Summary Plan Description

Health and Welfare ADP Totalsource®

Always Designing for People™

ADP TotalSource
10200 SW 72 Street
Miami, FL 33173

Dear Employee:

ADP TotalSource, Inc. is committed to excellence by providing our employees with World Class Service. This booklet (and accompanying benefit booklets) are the Plan Document and Summary Plan Description and reflect the available benefits under the ADP TotalSource, Inc. Health and Welfare Plan (the "Plan"), including medical, dental, vision, Flexible Spending Accounts, basic life insurance, accidental death and personal loss (AD&PL), short term and long term disability benefits and an employee assistance program, effective as of June 1, 2018 (except as otherwise noted).

If you have difficulty understanding any part of this booklet, you may obtain assistance by contacting a MyLife Advisor at (844) 448-0325 located at 10200 Sunset Drive, Miami, Florida 33173. Office hours are from 8:00 AM to 11:30 PM Eastern Time Monday through Friday.

Estimado Empleado:

ADP TotalSource, Inc. está comprometido a la excelencia al proveer a sus empleados un Servicio de Clase Mundial. Este folleto resume los beneficios disponibles bajo nuestro extensor plan de beneficios "ADP TotalSource, Inc. Health and Welfare Plan" el cual incluye planes médicos, dentales y visión; Cuentas de Gastos Flexibles, Seguros de Vida Básico; Seguro de Muerte Accidental y Pérdida Personal (AD&PL), Beneficios por discapacidad a corto y largo plazo, y un programa de asistencia al empleado.

Si usted tiene dificultad en comprender cualquier parte de este folleto, por favor llame a MyLife Advisor al (844) 448-0325 que esta localizado en 10200 Sunset Drive, Miami, Florida 33173. Nuestras horas de oficina son de 8:00 AM a 11:30 PM Hora del Este, de lunes a viernes.

From time to time, ADP TotalSource, Inc. modifies its benefits programs. When applicable, you will receive a Summary of Material Modification ("SMM") (or in some cases a notice) that explains material changes to the benefits programs. Changes detailed in the SMM or notice (as applicable) will be incorporated into the next SPD at a later date.

ADP TotalSource, Inc. reserves the right to amend any of this Plan or any Plan benefit feature, in whole or in part, at any time or from time-to-time without the consent of or, to the extent permitted by law, prior notice to you or your dependents. Although the ADP TotalSource, Inc. expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate this Plan or any Plan benefit or feature at any time without liability.

The terms "you" and "your" as used in this document refer to an individual who is otherwise eligible to participate in the Plan. Receipt of this document does not guarantee that the recipient is in fact eligible to participate in the Plan.

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Health and Welfare Plan Introduction

You may choose from a variety of benefits through the ADP TotalSource, Inc. (also referred to as "ADP TotalSource") Health and Welfare Plan (also referred to as the "Plan"). With this Plan, you select coverage best suited for your needs that will help protect you and your family from the financial burdens of rising health care costs for routine care and treatment of serious injury or illness.

Under the Plan, you may use pre-tax dollars to pay for the benefit options you select, cafeteria style, from the benefits "menu." You may also set aside money, tax-free, to use for dependent care expenses and certain medical expenses (see the section titled "Flexible Spending Accounts" or "Health Savings Accounts").

The Plan year runs from June 1st through May 31st ("Plan Year"). Coverage elected under the Plan will remain in effect as of your enrollment date through the end of the current Plan Year, May 31st, unless you experience a qualified change in status under Internal Revenue Code Section 125 that affects your eligibility to participate in the Plan. Please refer to the section titled "When Your Coverage Ends" or "Making Changes to Your Benefits." The annual Open Enrollment period for the Plan will take place during March or April each year for an effective date of June 1st. During the annual Open Enrollment period, you will be allowed to review and make changes to your elections for an effective date of June 1st.

Summary Plan Description and Plan Document

This booklet (along with the Summary of Benefits and Coverage and benefit highlights) found in your enrollment kit (if you are not receiving your enrollment materials electronically) and on the ADP TotalSource website (adptotalsource.adp.com) along with the confirmation statement kit provide the details of the specific benefit options available in your geographic area, including medical, dental, vision, Flexible Spending Accounts, basic life insurance, accidental death and personal loss (AD&PL), short term and long term disability benefits and an employee assistance program. Also, this booklet (along with the Summary of Benefits and Coverage and benefit highlights) and the Summary of Material Modifications, if any, constitute your Summary Plan Description (SPD) and Plan Document for the Plan (except as noted below) as required by Section 102 of the Employee Retirement Income Security Act of 1974, as amended (**"ERISA"**) and U.S. Department of Labor Regulation Sections 2520.102-2 and 2520.102-3 for the Plan.

This document with applicable attachments also constitutes the Summary Plan Description (and not the plan document) for the ADP TotalSource, Inc. Flexible Benefits Plan ("Flex Plan"), which includes a general purpose Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account. To the extent this summary is inconsistent with the plan document for the Flex Plan, to which the Health Care FSA plan is a component plan, the plan document for the Flex Plan controls.

This document also summarizes certain plans (identified below) which are not employee benefit plans under ERISA and whose benefits are not covered by ERISA, but are included in this booklet for your convenience:

- Health Savings Account (HSA)
- Employee Assistance Program (EAP);
- Dependent Care Flexible Spending Account (FSA); and
- State Temporary Disability Insurance (TDI).

The benefits described in this document reflect the Plans in effect on June 1, 2018, except as otherwise noted.

How to Use This SPD

- This document describes general provisions that apply to the Plan. The insurance certificate of coverage, contracts, or Summary of Benefits and Coverage for each underlying benefit identified in this SPD governs the benefits to be provided and include more details on how the benefit features operate.
- Read this entire SPD document and accompanying documents. Share this with your family and keep it in a safe place for future reference.
- Capitalized words in this SPD have special meanings and are defined in this document.
- This SPD supersedes any previous printed or electronic SPD for this Plan.
- You can find copies of this SPD and any future amendments at adptotalsource.adp.com or request printed copies by contacting a MyLife Advisor at 1-844-448-0325. You can also find copies of the insurance certificate of coverage at adptotalsource.adp.com .
- If there is any conflict between this document and the accompanying documents (other than Summaries of Material Modifications to this SPD or accompanying documents), then the accompanying documents will control unless otherwise required by law or specified herein.
- You and your dependents should not rely on any oral description of the Plan because the written terms of the Plan will always govern.
- Please contact a MyLife Advisor at MyLifeAdvisor@adp.com or 1-844-448-0325 if you have questions or need additional information about your benefits.

Eligibility

Eligibility varies by option and your worksite employer's elections. Please look under section headings in this booklet for details.

- Because your benefits are so important, we suggest you become familiar with the information in this booklet and keep it handy as a reference. If you have questions or need additional information, contact a MyLife Advisor (for details, see the section titled MyLife Advisors).

What Your Coverage Costs

Your portion of the cost for your benefits is determined in the sole and absolute discretion of your worksite employer and is based on your worksite employer's contribution towards your benefits. Your worksite employer may increase or decrease the amount of the required contribution at any time (subject to ADP TotalSource's approval). You are responsible for the costs remaining after employer contributions. Total costs include applicable fees and/or commissions. Your costs (after the employer contribution), depending on which benefit options and level of coverage you choose to elect, will be reflected on your enrollment election form and online at **adptotalsource.adp.com.**

Some of your contributions are deducted from your income each pay period before your federal income and Social Security taxes are calculated. The end result: your tax withholdings are reduced and you have more income to spend.

Options for Paying Your Portion of the Coverage

If you are not a Self Employed Individual (SEI), as defined by the Internal Revenue Code*, the Plan provides you with two options for paying your portion of the coverage costs. You may select to pay for your portion of the coverage costs with either pre-tax or post-tax dollars depending on your specific needs. Each option has a specific set of rules governing the types of changes that are allowed throughout the Plan Year. Please refer to the section titled "Making Changes to Your Benefits" for details.

If you are a Self Employed Individual (SEI), as defined by the Internal Revenue Code, eligibility to participate and tax treatment options available to pay your portion of the costs of coverage may vary by benefit option. Refer to the "Eligibility" section for each benefit option for more details.

* Due to the attribution rules of Section 318 of the Internal Revenue Code, in determining who is a greater than 2% S Corp shareholder for purposes of participation and taxation, please note that an S Corp owner's stock ownership is attributed to the owner's spouse, children, parents, and grandparents (if also working for the worksite employer). Please note that it is your responsibility to notify ADP TotalSource if any such familial relationship exist

PreTax Deductions

The Plan's standard (default) option for paying your portion of the medical, dental and vision coverage costs is with pre-tax dollars through convenient payroll deductions. Since your costs for coverage under this arrangement are deducted from your pay before taxes are withheld, you will not pay federal, Social Security, and in many cases, state and local income taxes on this money. Under this option, costs for all elected coverages through the Plan will be paid with pre-tax dollars.

Paying for your benefits on a pre-tax basis will marginally reduce your Social Security benefits when you retire or if you become disabled. The exact amount of the reduction will depend on the length of time between now and when you draw your Social Security benefits.

Post-Tax Deductions

In addition, ADP TotalSource also provides you with the flexibility of electing to pay for your portion of the medical, dental and vision coverage costs with post-tax dollars through convenient payroll deductions. Post-tax deductions for coverage costs will not result in a reduction of your Social Security benefits when you retire or if you become disabled. Since this is not the standard (default) option for paying for your portion of the coverage costs, if you elect this option, you must complete the ADP TotalSource Post-Tax Benefit Election form in addition to completing the ADP TotalSource enrollment process either online or by completing the ADP TotalSource Benefits Enrollment Application. You may contact a MyLife Advisor to obtain the ADP TotalSource Post Tax Benefit Election form. If you elect to pay for your portion of the coverage costs under this option, costs for all elected coverages through the Plan will be paid with post-tax dollars, with the exception of any elected contributions to the Health Care or Dependent Care FSAs, and a Health Savings Account.

Section 125 Pretax Benefits Example		
Employee Status:	Married with one child, spouse earns no income, file a joint return, paid biweekly.	
Annual Salary:	$60,000	
Annual Cost of Coverage:	$4,400	
	Without Pre-Tax Benefit	With Pre-Tax Benefit
1. Adjusted Gross Income	$ 60,000	$ 60,000
2. Salary Premium Reductions	$0	($ 4,400.00)
3. W-2 Gross Wages (line 1 minus line 2)	$60,000	$55,600
4. Standard Deduction	($24,000)	($24,000)
5. Taxable Income (line 3 minus line 4)	$36,000	$31,600
6. Federal Income Tax	($3,442)	($2,914)
7. FICA (7.65% of line 3)	($4,590)	($4,253.40)
8. After-Tax Premium Payments	($4,400)	$0
Net Spendable Income (line 3 minus lines 6, 7 & 8)	$47,568	$48,432.60
That's a savings of $864.60 for the year.		

Please note that the estimated tax savings is based upon the standard deduction and federal income tax rates for 2018, calculated using the IRS Withholding Calculator which can be accessed on the IRS website at www.irs.gov. How much you may actually save will depend upon what family members are covered, your actual contribution amount, total family income, and the tax deductions and credits claimed for the taxable year. You may also have state tax savings. Please note that pre-tax salary reductions also lower earned income, which may impact the earned income credit for eligible taxpayers.

Refunds, Rebates and Dividends

Any refund, rebate, dividend, experience adjustment, or other similar payment received by ADP TotalSource under a group insurance contract that is deemed by ADP TotalSource to be a "plan asset" will be used for the benefit of Plan participants or to defray reasonable Plan expenses, unless otherwise provided in the group insurance contract or required by applicable law. To the extent any such refund, rebate or dividend is distributed to you, you do not obtain a non-forfeitable right (or any property interest) in the applicable portion of any refund, rebate dividend, etc. until such time as a check drawn against those assets (e.g., a Medical Loss Ratio rebate check) is presented in a timely manner (e.g., within 60 days). If such check is not so presented, your right to the amount is forfeited. Any forfeited amount will be used first to reimburse ADP TotalSource for the costs it incurs in connection with administration of the Plan, unless otherwise required by applicable law.

MyLife Advisors

Your Source For Answers

We know navigating benefits decision can be complicated! MyLife Advisors are available to provide answers to your questions and to assist you with a wide range of benefit-related concerns. Whether you're seeking guidance with enrolling in benefits, have a life event coming up, or need clarity about benefits deductions, our MyLife Advisors are available to provide answers.

You can contact a MyLife Advisor by calling the toll free phone number 1-844-448-0325 or by sending an email to MyLifeAdvisor@adp.com. MyLife Advisors are available Monday through Friday, from 8:00 a.m. to 11:30 p.m., Eastern Time. In most cases they will be able to provide immediate answers or assistance – and if not, they will get back to you shortly with a resolution.

So, when should you contact a MyLife Advisor? Listed below are examples of the types of issues for which a MyLife Advisor can provide assistance. (The list is not all-inclusive; if you do not see your particular issue listed, call a MyLife Advisor for further assistance).

Benefit Elections

MyLife Advisors explain your choices, help you determine the overall cost of different benefit options available to you, as well as assist you with completing the necessary paperwork.

Benefits Confirmation

MyLife Advisors help you fully understand your benefits. They will also quickly troubleshoot problems and answer your questions about the benefits options you have chosen.

COBRA Rights

Find out about your Consolidated Omnibus Budget Reconciliation Act (COBRA) rights, the costs involved and the steps needed to enroll.

Status Change and HIPAA Special Enrollment

If you get married, have a child or experience any other qualified change in status or Health Insurance Portability and Accountability Act (HIPAA) special enrollment event, a MyLife Advisor can assist you with the paperwork required to initiate a change. A MyLife Advisor will also help answer questions relating to what qualifies as a "Change in Status" or HIPAA special enrollment event under the Plan. However, final determination of whether an event qualifies as an eligible event is subject to the Plan Administrator's review.

Benefit Claims

If you have an outstanding benefits claim, contact your insurance carrier's customer service department and work directly with them. In the great majority of cases, they can explain how your claim was processed or let you know if additional information is needed to process the claim. If, however, you encounter difficulty, a MyLife Advisor will assist in helping resolve claims issues by providing information regarding the process.

Medical, Dental, Vision and Flexible Spending Account Plan Options

Eligibility

Availability of medical, dental, vision and Flexible Spending Account (FSA) plan options depend on your worksite employer's elections, and insurance carrier availability. Therefore, all benefit options may not be available to you for election. Eligibility provisions outlined in this section are subject to applicable state or local laws.

Even if you otherwise meet the eligibility requirements noted below, you are not eligible to participate in the Plan if:

- you are covered by a collective bargaining agreement or the continuing terms and conditions of a collective bargaining agreement, unless the applicable collective bargaining agreement or its continuing terms and conditions specifically and explicitly provide for coverage by the Plan;
- you are classified by your worksite employer as an "independent contractor" or "consultant" (which status may be evidenced by the payroll practices or records of your worksite employer, or by a written or oral agreement or arrangement with you or with another organization that provides your services to the worksite employer, under which you are treated as an independent contractor or are otherwise treated as an employee of an entity other than a worksite employer (such as a leasing organization)), during the period so classified, irrespective of (i) whether you are treated as an employee of a worksite employer under common law employment principles; (ii) whether such characterization is subsequently challenged, changed or upheld by a worksite employer or any court or governmental authority, including, without limitation, if you are classified by a worksite employer as a "leased employee" (as described in Section 414(n) of the Internal Revenue Code of 1986, as amended ("Code")); and (iii) how you may be treated by a worksite employer for other purposes (such as employment tax purposes);
- you do not receive payment for service directly from ADP TotalSource's payroll, except that C-Corp Owners that do not receive payment for service directly from ADP TotalSource's payroll may elect medical (including HSA), dental and vision and the coverage under the Plan provided such Owner is working an average of 30 hours per week and the cost of coverage is fully paid by the worksite employer;
- you are in a class of employees designated by your worksite employer as not eligible for benefits, during the period so classified, irrespective of (i) whether you are treated as an employee of your worksite employer under common law employment principles; (ii) whether such characterization is subsequently challenged, changed or upheld by your worksite employer or any court or governmental authority; and (iii) how you may be treated by a worksite employer for other purposes (such as employment tax purposes);
- you are not a co-employee of a worksite employer and ADP TotalSource pursuant to a written agreement between a worksite employer and ADP TotalSource; or
- you perform services for a worksite employer under an agreement or arrangement, or with another organization that provides your services to the worksite employer, that states that you are not eligible for participation in the Plan.

New Hires and Waiting Period

- You are eligible to make a medical, dental, vision or FSA benefit election if:
- you are a regular full-time or part-time employee of an ADP TotalSource worksite employer residing or working in the United States, scheduled to work an average of 30 hours per week; and
- your worksite employer offers such benefits and you are in an eligible class as classified by your worksite employer; and
- you are in a class designated by your worksite employer as having a waiting period, and you have satisfied your worksite employer's specified waiting period (as indicated in your enrollment materials).

New Clients

If your worksite employer is a new client of ADP TotalSource, you are eligible to make a medical, dental, vision or FSA benefit election if:

- you are a regular full-time or part-time employee of an ADP TotalSource worksite employer residing or working in the United States, scheduled to work an average of 30 hours per week; and
- your worksite employer offers such benefits and you are in an eligible class as classified by your worksite employer; and
- you have satisfied your worksite employer's specified waiting period from your date of hire with the worksite employer.

Special Eligibility Provisions for Owners and Partners

An Owner or Partner includes 2% S-Corp Owners (those who own more than 2%), C-Corp Owners, Members of Limited Liability Companies (LLCs) and Partners of Partnerships (including limited partnerships and limited liability partnerships). Eligibility to make a medical (including

HSA), dental, vision and FSA benefit election varies by Owner or Partner status. The previously outlined eligibility requirements are applicable to Owners and Partners in addition to those outlined below.

- 2% S-Corp Owners and Members of an LLC that is taxed as an S-Corp may elect medical (including HSA), dental, vision and the Dependent Care FSA coverage under the Plan. Participation in the Health Care FSA is not permitted. If you are responsible for any portion of the coverage costs, the coverage can only be paid on a post-tax basis. You may be eligible for an above-the- line deduction on your income tax return for these contributions. Consult with your tax advisor. If you receive W-2 wages, you may elect HSA and Dependent Care FSA contributions, but only on a post-tax basis. If you do not receive W-2 wages, you may not participate in the Dependent Care FSA.

Note: Due to the attribution rules of Section 318 of the Internal Revenue Code, in determining who is a greater than 2% S Corp shareholder for purposes of participation and taxation, please note that an S Corp owner's stock ownership is attributed to the owner's spouse, children, parents, and grandparents (if also working for the worksite employer). Please note that it is your responsibility to notify ADP TotalSource if any such familial relationship exists.

- C-Corp Owners and Members of an LLC that is taxed as a C-Corp may elect medical (including HSA), dental, vision and the Health Care FSA and Dependent Care FSA coverage under the Plan. Costs for these coverages and contributions can be made on a pre-tax basis.
- Partners of Partnerships (including limited partnerships and limited liability partnerships) and Members of an LLC that is taxed as a Partnership may elect medical (including HSA), dental, vision and the Dependent Care FSA coverage under the Plan. Participation in the Health Care FSA is not permitted. If you are responsible for any portion of the coverage costs, the coverage can only be paid on a post-tax basis. HSA and Dependent Care FSA contributions may only be made on a post-tax basis.

Note: Employer contributions, including those made to an HSA, are generally considered taxable earnings for 2% S-Corp Owners, Partners of Partnerships and LLC Members (excluding Members of an LLC that is taxed as a C-Corp).

Special Eligibility Conditions for Dependent Care FSA

You may need to satisfy additional requirements to be eligible for the Dependent Care FSA. For further details, see the section entitled "Dependent Care FSA – Eligible Expenses and Limits."

Dependents

Your eligible dependents may be enrolled in the medical, dental and vision options on the same day you enroll. Eligibility for otherwise eligible dependents classified as domestic partners and dependents of domestic partners may vary depending on specific insurance carrier eligibility rules. Your worksite employer determines domestic partner benefit availability, unless otherwise mandated by state or local law.

The Plan defines an eligible dependent as:

- your spouse, unless you are legally separated;
- your domestic partner, if the applicable insurance carrier requirements have been met and your worksite employer has elected to offer domestic partner coverage or you live in a state that requires such coverage;
- your child(ren)* under 26 years of age whether married or unmarried, regardless of the child(ren)'s student or employment status and regardless of whether your home is the children's principal place of residence or whether you support the children financially;
- your domestic partners' child(ren) under 26 years of age (if the domestic partner is eligible for and receiving coverage or if otherwise required by state law);
- you or your covered domestic partners' unmarried dependent child(ren) aged 26 or older (see "Important note about dependent eligibility") if required by state law; and
- you or your covered domestic partners' disabled dependents.

