

# FOLLETT CORPORATION WELFARE BENEFITS PLAN

## SUMMARY PLAN DESCRIPTION

As Amended and Restated Effective January 1, 2025

This document, together with each component benefit plan's benefit booklet or certificate of insurance ("benefit booklet") constitute the summary plan description of the Follett Corporation Welfare Benefits Plan (the "Plan"). The Plan provides group medical, prescription drug, dental, vision, life, accidental death and dismemberment, disability, business travel accident, critical illness and accidental injury insurance benefits, health care flexible spending accounts, and severance benefits for eligible employees and for those employees' eligible dependents.

**Name of Plan:** Follett Corporation Welfare Benefits Plan

**Plan Sponsor:** Follett Corporation  
3 Westbrook Corporate Center, Suite 900  
Westchester, IL 60154

**Employer Identification Number:** 36-2369161

**Plan Administrator:** Follett Corporation Administrative Committee  
3 Westbrook Corporate Center, Suite 900  
Westchester, IL 60154  
(877) 888-7887, option 2

**Plan Number:** 503

**Plan Year:** January 1 to December 31

### **Type of Plan:**

The Plan is an employee welfare benefits plan providing group medical, prescription drug, dental, vision, life, accidental death and dismemberment, disability, business travel accident, critical illness and accidental injury insurance benefits, health care flexible spending accounts, and severance benefits for eligible employees and for those employees' eligible dependents.

### **Type of Administration:**

The Follett Corporation Administrative Committee is the Plan Administrator; however, the Employer has delegated certain Plan administrative functions to insurance companies and claims administrators. Plan benefits under the components of the Plan that are fully insured are administered in accordance with the terms of the respective insurance policies. Plan benefits under components of the Plan that are self-funded are provided in accordance with the claims administration procedures of the respective claims administrator. The Plan Administrator makes all of the decisions with respect to eligibility to participate in the Plan. The respective insurance companies and/or claims administrators are responsible for the

claims administration and payment of benefits. See **Claims Procedures** below for further information.

### **Agent for Service of Legal Process**

The name and address of the Plan's agent for service of legal process is:

Chief Legal Officer  
Follett Corporation  
c/o CT Corporation  
208 S. LaSalle Street, Suite 814  
Chicago, IL 60604

Service of legal process also may be made on the Plan Administrator and the insurers identified in the benefit booklet for the respective insured component of the Plan.

### **Eligibility and Benefits:**

All "Eligible Employees" may participate in the Plan. "Eligible Employee" means, except as otherwise provided in an applicable benefit booklet (including, but not limited to, the medical benefit booklet's use of a look-back measurement period approach for certain classes of employees), any individual who is regularly employed by an Employer on the Employer's United States payroll and classified as a full-time employee in the Employer's human resources information system, other than (a) a member of a collective bargaining unit unless the collective bargaining agreement specifically provides for their participation and (b) an Employee regularly scheduled to work less than 30 hours per week. The term "Eligible Employee" does not include any leased employee or any individual providing services to an Employer in the capacity of, or who is designated by the Employer in its sole discretion as, an independent contractor or as a temporary or part-time employee (except as provided otherwise in the applicable benefit booklet with respect to an Employee classified as part-time or temporary).

The term "Employer" as used in this summary refers to Follett Corporation and those U.S. affiliates that are participating employers in the Plan. As of January 1, 2025, those participating employers consisted of Follett Higher Education Group LLC.

### **Funding of the Plan and Source of Contributions:**

The Plan is funded in part by the Employer and in part with your contributions. The following coverages are fully insured, meaning claims are paid under group insurance policies issued by the insurer: medical (HMO), dental (DMO), vision, life, long-term disability, accidental death and dismemberment, critical illness and accident injury insurance, and business travel accident. The following coverages are self-funded, meaning claims are paid out of the Employer's general assets: medical (PPO), prescription drug, dental (PPO), short-term disability, health care flexible spending accounts, and severance benefits. The amount of your required contributions for each coverage under the Plan will be provided to you in advance of the time in which you may enroll in such coverage.

### **End of Coverage**

Unless otherwise indicated in a benefit booklet, you will lose coverage under the Plan when you are no longer eligible for coverage or the date your employment with the Employer terminates.

