Out-of-Area Plan (see explanation of the Out-of-Area Plan on the previous page) in most respects, including deductibles, coinsurance, out-of-pocket maximums, covered expenses and Reasonable and Customary charges.

However, there are some important differences between the two plans that you should note:

- The Post-65 Medical Plan coordinates with Medicare, which means that all expenses must first be submitted to Medicare before being considered for reimbursement by the Anthem BCBS Post-65 Medical Plan. This means that you and/or your covered dependent should be sure to enroll in Medicare Parts A and B three months before you become eligible for Medicare. Even if you do not enroll for both Medicare Parts A and B, claims will be reimbursed as if you were enrolled for both.
- You will be required to submit a claim form to be reimbursed for expenses. Since all claims for Medicare eligible participants must be coordinated with Medicare, you must submit a copy of the Medicare Medical Summary Notice along with your claim form.
- Since there is no network associated with the plan, you may receive care from any provider you choose. Please remember, however, that not all providers accept Medicare.
- Unlike most of the other Anthem BCBS plans, you are not required to notify Anthem Blue Cross and Blue Shield prior to receiving any care.

If a pre-65 retiree has a post-65 dependent, the pre-65 retiree and dependent will remain in the pre-65 plan, but Anthem will process claims for the post-65 dependent as secondary, with Medicare as primary.

The Nielsen Post-65 Medical Plan includes prescription drug coverage. If you enroll in Medicare Part D Prescription Coverage, you will not be able to participate in the Post-65 Medical plan.

Included in the High Coverage and Moderate Coverage Anthem Blue Cross and Blue Shield Medical Plans

Prescription Drug Coverage

When you enroll in the Anthem BCBS Moderate Coverage, High Coverage, Post-65 and Out-of-Area Plans you and your enrolled dependents are automatically covered by Anthem's pharmacy program, which provides you and your family a choice of affordable drugs on the Anthem Drug List/Formulary. You and your doctor should always work together to make the final decision on your health care and medications.

You can get your medications two ways: at a retail pharmacy for short-term medications—or through our mail order pharmacy for maintenance medications. You may fill a prescription for a maintenance medication a maximum of three times at a retail pharmacy. After that, you will be required to use the mail order pharmacy to fill prescriptions for maintenance medications.

What's a Formulary?

A formulary is a prescription drug list, which includes a wide selection of medications that offers you choice while helping to keep the cost of your prescription drug benefit affordable.

For the full list, consult the Anthem BCBS formulary drug list on www.anthem.com/nielsen.

Retail Pharmacist

You can get up to a 30-day supply of covered medication at a nearby retail pharmacy. You should make sure that the pharmacy participates in Anthem/NextRx's network by looking online at www.anthem.com/nielsen or by calling the toll-free number on your ID card.

Ordering new prescriptions or refills of short-term medications at a participating retail pharmacy is easy. Simply show your ID card at the pharmacy and pay your copayment. You pay:

- \$10.00 copayment for tier 1 drugs
- \$30.00 copayment for tier 2 drugs
- \$45.00 copayment for tier 3 drugs

Generic Incentive Policy

Your prescription drug coverage includes a "generic incentive." This means, if you purchase a brand-name drug for which a generic alternative is available, the plan does not pay more than what it would pay for the generic drug, and you are responsible for any cost in excess of that amount. If you choose a brand-name drug, you pay the full cost of the brand-name drug less the available plan benefit (that is, the amount that the plan would pay for the generic drug).

The following example illustrates how the generic incentive works.

Say you choose to fill a retail prescription with a brand-name drug instead of its generic equivalent. The brand-name drug costs \$160 for a 30-day supply, while the generic costs only \$60. Ordinarily, your copayment is based on which tier the drug you are purchasing falls under. However, because of the new generic incentive policy, the "available plan benefit" is limited to the full cost of the generic drug minus your tier 1 copayment. You are responsible for paying the difference between the cost of the brand-name drug and the available plan benefit, as follows:

Brand-Name Cost: \$160

Generic Cost: \$ 60

Available Plan Benefit: \$ 50 (full cost of the generic drug minus the tier 1 copayment or $\$60 - \$10 = \$50$)

Your cost: \$110

In this example, you'll pay \$100 more for the brand-name drug than you will for its generic equivalent.

Three-Tier Drug List

Anthem is dedicated to providing you with safe and effective medications backed by the latest research and clinical recommendations. As part of this commitment, they create and manage the Anthem Drug List/Formulary—a list of FDA-approved brand-name and generic medications. The medications on the Anthem BCBS drug list have been reviewed and recommended for their quality and effectiveness by the National Pharmacy and Therapeutics (P&T) Committee, an independent group of practicing doctors and pharmacists.