In addition, the Plan may cover your child (as defined by applicable state law) pursuant to a Qualified Medical Child Support Order ("QMCSO") to the extent the QMCSO does not require coverage not otherwise offered under the Plan. The Plan Administrator (or its designee) will notify you if a medical child support order has been received. The Plan Administrator (or its delegate) will make a determination as to whether the order is a QMCSO in accordance with the Plan's QMCSO procedures and will notify both you and the affected child once a determination has been made. You may request a copy of the Plan's QMCSO procedures, free of charge, by contacting a MyLife Advisor.

Provided that you remain eligible for coverage, your eligible children will generally be covered under the Plan until the end of the month, calendar year or Plan year in which they reach age 26 as specified in your Summary of Benefits and Coverage. Contact a MyLife Advisor if you need assistance determining your dependent's coverage end date due to reaching the limiting age.

Proof of Eligibility

You are required to provide proof of your covered dependent(s) eligibility upon request. If you fail to timely provide the documentation upon request to prove the eligibility of any of your covered dependents or the Plan Administrator (or its delegee) is unable to verify the submitted documentation, your dependent (or dependents) will lose coverage under the Plan whether or not he or she (they) is (are) otherwise eligible for benefits under the Plan. A dependent whose coverage is terminated due to lack of or insufficient documentation will not be eligible for COBRA coverage.

Important Notice to Eligible Employees and Their Dependents

You are required to provide proof of your dependent(s)' eligibility for Plan coverage upon request. Providing false or misrepresenting eligibility information could be grounds for employee discipline up to and including termination. In addition, ADP TotalSource reserves the right to terminate your and your dependent(s)' coverage prospectively without notice for cause (as determined by the Plan Administrator), or if you and/or your dependent(s) are otherwise determined to be ineligible for coverage under the particular benefit(s) at issue. Further, if you or your dependent(s) commits fraud or intentionally misrepresents a material fact in an application for coverage under the Plan, in connection with a benefit claim or appeal, or in response to any request for information by ADP TotalSource or its delegees (including the Plan Administrator or a claims administrator), the Plan Administrator may terminate your coverage retroactively upon 30 days notice. Failure to inform any such persons that you are covered under another group health plan or knowingly providing false information in order to obtain coverage for an ineligible dependent(s) are examples of actions that constitute fraud under the Plan. Coverage may also be terminated retroactively and without notice (unless required by law) if the Plan Administrator or its delegee determines that your dependent is ineligible for coverage under the particular benefit(s) at issue and such retroactive termination would not be considered a rescission under the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act"). The Plan Administrator shall decide such matters on a case-by-case basis. If the Group Health Plan pays benefits or expenses actually incurred or in excess of allowable amounts, due to error (including for example, a clerical error) or for any other reason (including, for example, your failure to notify the Plan Administrator or its delegees regarding a change in family status), the Plan Administrator reserves the right to recover such overpayment through whatever means are necessary, including, without limitation, deduction of the excess amounts from future claims and/or legal action.

*The Plan defines "child(ren)" as an employee's, his or her spouse's, or his or her covered domestic partner's natural child, adopted child, child placed for adoption, foster child, stepchild, child under legal guardianship or child named in a qualified medical child support order. Because eligibility for dependent children may differ by insurance carrier, please review your Certificate of Coverage or contact the applicable insurance carrier in order to determine the definition that applies to your applicable policy.

Eligibility for Children Over Age 26:

Dependent eligibility for over-age dependents (ages 26 and older) varies by insurance carrier and state. While the maximum age for dependent coverage varies by state, most insurance carriers will only cover eligible dependents up to the attainment of age 26. Since state laws apply directly to insurance carriers, the determination of whether a state mandate applies may depend upon where the particular policy that covers you or your dependent(s) was issued. Please refer to the "Dependent Eligibility Reference Guide" at adptotalsource.adp.com for more details regarding over-age dependent eligibility.

Michelle's Law – Continuation of Group Health Coverage for Certain Dependents

Michelle's Law allows continuation of group health coverage for up to one year for full-time students over the age of 26 who are dependent children and who are on medically necessary leaves of absence from a post-secondary educational institution. Refer to the "Coverage While on a Leave of Absence" section located on page 50 for further details regarding this law.

Taxation of Civil Union Partner/Domestic Partner Benefits & Other Non-Tax Qualified Dependents

Unless your civil union partner, domestic partner or a child (under age 26) of any of such individual who is not also your child ("Covered Child") is your tax dependent for health coverage purposes as defined by the Internal Revenue Code, you will be subject to federal income tax on the value of the coverage provided to such individual(s) less the amount you pay for the coverage on an after-tax basis. Generally, states follow federal law with respect to the taxation of such benefits. However, there are exceptions to this

rule. Some states exclude health benefits provided to such individuals from gross income for state income tax purposes, even if such person is not a tax dependent for health coverage purposes under federal law.

The following conditions must be met in order for your civil union partner or domestic partner to qualify as your tax dependent for health coverage purposes under federal law:

(i) you provide more than half of your domestic partner, or civil union partner's, total support for the calendar year;

(ii) you and your domestic partner, or civil union partner, have the same principal place of abode for the entire calendar year, except for temporary reasons such as vacation, military service, or education;

(iii) your domestic partner, or civil union partner, is a member of your household for the entire calendar year (and the relationship does not violate local law);

(iv) your domestic partner, or civil union partner, is not your (or anyone else's) "qualifying child" under the Section 152(c) of the Internal Revenue Code; and

(v) your domestic partner, or civil union partner, is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada, or Mexico.

If you satisfy these requirements, your civil union partner or domestic partner can be your federal tax dependent for health coverage purposes, even if you do not claim an exemption for him or her on your Form 1040.

A Covered Child may qualify as your tax dependent for health coverage purposes under federal tax law by satisfying the above requirements or by satisfying the "qualifying child" test for health coverage purposes.

ADP TotalSource's standard payroll practice is to permit employees to pay their portion of coverage costs on a pre-tax basis. If you have elected to cover one or more non-tax dependents, the portion of your medical, dental and/or vision premium related to such coverage will be converted to a post-tax deduction. The value of any coverage provided to a non-tax dependent will also require an imputed income adjustment. These imputed income payroll adjustments may increase your federal and state income tax liability.

Important Note:
If you cover a domestic partner, civil union partner and/or any Covered Child, you must complete a Certification of Dependent Tax Status for each covered individual indicating whether he or she is dependent for health coverage purposes under federal and/or state tax law. If you do not complete this Certification, we will treat your dependent as a non-tax dependent and you will be subject to imputed income for the fair market value of coverage provided to such individual.

When Coverage Under the Plan Begins

Your coverage for medical, dental, vision or FSA benefit options elected under the Plan will begin on the date you become eligible to participate provided that you elect coverage under the Plan by submitting your elections to ADP TotalSource prior to the enrollment deadline indicated in your ADP TotalSource enrollment materials. Medical, dental, vision and FSA coverage under the Plan is not automatic. Please refer to the "When to Enroll" and "How to Enroll" sections under Enrollment for more detailed information.

If you are a new hire and absent from work on the day your benefit coverage would otherwise become effective due to your own illness and for any health related factor (including absence due to Workers' Compensation leave, Family Medical leave due to your own illness or a non-qualified medical leave due to your own illness), your benefit election will begin on your regularly scheduled benefit effective date provided you have worked for ADP TotalSource for at least one full day prior to your absence. If you have not worked for ADP TotalSource for at least one full day prior to your absence, you will not be eligible to enroll in the Plan until the 1st day of the month following your return to work. If your worksite employer is a new client of ADP TotalSource and you worked one full day for your worksite employer prior to your absence from work, your benefit election will begin on the first day of the month in which your worksite employer has elected to participate in the Plan.

New Hires

Your effective date of coverage for the medical, dental, vision or FSA benefit elections made under the Plan will begin on the first day of the month following the completion of your worksite employer's specified waiting period (if any). For example, if you start work on April 5th and your worksite employer requires a 30-day waiting period, your coverage will begin effective June 1st (the first day of the month after you have been employed for 30 days). If the date you complete your waiting period falls on the first day of the month, your coverage will begin effective that same day. For example, if you start work on April 2nd and your worksite employer requires a 30-day waiting period, your coverage will begin on May 1st.

If your worksite employer does not require a waiting period, your effective date of coverage for the medical, dental, vision or FSA benefit elections made under the Plan will begin on the first day of the month following the completion of your first day of work (i.e., your date of hire). If you are hired on the first day of the month, your coverage will become effective that same day.

Important note about domestic partner and civil union partner eligibility and enrollment:

Your worksite employer determines the availability of benefit options to domestic partners and civil union partners, unless otherwise mandated by state or local law. To enroll such an individual and/ or his or her eligible dependent(s), the dependent(s) must satisfy the eligibility requirements detailed in the ADP TotalSource Domestic Partner Affidavit (to the extent applicable) and any insurance carrier specific affidavit of domestic partnership, and provide supporting documentation to ADP TotalSource. Contact a MyLife Advisor for more information.

New Clients

Your effective date of coverage for your medical, dental, vision or FSA benefit elections made under the Plan will begin on the first day of the month in which your worksite employer has elected to participate in the Plan (subject to any applicable waiting period that the worksite employer may impose).

Regaining Eligibility

If you are rehired or reclassified into an eligible class for benefits or transferred to an unrelated worksite employer, you may be required to satisfy your worksite employer's specified waiting period (if any) before enrolling in the Plan. If so, benefits will take effect on the first day of the month following the end of the employer's specified waiting period. Note that you must complete the enrollment process for the Plan to become enrolled. Prior coverage is not automatically reinstated.

However, your coverage will resume no later than the first day of the month following the date of your rehire, reclassification, or transfer if required by the Affordable Care Act or your worksite employer elects to waive its specified waiting period. Note that you must complete the enrollment process for the Plan to become enrolled. Prior coverage is not automatically reinstated.

If you have questions about the waiting periods, please contact a MyLife Advisor.

Plan Disclosure

Summary of Benefits and Coverage are included in your initial eligibility enrollment kit. If you receive your enrollment materials electronically, the Summary of Benefits and Coverage can be obtained online at **adptotalsource.adp.com**. If the Summary of Benefits and Coverage do not provide you with coverage information for a specific benefit, you should refer to the applicable insurance carrier's certificate of coverage or contact the insurance carrier directly. Benefit plan information on insurance carriers' certificates of coverages will supersede the benefit plan information found in the Summary of Benefits and Coverage in the event of any discrepancies.

The Summary of Benefits and Coverage for the options you elect will include the following:

- cost-sharing provisions such as deductibles, co-insurance and co-payment amounts for which you will be responsible;
- annual and/or lifetime maximums and preventive service allowances, if applicable;
- details on whether and under what circumstances coverage is provided for medical tests, devices and procedures;
- any conditions or limits applicable to obtaining emergency medical care;
- any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under the Plan.

In accordance with applicable law, none of the annual or lifetime dollar limits that may be included in a health plan offering shall apply to "essential health benefits," as such term is defined under Section 1302(b) of the Affordable Care Act (the "ACA"). Section 1302(b) defines "essential health benefits" to include, at a minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, and laboratory

services. The determination as to whether a benefit constitutes an "essential health benefit" will be made by the applicable insurance carrier.

You may also access the insurance carrier's website for network provider and prescription drug information. Their website address and phone numbers are listed on the Summary of Benefits and Coverage and also can be found on **adptotalsource.adp.com.**

Glossary of Health Coverage and Medical Terms

A Uniform Glossary of commonly used terms in health insurance coverage is available online at **adptotalsource.adp.com** in the TotalSource Forms Library. You may also request a paper copy of the Uniform Glossary of Terms by contacting a MyLife Advisor at 1-844-448-0325.

The Uniform Glossary of Terms is also available on the websites of the U.S. Department of Labor and the U.S. Department of Health and Human Services at the following links:

https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf

https://www.cms.gov/CCIIO/Resources/Forms-Reports-and Other-Resources/Downloads/UG-Glossary-508-MM.pdf

Medical Options

Each of us has different needs for medical coverage and your decision should be based on your personal situation. There are things you may want to consider as you determine which option is right for you and your family. Before selecting a medical option, review the Summary of Benefits and Coverage (SBC) found in your enrollment kit and online at adptotalsource.adp.com.
Ask yourself:

- What options have been made available to me?
- What are my expected medical expenses for the coming Plan Year?
- What would my out-of-pocket expenses be under the options available to me?
- What will this option cost me?
- Are my physicians in the option's network?
- Do I have any other sources of coverage?

ADP TotalSource offers more than one option, wherever possible. Insurance carriers for the options will vary according to geographic location. The following are general descriptions of the medical options that may be available to you.

Medical Benefit Options

Health Maintenance Organization (HMO)

An HMO is a comprehensive group medical plan with a network of physicians and hospitals. Benefits are available to you when these networks are used. At enrollment, you select a primary care physician (PCP) for yourself and each covered dependent. Your PCP manages the health care for you and your dependent(s) by authorizing specialist services, hospital procedures, lab work and diagnostic testing. Without a PCP authorization for these services (excluding obstetrical or gynecological care), the services will not be covered. Additionally, if you receive treatment from a non-participating network provider, your expenses will not be covered. Payment for non-covered expenses will be your responsibility. When you receive medical care, you must show your identification (ID) card and pay your portion of the charges, usually in the form of a co-payment. There are no claim forms to file. You may change your PCP by contacting the HMO carrier directly.

Open Access

An Open Access plan is a comprehensive group medical plan with a network of physicians and hospitals that gives you the freedom to see any doctor in the network, including specialists, without a referral. You are encouraged to select a PCP, but it is not required. The Open Access feature is often associated with traditional HMO products where you must use the network of providers and hospitals in order to have services covered by the plan. In some instances, there will be a Point of Service (POS) plan with Open Access, where you have direct access to network specialists and you can also visit any non-participating physician and receive out-of-network benefits with a deductible and higher out-of-pocket costs.

Point of Service (POS)

A POS is similar to an HMO, but also offers coverage for medical care obtained outside the provider network and without required referrals. You receive the highest benefit level when the network of physicians and hospitals is used. A PCP manages the health care for you and your dependent(s). At enrollment, you must select a PCP for yourself and each covered dependent. Your PCP must authorize specialist services, hospital procedures, lab work and diagnostic testing (excluding obstetrical or gynecological care). When you receive medical care inside the network, you must show your ID card and pay your portion of the charges, usually in the form of a co-payment. However, unlike an HMO, you can be covered for services received from providers outside the network. In this case, you may

have to pay the bill up-front and file a claim form for reimbursement. Benefits for these services are lower, which means your out-of pocket expenses may be higher. The percentage of coverage is based on charges the insurance carrier approves.

Preferred Provider Organization (PPO)

A PPO is a group of hospitals and physicians that contract to provide comprehensive medical service on a fee-for-service basis. These health care providers are referred to as network providers. Because network providers exchange discounted services for increased volume, you (the insured) have out-of-pocket costs that are lower than a non-negotiated fee schedule. PPOs offer both in-network and out-of-network coverage. The levels of coverage are higher and the out-of-pocket expenses are lower if you use participating network providers. When you receive medical care from a participating network provider, you must show your ID card and pay the appropriate co-payment, co-insurance or deductible, if applicable. There are no claim forms to file. When you receive medical care from a provider outside the participating provider network, you may have to pay the medical bill up-front and file a claim form for reimbursement. Out-of-network reimbursements are based on what the insurance carrier determines to be usual, customary and reasonable fees.

Exclusive Provider Organization (EPO)

An EPO is a group of hospitals and physicians that contract to provide comprehensive medical service on a fee-for-service basis. These health care providers are referred to as network providers. Because network providers exchange discounted services for increased volume, you (the insured) have out-of-pocket costs that are lower than a non-negotiated fee schedule. This EPO Plan only provides coverage when eligible health services are received from an in-network provider, except for emergency care. Otherwise, this Plan does not provide coverage when services are received from out of network providers. When you receive medical care from a participating network provider, you must show your ID card and pay the appropriate co-payment, co-insurance or deductible, if applicable. There are no claim forms to file. When you receive medical care from a provider outside the participating provider network, with the exception of emergency care, you will be responsible to pay the medical bill as there is no coverage out of network.

High Deductible Health Plan (HDHP)

An HDHP is a health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses that would qualify the insured to have a Health Savings Account ("HSA") - refer to the HSA section on page 28.

HDHP Annual Deductible and Out-of-Pocket Maximum

The annual deductible and out-of-pocket requirements are as follows:

	2017 Calendar Year		2018 Calendar Year	
	Annual Deductible Minimum	Annual Out-of-Pocket* Maximum	Annual Deductible Minimum	Annual Out-of-Pocket* Maximum
Self-Only Coverage	$1,300	$6,550	$1,350	$6,650
Family Coverage	$2,600	$13,100	$2,700	$13,300

***Out-of-pocket expenses include deductibles, co-payments and co-insurance, but not cost of coverage.**

The stated annual deductible and out-of-pocket maximum are subject to change by the IRS each January 1st.

There are additional coverages such as preventive care that may not be subject to the deductible and may be covered under a co-pay arrangement or at 100%.

Note that depending on the HDHP you elect, the deductible amount may be either embedded or non-embedded. HDHP plans with a non-embedded deductible require the total family deductible to be satisfied before plan co-insurance will apply for any member when there is more than one person insured. The family deductible can be satisfied by expenses from one person or any combination of covered members. The out-of-pocket maximum works the same way. HDHP plans with an embedded deductible allow each member of your family the opportunity to have your insurance policy cover their medical bills before the entire dollar amount of the family deductible is met. The individual deductible is "embedded" in the family deductible. Please refer to the Summary of Benefits and Coverage located at **adptotalsource.adp.com** or contact your insurance carrier directly to determine which deductible method applies. Plan coverage varies by insurance carrier.

Similar to a PPO, an HDHP also uses a network group of hospitals and physicians that contract to provide comprehensive medical service on a fee-for-service basis. These health care providers are referred to as network providers. Because network providers exchange discounted services for increased volume, you (the insured) have out-of-pocket costs

that are lower than a non-negotiated fee schedule. Most HDHPs, like PPOs, offer both in-network and out-of-network coverage. The levels of coverage are higher and the out-of-pocket expenses are lower if you use participating network providers. When you receive medical care from a participating network provider, you must show your ID card and pay the appropriate co-payment, co-insurance or deductible, if applicable. There are no claim forms to file. When you receive medical care from a provider outside the participating provider network, you may have to pay the medical bill up-front and file a claim form for reimbursement. Out-of-network reimbursements are based on what the insurance carrier determines to be usual, customary and reasonable fees.

Indemnity Plan

An Indemnity plan, commonly referred to as "traditional insurance," is offered in areas where other products are not available. There is no provider network. Therefore, you may receive treatment from any licensed medical provider. Indemnity plans have deductibles and co-insurance just like a PPO. In most cases, your health care provider will require you to pay for services up-front and then you would file a claim with the insurance carrier for reimbursement. Reimbursements are based on what the insurance carrier determines to be usual, customary and reasonable fees.

Deductibles and Out-of-Pocket Maximums

Deductible and out-of-pocket maximums are applicable to a calendar year (January 1 – December 31), and are not based on the ADP TotalSource Plan Year (June 1 – May 31). Deductible and out-of-pocket maximums are located on the Summary of Benefits and Coverage (SBC) located in your enrollment kit and online at **adptotalsource.adp.com**.

Usual, Customary and Reasonable Fees (UCR)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount is sometimes used to determine the allowed amount. **Usual** is the fee usually charged for a given service by a provider; **Customary** is a fee in the range of usual fees charged by similar providers in area; **Reasonable** is a fee that, according to the insurance carrier's review committee, meets the lesser of the two criteria or is justified under the circumstances. Please refer to the applicable insurance carrier's certificate of coverage for information on their determination of usual, customary and reasonable fees in processing claims from providers outside the network.

Consumer Choice Option (CCO) - Georgia Issued Policies Only

Georgia law, Senate Bill 210, requires health insurance policies issued in Georgia to offer a Consumer Choice Option (CCO) to Georgia residents enrolling in managed care plans. If you are a Georgia resident, the following applies to you. This option allows you to receive services from a non-network provider while still being covered at the in-network benefit level. However, the non-network provider that you choose must first agree to accept the insurance carrier's fee schedule of reimbursement and to comply with the insurance carrier's utilization management programs. If you elect the CCO on the enrollment application, you will pay an additional 17.5% of the monthly premium for managed care plans. The CCO availability on other plans and the additional monthly premium cost may vary by insurance carrier. You may elect the CCO at Open Enrollment, when newly hired, or when a qualifying change in status occurs. You may contact a MyLife Advisor if you have any questions.

Transition of Care

If you are in an active course of treatment or become pregnant when you change plans, you may not be able to continue with your current treating physician or durable medical equipment provider. However, depending on the benefit option and/or insurance carrier you have selected, if you are in an active course of treatment or you became pregnant before the effective date of the change, the medical carrier might authorize you to continue to receive care from a non-participating treating physician or to be covered for non-covered, rented durable medical equipment for a specified time at the in-network benefit level. This does not apply to all benefit options.