**Loss or Reduction of Benefits:**

The benefit booklets describe the circumstances that may result in a loss or reduction of benefits. The Employer reserves the right to amend or terminate all or any portion of the Plan at any time. Employees and their dependents do not become vested in any benefit or rights under the Plan.

**Claims Procedures:**

The benefit booklets generally describe the claims procedures to be followed in order to receive benefits under the Plan. However, if there are no such claims procedures contained in the benefit booklet for a particular component of the Plan, and for claims involving eligibility to participate (as distinguished from benefits entitlement), the following claims procedures shall govern:

- (a) All claims shall be filed in writing with the Plan Administrator.
- (b) Every claim that is properly filed shall be answered in writing within ninety (90) days (or one hundred eighty (180) days if special circumstances require an extension of time for processing the claim) of receipt stating whether the claim is granted or denied. If special circumstances require an extension of time for processing the claim, then the claimant shall be so notified within ninety (90) days. If the claim is denied, the claimant shall be provided specific reasons for denial; specific reference to the pertinent Plan provisions on which the denial is based; a description of any information necessary for the claimant to perfect a claim including an explanation of why such information is necessary; and an explanation of the Plan's claim appeal procedure including steps to be taken to submit the claim for review. Notwithstanding anything in the foregoing to the contrary, a claim for short-term disability benefits shall be answered in writing within forty-five (45) days (with two thirty (30) day extensions available) if special circumstances require an extension of time for processing the claim).
- (c) Within sixty (60) days after notice that a claim is denied, the claimant may file a written appeal to the Plan Administrator that shall include any comments, statements or documents the claimant may wish to provide. Notice of the decision on appeal shall be sent to the claimant within sixty (60) days of its receipt (or one hundred twenty (120) days if special circumstances require an extension of time for processing the appeal). In the event the claim is denied upon appeal, the Notice shall set forth the reasons for denial written in a manner calculated to be understood by the claimant and specific reference to the pertinent provisions of the Plan on which the denial is based. Any reasonable request from a claimant for documents or information relevant to his/her claim prior to his/her filing an appeal shall also be allowed. Notwithstanding anything in the foregoing to the contrary, if a claim for short-term disability benefits made on or after the Effective Date is denied, the claimant may file the written appeal to the Plan Administrator within one hundred and eighty (180) days after notice that a claim is denied. Notice of the decision on appeal shall be sent within forty-five (45) days of its receipt (or ninety (90) days if special circumstances require an extension of time for processing the appeal).

- (d) If notice of the denial of the claim or appeal is not furnished in the time limits set forth above, the claim or appeal shall be deemed denied.
- (e) The Plan Administrator shall retain exclusive authority to determine all questions regarding eligibility for Plan benefits and all determinations interpretations, rules, and decisions of the Plan Administrator or its delegate shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan.

**Amendment or Termination of the Plan:**

Follett Corporation retains the right to amend or terminate the Plan at any time, for any reason, with or without prior notice. In addition, termination of a group insurance policy between Follett Corporation and the insurer will constitute termination of that component of the Plan, unless Follett Corporation exercises its sole discretion to obtain a substitute contract of insurance.

**Statement of ERISA Rights:**

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, also called ERISA. ERISA provides that all Plan participants shall be entitled to:

- (a) Examine, without charge, all Plan documents, including copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports (Form 5500).
- (b) Obtain, upon written request to the Plan Administrator, copies of all Plan documents and other Plan information, including insurance contracts and the latest annual report (Form 5500), upon written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies).
- (c) 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 this summary annual report.
- (d) Continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You, your spouse or your dependents may have to pay for such coverage. Review the applicable certificates of coverage for the rules governing your COBRA continuation coverage rights.
- (e) Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject

to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan 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 welfare benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. (See **Claims Procedures** above.)

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request copies of the Plan documents and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If the Plan’s 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. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain documents about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**Newborns’ and Mothers’ Health Protection Act Notice:**

Under the Newborns’ and Mothers’ Health Protection Act, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable) following delivery. In any case, Plans and issuers may not require that a

provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Women’s Health and Cancer Rights Act Notice:**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Protheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact the Follett Benefits Department at [benefits@follett.com](mailto:benefits@follett.com) or (877) 888-7887, option 2, or call your health plan at the phone number on the back of your ID Card.

**Questions:**

If you have any questions about your Plan benefits, you are encouraged to contact Follett Benefits Department or the Plan Administrator.