Drugs on the Anthem Drug List/Formulary are grouped by tiers. To determine tier levels for different medications, go to www.anthem.com/nielsen, log in and click on the MyPharmacy tab and search the drug list. Or call the customer service number on your ID card.

Tier 1: Lowest copayment; includes drugs offering the greatest value within a therapeutic class. Some of these are generic equivalents of brand-name drugs.

Tier 2: Medium copayment; includes drugs that are generally the more affordable brand-name drugs. Other drugs are on this tier because they are “preferred” within their therapeutic classes, based on clinical effectiveness and value.

Tier 3: Highest copayment; includes higher cost brand-name drugs. Some tier 3 drugs may have generics or equivalents in tier 1 that could save you money.

Mail Order Drug Program

If you need medication on an ongoing basis, such as to treat asthma or diabetes, you can ask your doctor to prescribe up to a 90-day supply for home delivery.

You will pay just one copayment for each prescription or refill. You pay:

- \$25.00 copayment for tier 1 drugs
- \$75.00 copayment for tier 2 drugs
- \$112.50 copayment for tier 3 drugs

The Anthem/NextRx Mail Order Drug Program offers you the convenience and potential cost savings for your long-term prescription needs.

Mail Order Incentives

You can feel confident that your prescriptions will be filled accurately and with the highest quality, FDA approved medications. There are three separate quality checks:

- The prescription is entered into the system and checked against your personal information to look for possible allergies, interactions, duplications or other problems.
- A pharmacist checks the prescription to make sure it's accurate and checks for medication safety issues.
- After the prescription goes through the automated dispensing system, another pharmacist verifies that the right medication was dispensed and the prescription was filled accurately.

With the Mail Order Drug Program

With Anthem/NextRx, Anthem's preferred mail order pharmacy, convenient prescription delivery is just a phone call away. With our mail service pharmacy:

- You can get a 90-day supply of your medication for the same price as two and a half 30-day prescriptions filled at a retail pharmacy.
- Your medications are shipped free within seven days of receipt of a valid order, in unmarked and tamper-resistant packaging (standard shipping). Express shipping is available for an added charge.
- Next RX dispenses FDA-approved generic medications unless you or your doctor directs otherwise. Generics usually cost 30–60 percent less than brand-name medications.
- Care coordinators can answer your questions about benefits, savings opportunities and more. You can also talk directly to a licensed pharmacist.

Your medication will be delivered to you within seven days after you place your order. When placing your order, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for another prescription for a 14-day supply to be filled at your local participating retail pharmacy.

Using the Mail Order Drug Program for the First Time

Ask your doctor to write a new prescription for up to a 90-day supply, plus refills for up to one year. You may submit prescriptions:

- **Phone**—Ready to request a free cost savings estimate or need help obtaining a prescription from your doctor? An Anthem/NextRx pharmacy associate is ready to assist. Call **1-888-613-6091**, Monday through Friday, 8 am–11 pm and Saturday 8 am–7 pm Eastern time (TTY 800-221-6915). You will need to provide your prescription information, physician's name, phone number, names and strengths of medications, as well as credit card information (including the cardholder's name, account number and expiration date) for payment.
- **Mail**—To get an order form, call the customer service number on your ID card or go to **www.anthem.com/nielsen** and click the MyPharmacy tab. Select "View Forms," located in "Pharmacy Tools," and download the form. Mail the original prescription, the order form and payment information to:
Anthem/NextRx
PO Box 746000
Cincinnati, OH 45274-6000
- **Fax**—Have your physician fax your prescription information to **1-800-905-9815**. The prescription must be faxed directly from your doctor's office. If there is a question about your prescription(s), we will contact your physician. You will be billed later.

Using the Mail Order Drug Program for Refills

You can easily refill your home delivery prescriptions online, by telephone, or by mail. To make sure that you don't run out of your medication, remember to reorder 14 days before your medication runs out. You can find the refill date on your prescription bottle or on the refill slip that comes with every order.