An active course of treatment is defined as a planned program of services rendered by a physician or durable medical equipment provider starting on the date a physician first renders service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment. You should contact a MyLife Advisor for assistance.

Comparison Chart

	Health Maintenance Organization (HMO)	Open Access	Point of Service (POS)
Option Descriptions	• Comprehensive group medical coverage • Network of physicians, hospitals and ancillary providers • Plan benefits available in HMO network only	• HMO or POS health plans may have an Open Access feature • Comprehensive group medical coverage • Network of physicians, hospitals and ancillary providers	• Comprehensive group medical coverage • Network of physicians, hospitals and ancillary providers • Plan benefits available in POS network and out-of-network providers
Option Advantages	• Low out-of-pocket expenses and no claim forms to file	• Offers flexibility to access medical care from network specialists without a referral	• Flexibility to access medical care outside of the network or without necessary referrals, but your out-of-pocket expenses are higher
Main Point of Contact	• Network PCP election required for each covered person • The PCP manages all your health care needs	• Network PCP election is not required, however, it is suggested that you have a PCP to manage your health care needs within the network	• Network PCP election generally required for each covered person • The PCP manages all your health care needs within the network
Obtaining Medical Services	• See your network PCP, present ID card and pay your co- payment • PCP will coordinate your care and obtain authorizations required by health plan	• See your network provider, present ID card and pay your co-payment	• See your network PCP, present ID card and pay your portion of the charges (usually a co-payment) • If a provider outside the network is seen, you may have to pay the bill up- front and file for reimbursement • Out-of-pocket costs are higher when non-network provider is seen
Specialty Care	• A referral from your PCP is required for specialty care • Specialists must be in HMO network for coverage	• No referrals necessary • To receive maximum coverage under the plan, a network specialist must be seen	• A referral from your PCP is generally required for specialty care • To receive maximum coverage, your network PCP must refer you to a network specialist for care

Preferred Provider Organization (PPO)	Exclusive Provider Organization (EPO	High Deductible Health Plan (HDHP) (Health Savings Account (HSA) Qualified)	Indemnity Coverage
• Comprehensive group medical coverage with a network of physicians, hospitals and ancillary providers that contract on a fee-for-service basis	• Comprehensive group medical coverage • Network of physicians, hospitals and ancillary providers • Plan benefits available in EPO network Only	• Plan design must meet certain federal requirements in term of minimum deductible, maximum out-of-pocket costs • Comprehensive group medical coverage with a network of physicians, hospitals and ancillary providers that generally contract on a fee-for-service basis	• Medical coverage offered in areas where other products are unavailable • Indemnity options have deductibles and coinsurance
• Greatest flexibility in obtaining care both in and out of the network • No referrals needed for specialist care • Lower out-of-pocket costs than under a traditional, non-negotiated fee schedule	• Low Out-of-Pocket expenses and no claim forms to file • This option offers flexibility to access medical care from network specialists without a referral	• Coverage both in and out of the network, unless the HDHP is an HMO • No referrals needed for specialist care, unless the HDHP is an HMO • Lower out-of-pocket costs than under a traditional, non-negotiated fee schedule • Provides eligibility to open and contribute to a Health Savings Account	• You may receive treatment from any licensed medical provider
• Choose any provider as needed • Levels of coverage are higher and your out-of- pocket expenses are lower if you use participating network providers	• Network PCP election is not required, however, it is suggested that you have a PCP to manage your health care needs within the network.	• Choose any provider as needed • Levels of coverage are higher and your out-of-pocket expenses are lower if you use participating network providers	• Any licensed medical provider
• See a network provider, present ID card and pay applicable co-payment or co-insurance • If a provider outside the network is seen, you may have to pay the bill up-front and file for reimbursement • Out-of-network reimbursements for covered services are based on usual, customary and reasonable fees • May be balance billed by out-of-network provider	• See your network PCP and pay your copayment. (HDHP plans pay deductible and coinsurance). • Network PCP will obtain authorizations required by health plan.	• See a network provider, present ID card, and pay applicable deductible. All services are subject to deductible, and then coinsurance applies. Health plan's network negotiated fee schedule applies. • If a provider outside the network is seen, you may have to pay the bill up-front and file for reimbursement • Out-of-network reimbursements for covered services are based on usual, customary and reasonable fees • May be balance billed by out-of- network provider	• You may be required to pay for services up-front and then file a claim with the insurance carrier for reimbursement • Payments for health related charges for covered services are reimbursed based on usual, customary and reasonable fees • May be balance billed by out-of-network provider
• No referrals necessary	• No referral required for specialty care. • See a network specialist and pay your copayment. (HDHP plans pay deductible and coinsurance) • Network specialist will obtain authorizations required by health plan	• No referrals necessary, unless the HDHP is an HMO	• No referrals necessary

Plan Requirements

Refer to your Summary of Benefits and Coverage or specific insurance carrier certificate of coverage for a description of covered and non-covered services under the Plan.

Pre-certification

Many insurance carriers require that certain services be pre-certified or pre-authorized. Information about these requirements may be found in the Summary of Benefits and Coverage that is provided in your enrollment kit and online at **adptotalsource.adp.com** and/or your certificate of coverage.

Pre-certification is an administrative procedure whereby a physician submits a treatment plan to a third party before treatment is initiated. The third party reviews the treatment plan, indicating medical necessity of the prescribed treatment.

Pre-certification does not guarantee your eligibility for treatment or payment of services. However, the failure to obtain pre-certification for designated services will result in a reduction of benefits or an absolute denial of coverage. Check your certificate of coverage for specifics and if necessary, contact your insurance carrier directly for additional information before receiving treatment.

Coordination of Benefits

If you or your covered dependent has or is entitled to benefits under another insurance plan, you are subject to a coordination of benefits process. Coordination of benefits is designed to prevent the payment of benefits from exceeding 100% of any allowable expenses that have been incurred. Your insurance carrier may request an Explanation of Benefits (EOB) which provides detailed claim reimbursement information from any other plans under which you are insured. If any of these plans provide coverage for services that are also covered under the Plan, before any payments are made, the insurance carrier will determine which plan has the primary responsibility for paying plan benefits and which plan has secondary responsibility. The certificate of coverage provides more detailed information on how your benefits under this option will be coordinated with other coverage you may have.

HIPAA Privacy Rights

HIPAA imposes rules on the benefit options under the Plan which are "group health plans" within the meaning of HIPAA with respect to the use and disclosure of each participant's protected health information (PHI) in certain situations. In addition, HIPAA provides participants with certain rights with respect to their PHI, including the right to receive a privacy notice.

Please contact a MyLife Advisor at (844) 448-0325 or visit **adptotalsource.adp.com** if you would like to receive a copy of the Health Care FSA Plan's Notice of Privacy Practices. For all other Notices of Privacy Practices, contact the applicable insurance carrier.

HIPAA Privacy and Security

The provisions below related to HIPAA Privacy and Security shall apply to any benefit options under the Plan that are "group health plans" within the meaning of HIPAA.

For purposes of this section entitled "**HIPAA Privacy and Security**", the following terms have the following meanings:

- "Business Associate" means a person or entity that performs a function or activity regulated by HIPAA on behalf of the component plans provided under the group health plan and involving individually identifiable health information. Examples of such functions or activities are claims processing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation and financial services. A Business Associate may be a Covered Entity. However, Insurers and HMOs are not Business Associates of the plans they insure.
- "Covered Entity" means a group health plan (including an employer plan, insurer, HMO and government coverage such as Medicare); a health care provider (such as a doctor, hospital or pharmacy) that electronically transmits any health information in connection with a transaction for which the U.S. Department of Health and Human Services has established an electronic data interchange standard; and a health care clearinghouse (an entity that translates electronic information between nonstandard and HIPAA standard transactions).
- "Protected Health Information" or "PHI" means individually identifiable health information created or received by a Covered Entity. Information is "individually identifiable" if it names the individual person or there is a reasonable basis to believe components of the information could be used to identify the individual. "Health Information" means information, whether oral or recorded in any form or medium, that (i) is created by a health care provider, health care plan, employer, life insurer, public health authority, health care clearinghouse, or school or

university; and (ii) relates to the past, present, or future physical or mental health or condition of a person, the provision of health care to a person; or the past, present or future payment for health care.

- "Electronic Protected Health Information" or "ePHI" is protected health information that is transmitted or maintained in electronic media including, but not limited to, hard drives, disk, on the internet, or on an intranet.

Uses and Disclosures of PHI

The Plan may disclose a covered employee's PHI or ePHI to ADP TotalSource (or to an agent of ADP TotalSource) for plan administration functions, to the extent not inconsistent with HIPAA regulations. The Plan will not disclose PHI or ePHI to ADP TotalSource except upon receipt of a certification by ADP TotalSource that the Plan incorporates the agreements of the section of this document entitled "Privacy Agreements of ADP TotalSource", except as otherwise permitted or required by law.

Privacy Agreements of ADP TotalSource

As a condition for obtaining PHI from the Plan and its Business Associates, ADP TotalSource agrees that it will:

- Not use or further disclose such PHI other than as permitted by Plan or as required by law;
- Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to substantially the same restrictions and conditions that apply to ADP TotalSource with respect to such information;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of ADP TotalSource;
- Report to the Plan'sPrivacy Officer any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for in the Plan of which ADP TotalSource becomes aware;
- Make the PHI of a particular participant available for purposes of the participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA;
- Make records of certain types of disclosures that it may make of PHI of a particular participant so that ADP TotalSource may make available to the Plan the information required for the Plan to provide an accounting of disclosures pursuant to the participant's request for such an accounting in accordance with HIPAA;
- Make ADP TotalSource's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that ADP TotalSource still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, ADP TotalSource agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that there is adequate separation between the Plan and ADP TotalSource.

Employees with Access to PHI

Only those employees designated in the Plan's HIPAA Policies and Procedures as "Authorized Employees" will be given access to the Protected Health Information. The Authorized Employees may only use the Protected Health Information for group health plan administrative functions that the Plan Sponsor performs for the group health plan.

Mechanism for Resolving Noncompliance

If ADP TotalSource or the Authorized Employees determine that any Authorized Employee has violated any of the restrictions of the Plan, then such individual shall be disciplined in accordance with the policies of ADP TotalSource up to and including dismissal from employment. ADP TotalSource will arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

Security Agreements of the Company

As a condition of obtaining or maintaining e-PHI from the Plan, its Business Associates, insurers or HMOs, ADP TotalSource agrees that it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and ADP TotalSource is supported by reasonable and appropriate security measures;

- Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;
- Report to the Plan's Security Officer any security incident of which it becomes aware. For purposes of the Plan, security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI; and
- Upon request from the Plan, provide information to the Plan on unsuccessful or attempted unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to ADP TotalSource.

What Services are Covered

Refer to the Summary of Benefits and Coverage and other accompanying documents for a specific listing of covered and non-covered services under your applicable insurance plan.

The following subsections are applicable only to the medical plan options of this Plan.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for a mother or newborn child for any length of hospital stay in connection with childbirth to 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) after the delivery.

The federal law applies unless state law requires a longer length of stay. You should check your insurance carrier's certificate of coverage to see if a longer length of stay rule applies.

Health plans may not require that a provider obtain authorization from the Plan for prescribing a length of stay less than 48 hours (or 96 hours).

The Affordable Care Act

Primary Care Physician (PCP) and OB/GYN Selection

The benefit options under the Plan generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the health plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You or your dependents do not need prior authorization from ADP TotalSource health insurance carriers or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your health insurance carrier at the phone number indicated on the Summary of Benefits and Coverage provided in your benefits enrollment kit and online at **adptotalsource.adp.com**.

Emergency Care

Generally, the Plan will provide coverage for emergency care in an out-of-network facility at the same level of cost-sharing as is applicable to emergency care in an in-network facility.

Recommended Preventive Services

The Plan benefit options must provide certain "Recommended Preventive Services" on an in-network basis at no cost to you and your dependents. To determine which services provided on an in-network basis are "Recommended Preventive Services" for which no co-payments may be charged and no cost-sharing may be imposed, please refer to the Summary of Benefits and Coverage for the applicable benefit option.

Essential Health Benefits and Plan Limits

Annual dollar limits and lifetime dollar limits do not apply to "Essential Health Benefits" (as defined by the Affordable Care Act). Essential Health Benefits include certain covered benefits, items and services that fall within the following categories:

- ambulatory patient services,
- emergency services,
- hospitalization,
- maternity and newborn care,
- mental health and substance use disorder services, including behavioral health treatment,
- prescription drugs,
- rehabilitative and habilitative services and devices,
- laboratory services,
- preventive and wellness services,
- chronic disease management, and
- pediatric services, including oral and vision care.

These restrictions and prohibitions regarding limitations in the medical plan do not apply to services (even Essential Health Benefit services) which are limited by the number of visits or other criteria. For example, if a medical plan provision provides that coverage for a physical therapist is limited to 30 visits per year per covered person, this limitation is not prohibited by the law which restricts the medical plan from imposing certain annual or lifetime dollar limits.

Benefits that do not constitute Essential Health Benefits, as determined in accordance with the Plan Administrator's good faith interpretation of the requirements of federal law and any applicable medical plan provisions, may still be subject to annual and lifetime dollar limits. For further details about the limits, refer to the applicable Summary of Benefits and Coverage.

Mental Health Parity Act

This law requires group health plans and health insurance issuers to ensure that financial requirements (such as copays, deductibles) and treatment limitations (such as visit limits) applicable to mental health and chemical dependency use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Women's Health and Cancer Rights Act

This law requires plans that provide medical and surgical benefits for mastectomies to provide coverage for certain procedures, including reconstructive surgery following a mastectomy, as requested from the patient in consultation with her physician. This benefit applies to any covered employee or dependent, including you, your spouse, and your children.

If you receive benefits under the Plan in connection with a mastectomy, the following coverage will be provided in a manner determined in consultation with the patient and the attending physician:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses (e.g., breast implant); and
- treatment for physical complications of all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction are subject to any annual deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the applicable Plan benefit option.

Dental and Vision Options

ADP TotalSource has partnered, wherever possible, with dental and vision carriers that offer dental and vision options to cover you and your eligible dependents. The dental and vision benefit summaries found in your ADP TotalSource enrollment kit and online at **adptotalsource.adp.com** describe the coverage available to you. The following are general descriptions of dental and vision options that may be available.

Dental Benefit Options

Dental Maintenance Organization (DMO)

The DMO Dental option is a network of dentists (like doctors in an HMO) that provide comprehensive dental services at pre-negotiated rates. You must select a participating provider for you and each covered dependent and receive treatment only from that provider. You may change your participating provider by contacting the DMO directly. There are no claim forms, no deductibles, and no dollar limits. Covered services include both preventive and restorative procedures. Preventive services are generally available at no cost. The co-payments for minor and major services may vary from state to state. In some cases, orthodontic services may also be available. Please refer to the benefit summaries for details.

Dental Preferred Provider Organization (PPO)

The PPO Dental option provides the flexibility to see any dentist. Services by a network dentist are at a pre-negotiated rate and you will receive a higher level of benefit and lower out-of-pocket costs when you use a network dentist. You are responsible for any co-insurance amount, but you will not be billed any balance above the pre-negotiated rate with the dentist. If you choose to see a dentist that is not in the network, the benefits are generally paid in accordance with the usual, customary and reasonable fees and you will be responsible for any charges as determined by the Dental PPO not paid by the Plan.

Each time you receive services, you may choose an in-network or an out-of-network provider. When you choose a dentist in the PPO network, you save money. If you choose a dentist outside the PPO network, your out-of-pocket costs will be higher.

VisionBenefit Options

Vision Option

With the Vision option you can save on eye exams, contact lenses and eyeglasses. The benefits vary depending on whether services are provided in-network or out-of-network. This benefit is available for you and your eligible dependents. Please refer to the benefit summary for details.

Flexible Spending Accounts (FSAs)

Health Care and Dependent Care Flexible Spending Account Options

The Flexible Spending Account (FSA) Options – which include the Health Care FSA, Limited Heath Care FSA and the Dependent Care FSA - allow you to pay for certain medical and dependent care expenses with pre-tax dollars. Your contributions are deducted from your income each pay period before your federal income and Social Security taxes are calculated. As you incur eligible expenses you are reimbursed tax-free – you never have to pay taxes on those reimbursements. The end result is that your tax withholdings are reduced and you have more income to spend.

Facts About the FSAs

Who May Incur Expenses

For purposes of reimbursement of eligible medical expenses under the Health Care FSA, an eligible dependent includes only an individual who is your tax dependent as defined in Section 152 of the Internal Revenue Code (determined without regard to Sections 152(b)(1), (b)(2) and (d)(1)(B), or your child (as defined in Section 152(f)(1) of the Code) until the end of the year in which the individual reaches age 26. Refer to the Dependent Eligibility Reference Guide and your insurance carrier's certificate of coverage for details on when the Plan's medical benefit coverage ends for children that attain age 26.

For purposes of reimbursement of eligible dependent care expenses under the Dependent Care FSA, an eligible dependent includes only an individual who is a "qualifying child" or "qualifying relative."

A "qualifying child" generally includes someone who:

- bears a familial relationship to you (e.g., a child or stepchild, sibling, or step-sibling, or a descendant of any such relative);
- lives with you for more than half of the calendar year;
- does not provide more than one-half of his or her own support for the calendar year; and
- has not reached age 13 or is permanently and totally disabled at any time during the calendar year.

A "qualifying relative" generally includes someone who:

- bears a familial relationship to you (e.g., a child or stepchild, sibling or step-sibling, parent or step-parent, grandparent, niece, nephew, in-law) or is a member of your household (excluding an individual who was your spouse at any time during the taxable year);
- is mentally and physically incapable of self-care;
- lives with you for the entire calendar year;
- does not provide more than one-half of his or her support for the calendar year; and
- is not a qualifying child of you or any other taxpayer for the calendar year.

When Expenses Must Be Incurred

Expenses reimbursed under the FSAs must be incurred during the same Plan Year for which you elect to be enrolled in the FSAs and within your effective dates of coverage. Expenses incurred before your coverage begins may not be reimbursed. Expenses are considered "incurred" when you or your dependents are provided with the medical care or dependent care and not when you are formally billed, charged or actually pay for the services.

Please estimate carefully when determining the amount you wish to contribute to the FSA. Under the Internal Revenue Code "use it or lose it" rule, if you do not incur enough eligible expenses during the Plan Year to submit for reimbursement, you will forfeit any unused contribution amounts. However, participants in the Health Care FSA and Limited Health Care FSA are permitted to carry over up to $500 of their remaining account balance as of the current Plan Year claim filing deadline.

Requesting Reimbursement

The last day to file an FSA claim for the Plan Year is July 30th (i.e., 60 days following the end of the Plan Year). Claims submitted with a post-marked date after July 30th will not be paid. Make sure to plan accordingly to avoid forfeiture of your FSA funds.

Health Care FSA, Limited Health Care FSA and Dependent Care FSA participants can get immediate reimbursement when using their Spending Account Card, which works like a bank debit card. However, you can still choose to pay for your eligible health care and dependent care expenses out of your pocket and then fax, mail or submit an online claim reimbursement request along with your receipt for the expense.

You can submit an online reimbursement request and access claim forms and further details on how to submit claims by visiting the Optum secure website at **www.optumbank.com** and logging in under your account. If it is your first visit to Optum, you will need to register on the website by clicking "Register for online access".

Claims for health care expenses that do not require a prescription (such as diabetic supplies and bandages) must include a receipt that includes the following (in addition to any other documents that the FSA Claims Administrator may require):

1. the patient's name; and
2. the provider's name; and
3. the date of the service or purchase; and
4. the name of the medicine, drug or service that was purchased; and
5. the amount of the purchase.

Proof of claim can include copies of bills, itemized receipts, cancelled checks, or an Explanation of Benefits from the insurance carrier. Submission of the box or other packaging of the medical supply or an affidavit signed by the employee, spouse or dependent is not sufficient substantiation. A credit card receipt without itemization of the medical expense is not sufficient substantiation.

When you submit a claim for reimbursement from the Health Care FSA or Limited Health Care FSA, your reimbursement will be made based on the total dollar amount of your election for the Plan Year. Your payroll deductions will continue throughout the remainder of the Plan Year. Under federal income tax regulations, you are responsible for making your full pre-tax election contribution even if you received the full benefit earlier in the Plan Year.

Health Care FSA Carryover Rules

Participants in the Health Care FSA and Limited Health Care FSA are permitted to carry over up to $500 of their account balance remaining as of the end of the Plan Year claim filing deadline. Eligible carryover amounts will be applied to the following Plan Year. Any account balance in excess of $500 remaining as of the end of the Plan Year claim filing deadline will be forfeited as required by IRS regulations.