- **Online**—Go to www.anthem.com/nielsen, log in and click the MyPharmacy tab. "Refill a Prescription" is located in the left-hand column. You can also review the status of existing orders while online.
- **Phone**—Get your prescription label and credit card ready. Call **1-800-962-8192** and select the "Automated Refill Order Line" option from the menu, or press "0" at any time to talk to a care coordinator. If you are speech or hearing impaired, call **1-800-221-6915**. Follow the prompts to place your order.
- **Mail**—Complete an order form and include the preprinted refill form indicating the medication being requested or write the prescription refill number in the area provided. Mail the order form with the proper payment to:

Anthem/NextRx
PO Box 746000
Cincinnati, OH 45274-6000

ID Cards

New Anthem BCBS High, Moderate, Out-of-Area and Post-65 Plan members will receive an ID card in the mail. Your new ID card will also serve as your prescription drug coverage card. If you are covering one or more dependents, you will receive an ID card for each covered dependent in the dependents's name. All cards will feature the Anthem Blue Cross and Blue Shield logo, which includes the widely recognizable Blue Cross and Blue Shield symbol, as well as the BlueCard PPO suitcase, which represents your access to the BlueCard network across the country.

Specialty Pharmacy

Anthem's preferred specialty pharmacy, PrecisionRx Specialty Solutions, puts people with chronic, complex conditions in the center of a robust specialty medication support program of personal care coordinators, registered nurses and clinical pharmacists. These teams provide intense disease- and therapy-specific care management, help improve communication between doctors and their patients, and provide an additional level of support not available through a retail pharmacy.

The disease- and therapy-specific care coordination helps promote quality, safety and clinical effectiveness in treating complex, chronic diseases and conditions, which include, but are not limited to:

- Asthma
- Cancer
- Gaucher
- Hemophilia/Bleeding Disorders
- Hepatitis C
- HIV/AIDS
- Infertility
- Multiple Sclerosis
- Primary Immune Deficiency
- Psoriasis
- Pulmonary Arterial Hypertension
- Rheumatoid Arthritis
- Respiratory Syncytial Virus
- Transplant

Ordering Specialty Medications:

- **Phone**—Call **1-800-870-6419** to verify your information. Care coordinators are available Monday through Friday, 8 am to 10 pm Eastern time.
- By fax—You can have your doctor fax your prescription(s) and a copy of your ID card to **1-800-824-2642**.

Filing Claims

You have 12 months from the date of service to file claims. You can get claim forms from the Fidelity NetBenefits Web site or by calling the Fidelity Benefits Service Center.

Personal Health Advocate Service

The Personal Health Advocate Service offers support for a wide variety of medical conditions. The registered nurse assigned to you will work with you to develop a personal action plan designed to help you manage your condition(s), avoid or minimize complications and improve the quality of your life.

Your Personal Health Advocate can help you:

- Address your health care questions and concerns.
- Select hospitals and providers that are right for your needs.
- Better understand your diagnosis and treatment options.
- Understand and follow your physician's plan of care.
- Stay healthy by recommending preventive care and identifying your health risks.
- Promote self-management of targeted chronic or complex conditions.
- Understand your medications and any alternative options available to you.
- Coordinate your services before, during and after a hospital stay.

Through your Personal Health Advocate Service you will have access to your registered nurse, as well as to other clinical professionals, such as behavioral health specialists, disease management nurses, dieticians and pharmacists. Your Personal Health Advocate can help identify what services are available to you and, more importantly, explain how each can be used to meet your specific needs. You can also connect online to a host of educational materials and health topics.

Examples of some conditions that have specialized programs include:

- Asthma
- Chronic Obstructive Pulmonary Disorder (COPD)
- Heart Failure
- Coronary Artery Disease
- Diabetes
- Depression

Of course, the Personal Health Advocate Service does not take the place of your doctor. But it is a great resource that will help you and your doctor make informed decisions about your health. The goal of the Personal Health Advocate Service and the other special resources provided with it is to help you and your family gets the right care, at the right place, at the right time.

To contact a Personal Health Advocate, call the toll-free 24/7 NurseLine / 360° Health Programs number on your ID card, **1-866-623-3809**, and listen for the My Health Coach prompt.

24/7 NurseLine

What do you do when it's midnight and your child develops a high fever? Or you're out of town for the holidays, you don't feel well, and need to find a doctor?

You call Anthem's 24/7 NurseLine. When you do, you'll speak directly to a registered nurse who can help answer your health-related questions. Discuss symptoms you or a loved one is experiencing and get help making informed decisions like whether you should get medical attention, the best place to get it and more.

The call is toll-free and the service is available anytime—days, nights, weekends and holidays. Plus, your call is confidential. The 24/7 NurseLine can help you get the information you need, when you need it. Then, you can make a more informed decision about your health and find some peace of mind.