FSA Spending Account Card

When you enroll in a Health Care FSA,Limited Health Care FSA or Dependent Care FSA, you'll automatically receive a Spending Account Card that works like a bank debit card, providing you immediate reimbursement for your eligible health care and dependent care expenses and reducing the need to file claims for reimbursement.

FSA Claim Filing Deadline

Claims for qualified medical and/or dependent care expenses incurred during the Plan Year may be submitted at any time during the Plan Year, but no later than 60 days after the end of the Plan Year. Therefore, the last day to file a claim for a Plan Year is July 30th following the end of that Plan year. For example, the claims filing deadline for claims incurred in the 2018-2019 Plan Year is July 30, 2019.

When you submit a claim for reimbursement from the Dependent Care FSA, your reimbursement will be limited to the amount that has been contributed to date. If your claim exceeds the amount available for reimbursement, the remaining balance of the claim will be paid once funds are available for reimbursement. Your payroll deductions will continue throughout the remainder of the Plan Year.

You may obtain a copy of the FSA Claim Forms by contacting a MyLife Advisor or by logging into your Optum account at **www.optumbank.com.**

Claims for reimbursement generally are paid within 30 days from the date of receipt. These reimbursements are not taxable.

How will my FSAs be affected if I am transferred from one client company to another?
If there is no lapse in benefits coverage, contributions to the Health Care FSA and/or Dependent Care FSA will continue accordingly.

How are my contributions to the FSA plans affected in the event of a Family Medical Leave (FMLA) and other Qualified Leave?
If you are absent from work due to FMLA or another qualified leave, your participation in your **Health Care FSA or Limited Health Care FSA** will continue. Medical expenses incurred while you are on leave are eligible for reimbursement. Once you return to active employment, your pre-tax contribution amount will be adjusted to make-up for any missed contributions.

Due to Internal Revenue Code regulations, your participation in the Dependent Care FSA will be suspended during your leave of absence. You will not be permitted to continue contributions towards your **Dependent Care FSA** during your leave. Additionally, dependent care expenses incurred while you are on leave are not eligible for reimbursement. If you return to active employment during the same Plan Year, your original Dependent Care FSA election will be reinstated or you may make a new election for the remainder of the Plan Year.

What happens to my FSAs if my employment ends?
If your employment ends, your coverage under the FSAs ends on your last day of employment. You will be eligible to submit claims incurred through your termination date only. You will have until 60 days after the end of the Plan Year to file any eligible claims incurred through your termination date. Based on the Plan Year you must file any eligible claims for reimbursement no later than July 30th.

The **Health Care FSA and Limited Health Care FSA** may be continued through the Consolidated Omnibus Budget Reconciliation Act (COBRA) until the end of the Plan Year in which the COBRA event occurs. If you continue this coverage through COBRA, you will be required to continue making contributions on an after-tax basis. Your continued monthly Health Care FSA contribution amount must be equal to your monthly contribution prior to your COBRA qualifying event. Following the end of your employment, you should be given a notice that explains your election rights under COBRA. Refer to section titled "Continuation of Coverage under COBRA" for further details.

Note: The Dependent Care FSA cannot be continued after your employment ends.

Can I re-enroll if I am rehired within the same Plan Year?
If you are rehired or reclassified into an eligible class for benefits, you are eligible for FSA benefits on the first day of the month following the date you meet your worksite employer's specified waiting period, if any.

If you have any questions about the waiting periods, please contact a MyLife Advisor.

You should plan carefully when making a new FSA election upon rehire. Make sure to consider the number of months remaining in the Plan Year when designating your FSA contribution amount so that you do not over-contribute and risk forfeiture of your funds.

Note: Claims incurred following termination or during the waiting period following rehire will not be eligible for reimbursement.

What happens to money left in my FSAs at the end of the Plan Year?
Remember, you have 60 days after the end of the Plan Year to submit claims for reimbursement for any unused FSA balances. But after this 60-day period, you will lose any money left in your FSAs except as detailed in the Health Care FSA section. This is because the IRS requires the Plan Administrator to forfeit unused FSA account balances. If there are forfeited FSA account balances, the Plan Administrator may use these funds to offset the expenses of administering the Plan. You should carefully plan your contributions, and carefully estimate your expenses, to minimize

the risk that your FSA contributions will be forfeited. Refer to the Health Care FSA Carryover Allowance section for details on carryover rules.

Health Care FSA

You can use a Health Care FSA for expenses that your medical, dental and vision options do not cover. You also can use it to pay for your share of the cost of physician expenses (including co-payments), coinsurance cost share or for prescription drugs. Your qualified tax dependents' expenses also are eligible.

A Health Care FSA allows you to pay for these types of expenses with pre-tax dollars, thereby reducing your taxable income. Participating in the Health Care FSA usually is a greater advantage than taking an itemized tax deduction for eligible expenses. That is because only those eligible expenses exceeding 7.5 percent (increasing to 10% in 2019) of your annual adjusted gross income are tax deductible, and few people reach these levels.

The example tax savings table below shows that using the Health Care FSA, Joe was able to save $491.25 for the taxable year, thereby lowering his tax liability. Joe can be reimbursed for medical expenses tax-free from the Health Care FSA. Please note that the estimated tax savings is based upon the standard deduction and federal income tax rates for 2018, calculated using the IRS Withholding Calculator which can be accessed on the IRS website at **www.irs.gov**.

Due to restrictions under the Affordable Care Act (ACA) and the Health Insurance Portability and Accountability Act (HIPAA), the Health Care FSA is only offered to individuals that are also offered group health coverage through ADP TotalSource or their Worksite Employer.

How much you may actually save will depend upon what family members are covered, your actual contribution amount, total family income, and the tax deductions and credits claimed for the taxable

Example of Health Care FSA Tax-Saving Advantage

Joe has estimated his out-of-pocket medical expenses to be $2,500 for each Plan Year, June 1 through May 31. After careful consideration, Joe decided to enroll in the Health Care FSA. The following illustrates how he made his decision based upon tax rates in effect in 2018 assuming that Joe is married, filing jointly with one child and gets paid biweekly.

	Without Health Care FSA	With Health Care FSA:
1. Adjusted Gross Income	$ 60,000	$ 60,000
2. Salary Premium Reductions	$0	($2,500)
3. W-2 Gross Wages (line 1 minus line 2)	$60,000	$57,500
4. Standard Deduction	($24,000)	($24,000)
5. Taxable Income (line 3 minus line 4)	$36,000	$33,500
6. Federal Income Tax	($3,442)	($3,142)
7. FICA (7.65% of line 3)	($4,590)	($4,398.75)
8. After-Tax Premium Payments	($2,500)	$0
Net Spendable Income (line 3 minus lines 6, 7 & 8)	$49,468	$49,959.25

That's a savings of $491.25 for the year.

year. You may also have state tax savings. Please note that pre-tax salary reductions also lower earned income, which may impact the earned income credit for eligible taxpayers.

Contribution Limits

For the 2018-2019 Plan Year, Health Care FSA contributions are limited to $2,650 in accordance with the Affordable Care Act (indexed for cost-of-living adjustments per Plan Year). Therefore, if you elect to participate in the ADP TotalSource Health Care FSA your contribution election will be applied based on the respective Plan Year period of June 1 – May 31.

Contributions must be no less than $50 per Plan Year toward your medical expenses.

Reimbursements under the Health Care FSA are made with your pre-tax contribution elections only. No insurance carrier pays these benefits.

Once you have submitted your expenses and received reimbursement from the Health Care FSA, they cannot be claimed as an itemized tax deduction.

If you are newly hired in the middle of a Plan Year, please plan carefully when making your FSA election. Make sure to consider the number of months remaining in the Plan Year when designating your FSA contribution amount so that you do not over-contribute and risk forfeiture of your funds.

Missed Contributions

There are several instances that may cause you not to have a contribution on any given pay cycle. If you miss a contribution due to an irregular pay cycle, the missed contributions will be taken in a one-time adjustment on a future paycheck.

Health Care FSA Carryover Allowance

Participants in the Health Care FSA (including the Limited Health Care FSA) are permitted to carry over up to $500 of their remaining account balance as of the current Plan Year claim filing deadline. Eligible carryover amounts will be applied to the following Plan Year and must be exhausted by the end of the year in which the funds are carried into, unless you enroll in the Health Care FSA (including the Limited Health Care FSA) for the following Plan Year. You will forfeit any unused carryover amount at the end of the following Plan Year if you do not make an election for that next Plan Year. For example, if you have a carryover amount related to the 2018 Plan Year and you do not make an election for the 2019 Plan Year, any unused carryover amount related to the 2018 Plan Year will be forfeited at the end of the 2019 Plan Year. The carryover of up to $500 does not affect the maximum amount that a participant can elect to contribute in the new Plan Year.

Eligible Expenses

IRS Publication 502 Medical and Dental Expenses provides guidance on what medical expenses are eligible. However, some expenses that are deductible under IRS Publication 502 may not be reimbursable under the Health Care FSA (such as insurance premiums and related costs).

In accordance with the Affordable Care Act, individuals will be prohibited from using the Health Care FSA for the cost of over-the-counter medications that are not otherwise prescribed by a physician. Insulin and diabetic supplies remain eligible without a prescription.

Limited Health Care FSA

If you enroll in a High Deductible Health Plan, you may only participate in the Limited Health Care FSA. This means that you may only submit eligible dental, vision and certain preventive care expenses for reimbursement. The Limited Health Care FSA will not reimburse medical expenses other than those expenses that qualify as preventive care expenses.

For further details, please refer to the Health Savings Account section.

Managing Your FSA

The best place for you to find all the information you need to manage your FSA, including details of eligible health care expenses for both the Health Care FSA and Limited Health Care FSA, is the secure Optum website at **www.optumbank.com**. If it is your first visit to Optum, you will need to register on the website by clicking "Register for online access". Alternatively, you can call a MyLife Advisor at 844-448-0325 to be transferred to the Optum service center. The Optum service center is staffed Monday through Friday from 8:00 a.m. to 10:00 p.m. Eastern Time.

Eligible Health Care FSA Expenses

The following lists examples of expenses that are eligible for reimbursement to you as part of the Health Care FSA. This is not intended to be a complete list.

- acupuncture
- alcohol and drug abuse treatment
- ambulance costs
- artificial insemination
- artificial limbs
- artificial teeth or dentures
- birth preventive surgery

- Braille books and magazines
- care of mentally handicapped dependents
- childbirth classes (charges for mother only)
- chiropractic costs
- co-insurance
- co-payments
- contact lenses
- cosmetic surgery (only for congenital abnormality due to injury, trauma or disfiguring disease)
- cost of operations and treatments
- cost for physical or mental illness
- crutches
- deductibles
- dental educational programs, plaque repairs control and oral hygiene
- dental fees
- diagnostic fees
- diabetic supplies
- special housing for disabled persons
- extra dental cleanings
- eyeglasses and examination fees
- hearing exams, devices and batteries
- insulin
- invitro fertilization
- laboratory fees
- licensed massage therapy
- nursing fees
- obstetrical expenses with medical necessity
- orthodontia
- orthopedic shoes
- oxygen
- physician fees
- prescribed medicine (including vitamins and contraceptives)
- psychiatric care
- psychologist fees
- radial keratotomy or similar procedures (such as Lasik)
- routine physical exams
- seeing-eye dog
- smoking cessation programs
- special telephone equipment and related repairs
- special communication equipment for the deaf
- special education for the blind
- surgical fees
- therapy treatments
- weight loss programs not including food items (if prescribed by a physician to treat a specific existing disease)
- wheelchairs
- x-rays

Some health care treatments and services deemed cosmetic in nature require written proof of medical necessity from your health care provider to receive reimbursement.

Ineligible Health Care FSA Expenses

The following list is an example of expenses that are not eligible for reimbursement to you as part of the Health Care FSA. This is not intended to be a complete list.

- Expenses reimbursed through any other insurance policy or plan
- Expenses incurred outside of the Plan Year in which you are enrolled
- Expenses claimed as deductions on your income tax return
- Expenses incurred before your coverage begins
- Expenses incurred after your employment ends - unless you make an election to continue the Health Care FSA through COBRA, and then only through the end of the Plan Year in which you terminated employment or the date you terminate your COBRA coverage in that same year, whichever is latest. Expenses incurred beyond the qualifying event Plan Year are only eligible if you have carryover funds remaining. Refer to the "Health Care FSA Carryover Allowance" section for more details.
- Coverage costs for medical, vision or dental coverage under the Plan
- Coverage costs for Long Term Care (except for qualified Long Term Care insurance as determined by the IRS)
- Cosmetic-related medical or dental services or medications
- Health club dues
- Over-the-Counter drugs (other than insulin) (including cosmetic, dietary supplements or other drugs that are merely beneficial to your general health), unless you have a prescription from an authorized health provider
- Weight loss programs intended to improve the participant's appearance, general health and/or sense of well-being
- Dietary supplements, toiletries and cosmetics, etc.

Dependent FSA

People with young children or who care for disabled dependents know how expensive it is to pay for dependent care. But with this account, you have a tax-free way to pay for qualifying, work-related dependent care costs and it means more cash in your pocket.

Child Care Tax Credit

The federal government allows a child care tax credit to families when they file their tax returns. If your income is below a certain level, the child care tax credit may be more beneficial to you than enrolling in the Dependent Care FSA.

Because ADP TotalSource cannot assist you with individual tax advice, please make your decision carefully. Contact your tax advisor or review IRS Publication 503 Child and Dependent Care Credit. It provides guidance on eligible and ineligible dependent care expenses.

You may not claim the child care tax credit for child care expenses that are reimbursed under the Dependent Care FSA. If you have additional expenses the Dependent Care FSA does not reimburse, you may claim the child care tax credit, subject to all IRS rules.

Contribution Limits

If you elect to participate in the Dependent Care FSA, you can contribute up to $5,000 ($2,500 if married filing separately), but not less than $50, per Plan Year toward your dependent care expenses. Note that if more than $5,000 (if married filing jointly) or $2,500 (if single or married filing separately) is contributed to the Plan during a single calendar year, the excess amount will be included in your taxable income and wages. Please take caution when electing your Dependent Care FSA contribution limit to ensure that your Plan year elections (for June 1st – May 31st) do not cause you to exceed the IRS calendar year contribution limit.

If you are newly hired in the middle of a Plan Year, please plan carefully when making your FSA election. Make sure to consider the number of months remaining in the Plan Year when electing your FSA contribution amount so that you do not over-contribute and risk forfeiture of your funds.

Contribution Limits for Highly Compensated Employees

Highly compensated employees will only be permitted to contribute to the Dependent Care FSA up to the amount of $2,000 per Plan Year. In addition, ADP TotalSource may, at any time before or during the Plan Year (June 1 - May 31), notify a highly compensated employee that he or she must discontinue pre-tax contributions to the Dependent Care FSA or that he or she must limit such pre-tax contributions to a particular dollar amount below the $2,000 maximum if ADP TotalSource determines in its discretion that such action is necessary or advisable in order to satisfy the nondiscrimination requirements applicable to the Dependent Care FSA.

For the 2018-2019 Plan Year, a "highly compensated employee" is defined by the IRS as an individual that (a) owns (or constructively owns) more than 5% of the stock, capital or profits interest of a worksite employer on any day during the Plan Year, or (b) will be paid compensation by ADP TotalSource in excess of $120,000 annually. The definition of a highly compensated employee may change for future Plan Years.

Missed Contributions

There are several instances that may cause you not to have a contribution on any given pay cycle. If you miss a contribution due to an irregular pay cycle, the missed contributions will be taken in a one-time adjustment on a future paycheck.

Managing your FSA

The secure spending account services website is the best place for you to find all the information you need to manage your Dependent Care FSA, including details of eligible dependent care expenses. You can access the spending account online services by logging on to **www.optumbank.com** . Alternatively, you can call a MyLife Advisor at 844-448-0325 to be transferred to the Optum service center. The Optum service center is staffed Monday through Friday from 8:00 a.m. to 10:00 p.m. Eastern Time.

Dependent Care FSA Eligible Expenses

Generally, you may use your Dependent Care FSA to pay for eligible dependent care expenses. The following rules apply:

- Care for your eligible dependent(s) must be necessary for you and your spouse (if you are married) to work, look for work, or go to school full-time. If you are married, your spouse must be gainfully employed, be a full-time student, or physically or mentally incapable of self-care.
- You must incur the expense during the plan year and within the time frame you are participating in the account.

The expense must also be for the care of an eligible dependent. An eligible dependent is an individual who is a "qualifying child" or "qualifying relative."

A "qualifying child" generally includes someone who:

- bears a familial relationship to you (e.g., a child or stepchild, sibling, or step-sibling, or a descendant of any such relative);
- lives with you for more than half of the calendar year;
- does not provide more than one-half of his or her own support for the calendar year; and
- has not reached age 13 or is permanently and totally disabled at anytime during the calendar year.

A "qualifying relative" generally includes someone who:

- bears a familial relationship to you (e.g., a child or stepchild, sibling or step-sibling, parent or step-parent, grandparent, niece, nephew, in-law) or is a member of your household (excluding an individual who was your spouse at any time during the taxable year);

- is mentally and physically incapable of self-care;
- lives with you for the entire calendar year;
- does not provide more than one-half of his or her support for the calendar year; and
- is not a qualifying child of you or any other taxpayer for the calendar year.

Below are examples of dependent care expenses that are considered eligible:

Eligible Expenses

- dependent care costs that you must pay to enable you to work. If you are married, your spouse also must be gainfully employed or looking for work, be a full-time student or physically or mentally incapable of self-care;
- dependent care costs for an eligible dependent who is under 13 years of age – the IRS requires the provider to be a qualified day care center or a person who is not your dependent. A relative age 19 or older can provide qualified dependent care assistance if you do not claim him or her as a dependent for income tax purposes;
- non-nursing care costs for a dependent 13 years of age or older who is physically or mentally incapable of self-care;
- dependent care costs provided in a nursery school, day care center that meets applicable federal, state, and local regulations, or babysitter fees for purposes of maintaining gainful employment for you and your spouse or if you or your spouse is a full time student or physically or mentally incapable of self-care;
- certified "away from home" facilities costs (providing not more than 12 hours per day).

Below are examples of dependent care expenses that are considered ineligible:

Ineligible Expenses

- food or clothing costs;
- medical expenses;
- costs for a dependent's education (other than education a nursery school provides);
- expenses for transportation of a dependent to and from the provider of dependent care services except where transportation is required to maintain gainful employment (such as a school bus to and from the dependent care provider);
- fees to a day care center that do not comply with all federal, state, and local laws applicable to child care centers;
- dependent care costs that are covered by the federal tax credit for dependent care on your federal tax returns;
- costs for a nursery school, day care center or baby-sitter outside of scheduled working hours. Example: Dependent care provided while you are out enjoying entertainment or running errands.

The eligible and ineligible expenses listed above are only a guide. There may be other expenses in addition to the ones above that may be eligible or ineligible. To learn more, consult IRS Publication 503 or your tax advisor.

When Coverage Under the Plan Ends

Coverage under the medical, dental and vision benefit options will end on the earliest of:

- the last day of the month in which your employment ends and/or you experience certain changes in status and other mid-year life events, including a temporary or permanent lay-off, non-qualified leave or reduction in hours that result in the termination of your benefits;
- the last day of a period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made when due;
- the date the Plan in which you were enrolled is terminated;
- the last day of the month in which you are no longer eligible for coverage under the Plan in which you are enrolled;
- the day you die and, with respect to your eligible dependents, the last day of the month in which you die; or
- the day you cancel your coverage.

Coverage under the FSA benefit options will end on the last day of your employment. If benefit coverage costs were deducted to cover the following month's costs, they will be reimbursed upon termination of coverage. Because you will receive coverage under any medical, dental and/or vision plans that you elected to participate in through the last day of the month, any employee contribution amount that you owe for such coverage for the month in which your employment ends or you experience a change in status will be deducted from your final paycheck. Please note that this deduction may be greater than your normal payroll deduction.

Only the medical, dental, vision and Health Care FSA (including the Limited Health Care FSA) benefit options may be continued through COBRA at your expense. See the section titled "Continuation of Coverage under COBRA."

Health Savings Account (HSA)

A Health Savings Account allows you to set aside money on a pre-tax basis that can be used to cover most unreimbursed medical expenses (provided they qualify as tax deductible), pay for dental and vision care expenses or in the event you can cover your medical costs without using the funds from the HSA, you can use these funds to save for the future. Unlike FSAs, the funds in the HSA are not forfeited if you do not use them – they accumulate year after year. You may contact a MyLife Advisor for further information regarding HSAs at (844) 448-0325.

Eligibility

In order to be eligible to open an HSA, you must satisfy several requirements on a monthly basis:

- you must have health coverage under a qualified High Deductible Health Plan (HDHP); and
- you cannot be covered under another health plan (such as the general purpose Health Care FSA) that is not a HDHP, unless the health plan provides very limited coverage such as the Limited Health Care FSA, dental or vision; and you must not be entitled to and enrolled in Medicare benefits (due to age or disability) or be eligible to be claimed as a dependent on another person's tax return.

If an individual is otherwise eligible for Medicare Part A or Part B but is not actually enrolled they may contribute to an HSA until the month that individual is enrolled in Medicare.

Please note that an individual is automatically enrolled in Medicare Part A upon reaching their Social Security retirement benefits age and at that point would no longer be eligible to contribute to an HSA. To find out when you will reach your Social Security retirement age, visit **www.socialsecurity.gov.**

Note: If you choose to enroll in an HDHP and an HSA, you are not eligible to participate in the Health Care FSA but can elect to participate in the Limited Health Care FSA. See page 26 for Limited Health Care FSA details

Note that it is the Plan's intention to comply with Department of Labor guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

The HSA described in this section is not an arrangement that is established and maintained by ADP TotalSource, Inc. Rather, the HSA is established and maintained by the HSA trustee. However, for administrative convenience, a description of the HSA is provided in this section.

Contribution Limits

Up to certain limits, contributions to an HSA are tax deductible. In general you are permitted to contribute the sum of the monthly limitations for months during the taxable year that you are covered through an HDHP and therefore eligible to make an HSA contribution. The monthly limitation for any month is 1/12 of the applicable contribution limit described below. As a result of the Tax Relief and Health Care Act of 2006, you may choose to contribute up to the maximum contribution limitation for a taxable year as long as you were enrolled in an HDHP during the last month of the taxable year. If you do not remain covered by an HDHP for the 12-month period following the end of the tax year in which you first enrolled in the HDHP, you will be subject to income tax and a 10% penalty tax on any amount of the annual contribution limit that you would not normally have been permitted to make had you not made the "make up" contribution. The 10% penalty is includible in your income in the year in which you fail to remain HSA-eligible.

	2017 Calendar Year	2018 Calendar Year
Contribution Limit (individual coverage)	$3,400	$3,450
Contribution Limit (Family coverage)	$6,750	$6,900

If you are age 55 or over by the end of 2018, the IRS allows you to contribute an additional "catch-up" amount of $1,000 for 2018 and future calendar years.

Employee Contributions

If you elect to open an HSA account through the current ADP TotalSource HSA provider or your worksite employer sponsors an HSA, your contributions to the HSA will be deducted on a pre-tax basis as long as you are not considered a Self-Employed Individual. Otherwise, you'll take a tax deduction on your tax return. Pre-tax contribution eligibility may vary depending on your employment arrangement with your employer. Please note that there are currently three states that tax HSA contributions: Alabama, California, and New Jersey. New Hampshire and Tennessee tax earnings on HSA contributions. If you are eligible to make a pre-tax contribution and are subject to taxation in one of these states, the amount of your HSA contribution will not be included in your income when determining your federal income tax withholding amount, but will be included to determine the applicable state and/or local tax withholding amount.

When determining the amount of your contribution to the HSA you must take into consideration the following:

- your contribution limits based on your level of coverage; and
- any monthly amount that is being contributed to your HSA by your employer. If your employer is contributing to your HSA account, you will need to reduce your contribution by the monthly amount your employer has elected to contribute on your behalf.

Your paycheck deduction will be calculated based on a "Per Year" or "Per Pay Period" basis as elected by you. If you elect to contribute on a Per Pay Period basis, then you choose the amount to be deducted from each paycheck. If you elect to contribute on a Per Year basis, your paycheck deductions will be calculated based on your elected annual contribution divided by the remaining payrolls in the Plan Year. Note deductions are calculated on a Plan Year basis and not calendar year.

Employee contributions to an HSA will begin on the first pay period following the establishment of your HSA account and will be collected through payroll deduction. You can increase or decrease or cancel the amount of your contribution to an HSA at any time on a prospective basis. Contact a MyLife Advisor at (844) 448-0325, Monday through Friday, from 8:00 a.m. to 11:30 p.m. (Eastern Time) for assistance with making changes to your current HSA contributions through ADP TotalSource. You can also make changes online at adptotalsource.adp.com by navigating to Myself > Benefits > Enrollments. Your contribution change will take effect within two pay periods. Note that total contributions to your HSA are limited.

Employees are responsible for initiating and informing ADP TotalSource of any changes to their current elected contribution amounts throughout the year and/or during the annual Open Enrollment period. ADP TotalSource will not adjust your elected contributions to an HSA account without your authorization unless you reach the maximum allowable annual contribution. Your HSA elected contribution will automatically be lowered to $0 once you have reached the IRS maximum allowable annual contribution.

You have until generally April 15th (check with the IRS for due date for the filing year) to make additional HSA contributions and designate them to apply to the prior tax year as long as you were participating in an HDHP. Remember, however, that you may not contribute more than the maximum HSA contribution limits.

Please note that catch-up contribution amounts can be included in the determination of your HSA contribution amount.

Employer Contributions

If your worksite employer has elected to contribute to your HSA, those contributions will begin on the first month following the establishment of your HSA account. Worksite employer contributions will be credited to your HSA account on a monthly basis on or around the 15th of each month.

Don't delay establishing your HSA account or you may miss worksite employer contributions to your HSA (if applicable).

Excess Contributions

The IRS imposes a penalty on excess contributions, but allows, under certain circumstances, for corrective distributions to be made. Additionally, you would be required to pay tax on any interest earned on those excess funds.

It is each individual account holder's responsibility to ensure that HSA contributions do not exceed maximum limits. It is also the account holder's responsibility to make sure that his/her distributions are for qualified medical expenses.

HSA Account Maintenance Fee

If you elect to open an HSA through the current ADP TotalSource HSA provider, an account maintenance fee will be charged to you and deducted directly from your HSA account, unless the worksite employer has elected to pay these fees on your behalf. The withdrawn fee counts toward your contribution limit.

Therefore, you are not permitted to contribute to your HSA account additional funds (above the limitations that would otherwise apply) in order to make up for the withdrawn maintenance fee. However, if your worksite employer has elected to pay the HSA account maintenance fee on your behalf, the payment of these fees is not considered an employer contribution and does not count toward the IRS maximum HSA contribution limits.

Facts About HSAs

What types of medical expenses can be paid from my HSA?

- Your HSA can be used to pay for qualified medical expenses that apply toward your HDHP deductible. Additionally, you can pay for qualified medical expenses that your HDHP doesn't cover. Qualified medical expenses are listed under IRS Code Section 213 (d) and are updated periodically. Please refer to the IRS website (www.irs.gov, Publication 502) for the most current information published by the IRS. Your HSA cannot be used to pay for most health insurance premiums, except the following premiums may be reimbursed from HSA funds on a tax-free basis:
- Qualified long-term care insurance premiums
- COBRA premiums
- Health plan coverage while an individual is receiving unemployment compensation
- Medicare premium and out-of-pocket expenses, other than Medigap coverage
- Employee's share of premiums for employer-sponsored retiree health insurance

In accordance with the Affordable Care Act, HSA funds cannot be used for the purchase of over-the-counter (OTC) medications unless they are prescribed by a physician. Insulin and diabetic supplies remain eligible without a prescription.

Whose medical expenses can be paid for from my HSA?
You may use your HSA funds to cover qualified medical expenses for:

1. You and your spouse, or your domestic partner, civil union partner or each of his or her covered children if he/she or they qualify as your federal tax dependent, as described below;
2. Any dependent you claim on your tax return; and
3. Any person you otherwise could have claimed as a dependent on your return except that:

- The person filed a joint return,
- The person had gross income above a certain amount. (In 2017, that amount was $4,050, or more), or
- You, or your spouse if filing jointly, could be claimed as a dependent on someone else's tax return in that year.

It's important to note that eligibility for dependents is aligned with tax dependent eligibility, as opposed to medical plan eligibility. That means your dependents for purposes of the HSA are not required to be enrolled under the HDHP, a non-HDHP or any other health plan in order for the expenses to be eligible or reimbursement.

Keep in mind that if the option in which you are enrolled allows you to cover your child under the HDHP until the end of the month (or year) in which he or she turns 26, unless that child is your dependent as described in 1-3 above, you **cannot** use your HSA funds to cover any of his or her medical expenses for that period.

If I am enrolled in family HDHP coverage and my spouse and/or dependents are also covered by a non-HDHP plan, Medicare or Medicaid, how much can I contribute to the HSA?
You may contribute the statutory maximum for family coverage. Other non-HDHP coverage of dependent children or spouses does not affect your contribution limit.

Can I have a Flexible Spending Account (FSA) if I have an HSA?
Federal Regulations do not allow individuals to receive reimbursement for medical expenses tax free through a Health Care FSA and contribute to an HSA during the same Plan Year. If you are actively contributing to an HSA and/or your worksite employer contributes to your HSA, you cannot have other coverage including an FSA, unless the FSA is a limited purpose Health Care FSA, which means that it only reimburses dental or vision expenses such as dental and vision co-payments, deductibles and/or co-insurance payments, dental and orthodontic treatment and

vision care, including eyeglasses and contact lenses and certain preventive care expenses such as immunizations and routine examinations and procedures. Under the Plan, if you enroll in an HDHP option and also enroll in the Health Care FSA, the Health Care FSA will only reimburse dental, vision and preventive care expenses. This is known as a "limited purpose FSA" for HSA participants. The Limited Health Care FSA will not reimburse medical expenses that do not qualify as preventive care expenses. Also, if you have a Health Care FSA carryover from the prior Plan Year, your Health Care FSA carryover will be converted to a Limited Health Care FSA carryover due to IRS rules.

What happens if I use my HSA to pay for non-qualified medical expenses?

A distribution of funds for reasons other than qualified medical expenses prior to age 65 is taxable and subject to a 20% additional penalty. The HSA account holder would need to report this on the tax return for the corresponding tax year.

Opening a Health Savings Account

If you have elected coverage under an HDHP through the Plan, you are eligible to open an HSA through the current ADP TotalSource HSA provider. For information on how to open an HSA through the current ADP TotalSource HSA provider, please refer to the enrollment materials and instructions provided in your enrollment kit and online at **adptotalsource.adp.com**.

If you have elected coverage under an HDHP through the Plan and you do not elect to open an HSA through the current ADP TotalSource HSA provider, you may still open an HSA directly through any qualified HSA provider. ADP TotalSource will not, however, process pre-tax payroll deductions for an employee HSA account that is established through a custodian other than the current ADP TotalSource HSA provider.

Opening an HSA Account through ADP TotalSource Provider

Once you submit your HSA enrollment materials to the HSA provider, your information will be reviewed and, as required by Federal Law, your identity will be verified before an account can be opened in your name. The provider will use information you provide with the Enrollment Form and Adoption Agreement (including your name, home address, date of birth and Social Security number) to verify your identity. If your identity is not able to be verified, Optum will reach out to you via mail to obtain additional documentation verifying your identify.

Once your identity has been verified, you will generally receive your new HSA materials within 7-10 business days. At that time, you will receive instructions on how you can make your own direct contributions to your account. You should expect to see HSA payroll deductions on your pay stub shortly thereafter, consistent with the timing of your normal payroll process.

Does the HSA have to be opened at the same time I enroll in an HDHP?

No, you can open an HSA at any time as long as you are enrolled in an HDHP.

Will a delay in opening an HSA affect the enrollment in the HDHP with the carrier?

No, enrollment in the HDHP is a separate event not linked to enrollment in an HSA. You can enroll in the HDHP without opening an HSA. However, if your worksite employer provides employer contributions, you will not receive worksite employer contributions until your HSA is opened. Any worksite employer contributions for which you were otherwise eligible before your HSA was opened will be forfeited.

Accessing Funds

The use of your HSA funds is managed by you. You determine how to best use your available HSA balance and report the activity as required on your tax return. You are not required to spend all the funds contributed to your HSA within the same year. Unlike a Flexible Spending Account, unused funds will accumulate year after year in your HSA. Unused funds are not forfeited.

There is no limit on the number of withdrawals or fund distributions you can make from your HSA up to the available balance. You may withdraw funds at any time. Please note, however, that distribution of funds for reasons other than qualified medical expenses prior to age 65 is taxable and subject to a 20-percent penalty.

Tax Reporting

Are there any tax forms that I will receive to prepare my taxes at year end?

Yes, you will be sent the necessary tax forms. First, you will receive a Form 5498-SA that shows all of the contributions you (and your employer) made to your HSA. Second, if distributions were made from your HSA, you will receive a Form 1099-SA that shows the amount of any distributions made from your HSA during the calendar year. Also, if you open an HSA through the ADP TotalSource provider, your Form W-2 will show the amount of any pre-tax contributions you made to your HSA and any contributions your worksite employer made to your HSA. Please consult your tax advisor for further information regarding your specific situation.

Group Life and Disability Plan Options

Eligibilty

Availability of group life and disability benefit plan options depends on your worksite employer's election. If you are unsure whether you are eligible for a particular option, you should contact a MyLife Advisor. Eligibility provisions outlined in this section are subject to applicable state or local laws.

New Hires

If your worksite employer has elected to offer any of the group life and/or disability benefit options, you are eligible to participate in them, if:

- you are a regular full-time or part-time employee of an ADP TotalSource worksite employer residing or working in the United States, scheduled to work an average of 30 hours per week; and
- you are in an eligible class; and
- you satisfy the insurance carrier's Active Work Provisions; and
- you have satisfied the worksite employer's specified waiting period.

Employees with no waiting period

If your worksite employer has elected to offer any of the group life and/or disability benefit options, and you are classified as an employee who does not have a waiting period, you are eligible to participate in them, if:

- you are a regular full-time or part-time employee of an ADP TotalSource worksite employer residing or working in the United States, scheduled to work an average of 30 hours per week; and
- you are in an eligible class; and
- you satisfy the insurance carrier's Active Work Provisions.

New Clients

If your worksite employer is a new client of ADP TotalSource and has elected to offer any of the group life and/or disability benefit options, you are eligible to participate in them, if:

- you are a regular full-time or part-time employee of an ADP TotalSource worksite employer residing or working in the United States, scheduled to work an average of 30 hours per week; and
- you are in an eligible class; and
- you satisfy the insurance carrier's Active Work Provisions; and
- you have satisfied the worksite employer's specified waiting period from the date of hire with the worksite employer.

Self Employed Individual (SEI)

Defined as 2% S-Corp Owners (those who own more than 2%), Partners (including partnerships and limited liability partnerships) and LLC (limited liability corporations) members (excluding Members of an LLC that is taxed as a C-Corp) are eligible for coverage under the group life and/or disability benefit options if your worksite employer has elected to offer them. Certain types of group life coverage may not be available to all SEIs.

Due to the attribution rules of Section 318 of the Internal Revenue Code, in determining who is a greater than 2% S Corp shareholder for purposes of participation and taxation, please note that an S Corp owner's stock ownership is attributed to the owner's spouse, children, parents, and grandparents (if also working for the worksite employer). Please note that it is your responsibility to notify ADP TotalSource if any such familial relationship exists.

Note: Employer contributions are considered taxable earnings for the SEIs.

Dependents

Dependents are not eligible to enroll in any of the group life and/or disability benefits.

When Coverage Under the {lan Begins

Your coverage for the group life and disability benefit options under the Plan will begin on the date in which you become eligible to participate unless you are not actively at work* on the day you would otherwise become eligible, so long as you elect coverage under the Plan by submitting your elections to ADP TotalSource prior to the enrollment deadline indicated in your ADP TotalSource enrollment materials, if these coverages are not offered to you on an automatic basis by your worksite employer. To determine if these coverages are offered to you automatically, please refer to the enrollment form in your enrollment kit, or online at adptotalsource.adp.com, or contact a MyLife Advisor at (844) 448-0325.

Your effective date of coverage under the group life or disability options will fall on the first day of the month following the completion of your worksite employer's specified waiting period. For example, if you start work on April 5th and your worksite employer requires a 30-day waiting period, your election will be effective on June 1st (the first day of the month after you've been employed for 30 days). If the date you complete your waiting period falls on the first day of the month, your effective date of coverage is that same day. For example, if you start work on April 2nd and your worksite employer requires a 30-day waiting period, your election will be effective on May 1st.

Refer to the Active at Work provision in the insurance carrier's Certificate of Coverage for further details.

Regaining Eligibility

If you are rehired or reclassified into an eligible class for benefits, you may be required to satisfy your worksite employer's specified waiting period before enrolling in the Plan. Benefits will take effect on the first day of the month following the end of the worksite employer's specified waiting period and subject to the insurance carrier's Active at Work provisions as detailed in the insurance carrier's certificate of coverage. If you have questions about the waiting periods, please contact a MyLife Advisor.

You must complete the enrollment process for the Plan to become enrolled. Prior coverage is not automatically reinstated.

Basic Life and Accidental Death & Personal Loss (AD &PL)

Basic life and AD&PL insurance may be available to you under the Plan. Your worksite employer determines the benefit availability and amount of coverage. Please contact a MyLife Advisor to determine your benefit amount.

Life Benefits

Benefits for the basic life and accidental death & personal loss policy are reduced beginning at age 65 and thereafter in accordance with the schedule specified in the life policy. Depending on your coverage, you may be able to continue your life insurance coverage by converting the portion of the policy that is being reduced to an individual policy in the event you reach the age of reduction or cease to be eligible under the Plan. You should contact your life insurance carrier immediately if you want to convert to an individual policy. A MyLife Advisor can refer you to the appropriate insurance carrier for conversion information. Generally, you must convert to an individual policy within 30 to 60 days of the date you experience a reduction in coverage or cease to be eligible under the Plan.

Designating and/or Updating Beneficiary(ies)

Upon initial enrollment into a group life plan you will need to designate at least one beneficiary. Designating a beneficiary is an important part of your coverage under any group life plan. You can designate multiple primary and/or contingent beneficiaries as needed. Beneficiary designations can be changed throughout the life of the policy by either completing the Beneficiary Designation Change Form or by indicating changes during the annual enrollment process. For more detailed information regarding the effective date of the change, please refer to your group life insurance certificate of coverage. You may contact a MyLife Advisor to obtain a Beneficiary Designation Change Form.

In the event that you do not have a beneficiary designated for your group life insurance policy, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the listed classes in the insurance carrier's certificate of coverage. In the event that you have a qualified domestic partner, the named domestic partner will be included under the definition of spouse for purposes of life insurance benefit payout if you have completed and submitted the Affidavit of Domestic Partnership to ADP TotalSource and have filed your domestic partnership with public records, if required by law.

Imputed Income

Group Term Life

Under Internal Revenue Code Section 79, the value of employer-provided group term life insurance in excess of $50,000 must be included in your income. Any taxable group term life coverage provided to you will be included in your income on your paycheck and will be subject to all applicable withholding taxes. This income will also be reflected on your Form W-2.

NOTE: The full value of any employer-provided group term life insurance coverage will be considered taxable income for 2% S-Corp Owners and Members of an LLC that is taxed as an S-Corp. Any taxable group term life coverage provided to you will be included in your income on your paycheck and will be subject to all applicable withholding taxes.

Long Term Disability (LTD)

Long Term Disability (LTD) insurance may be available to you under the Plan. Your worksite employer determines the benefit availability and amount of coverage. If your worksite employer offers this benefit to you, your enrollment in this benefit is automatic. The LTD coverage provides replacement income if

ou become disabled while insured under the LTD portion of the Plan. LTD benefits paid to you may be considered taxable income to the extent your worksite employer paid the costs for such coverage. Please contact a MyLife Advisor to determine your benefit amount and/or refer to the benefit highlights or summary provided to you at open enrollment. The LTD benefit cannot be converted if you cease to be eligible for the coverage.

Survivors Death Benefits

In the event of your death while LTD benefits are payable, and on the date of your death, you have been continuously Disabled for at least 180 days, the insurance carrier will pay a Survivors Death Benefit. If you do not designate a beneficiary for any applicable Survivors Death Benefit at the time of filing a claim for Long Term Disability benefits, Survivors Death Benefits will be paid according to the schedule outlined in the insurance carriers' certificate of coverage. In the event that you have a qualified domestic partner, the named domestic partner will be included under the definition of spouse for purposes of survivor death benefit payments if you have completed and submitted the Affidavit of Domestic Partnership to ADP TotalSource and have filed your domestic partnership with public records, if required by law.

Short Term Disability (STD)

If your worksite employer has elected to offer Short Term Disability insurance (STD), you may be eligible for this benefit. Your worksite employer determines the benefit amount that will be provided. This coverage provides replacement income should you become disabled while insured under the STD option of the Plan. Benefits paid to you under the STD option are considered taxable income. Please contact a MyLife Advisor to determine your benefit amount, if any.

Many of the medical, life and ancillary benefits are portable or convertible to individual policies. Please contact a MyLife Advisor to obtain information on conversion or COBRA continuation.