- Get help anytime, 24 hours a day, seven days a week, 365 days a year
- Call the 24/7 NurseLine at 1-800-875-9176

HMOs

(only for retirees and covered dependents who are under 65)

Local health plans are offered in a few locations where a significant number of participants do not have access to a fully developed Anthem BCBS provider network, or where the cost of the local health plan is significantly less than that of the Anthem BCBS plans. Individuals in these locations will also be able to select one of these two Anthem Blue Cross and Blue Shield plans.

These local health plans are available:

- California: Blue Cross and Blue Shield of California
- Florida: AvMed

If you are eligible to participate in a local health plan, it will be indicated on NetBenefits. Most of these local plans have prescription drug benefits. For further information, contact the local insurance carrier. (See the Benefits Resource List on page 18.)

Dental Benefits

Two Choices for Dental Care

Nielsen offers two different plans for caring for your dental health. The CIGNA Dental Care HMO covers services from network providers only. The CIGNA Dental PPO covers both in-network and out-of-network care.

Naming a Primary Care Dentist Under the CIGNA Dental Care HMO

If you enroll in the Dental Care HMO, you and each family member must designate a Primary Care Dentist. To elect a Primary Care Dentist, contact CIGNA Member Services at 1-800-CIGNA24.

CIGNA Dental Care HMO

The CIGNA Dental Care HMO, which covers only in-network dental-care services, has the lowest total out-of-pocket costs. You will pay a pre-set discounted fee* for dental services, and there are no claim forms and no deductibles.

If you select the Dental Care HMO, your primary care dentist will manage all your dental care—providing referrals as necessary. Therefore, each covered family member must select a primary care dentist. To select (or change) a primary care dentist, call CIGNA Member Services or log on to the CIGNA Web site (see the Benefits Resource List on page 15 of this brochure). In the event your dentist drops out of the network during the year, you will need to choose another network dentist.

BENEFITS	DENTAL CARE HMO (IN-NETWORK ONLY)
Annual Maximum Reimbursement	Not applicable
Lifetime Maximum for Orthodontia	24 months of interceptive/comprehensive treatment
Annual Deductible (Individual/Family)	None
Preventive and Diagnostic Care	No Cost to you
Basic Restorative Care	You pay pre-set fee*
Major Restorative Care	You pay pre-set fee*
Orthodontic Care	You pay pre-set fee*

*See the Cigna DHMO Fee Schedule at www.cigna.com or <http://netbenefits.fidelity.com>

Dental ID Cards

CIGNA will provide dental cards only to those enrolled in the Dental Care HMO. You will not receive an ID card if you enroll in the CIGNA Dental PPO, as the in-network providers will check your participation in the plan before submitting a claim. If you are enrolled in the PPO and want an ID card, log into NetBenefits, under Reference Library, click CIGNA ID Cards and print out a paper ID card.

CIGNA Dental PPO

The CIGNA Dental PPO is available to all Nielsen retirees because the PPO plan provides benefits whether you use an in- or out-of-network dentist. Like a medical PPO, your dental costs will be lower in-network, because network dentists discount their fees for service according to their contracts with CIGNA. Unlike the medical PPO, the dental PPO reimburses your expenses at the same coinsurance percentage whether you use an in or out-of-network dentist.

When you receive care from an in-network dentist, your dentist will submit claims for you, CIGNA will pay a percentage of the contract amount to the dentist, and you will pay the difference plus a small annual deductible, if applicable. If you go out-of-network, you submit the claim form, CIGNA reimburses either you or the provider a percentage of the non-discounted reasonable-and-customary charge, and you pay the difference plus an annual deductible if applicable.

If you choose this plan, you will not need to choose a primary care dentist, and you will not need referrals. Each time you need dental care; you can choose to go either in- or out-of-network. When you go to any dentist for the first time, bring a claim form along with you so that your dentist can submit your claim correctly. (You can print claim forms from NetBenefits.)

To find a Core Network dentist, go to myCIGNA.com.

BENEFITS	DENTAL PPO IN-NETWORK	DENTAL PPO OUT-OF-NETWORK
Annual Maximum (Excluding Orthodontics)	\$1,500 per person	\$1,500 per person
Orthodontic Lifetime Maximum	\$1,500 per person combined in- and out-of-network	\$1,500 per person combined in- and out-of-network
Annual Deductible (Individual/Family)	Based on discounted fees	Based on reasonable and customary allowances
Annual Deductible (Individual/Family)	\$50/\$150	\$50/\$150
Preventive and Diagnostic Care	No cost to you (up to reasonable and customary allowances)	No cost to you (up to reasonable and customary allowances)
Basic Restorative Care	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
Major Restorative Care	You pay 50% coinsurance after deductible	You pay 50% coinsurance after deductible
Orthodontic Care	You pay 50% coinsurance after deductible	You pay 50% coinsurance after deductible

To find a Core Network dentist, go to myCIGNA.com.