When Coverage Under the Plan Ends

Coverage under the group life benefit options will end on the last day of the month in which your employment ends and/or you experience a change in status including a temporary or permanent lay-off, non-qualified leave or reduction in hours that result in the termination of your benefits. Coverage under the disability benefit options will end on the last day of your employment. If deductions were taken from your pay to cover the following month's costs, they will be reimbursed upon termination of coverage.

Group life and disability coverage may not be continued through COBRA. Information regarding conversion options for the group life options may be obtained by contacting a MyLife Advisor. **You must complete your life conversion application within 60 days of your termination date.** There are no conversion options available for the disability benefits. In the event that you are receiving disability benefits at the time your employment ends, your claims will continue to be paid according to the Plan provisions.

Disability benefits end on your last day of employment or reclassification into an ineligible class. If you are receiving disability benefits at the time your employment ends, your claims will continue to be paid according to the Plan provisions.

State Temporary Disability Insurance (TDI)

If you live in California, Hawaii, New Jersey, New York, Puerto Rico or Rhode Island, your state provides mandated temporary disability insurance, and you are required to contribute toward the cost of the state disability plan in your area. State regulations control contribution levels and impose maximums. The LTD and STD options of the Plan will coordinate with the state temporary disability insurance programs and pay benefits as a secondary payor. Note that any State TDI benefits offered by your worksite employer are not intended to be an employee benefit plan under ERISA and such benefits are not covered by ERISA.

Enrollment

If you are eligible, you will receive benefits enrollment materials with information about the benefits that your worksite employer has selected to offer as well as particulars about the enrollment process. A MyLife Advisor can assist you in the explanation of these benefits.

Medical, Dental, Vision, Life, LTD, STD, Flexible Spending Accounts and Health Savings Account

When to Enroll

It is important to complete the enrollment process for the options you are eligible to participate in under the Plan prior to the Enrollment Deadline indicated in the enrollment materials. This will ensure a smooth enrollment and that appropriate payroll deductions are made in a timely manner. The benefit options you enroll in will take effect once you meet any applicable waiting periods or other requirements. These requirements can be found in this SPD or the insurance carrier's certificate of coverage for the option you chose.

If you do not enroll in any options under the Plan when you first become eligible (either because you chose to waive benefits or your enrollment information was not submitted by the Enrollment Deadline indicated in the enrollment materials), you will not be allowed to elect coverage under any of the options unless one of the following occurs (whichever comes first):

- you experience a qualified change in status (for further details, see the section titled, "Making Changes to Your Benefits"); or
- you experience a special enrollment event under HIPAA (for further details, see the section titled, "HIPAA Special Enrollment Rights"); or
- the next annual Open Enrollment period, which is usually held from March through April of each year with benefit elections becoming effective on June 1.

How to Enroll

To assist you with processing your enrollment into the Plan in a timely manner, ADP TotalSource provides you with several enrollment options. You may use either of the following enrollment methods to complete the enrollment process:

- log on to **adptotalsource.adp.com** and complete the online enrollment process; or
- complete and return the ADP TotalSource enrollment materials enclosed in the paper enrollment kit provided to you at your time of eligibility (if you did not receive your enrollment materials electronically).

Contact a MyLife Advisor at (844) 448-0325 if you have any questions regarding your benefits or the enrollment process.

Waiving Coverage

If you do not enroll in benefits when you are first eligible or during a subsequent annual Open Enrollment period and are declining coverage under the medical option because you are covered under another medical plan, you must state this reason during the enrollment process in order to qualify for future special enrollments under HIPAA. You can indicate your reason for declining medical plan coverage through either enrollment option outlined in the section titled "How to Enroll".

If you later lose coverage under the other medical plan, you may enroll in the medical option within 60 days of loss of the other coverage under the HIPAA Special Enrollment rules. Because declining medical coverage is a serious matter affecting you and your family, any decisions you make should be considered carefully. For additional information, refer to the section titled "HIPAA Special Enrollment Rights" in this booklet.

New York Requirement to Enroll in Health Coverage

New York Insurance Law, Section 4235(c)(1)(A), requires eligible employees to be enrolled in a health plan when their employer contributes 100% for the employee-only coverage tier level of health coverage. Under these circumstances, you may not waive health coverage for any reason including if you have an offer of coverage through a spousal group health plan or through the Health Insurance Marketplace. **Please note that this requirement does not apply to self-employed individuals subject to imputed income on the value of their health insurance premium.**

Pursuant to the law, ADP TotalSource must automatically enroll any employee who is eligible for a 100% employer contribution for any health plan offering issued out of New York, if they fail to make a health plan election on their own. Such employees will be automatically enrolled in the lowest-cost employee-only health insurance benefit option that is issued out of New York. Dependents will not automatically be enrolled.

Upon automatic enrollment, you will not be permitted to drop your health coverage through the ADP TotalSource, Inc. Health and Welfare Plan during the respective Plan Year unless your employer no longer provides a 100% contribution towards a health plan offering available to you or in the event you are no longer eligible for such coverage.

New York Enrollment Requirement - Dual Health Coverage and Health Savings Account (HSA) Participation

In the event ADP TotalSource automatically enrolls an employee that is also enrolled through a spousal group health plan, the employee should review each policy to determine which policy will be primary. In many cases, the coverage provided through the Plan will be the employee's primary health insurance coverage and the spousal group health coverage will be considered secondary health coverage. Additionally, under these circumstances, an employee will not be eligible to contribute to an HSA or receive employer contributions toward an HSA, if they are enrolled in a High Deductible Health Plan (HDHP) through ADP TotalSource and the spousal group health coverage is not a qualified HDHP.

ADP TotalSource does not collect information concerning spousal group health coverage and will not actively stop HSA contributions in such cases. Employees should consult with their tax advisor if they are uncertain whether they are eligible to make HSA contributions based on their individual circumstances.

For more information, please refer to the New York Department of Financial Services website at **http://www.dfs.ny.gov/insurance/ogco2010/rg101215.htm** and search for Group Health Insurance, Waiver of Coverage.

Flexible Spending Account Enrollment Considerations

If you choose to elect to participate in either of the Flexible Spending Account plan options, make sure to consider the following items prior to deciding to enroll:

- review and understand the section in this SPD titled "Facts about the FSAs"; and
- estimate what your out-of-pocket expenses will be for the Plan Year; and
- determine if you have any other product options available to you, such as a Health Savings Account; and
- determine the Plan Year contribution amount you wish to elect to contribute, if any, taking into consideration the number of months remaining in the Plan Year to incur eligible expenses.

If you elect to participate in either of the Flexible Spending Accounts, the Plan Year contribution elections you make will be divided by the number of pay periods remaining in the Plan Year and deducted from your paycheck each pay period. You are responsible for all contributions towards your FSA options. Your worksite employer does not contribute toward either of the FSA options.

Once you have enrolled in the FSA options, you may not cancel or change the amount of your pre-tax contribution for the remainder of the Plan Year unless there is a change in family or employment status for which a change is permitted under the Plan. For more information and deadlines on enrollment changes due to a qualified change in status, refer to the section titled "Making Changes to Your Benefits."

Open Enrollment Elections

New enrollment materials will be provided to you during the annual Open Enrollment period, which is usually held from March through April of each year with benefit elections becoming effective June 1. To simplify the process, if you are currently enrolled, you will NOT be required to make new elections. You will either be automatically re-enrolled in your existing option at the same coverage level (but at the new Plan Year's contribution cost), or if your current elections are no longer available, you will be enrolled in the corresponding replacement options (at your current coverage level but at that option's contribution cost), unless you complete the enrollment process indicating your changes.

Exception: You will NOT automatically be re-enrolled in either of the FSA options. Coverage under either of the Flexible Spending Accounts will end on May 31st of each year. Re-enrollment in the Flexible Spending Accounts requires that you re-elect coverage each Plan Year for an effective date of June 1st.

Additionally, if you are currently contributing to an HSA through ADP TotalSource, your contribution elections will not change unless you submit a request to increase, decrease or cancel your current contributions. ADP TotalSource will not automatically make adjustments to your elected HSA contributions as a result of plan changes. If you are currently contributing to an HSA through ADP TotalSource and you elect to enroll in a non-HDHP plan for the new Plan Year, or your worksite employer no longer continues to offer HDHP coverage through ADP TotalSource, you cannot continue contributing to an HSA through ADP TotalSource effective the first day of the new Plan Year (June 1). You may contact a MyLife Advisor for more information.

To simplify the annual Open Enrollment process, if you are currently enrolled, you will be automatically re-enrolled in the same coverage option (or if that option is not available, in a similar or replacement option) with the same dependents (but at the new Plan Year's contribution cost) unless you complete the enrollment process indicating your changes.

Exception: You will NOT automatically be re-enrolled in either of the FSA options. Coverage under either of the Flexible Spending Accounts will end on May 31st of each year. Re-enrollment in the Flexible Spending Accounts requires that you re-elect coverage each year for an effective date of June 1st.

Complete the enrollment process under the Plan prior to the Enrollment Deadline indicated in the enrollment materials.

Making Changes to Your Benefits

When to Make Changes

The Plan Administrator will allow you the option to make changes to your elections during the annual Open Enrollment period, which is usually held from March through April of each year with benefit elections becoming effective June 1, or if you are participating on a pre-tax basis and experience a qualified change in status under Internal Revenue Code Section 125. Also, if you experience a special enrollment event under HIPAA, you may enroll yourself or your eligible dependent(s) in the medical option.

Note: If you are participating on a post-tax basis, please refer to the section titled "Post-Tax Participation."

What is a Change in Status under Internal Revenue Code Section 125

The following events allow you to make changes to your medical, dental, vision, and in some cases, FSA elections outside of the annual Open Enrollment period. Because of Internal Revenue Code regulations, your enrollment changes must be consistent with your qualified change in status. ADP TotalSource will advise you if your request for an enrollment change is not consistent with these rules.

Note: If the main purpose of employment termination is the intent to alter a benefit election, then termination will not trigger an opportunity to change elections. In such cases, you will be allowed only to re-enroll in the benefit options that were in effect at the time of your termination of employment. Election changes will not be allowed until the next annual Open Enrollment period for an effective date of June 1 or in the event of a change in status or HIPAA special enrollment event, whichever comes first.

Qualified changes in status can include:

- a change in your legal marital status such as marriage, divorce, death of a spouse, legal separation, annulment or domestic partner eligibility;
- a change in your number of eligible dependents due to birth, adoption, placement for adoption, appointment of legal guardianship, death or a dependent that satisfies or ceases to satisfy the dependent eligibility rules;
- a change in employment status for you, your spouse or your dependent only if it affects your current elections. This can include ending or beginning employment, a strike or lockout, a reduction or increase in the hours worked affecting eligibility, beginning or returning from an unpaid leave of absence or a change in worksite;
- a change in residence for you, your spouse or your dependent, but only if it affects your current elections;
- for the medical, dental and vision options only: When you are served with a Qualified Medical Child Support Order (QMCSO) as approved by ADP TotalSource;
- entitlement to Medicare or Medicaid by you, your spouse or dependent;
- significant cost changes (increase or decrease) made by the independent third party providers (healthcare providers) or from an action taken by a worksite employer such as the reduction in the amount of employer contributions for a class of employee;*
- coverage changes (significant curtailment with or without a loss of coverage);*
- addition or improvement of a benefit package option; *
- change in coverage under another employer plan; *
- loss of coverage under other group health coverage for the employee or eligible dependents losing coverage under any group health coverage sponsored by a governmental or educational institution, including the following: (not applicable to the Flexible Spending Accounts)

1. a state's children health insurance program (SCHIP) under Title XXI of the Social Security Act;

2. a medical care program of an Indian Tribal government, the Indian health service or a tribal organization;

3. a states health benefit risk pool; or

4. a foreign group government group health plan.

* These change in status events do not apply to an election change with respect to a Health Care FSA or Limited Health Care FSA.

NOTE: The purchase of an individual health coverage policy is not a qualified event that allows you to make changes to your benefits with ADP TotalSource outside of the annual Open Enrollment period.

Permissible types of benefit changes
Your election change must be consistent with the change in status. For example, if you and your spouse divorce during the Plan Year, you may elect to decrease your levels of coverage (e.g., from "employee and spouse" to "employee only" coverage), but you may not change your coverage election (e.g., from an HMO to PPO) unless you experience a HIPAA special enrollment event (refer to "HIPAA Special Enrollment Rights" section for further details). A MyLife Advisor can assist you in determining what election changes satisfy the Internal Revenue Code consistency rule. However, the Plan Administrator's determination of whether a change in status is consistent with your request will be final.

Who determines what's permissible
The Plan Administrator may, in its sole discretion, determine whether your election change satisfies the change in status events under the IRS regulations. The Plan Administrator may apply any change in status rule on a case-by-case basis in a uniform manner without discrimination. The application or failure to apply a change in status rule will neither limit nor prohibit the Plan Administrator's right to apply the rule on subsequent occasions. Any application of a change in status rule will conform to consistency requirements under the regulation and to the terms of any applicable insurance policy, including any HMO contracts where applicable.

How to Make Changes
In the event that you experience a qualified change in status, you must notify the Plan Administrator of your change in status within 60 days of the event. You must also submit your completed enrollment change form and proof of the status change documentation such as birth or marriage certificate within 60 days from the date of the event or your request for benefit election changes will be denied.

Required Forms
The following are required forms and documents:

- ADP TotalSource – Change in Status Form/Special Enrollment Request Form;
- proof of change in status or special enrollment event documentation;
- you may also be required to submit an insurance carrier enrollment/change form.

The change in status / Special Enrollment Request Form can be obtained by either contacting a MyLife Advisor or online at **adptotalsource.adp.com**.

Proof of Change in Status Requirements
The following is a list of acceptable documentation to prove a change in status has occurred or that you qualify for special enrollment. However, this list is not intended to be all-inclusive. You should contact a MyLife Advisor if you are not sure what documentation is acceptable for your change in status.

Supporting documentation can include:

- **Birth of a Child** – Birth certificate, hospital certificate or hospital bill
- **Marriage** – Marriage certificate
- **Death** – Death certificate, funeral home/burial certification
- **Adoption** – Court documentation of adoption
- **Appointment of Legal Guardianship** – Court documentation finalizing the guardianship appointment
- **Divorce** – Divorce decree
- **Legal Separation** – Court documentation of legal separation (Note: must be a legal "status" under state law and not only separation before divorce)
- **Loss of other Health Coverage** – Letter of termination from prior health insurance carrier
- **Domestic Partner Affidavit or Eligibility Termination Notice**

Do not delay in submitting your completed enrollment request. Late notifications will not be processed and will only be accepted during the next annual Open Enrollment period or if you experience another qualified change in status event (whichever comes first).

Effective dates of coverage for change

All approved benefit election changes resulting from a qualified change in status or special enrollment will be effective on the first day of the month following the receipt and approval of your completed change in status form and proof of change in status or special enrollment event documentation, but not earlier than your change in status or special enrollment event date. However, in the case of a birth, adoption or placement for adoption, the effective date for the benefit election change will be the day of the event (e.g., birth, adoption).

Remember that your completed change in status form must be received within 60 days from the date of the change in status or special enrollment event.

Dependent	Effective Date of Coverage
Spouse (marriage)	First day of the month after you complete the change in status form (and provide supporting documentation for the event) to add your new spouse to coverage
Newborn Children	Your child's date of birth
Adopted Children	The date of adoption or placement for adoption

Additional Information Regarding Your Change in Residency

If you or any of your covered dependents temporarily or permanently relocate or have a change of address, you must first notify ADP TotalSource by either:

- contacting a MyLife Advisor; or
- logging online at **adptotalsource.adp.com**.

Option availability, level of coverage and cost of coverage may vary by service area. If you relocate outside of your current service area, you may not be eligible for the benefits in which you are currently enrolled. If your change in residence affects your eligibility under one or more of the options under the Plan, you must complete and return the ADP TotalSource Benefits Change in Status Form. By notifying ADP TotalSource of your relocation, we can help to ensure that coverage in the Plan continues without interruption. You may contact a MyLife Advisor for information on whether or not your change in residence affects your eligibility and for instructions on where to send your completed form(s).

Where you reside affects the benefit plan options available to you. So, it is important to advise a MyLife Advisor of your current address and phone number.

HIPAA Special Enrollment Rights

Under HIPAA, you are allowed to enroll in the medical option offered by the Plan without having to wait until the next annual Open Enrollment period under certain conditions including "special enrollment." The special enrollment period only applies to the medical option and the corresponding pre-tax election to pay for such benefits.

To take advantage of special enrollment for the medical option, the following conditions must exist, and a MyLife Advisor must receive your completed request for enrollment within 60 days from the date of the special enrollment event. If you fail to complete and submit the appropriate enrollment forms within 60 days, you will need to wait until the next annual Open Enrollment or change in status, whichever occurs first.

If you are eligible, you or your dependent can request special enrollment only in the medical option:

- when you have a newly acquired dependent through marriage, birth, adoption, placement for adoption or appointment of legal guardianship; or
- when there is involuntary loss of other health coverage of any kind (including COBRA). Involuntary loss of coverage does not include loss of coverage resulting from failure to pay required insurance premiums; or
- you or your dependents are eligible but not enrolled in the medical option and lose coverage under Medicaid or a State's Children's Health Insurance Program (CHIP), or you and your dependents become eligible for a State's premium assistance under Medicaid or CHIP.

In the case of the birth, adoption or placement for adoption of a child, your enrollment election will be effective retroactively to the date of the event, as long as an ADP TotalSource receives the enrollment election within 60 days after the event. Your pre-tax payroll contributions will change prospectively as of the next payroll period following the date ADP TotalSource receives your request for enrollment, but not earlier than the date of the special enrollment event.

Conditions Required to Qualify for a Special Enrollment:

- you are covered under another group health plan or other health insurance, including COBRA coverage, when the Plan was offered to you upon your initial eligibility period or during a subsequent Open Enrollment period; and
- you indicated during the enrollment process that you declined the medical option enrollment because you had other medical plan coverage.

If both of the above conditions are met, you will qualify for a special enrollment period if:

- your other group health plan or other health insurance was terminated because you are no longer eligible for such coverage (including for reasons of exceeding a lifetime maximum limit, or if an HMO or other similar arrangement ceases to provide coverage to individuals who no longer reside, live or work in a service area and no other coverage option is available to the individual) or because worksite employer contributions towards your coverage are terminated; or
- your COBRA coverage period has expired for reasons other than your failure to pay COBRA premium. Refer to the section titled "Making Changes to Your Benefits" for additional information including how to request a special enrollment and the effective date of a special enrollment.

Permissible types of benefit changes

If you or your eligible dependent experiences a HIPAA special enrollment event, you may enroll in any of the benefits options that are available to similarly situated new employees (with respect to the medical option).

Post-Tax Participation

If you elect to pay for your portion of the cost of coverage with post-tax dollars, you will be allowed to cancel or reduce your medical, dental and vision coverage at any time during the Plan Year. However, if you or your eligible dependent(s) wish to enroll in medical, dental or vision coverage at a later date, you will be required to enroll during the annual Open Enrollment period for an effective date of June 1. Note: In the event that your life and/or long term disability coverage is tied to your medical coverage election, the cancellation of your medical coverage will result in the cancellation of life and/or long term disability coverage. If you have questions regarding the reduction or cancellation of coverage while participating on a post-tax basis, you may contact a MyLife Advisor.

Note: Since contributions to either of the Flexible Spending Accounts are always pre-tax, you will not be able to make changes outside of the changes indicated above in the section titled "What is a Change in Status under Internal Revenue Code Section 125."

ADP TotalSource must receive your completed enrollment request if you experience a special enrollment event within 60 days from the date of the event in order to be eligible to make benefit election changes. Contact a MyLife Advisor for instructions on where to send your completed form(s).

Claims Review and Appeal Process

Your claims will be processed under the following procedures except to the extent inconsistent with the insurance carrier's claims and appeals procedures, in which case the insurance carrier's claims and appeals procedures will apply. For more detailed information, you may review the insurance carrier's Certificate of Coverage or contact them directly to obtain specific claim/appeal procedures

Filing a Claim

In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the applicable claims administrator to file a written claim (or oral claim, in the case of an "urgent" claim) or appoint his or her authorized representative by following the procedures set forth by the claims administrator. Other than for the FSA options, the insurance carrier issuing the insurance certificate of coverage for the benefit option under the Plan is the "Claims Administrator".

In general, when you need to file a claim, use the addresses listed in the Summary of Benefits and Coverage or your insurance card, on the applicable claims form, or in the "Facts About the Plan" section of this document. When your claim is received by the Claims Administrator, it will be reviewed and the Claims Administrator will determine how to pay your claim on behalf of that benefit option under the Plan. Claims forms are available from the Claims Administrator.

To ensure proper filing of claims, refer to the claims filing procedures that are set forth in the applicable insurance carrier's procedures. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure.

Claim-Related Definitions

This section provides general information about the claims and appeals procedure applicable to the Plan under ERISA. Note that state insurance laws may provide additional protection to claimants with fully-insured benefits and if so, those rules will apply. The State TDI benefits, EAP, HSA, and the Dependent Care FSA are not employee benefit plans under ERISA and the benefits under those plans and programs are not covered by ERISA. However, ADP TotalSource has decided to apply the claims review and appeal processes set forth in this section to the Dependent Care FSA. Refer to the materials provided by your HSA custodian for any claims or appeal processes in connection with reimbursements under the HSA.

- **Claim**
  Under ERISA, a claim is a request for benefits under a plan made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved. Under the Plan, a casual inquiry (even if it is in writing) regarding eligibility requirements or a casual inquiry about benefits under such benefit option is not treated as a claim and is not subject to these claim and appeal procedures, unless the Plan Administrator (or its delegee) decides to treat such inquiry as a claim.

  The group health plan benefits under the Plan recognize four categories of health benefit claims:

- **Urgent Care Claims**
  "Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise.

- **Pre-service Claims**
  "Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

- **Post-Service Claims**
  "Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

- **Concurrent Care Claims**
  "Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However,

the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

- **Adverse Benefit Determination**
  If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes, for example, a decision to deny benefits based on:

  - An individual being ineligible to participate in the Plan;
  - Utilization review;
  - A service being characterized as experimental or investigational or not medically necessary or appropriate; and
  - A concurrent care decision.

- **Initial Claim Determination**
  For each of the benefit options under the Plan, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by ERISA. The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue.
  The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

  In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

  - The specific reasons for the adverse determination;
  - The specific plan provisions on which the determination is based;
  - A request for any additional information needed to reconsider the claim and the reason this information is needed;
  - A description of the Plan's review procedures and the time limits applicable to such procedures;
  - A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review, except in the case of the State TDI benefits, HSA, and Dependent Care FSA, which are not ERISA plans;

- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request (for health claims, and disability claims filed before April 1, 2018 only).
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request (for health and disability claims only); and
- In addition to the notice standards described above, any notice of denial to a claimant enrolled in a disability plan whose claim for disability benefits was filed on or after April 1, 2018, will include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by the claimant to the Claims Administrator of health care professionals treating the claimant and vocational professionals who evaluated the claimant, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Claims Administrator in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding the claimant made by the Social Security Administration and presented to the Claims Administrator. The notice will also include a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for disability benefits.
- For adverse determinations for a benefit of the group health plan involving urgent care, a description of the expedited review process for such claims. This notice may be provided orally within the timeframe for the expedited process, in which case, written notice will be provided no later than 3 days after the oral notice.
- In addition to the notice standards described above, to the extent required by the Affordable Care Act, any notice of denial to a claimant enrolled in the group health plan may include the following: (a) information identifying the claim involved, including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis and treatment codes (and the corresponding meaning of those codes); (b) the reason or reasons for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used to deny the claim; (c) a description of available internal appeals and external review processes, including how to initiate an appeal; and (d) contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review processes.

Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for "concurrent care" decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days. Dental Plan, Vision Plan and Health Care FSA Plan claims are all considered non-urgent "post-service" claims.

	Medical, Vision, Dental and Health Care FSA Plans				Long-Term Disability and Short-Term Disability Plans	Life Insurance, AD&D, and Dependent Care FSA Plans
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Time frame for the Planto Provide a Notice of Determination	Notice of determination (whether adverse or not) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. Notice of determination may be oral with a written or electronic confirmation to follow within 3 days. If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours after receipt of the claim, provided that any such claim is made to the Component Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.	Notice of determination (whether adverse or not) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.

	Medical, Vision, Dental and Health Care FSA Plans				Long-Term Disability and Short-Term Disability Plans	Life Insurance, AD&D, and Dependent Care FSA Plans
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Extensions	If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.*	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.*	N/A	The Plan has up to 30 days, if necessary due to matters beyond the Plan's control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the period(s) ends.*	The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).	You have at least 45 days to provide any missing information.	You have at least 45 days to provide any missing information	N/A	You have at least 45 days to provide any missing information.	No rule.
Other Related Notices	Notice that your claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan).	Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).	N/A	N/A	N/A	N/A

* 15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.

Appealing a Claim

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart that follows. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Appeals Reviewer (which will be a person or entity at the applicable insurance carrier, except in the case of the FSAs).

The review will be conducted by the Appeals Reviewer or other appropriate named fiduciary. In either case, for health and disability claims only, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination (for health and disability claims only) is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination. In addition, for disability claims filed on or after April 1, 2018, before the Appeals Reviewer can issue an adverse benefit determination on review, the Appeals Reviewer will provide (i) any new or additional evidence considered, relied upon, or generated by or at the direction of the Appeals Reviewer or its designee, and (ii) any new or additional rationale upon which the adverse decision on appeal is based. This information shall be provided to you free of charge and sufficiently in advance of the decision to provide you with a reasonable opportunity to respond.

You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination (for health and disability claims only). The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

The Appeals Reviewer will provide you with written notification of the Plan's determination on review, within the time frames described below. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review, except in the case of State TDI benefits, EAP, HSA, and Dependent Care FSA, which are not ERISA plans; and, for disability claims filed on or after April 1, 2018, a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request (for health claims and disability claims filed before April 1, 2018 only); and, for disability claims filed on or after April 1, 2018, either the internal rules, guidelines, protocols or similar criteria that were relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist;

- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request (for health and disability claims only); and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures, as well as information as to how the claimant may obtain information about alternative dispute resolution options from the Department of Labor or state regulators.
- In addition to the notice standards described above, for disability claims filed on or after April 1, 2018, any notice of denial with respect to a claimant's disability claim will include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by the claimant to the Appeals Reviewer of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Appeals Reviewer in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination regarding the claimant made by the Social Security Administration and presented to the Appeals Reviewer.

In addition to the notice standards described above to the extent required by the Affordable Care Act, any notice of denial to a claimant enrolled in group health plan may include the following: (a) information identifying the claim involved, including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis and treatment codes (and the corresponding meaning of those codes); (b) the reason or reasons for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used to deny the claim and a discussion of the decision; (c) a description of available internal appeals and external review processes, including how to initiate an appeal; and (d) contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review processes.

All decisions are final and binding.

Time Frames for Appeals Process

The claims appeals procedures for a specific benefit are set forth in the Summary of Benefits and Coverage or insurance carrier's certificate of coverage for that benefit. Please consult that document for the specific benefit involved. Where not otherwise covered by that document, the following procedures will apply.

The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days. The benefit option can require two levels of mandatory appeal review.

	Medical, Vision, Dental and Health Care FSA Plans			Long-Term Disability and Short-Term Disability Plans	Life Insurance, AD&D, and Dependent Care FSA Plans
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims	Non-Urgent Care Post-Service Claims		
Period for Filing Appeal	You must file within 180 days.	You must file within 180 days.	You must file within 180 days.	You must file within 180 days.	You must file within 60 days.
Time frame for Plan to Provide Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.	Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.	Within a reasonable period of time, but not later than 45 days after receipt of request for review.	Within a reasonable period, but not later than 60 days from receipt of request for review.
Extensions	None.	None.	None.	Additional 45 days if special circumstances require extension (with period "tolled" until you respond to any information request from the Plan).	Additional 60 days if special circumstances require extension.

*An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service, or post-service claim, depending on the facts.

Judicial Review

You (or an appointed representative) (except in the case of the State TDI benefits, EAP, HSA, and Dependent Care FSA) must timely pursue all the claim and appeal rights described above before you may file a lawsuit under Section 502(a) of ERISA. This rule means that you may not bring any action to recover benefits unless and until the applicable claim and appeal rights described above have been exercised and the benefits requested in such appeal have been denied in whole or in part (or there is any other adverse benefit determination). If you wish to seek judicial review of the denial of any appeal under the Health Care FSA Plan, you must file a lawsuit under Section 502(a) of ERISA (to the extent applicable) **within one year** after the date on which all administrative remedies under that plan are exhausted, that is by the earlier of the date on which an adverse determination on review is issued by the Appeals Reviewer or the last day on which a final decision should have been issued, or you will be forever prohibited from commencing such action. Refer to the applicable insurance carrier Certificate of Coverage for any deadlines to file a lawsuit in connection with a benefit under that plan.

Under the State TDI benefits, EAP, HSA, and Dependent Care FSA, you are not entitled to file a lawsuit under Section 502(a) of ERISA since such plans are not employee benefit plans under ERISA. Under those plans, you are required to exhaust any administrative remedies before filing a lawsuit in connection with the denial of your appeal for benefits and any such lawsuits must be filed **within one year after** the date on which all administrative remedies under those plans are exhausted. If any such judicial proceeding is undertaken, the evidence presented will be strictly limited to the evidence timely presented to the Appeals Reviewer.

Employee Assistance Program (EAP)

As an employee, you and your family members are eligible for the Employee Assistance Program (EAP) immediately upon your date of hire. This benefit is a confidential service designed to help you and your family with a variety of personal challenges, such as stress, alcohol or drug abuse, marriage or family problems, anxiety or depression. There is no charge to you for this benefit.

When you need help, call the 24-hour EAP help line at (866) 574-7256. Your EAP coordinator may arrange a referral with a licensed mental health professional or other assistance agency in your area. You and each of your qualified dependents may see the licensed professional up to three sessions per episode, for a maximum of three episodes, at no charge. There is a maximum of nine sessions, per person, per calendar year. The EAP may work with you to coordinate additional services, if necessary.

Information about you and your dependents, and all discussions, are held in the strictest confidence. Federal and state regulations dictate that information about your personal situation cannot be released without your written permission. Exceptions may be made in the case of extreme emergencies (e.g., suicidal threat).

If you or your dependents require treatment beyond what the EAP offers, you may be covered for additional services under your medical benefit coverage. The EAP will coordinate the transition of your care to a provider within your medical benefit option. If you do not have coverage under the medical benefit option, the EAP can direct you to low-cost services offered within your community.

EAP Help Line
The 24-hour help line for the EAP services is (866) 574-7256.

Coverage While on a Leave of Absence

Family Medical Leave (FMLA) and Other Qualified Leaves

The Family and Medical Leave Act (FMLA) allows you to take unpaid family/medical leave within any 12-month period and be restored to the same or equivalent position immediately upon your return from leave provided you have:

- worked for a covered employer for at least 12 months; and
- worked for a covered employer for at least 1,250 hours in the 12 months prior to your requested leave;
- work at a location in the U.S. or in any territory or possession of the U.S. where at least 50 employees are employed by the employer within 75 miles.

Note: Eligible employees may take up to 26 weeks of unpaid leave to care for a family member who is wounded while on active military duty.

A "rolling" 12-month period measured backwards from the date you take leave will be used for computing the period within which the 12 weeks of leave may be taken. You may be required to use any accrued paid time off for your FMLA leave of absence. You also may be eligible for STD or LTD payments and/or workers' compensation benefits if your FMLA leave is due to your own illness or injury. Using paid time off, STD, LTD or workers' compensation will not extend the maximum time allowed of 12 weeks of FMLA leave per rolling 12-month period. For more information about FMLA eligibility, please refer to the "Family and Medical Leave of Absence Policy" found in ADP TotalSource's Basic Employment Policies or contact a MyLife Advisor.

If you are absent from work due to FMLA or another qualified leave, you may choose to suspend or continue participation in your benefit options, except for the Dependent Care FSA which will be suspended as of the date you begin your FMLA. If you continue your participation, your worksite employer may require that you continue to pay your portion, if any, of the benefit options costs or your benefits may be canceled. If you suspend your participation, benefit expenses incurred while you are on leave will not be covered under your group health plans. You will have the right to be reinstated in your benefit options coverage upon returning from FMLA leave. Accrual of benefits such as paid time off will be suspended for the duration of the leave.

If you elect not to return to work at the end of the leave period, you will be required to reimburse ADP TotalSource and/or your worksite employer for its portion of the costs paid towards maintaining your coverage during your leave. However, exceptions may be made if you cannot return to work because of a serious health condition or because of other circumstances beyond your control.

Upon expiration of your FMLA leave, you will be offered the option to continue your health benefits coverage through COBRA. Please see the section titled "Continuation of Coverage Under COBRA" for more details.

For details on how your enrollment in the Flexible Spending Accounts (FSA) is affected during FMLA leave, refer to the section titled, "Facts about the FSAs."

Military Leaves of Absence Under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

A "Military Leave" is an absence from employment with your worksite employer due to the performance of duty, on a voluntary or involuntary basis, in a uniformed service of the United States, under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which you are absent from a position of employment for the purpose of an examination to determine your fitness to perform any such duty. Under the Plan, you will not be treated as absent due to Military Leave unless:

- you have given advance notice of your Military Leave to your worksite employer;
- the cumulative length of your absence and absence for prior Military Leaves from your worksite employer does not exceed five years or such other period of time permitted by the Uniformed Services Employment and Re-employment Rights Act of 1994, as amended ("USERRA"); and
- you report to, or submit an application for re-employment to the worksite employer by the deadline imposed by ADP TotalSource in accordance with USERRA.

If you are absent from work due to a "Military Leave" for a period of 31 days or less, your coverage under the Plan options will continue during the 31 days, except for the Dependent Care FSA which will be suspended as of the date you begin your military leave. Additionally, contributions to a Health Savings Account will be suspended. You and your worksite employer contributions for coverage that will remain in effect will be the same as for similarly situated active participants in the Plan. Upon your return to work, you must pay your portion, if any, of the cost for coverages that continued during your military leave of 31 days or less.

Your coverage under the Dependent Care FSA will be automatically reinstated without any waiting period upon your active return to work after a Military Leave of 31 days or less. Likewise, Health Savings Account contributions in effect at the time of the leave will resume upon your return to work after military leave. If your military leave of 31 days or less occurs at the same time as a change in Plan Year (i.e. June 1st) you may be required to make new plan elections effective for the new Plan Year. Additionally, if you experience a qualified change in status or a HIPAA special enrollment event while on Military Leave you may make benefit election changes, consistent with the change, upon your return.

Claim reimbursement from your Health Care FSA balance during your Military Leave of 31 days of less will be the same as for similarly situated active participants in the Plan.

Your participation in the Dependent Care FSA will be suspended during your Military Leave of 31 days or less, but you may submit claims for reimbursement of eligible dependent care expenses incurred prior to the effective date of your military leave through the end of the Plan Year in which your leave begins. If you return to active employment with your worksite employer during the same Plan Year, your original Dependent Care FSA election will be reinstated or you may make a new election for the remainder of the Plan Year. Your Dependent Care FSA will be adjusted for any payments made before the start of, or during, your leave. Your participation in a Health Savings Account will be suspended during your Military Leave of 31 days or less, but you may continue to submit claims for reimbursement of eligible expenses.

If you are absent from work due to a Military Leave for a period in excess of 31 days, your coverage under the medical, dental, vision and Health Care FSA options that were in effect at the end of the 31 days may be continued for up to 24 months from the first day of absence greater than 31 days (or if earlier, until the day after the date you're required to apply for or return to active employment with your worksite employer). Your contributions for the continued coverage will be the same as for a COBRA beneficiary.

Whether or not you continue coverage during Military Leave, you may reinstate coverage under the Plan effective as of the date you return to active employment under the provisions of the Uniformed Services Employment and Re-employment Rights Act, except to the extent that the waiting period would have been required if coverage had not terminated due to military service. You will be provided with enrollment materials and/or instructions in order to make a new election upon your return to active employment.

Non-Qualified Leaves of Absence (Non-FMLA)

If you are absent from work due to a non-qualified leave of absence and you return to work within the same calendar month in which you commenced the non-qualified leave, your benefits will not terminate. Upon your return to work, you will not be permitted to make changes to your benefit elections unless you experienced a change in status or HIPAA special enrollment event during your non-qualified leave.

If your non-qualified leave causes you to lose benefits eligibility your coverage is not automatically reinstated upon your return to work. Upon your return to work you must complete the enrollment process for the Plan in order to become enrolled in benefits. If you choose to enroll, your benefits will be effective the first day of the month following the completion of your worksite employer's specified waiting period, unless your employer has waived its specified waiting period in which case your benefits will be effective the first day of the month following your return to work. You will be provided with enrollment materials and/or instructions in order to make a new election upon your return to work.

Continuation of Coverage Under COBRA

A federal law known as the Consolidated Omnibus Budget Reconciliation Act or COBRA requires that most employers sponsoring group medical plans offer employees and their families the opportunity to temporarily continue their health coverage in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the COBRA continuation coverage provisions of the law. (You and your spouse or domestic partner should take the time to read this notice carefully.)

Eligibility

If you and your spouse, domestic partner, dependent children and/or dependent children of a covered domestic partner including your newborn, adopted child, child placed for adoption, or a child of yours (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order (if any) are covered under the medical, dental, vision or Health Care FSA options and you lose coverage after one of the events listed below, you and your spouse, domestic partner, dependent child(ren) and/or dependent children of a covered domestic partner may have the right to elect COBRA continuation coverage. These COBRA events include:

- reduction in your hours of employment; or
- termination of your employment (for reasons other than gross misconduct on your part) including retirement. If you terminate employment following an FMLA leave, then the event will occur on the earlier of the date you indicated you were not returning to work or the last day of the FMLA leave.

In addition, a covered spouse, domestic partner* or a dependent child and/or a dependent child of a covered domestic partner* (including a newborn child, an adopted child or a child placed for adoption) and/or a child (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order of an enrolled ADP TotalSource worksite employee has the right to elect COBRA continuation coverage if their coverage is lost due to one of the following events:

- your death; or
- divorce or legal separation of you and your spouse or loss of domestic partner eligibility; or
- in the case of a dependent child or the dependent child of a covered domestic partner* only, when your dependent child reaches the maximum age and loses coverage under the medical, dental or vision options.

*COBRA extension for domestic partners and dependent children of a covered domestic partner varies by insurance carrier. Please refer to your insurance carrier's certificate of coverage for determination of COBRA continuation for domestic partners and dependent children of covered domestic partners.

Notification

Your worksite employer will notify ADP TotalSource of a loss of coverage following a reduction in hours or termination of employment within 30 days of the event. Within 14 days of receiving a notification from your worksite employer, ADP TotalSource will in turn send you and/or your qualified beneficiary (ies) a Notice of Continuation Rights and Election Form to the last known address on file. Similar rights may apply to certain retirees, spouses, and dependent children if your employer files for bankruptcy and there is a loss in coverage.

You Must Give Notice of Some Qualifying Events

You or your spouse, domestic partner, dependent children and/or dependent children of a covered domestic partner including your newborn, adopted child or child placed for adoption (if any) are responsible for notifying an ADP TotalSource MyLife Advisor within 60 days of the following events:

- divorce;
- legal separation;
- loss of domestic partner eligibility; or
- a child losing dependency status under the Plan.

You must notify a MyLife Advisor within 60 days after the qualifying event occurs by using the form of notice available from a MyLife Advisor. You must timely provide this notice to a MyLife Advisor at the Plan contact address indicated at the end of this booklet or you and/or your dependents will not be offered the COBRA continuation coverage. You may contact a MyLife Advisor at (844) 448-0325 to obtain the appropriate form of notice.

Once notice of a qualifying event, second qualifying event, or determination of disability by the Social Security Administration is provided to ADP TotalSource as outlined above, a ADP TotalSource will determine whether you or your spouse, domestic partner, dependent children and/or dependent children of a covered domestic partner including your newborn, adopted child or child placed for adoption (if any) are eligible for COBRA continuation coverage. If it is determined that you or your spouse, domestic partner, dependent children and/or dependent children of a covered domestic partner including your newborn, adopted child

or child placed for adoption (if any) are not eligible for COBRA continuation coverage, ADP TotalSource will provide you, your spouse and domestic partner, with notice of this determination within 14 days after receiving the notice of the qualifying event, second qualifying event or determination of disability by the Social Security Administration.

NOTE: In the event that you notify a MyLife Advisor outside of the 60-day timeframe for those qualifying events for which you or your family is responsible for notification, ADP TotalSource will make the appropriate changes to your active coverage (e.g., terminate an ex-spouse's coverage); however continuation coverage under COBRA will not be extended to those dependents impacted by the change.

Election

After receiving the Notice of Continuation Rights and Election Form, you have 60 days from the date of the notification or the date of the loss of coverage, whichever is greater to elect COBRA coverage. If you do not return the form within 60 days, you are no longer eligible to elect COBRA coverage.

COBRA extension for domestic partners and dependent children of a covered domestic partner varies by insurance carrier. Please refer to your insurance carrier's certificate of coverage for determination of COBRA continuation for domestic partners and dependent children of covered domestic partners.

Duration of COBRA Coverage

The duration of COBRA coverage depends on the COBRA event and when it occurs. The following rules apply:

Termination of employment or reduction in hours. If you lose coverage because of your termination or reduction in hours, you, your spouse, domestic partner, dependent children and/or dependent children of a covered domestic partner, or a child (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order (if any) may elect up to 18 months of COBRA coverage from the date coverage is lost.