Health Advocate

Health Advocate is the nation's leading health care advocacy and assistance company. When you call, you'll be assigned a personal health advocate from their team of registered nurses, doctors and benefits experts. Your personal health advocate can answer questions, help untangle claims problems, resolve issues with insurance, work with you to locate a specialist—even help understand your choices regarding a serious illness.

Health Advocates help you solve problems and find solutions related to your health care and health insurance needs. The program is not a substitute for your health insurance plan. Rather, it complements basic health coverage by providing a range of services.

Health Advocate can help with:

- Finding the best doctors and hospitals
- Resolving insurance claims
- Assisting with eldercare issues
- Saving money on health care bills
- Navigating within an insurance company to help obtain approval for needed services
- Locating and researching current treatments for a medical condition
- Securing second opinions helping to provide peace of mind
- Assisting with correcting billing mistakes
- Scheduling appointments with hard-to-reach specialists
- Obtaining unbiased health information to help make an informed decision
- Identifying renowned “best-in-class” medical institutions regarding serious illness or injury
- Assisting with a complex medical condition
- Protecting your privacy
- And more

Contact Health Advocate at **1-866-695-8622** or **answers@HealthAdvocate.com**.

Benefits Resource List

FOR QUESTIONS ABOUT	WHAT TO ASK	WHO TO CONTACT
Your general health and welfare benefits	For any questions on enrollment, eligibility, your current elections, plan costs, Summary Plan Descriptions, claim forms, qualified life event changes (such as marriage or birth of a child)	Fidelity Benefits Service Center 1-800-500-2363 NetBenefits® http://netbenefits.fidelity.com International calls dial your country's AT&T Access Number + 800-500-2363. Access numbers are available on line at http://www.att.com/traveler or from your local operator.
Help navigating the health care system, problem claims, choosing a medical plan	For any questions relating to choosing and using your health care benefits, including how to find a doctor or specialist, help getting a claim issue resolved, support for choosing a medical plan	Health Advocate 1-866-695-8622 www.healthadvocate.com
Anthem BCBS medical plans (Health Savings Plan, Moderate Coverage Plan and High Coverage Plan, Out-of-Area Plan and for questions about the Prescription Drug Program)	For network provider directories; for questions on medical coverage, claims status, pre-notification	Anthem Blue Cross and Blue Shield 1-800-875-9176 www.anthem.com/nielsen Health Savings Plan members call 1-800-992-4815
ACS BNY Mellon	Questions about your Health Savings Account	ACS BNY Mellon 1-877-472-4200
CIGNA Dental PPO	For questions on dental coverage, network providers, and claims payments	CIGNA 1-800-CIGNA24 http://www.cigna.com or http://www.mycigna.com
CIGNA Dental Care HMO	To chose a primary care dentist, check directories of network providers, and for questions on dental coverage	CIGNA 1-800-CIGNA24 http://www.cigna.com or http://www.mycigna.com
Anthem BCBS	Pharmacy claims	www.anthem.com/nielsen
Health Management (for Anthem BCBS members)	For questions about health care or where to go to get the best treatment	24/7 NurseLine/360 Health Services 1-866-623-3809
Anthem/NextRx	To place an order for maintenance medication	1-800-962-8192
HMOs	For questions on medical coverage, including prescription drug coverage for the local plans and on network providers and pharmacies	AvMed 1-800-882-8633 http://www.avmed.org Blue Cross of CA 1-888-887-9154 http://www.anthem.com/ca

The information in this document, provided by The Nielsen Company contains a summary of the benefits provided under the plans. Details are provided in the summary plan descriptions. The plan documents are the official plan text, which governs the operation of the plans. The language used in this brochure is not intended to create nor is to be construed to create a contract between The Nielsen Company and any one of The Nielsen Company's (or its subsidiaries') employees or former employees. In the event that the content of this brochure or any oral representations made by any person regarding the plan conflicts with or are inconsistent with the provisions of the plan document, the provisions of the plan document control. Your enrollment in Nielsen's benefit plans is subject to all limitations of the plan, including at work requirements and eligibility requirements. The Nielsen Company reserves the right to amend, modify or terminate any or all of the plans at any time.

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