Death of the Employee, Divorce, Legal Separation, Loss of Domestic Partner eligibility or a Dependent Reaching Maximum Age under the Plan.

If coverage is originally lost by your spouse, eligible domestic partner or dependent children due to your death, divorce, legal separation from your spouse, termination of domestic partner relationship or for a dependent child reaching the Plan's maximum coverage age, your spouse or domestic partner and/or dependent children may elect up to 36 months of COBRA coverage from the date coverage is lost. If coverage is originally lost due to your termination or reduction in hours, and one of these events occurs within the first 18 months of COBRA coverage, your spouse or domestic partner and/or dependent may elect to continue COBRA coverage for a maximum of 36 months starting from the original loss of coverage due to your termination or reduction in hours.

Coverage under another group health plan after COBRA has been elected. If you, your spouse, domestic partner or dependent becomes covered under another group health plan after COBRA has been elected, COBRA coverage will end.

Medicare entitlement before the loss of coverage due to termination of employment or reduction in hours.
If you, your spouse, domestic partner or dependent are entitled to (that is, covered by) Medicare before the loss of coverage due to your termination of employment or reduction in hours, COBRA coverage may be elected as follows:

- The person entitled to Medicare may elect up to 18 months of COBRA coverage from the date coverage is lost under the Plan; or
- If you, as the employee, are entitled to Medicare, you are limited to an 18-month COBRA election and your spouse or domestic partner and dependents (if any) may elect COBRA coverage for the longer of 18 months from the date of your termination or reduction in hours, or 36 months from the date you, the employee, became entitled to Medicare.

Medicare entitlement after COBRA has been elected. If you, your spouse, domestic partner or dependent becomes entitled to (that is, covered by) Medicare after electing COBRA coverage, COBRA will end for that person on the Medicare entitlement date. All other qualified beneficiaries (i.e., spouse and/or dependent) can continue COBRA through the original COBRA coverage period.

Special Extension Rule for Social Security Disability.
If your coverage is lost because of your termination or reduction in hours, and you, your spouse, domestic partner or a dependent is determined to be disabled by the Social Security Administration (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage, the original 18 months of COBRA coverage may be extended up to 11 months for a total of 29 months. The disabled person does not have to elect the extension in order for a covered family member to elect it. The Plan Administrator must receive notice of the Social Security disability determination within 60 days of the disabled person's receiving the notice and before the end of the original 18-month COBRA coverage period in order to elect the 11-month extension. If Social Security disability ends, the Plan Administrator must be notified within 30 days of the date the disabled person receives notice. COBRA coverage that has exceeded the original 18-month continuation period will end for all COBRA beneficiaries when the individual is no longer Social Security disabled. If an 11-month extension is elected, the cost of COBRA coverage will increase for the additional 11 months of coverage.

- **Special Rule for Health Care FSAs.**
  Your continued monthly Health Care FSA contribution amount must be equal to your monthly contribution prior to your COBRA qualifying event. If you continue this coverage through COBRA, you will be required to continue making contributions on a post-tax basis. Expenses incurred after your employment ends are not eligible for reimbursement to you as part of the Health Care FSA – unless you make an election to continue the Health Care FSA through COBRA, and then only through the end of the Plan Year in which you terminated employment or the date you terminate your COBRA coverage in that same year, whichever is latest. Expenses incurred beyond the qualifying event Plan Year are only eligible if you have carryover funds remaining. Refer to the "Health Care FSA Carryover Allowance" section for more details.

- **End of Coverage Before Maximum COBRA Coverage Period for the Health Care FSA**
  If you or your family members elect COBRA coverage for the Health Care FSA, the coverage will be continued only through the end of the Plan Year in which the COBRA event occurs. The COBRA coverage for the Health Care FSA may terminate before the end of the Plan Year, on the first to occur of the following events:

  1 ADP TotalSource no longer provides FSA coverage to any of its employees; or

  2. The costs for your continuation coverage is not paid when due.

  COBRA coverage is provided subject to your eligibility for coverage. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

The Plan permits participants in the Health Care FSA to carry over up to $500 of their remaining account balance from the prior Plan Year. If you elect to continue your Health Care FSA coverage through COBRA, up to $500 of any funds remaining in your Health Care FSA account at the end of the Plan Year in which you elected COBRA will carry over to the following Plan Year. Any Health Care FSA carryover balance must be used by the earlier of the end of the Plan Year to which it is carried over or the end of the applicable COBRA continuation coverage period (for example, 18 months for a qualifying event that is a termination of employment).

Note: The Dependent Care FSA cannot be continued after your employment ends.

End of Coverage Before Maximum COBRA Coverage Period
If you or your family members elect COBRA coverage for the medical, dental and vision options, the coverage will be continued through the maximum COBRA continuation period. The COBRA coverage may terminate before the maximum continuation period on the first to occur of the following events:

- ADP TotalSource no longer provides group health coverage to any of its employees; or
- The cost for your COBRA coverage is not paid when due; or
- After COBRA is elected, you, your spouse or dependent first becomes covered under another group health plan.; or
- After COBRA is elected, you, your spouse or dependent first becomes entitled to (that is, covered by) Medicare; or
- The continuation period was extended to 29 months due to your disability, your spouse, domestic partner or dependent's disability and the Social Security Administration has made a final determination that you, your spouse, domestic partner or dependent are no longer disabled.

Notice of Termination

If COBRA coverage is terminated before the maximum coverage period, the Plan Administrator will provide you, your spouse or domestic partner with notice of that termination. The notice will be provided as soon as practicable following the Plan Administrator's determination that continuation coverage shall terminate. The notice should contain:

- the reason why continuation coverage was terminated earlier than the end of the maximum period;
- the date of termination of continuing coverage; and,
- any rights your qualified beneficiaries – i.e., your spouse, domestic partner, dependent children and/or dependent children of a covered domestic partner including your newborn, adopted child or child placed for adoption, if any – may have under the Plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right.

Cost of COBRA Coverage

If you or your family members elect COBRA coverage, you will be required to pay for the cost of that coverage. Under COBRA, the covered person can be charged up to 102% of the cost of coverage. The additional 2% is for administrative fees. If COBRA coverage is continued for an additional 11 months due to Social Security disability, COBRA allows a charge of 150% of the cost of coverage. When a COBRA event occurs, information on the cost of coverage will be included with the COBRA election forms. Each COBRA beneficiary has a right to make an independent COBRA election. Parents or a legal guardian may make the election for minor dependent children who are eligible for COBRA. COBRA payments must be made on time in order for coverage to continue. There is a grace period of 30 days for the regularly scheduled monthly coverage costs. If there is a conversion privilege under the medical, dental or vision coverage options elected under COBRA, conversion to individual coverage is available only upon completion of the 18, 29, or 36-month continuation coverage period that applies.

If you have any questions about COBRA, please contact the Plan Administrator or a MyLife Advisor. Also, if you have changed marital status, or if you, your spouse, domestic partner or dependent children have changed addresses, please notify the Plan Administrator or a MyLife Advisor.

Your Rights Under ERISA

Participants in the Plan (other than State TDI benefits, EAP, HSA, and Dependent Care FSA) are entitled to certain rights and protections under the Employee Rights under the ERISA. They are outlined below.

Your Right to Information About the Plan and Benefits

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, all Plan documents governing the Plan including insurance contracts and a copy of the latest annual report (Form 5500 Series) the Plan has filed with the U.S. Department of Labor. This examination may be done at the Plan Administrator's office and at other specified locations, such as worksites.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD. The charge to cover copying costs will be $.25 per page for any part thereof.
- 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.
- Continue health care coverage for yourself, spouse, domestic partner or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents will be required to pay for this coverage. Review this SPD for the rules governing your COBRA continuation coverage rights.

Requirements for Fiduciaries

In addition to creating rights for participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the employee benefit Plan. These individuals, known as "fiduciaries", have a duty to do so prudently and in the interest of participants and their beneficiaries.

No one may fire or otherwise discriminate against a participant in any way to prevent that participant from obtaining a benefit or exercising rights under ERISA.

Legal Actions

You may not sue on a claim for benefits until you have first completed the claims review/appeal process as provided for in the Plan document. If your claim is for a benefit under one of the Plan's insured arrangements, you should follow the claims procedure described in the insurance carrier's certificate of coverage. If your claim is for a benefit under an arrangement that is not insured (such as the Health Care or Dependent Care FSAs, or a determination as to whether you are eligible to make pre-tax contributions), you should follow the claims procedure described in the section entitled "Flexible Spending Accounts."

Enforcing your rights

If a Plan participant's claim for a Plan benefit is denied or ignored in whole or in part, he or she has 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 the time schedules specified in the Plan's claims procedures. Under ERISA, there are steps that a Plan participant may take to enforce the rights listed above.

- If a Plan participant has a claim for benefits that is denied or ignored, in whole or in part, he or she may file suit in a state or federal court after completing the Plan's claims procedures. You must exhaust the Plan's claims procedures before filing suit.
- If the Plan participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the participant may file suit in federal court.
- If the Plan participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, you may file suit in 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 the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, the participant may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If the Plan participant is successful, the court may order the person who has been sued to pay these costs and fees. If the Plan participant loses and the court finds the claim to be frivolous, the court may order him or her to pay these costs and fees.

Assistance with your questions

If you, your spouse, domestic partner or dependents have any questions about this Plan, you should contact the Plan Administrator.

If you, your spouse, domestic partner or dependent, as Plan participants, have any questions about this statement or his or her rights under ERISA, or if you need assistance 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 Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Facts About the Plan

Plan Name
ADP TotalSource, Inc. Health and Welfare Plan

Plan Number
501

Effective Dates
The original effective date of the Plan was January 1, 1989. The provisions of the Plan as described in this SPD and Plan Document are effective as of January 1, 2018.

Plan Year
Your Plan's records are maintained for a 12-month period of time. This is known as the Plan Year. The Plan Year for the medical, dental, vision, life, AD&PL, disability and FSA benefits begins June 1 and ends May 31.

Employer/Plan Sponsor
ADP TotalSource, Inc.,
10200 Sunset Drive
Miami, Florida 33173
(305) 630-1000
Employer Identification Number: 59-3216484

Plan Administrator
The ADP TotalSource, Inc.
Health and Welfare Benefits Committee
10200 Sunset Drive
Miami, Florida 33173
(305) 630-1000

Trustees of the ADP TotalSource, Inc. Health and Welfare Plan Trust
The Trustees include:
Kristen Appleman, Vice President Health & Wealth
Mark Acquadro, Vice President Finance
Pawan Chhabra, Chief Financial Officer

The Trustees may be contacted at:
ADP TotalSource, Inc.
ATTN: Health and Welfare Benefits Committee
10200 Sunset Drive
Miami, Florida 33173
(305) 630-1000

Fiduciary
The ADP TotalSource, Inc. Health and Welfare Benefits Committee is the named fiduciary for the medical, dental, vision, life, AD&PL, disability and Health Care FSA benefits. All of the benefits under this Plan other than the Health Care and Dependent Care FSAs are insured. Where a benefit is insured, the insurer is the fiduciary for purposes of any payment of claims for benefits.

Claims Decisions
Under the terms of the insurance contracts issued for the benefit options under the Plan (other than the FSA options), the insurance carrier issuing the contract has full discretionary authority to make all benefit decisions concerning eligibility for benefits under the contract, payment of claims or benefits and interpretation of the terms and provisions of the insurance contract. Only the insurance carrier can resolve insurance contract ambiguities, correct errors or omissions in the contract and interpret contract terms. The insurance carrier has the full discretionary authority to interpret, construe and administer the terms of such policies and its decisions are final and binding on all parties.

FSA Claims Administrator
Optum Bank, Inc.
11000 Optum Circle
Eden Prairie, MN 55344
Customer Service (844) 448-0325

Name and Address of Agent for Service of Legal Process
Division Counsel
ADP TotalSource, Inc.
10200 Sunset Drive
Miami, Florida 33173
(305) 630-1000

Service of process may also be made to the Plan Trustee or the Plan Administrator.

Type of Administration

For each of the insured benefit options under the Plan (all benefit options other than the Health Care and Dependent Care FSAs), ADP TotalSource enters into an insurance contract with an insurance carrier. The insurance carrier issuing the contract has full discretionary authority to make all benefit decisions concerning eligibility for benefits under the contract, payment of claims or benefits and interpretation of the terms and provisions of the insurance contract. Only the insurance carrier can resolve insurance contract ambiguities, correct errors or omissions in the contract and interpret contract terms. The insurance carrier has the full discretionary authority to interpret, construe and administer the terms of such policies and its decisions are final and binding on all parties. Neither ADP TotalSource nor The ADP TotalSource, Inc. Health and Welfare Benefits Committee guarantees the payment of any benefit described in an insurance or HMO coverage contract and you must look solely to the insurance carrier or HMO for the payment of benefits. For the benefit options under the Plan that are not insured (the Health Care and Dependent Care FSAs only), the Health and Welfare Benefits Committee reserves the full discretionary authority to interpret and apply the terms and provisions of the Plan documents, including this SPD, to resolve any ambiguities or inconsistencies, to correct any errors or omissions and to make any determinations regarding eligibility to enroll or continue coverage under the Plan.

Decisions made by the Health and Welfare Benefits Committee are final and binding on all parties.

Discretionary Authority

To the extent the operation of one or more of the benefits under the Plan is not governed solely by the terms of the applicable insurance contract, The ADP TotalSource, Inc. Health and Welfare Benefits Committee reserves the full discretionary authority to interpret and apply the terms and provisions of the Plan documents, including this SPD, to resolve any ambiguities or inconsistencies, to correct any errors or omissions and to make any determinations regarding eligibility to enroll or continue coverage under the Plan. Decisions made by The ADP TotalSource, Inc. Health and Welfare Benefits Committee shall be final and binding on all parties.

Plan Administrator

The Plan Administrator has (i) the power and authority in its sole, absolute and uncontrolled discretion to control and manage the operation and administration of the Plan and (ii) all powers necessary to accomplish these purposes.

The Plan Administrator will administer the Plan in accordance with established policies, interpretations, practices, and procedures and in accordance with the requirements of ERISA and other applicable laws. With respect to the Plan, the Plan Administrator has discretion (i) to interpret the terms of the Plan, (ii) to determine factual questions that arise in the course of administering the Plan, (iii) to adopt rules and regulations regarding the administration of the Plan, (iv) to determine the conditions under which benefits become payable under the Plan and (v) to make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan. Subject to any applicable claims procedure, any determination made by the Plan Administrator will be final, conclusive and binding on all parties. The Plan Administrator may delegate all or any portion of its authority to any person or entity.

DESPITE ANY PLAN PROVISION TO THE CONTRARY, THE POLICIES, CONTRACTS OR BOOKLETS FOR EACH UNDERLYING PLAN FEATURE GOVERN THE BENEFITS TO BE PROVIDED, AND THE PROVIDERS FOR EACH PLAN FEATURE ARE RESPONSIBLE FOR MAKING BENEFIT DETERMINATIONS UNDER EACH SUCH PLAN FEATURE, NOT THE PLAN ADMINISTRATOR. IF THERE IS ANY CONFLICT BETWEEN THIS PLAN DOCUMENT AND SUCH POLICIES, CONTRACTS OR BOOKLETS, THEN SUCH OTHER DOCUMENTS WILL CONTROL.

Funding

The medical, dental, vision, basic life and short term and long term disability benefit options under the ADP TotalSource, Inc. Health and Welfare Plan are all fully insured. Group medical, dental, and vision coverage costs are paid with pre-tax employee contributions and employer contributions. Worksite employee and worksite employer contributions towards coverage costs are remitted as premiums directly to the insurance companies issuing the insurance contracts or otherwise used to pay Plan expenses.

ADP TotalSource has established the ADP TotalSource, Inc. Health and Welfare Plan Trust (the "Trust"), a Voluntary Employees' Beneficiary Association (VEBA), for the purpose of providing welfare benefits, including, but not limited to, disability, medical and dental benefits, by defraying reasonable costs of the Plan. The Trust is funded from time to time by demutualization proceeds, settlement proceeds, and assets related to rebates that involve certain insurance carriers that issued policies covering Plan participants.

Amending and Terminating the Plan

ADP TotalSource intends to maintain the ADP TotalSource, Inc. Health and Welfare Plan indefinitely for the benefit of electing worksite employees. However, ADP TotalSource reserves the right, at any time and for any reason, to amend or terminate the Plan or any one or all of the separate options available for worksite employee election under the Plan.

If one or more options are terminated or amended or the entire Plan is terminated or amended, the rights of participants are limited to reimbursement for covered expenses or benefit claims incurred before the amendment or termination of the applicable option or the Plan. Participants do not have vested benefits under the Plan.

Subrogation and Right of Reimbursement

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to all rights of recovery a covered person has against any party potentially responsible for making any payment to a covered person due to a covered person's injury or illness, to the full extent of benefits provided or to be provided by the Plan. In addition, if a covered person receives any payment from any potentially responsible party as a result of an injury or illness, the Plan has the right to recover from, and be reimbursed by, the covered person for all amounts this Plan has paid and will pay as a result of that injury or illness, up to and including the full amount the covered person receives from all potentially responsible parties. A covered person includes, for the purposes of this provision, anyone on whose behalf the Plan pays or provides any benefit, including but not limited to the minor child or dependent of any Plan member or person entitled to receive any benefits from the Plan.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a covered person due to a covered person's injury or illness or any insurance coverage, including but not limited to uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, med-pay coverage, workers' compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

The covered person shall do nothing to prejudice the Plan's subrogation and reimbursement rights and shall, when requested, fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the covered person to notify the Plan within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries sustained by the covered person. Any and all such funds recovered by the covered person shall remain traceable from the responsible party to the covered person and in the hands of the covered person. A covered person shall not dissipate any such funds received before reimbursing the Plan.

The covered person acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential responsible parties and are to be paid to the Plan before any other claim for the covered person's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the covered person which is insufficient to make the covered person whole or to compensate the covered person in part or in whole for the damages sustained. The Plan will pay an equitable portion of the attorneys' fees associated with recovering the covered person's damage claim.

The terms of this entire subrogation and reimbursement provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the covered person identifies the medical benefits the Plan provided. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only.

If any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator has the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Recovery Provisions

Right of the Plans to Recover Improperly Paid Benefits

The Plan has the right to recover an amount paid by it in error. For example, if you receive benefits for a service in error, or you receive benefits from the Plan and from another plan for the same service, the Plan and the Claims Administrator have the right to recover the amount paid to you in error or paid to you by the other plan. You are not permitted to receive total benefits above the cost of the service provided. The same is true if payment is made in excess of the amount that should have been paid under the Plan.

Refund of Overpayments

If benefits are paid under the Plan for expenses incurred, you or any other person or organization that received such payment must refund the overpayment to the Plan if:

- all or some of the expenses incurred were not paid by you or did not legally have to be paid by you, including for example, but not limited to, expenses incurred as a result of fraud; or
- all or some of the payment made under the Plan exceeded the benefits available under the Plan.

The overpayment equals the amount of benefits paid in excess of the amount that should have been paid under the Plan.

If the refund is due from another person or organization, then you agree to assist the ADP TotalSource in obtaining the refund when requested.

If you, or any other person or organization that was paid, do not promptly refund the full amount, the amount owed may be deducted from any future claim reimbursements.

No Guarantee of Tax Consequences

ADP TotalSource does not make any commitment or guarantee that any amounts paid to you or for the benefit of you will be excludable from your gross income for federal or state income employment tax purposes, or that any other federal or state tax treatment will apply to or be available to any participant. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income and employment tax purposes, and to notify ADP TotalSource if you have reason to believe that any such payment is not so excludable.

Severability

If any provision of this SPD is held invalid, unenforceable or inconsistent with any law, regulation or requirement, its invalidity, unenforceability or inconsistency will not affect any other provision of this SPD, and the SPD shall be construed and enforced as if such provision were not a part of the SPD.

Applicable Law

The Plan shall be construed and enforced according to the laws of the state of Florida to the extent not preempted by any federal law.

No Vested Interest

Except for the right to receive any benefit payable under the Plans in regard to a previously incurred claim, no person shall have any right, title, or interest in or to the assets of ADP TotalSource.

Employer Records

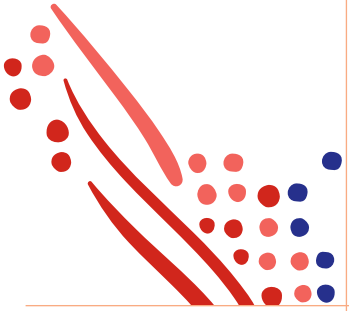
The records of ADP TotalSource with respect to any person's employment, employment history, absences, illnesses, and all other relevant matters are conclusive for plan administration purposes.

Plan is Not an Employment Contract

The Plan will not be construed as a contract for or of employment, nor will it be construed as guaranteeing any terms or conditions of employment.

Notes

Notes



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